Canadian Political Science Review
CPSR
A New Journal of Political Science

Renewing Health Governance: A Case-Study of Newfoundland and Labrador

Dr. Stephen Tomblin and Jeff Braun Jackson *(Memorial University)*[*]

Abstract

There were several new policy reforms and discourses that intersected with the Canadian health public agenda during the 1990s. Despite new circumstances and widespread Pan-Canadian pressure and leadership calling for common health reforms, these transformations across jurisdictions or policy fields were not "inevitable" as often forecast by boosters. Our objective is to better understand the role of local contextual factors (culture, institutions, and interests) and how these have influenced provincial experiences with policy reforms. These contextual factors do not exercise similar degrees of influence upon policy change. Our goal is to explore and evaluate how health care reform evolved in Newfoundland and Labrador (NL).

Introduction

There were several new policy reforms and discourses that intersected with the Canadian health public agenda during the 1990s. Despite new circumstances and widespread Pan-Canadian pressure and leadership calling for common health reforms, these transformations across jurisdictions or policy fields were not "inevitable" as often forecast by boosters. Our objective is to better understand the role of local contextual factors (culture, institutions, and interests) and how these have influenced provincial experiences with policy reforms. These contextual factors do not exercise similar degrees of influence upon policy change. Our goal is to explore and evaluate how health care reform evolved in Newfoundland and Labrador (NL). Our case-study was part of a larger national, cross-provincial research project that analyzed the key elements of health policy change, or lack thereof.

[*] *Stephen G. Tomblin, Department of Political Science, Memorial University of Newfoundland, St. John's, NL A1B 3X9 Canada stomblin@mun.ca and Jeff Braun Jackson, Department of Political Science and Women's Studies, Memorial University of Newfoundland, St. John's, NL A1B 3X9 Canada jjackson@morgan.mun.ca*

The literature on policy innovation and reform suggests that "policies are not the inevitable product of economic or social conditions. They are formulated, adopted and consolidated through intellectual debate, political struggle and administrative planning. Each stage of the process involves disputes over relevant problems and feasible solutions among individuals and groups mobilized to shape the policy agenda."[1] Understanding these dynamics across jurisdictions requires knowing what is going on at the grass roots level.

The dynamics of Canadian health public policy change involve learning more about the context and interplay among ideas, institutions, and interests. The key to our case-study is to map out the contextual factors that explain different patterns of state-society relations and health policy traditions within Newfoundland and Labrador. While there has been much academic discussion of the dynamic drivers and constraints that have shaped national policy innovation during periods of crisis and protest, there has been much less focus on examining policy innovation dynamics within specific jurisdictions such as provinces.

What sets Canada apart from most modern-industrial countries is its unique system of province-building and decentralization. Effecting universal-national policy transformation has always been a challenge in Canada, and this helps explain why National Policies were abandoned in the 1980s.[2] As illustrated by various implementation challenges connected with H1N1 flu vaccination, it is not always easy to get everyone singing from the same hymn book.

It has always been very difficult to define national problems in the context of a highly decentralized federal system, where both provinces and health professionals (public and private) enjoy much autonomy and independence. To be sure, these professional interests operate either as agents for competing provincial states, or as entrepreneurs in competitive markets or multi-level systems of governance. There is much we still do not know about how contextual factors, such as intergovernmental, interdepartmental and inter-professional relations shape the pace and direction of technical-political reforms.

In the past, policy debates have tended to ignore the narrow limits for reform set by contextual conditions. For example, past modernization theorists (popular during the second National Policy), argued that federalism had become obsolete in an era of central planning. But this never happened in Canada where province-building and federalism thrived. For example, the historical-institutional literature on province-building provided a number of critical insights on how embedded ideas, interests, and institutions shaped the pace and direction of technical-political change and restructuring. [3] These fundamental debates over state-society relations are critical to our analysis.

We do not assume that change is "inevitable" and our intent is to focus more on how local contextual factors have either facilitated or constrained new reforms. Our discussion is designed to place reform ideas, interests, and institutions in historical-institutional context by exploring the dynamics of policy change.

In the beginning, the NL case-study was designed to examine policy innovation across different policy categories. It was part of a larger Canadian Institute for Health Research (CIHR) comparative provincial studies on policy reform.[4] Regionalization was the only policy reform to succeed in Newfoundland and Labrador. Emphasis in this paper is focussed on understanding the critical factors and conditions that helped explain why regionalization emerged on the public

agenda albeit within a narrow framework. We assume that once governance structures and processes exist, even if there is some kind of crisis requiring action, we cannot predict future patterns of reform without carefully considering the internal conditions and institutional configurations that shape the way different societies respond to political problems. We will also briefly consider why the other health reforms were never embraced or institutionalized.

We began by relying upon pertinent documents (archives, grey literature, Hansard, media reports) to provide a map or outline of critical reform issues that mattered in the 1990s. Key insights were generated from data obtained from face-to-face and telephone interviews conducted between September, 2004 and March, 2005. A total of 30 individuals were interviewed for times varying from 40 to 110 minutes in duration. The individuals were selected based on their current or past participation in the health policy community in Newfoundland and Labrador since 1990. Persons are currently or were members of regional health authorities (RHAs), politicians, civil servants, members of interest groups, health professionals and union leaders. Interviews were recorded on audio tape and transcribed by an individual hired for that purpose. Twenty-eight interviews were conducted by Tomblin and Braun-Jackson completed the remainder. Braun-Jackson reviewed the transcripts for all interviews and checked them for accuracy. All participants were given the opportunity to review their individual transcript prior to coding and analysis. Participants were free to participate or not and were provided with a description of any possible harm that could occur if they participated in the project.

Analysis was carried out using QSR N6 software. Transcripts were loaded into data files and were coded based on a template supplied by John Lavis, head of the Ontario research team for the project. We wanted to know more about the constraints and drivers generated by local conditions, including competing actors, structures, ideas, technical knowledge and capacity and how these determined the ability of leaders to advance new agendas, mobilize coalition support, and embed a technical-political fix through legislation.

Transformation and Change

The literature in political science offers competing intellectual constructs for understanding patterns of policy reform. These competing state-society theories offer different ways for analyzing and capturing key factors that influence policy reforms or outcomes. From an institutional perspective, state capacity and autonomy matter most. The clear consensus from our participants was that the main reason regionalization was pushed onto the public agenda so fiercely had much to do with the institutional incentives involved, and opportunities available, to construct provincial ideas and build coalition support.

Regionalization emerged in response to the fiscal imperative as well as increasing social diversity. But we were also told that regionalization was understood to be very flexible as a political tool. It had also been employed in very different critiques over time, so there was an opportunity to defend core traditions. Regionalization as a concept or theory of restructuring has emerged repeatedly in NL. Yet, economic, health, municipal, education and other sub-provincial regional experiments remained in separate orbits and never became very integrated or powerful across policy silos. This undermined any potential threat to the premiers from the grass roots level.

World of its Own: Perceptions and Realities Confronted

In the case of privatization, waiting list reform, alternative systems of payment, drug reform, and needs-based budgeting, there were simply fewer political incentives or resources to anchor competing frameworks that would be both viable and popular. NL is a province that has not witnessed much legislative health reform nor does it have strong historical tradition of building and strengthening essential modern civil society institutions.[5]

When NL joined Canada in 1949, several formal institutions were started anew or recreated in an effort to quickly become more industrial and modern. For example, the municipal system of government was not well advanced, and provincial subsidies and programs helped expand the program thereafter. There was not even a pan-provincial highway system necessary to create a more integrated provincial economy. NL, in 1949, lacked critical policy capacity, market capitalist and democratic traditions. The province did not have the kind of civil society, organizations, networks, or systems of integrated communication normally associated with transformation or big bang change.

From 1949 to 1972, Joey Smallwood took full advantage of these historical divisions to impose a policy of modernization that pitted urban against rural communities. These conditions helped mobilize a more independent, province-centred vision under the Progressive Conservative party that was led first by Frank Moores and then Brian Peckford.

For much of its history, the NL has been deeply divided internally (church, economy) and there are embedded competing expectations and political experiences that have made it very difficult to renew governance and then get a consensus on key technical-political issues. These embedded traditions have added much to the challenge of building trust for big bang policy changes. Under these circumstances, it is no wonder that getting a policy consensus for various health reforms has been difficult.

As we know in developing countries, transformations and policy restructuring are greatly influenced by dissimilar political and academic resources and experiences. NL began socially and economically far behind other provinces and inherited different divisions and historical realities. There was not even a degree-granting research institution to generate political-technical solutions, facilitate public policy discussions, data management, consensus, integration, or knowledge transfer across rural-urban communities until 1949. Nor was there much opportunity to ensure that local problems and dissimilar contexts were accurately reflected in new policy, concepts, frameworks, or political visions that were developed and imposed externally.

In fact, the combination of powerful leaders and sense of isolation have reinforced much focus on the need for provincial self-reliance and territorial self-determination as opposed to adopting common approaches to policy reform based on the experiences of other jurisdictions. Several of our informants suggested that NL has it own unique brand of province-building and suspicion of top-down, urban-biased, universal calls for transformation. NL is a place where there is much public cynicism of outside experts and it is not easy for bureaucratic or political elites to launch new ideas, frame questions, reduce or build coalition support, or gain citizen trust. It is a political game that is highly decentralized. Rhetoric is a more likely response than big bang change.

During the early years of settlement, Protestant and Catholic communities operated for the most part in their own orbits.[6] Only with the final collapse of religious control over education and health policy in the 1990s did conditions and public pathways fully emerge. These institutional aspects of provincial government remained underdeveloped for decades. Predictably, an internal dualism between townies[7] and outports has always made it difficult to work together based on a common vision and build interactive learning networks. In such a context, it is no surprise that picking common external enemies designed to unite the province has proven to be a popular political strategy.

Viewed historically, Confederation was sold as a way to break the power of the merchants and other elites through the rise of the welfare state. But there is little empirical evidence to suggest that the first NL government was strongly committed to policy experimentation. For the most part, debates over Confederation focused more on external than internal forces. While Smallwood was a modernization booster, he operated in a period when he received generous federal transfers with few conditions attached. He was a very dominant premier and never built a very sophisticated planning structure - certainly not one capable of promoting new forms of integration, contestation, and interaction.

In the early 1970s, such a personalized, populist approach to governance was replaced by a neo-nationalist group of reformers who were determined to be "masters in their own house." It was a time of bureaucratic expansion, and Newfoundland's own "Quiet Revolution." But because of challenges associated with internal divisions, limited resources, the decline of the cod fishery, and other changes, renewing governance proved to be a daunting task.

Policy collaboration and networking across territorial lines or policy fields has remained underdeveloped in NL. Agenda setting has tended to be dominated by powerful premiers. The departmentalized nature of provincial government coupled with the construction of unconnected economic, health, education, and municipal regions have created other barriers.

In our study of change or lack thereof, regionalization stands out. Viewed in historical context, however, the regional idea is not a radical notion, especially when you consider the number of regional experiments that have taken place in municipal, education, economic and even Atlantic Canadian/Eastern Premiers regional initiatives. Regional integration as a domestic reform idea has emerged often in dissimilar multi-level NL governance debates. While the regional idea has proven to be popular at the agenda-setting stage, from a governance perspective at least, these regional silos have contributed little to the goal of steering effectively, or integrating communities. At the Atlantic Canada regional level, the idea has been more controversial. For example, Joey Smallwood left the regional experiment in a spat over fiscal federalism, and Premier Peckford argued that the concept of Atlantic Canada was a myth and he instructed his Deputy Ministers to never accept the idea of Atlantic cooperation. [8] It is worth noting regionalization within NL is about devolving power and respecting social diversity. Atlantic Canada approaches reinforce holding common perspectives at the executive level. These are very different objectives and work at cross-purposes. Only in the case of regionalization, when the provincial state had a keen interest in defending itself politically from federal cuts was there much interest in establishing health regions through legislation. As in other parts of the country, the provincial government was hoping to download some of the blame for cutting rural hospitals and delisting services. While communities got more power, the provincial government managed to survive the "blame game."

Viewed historically, the regional idea was not a new idea in Canada or NL. While there were attempts to devolve power to the regions, it also helped facilitate the closing of rural buildings and services, in a way that was homogenizing, yet reduced political blame. On the other hand, the regional strategy also helped consolidate power in mega-regions and service-based economies that were being pushed by Industry Canada and economic development departments at the provincial level.

For example, the Eastern Regional Health Authority had a budget of nearly $1 billion and has always employed more people than the offshore oil and gas sectors ever did. This pattern of consolidation of services has also appeared repeatedly in Gander, Corner Brook and other regional centers. Despite these new realities, the fact that the regional vision has remained ambiguous and slippery (with limited citizen engagement) has added much to its political appeal and sustainability. When it comes to regional planning, provincial government actors maintain much more control over incremental decision-making in comparison to launching a new program of privatization.

For the most part, regionalization as a reform game operated with a different set of conditions, interests, expectations, and opportunities for the provincial government and other supporters of the status quo. It was by no means a radically new idea and was popular in most political camps. Viewed from this perspective, there were many incentives to champion limited regional reforms. Put simply, there were few political risks involved.

Big bang changes are always possible in times of crisis, but this requires new ideas, with motivated leaders capable of building and sustaining a new regime. For example, the medical profession has operated in its own system of service delivery and these partners enjoyed much independence and autonomy in the old state-society system of interfacing. The same could be said about drug companies and other private sector actors. In NL, regionalization did bring about change, but these changes were a reflection of contextual factors too. Inevitable changes never really emerged and the autonomy and power of old regimes were accommodated. Regional reforms were primarily a product of the fiscal crisis, but they also demonstrated a need to strike a balance in governance that was not only viable but created an alternative avenue to organize public-private interactions within the province.

Policy-Political Context: Historical Overview

NL is well known for its underdeveloped political-policy institutions, fragmented, small scale, staple-based communities, dualistic political culture/economy, island traditions and history of external dependency on the national state. “The questions of integration and whether it is worth sacrificing home rule for industrial capitalism have a long tumultuous history in the province. The fact that Newfoundlanders have been divided on these issues, since they rejected the 1867 integration option helps us to understand their strong opinions”[9] against externally concocted technical or “mainland” political frameworks. As one would expect, this has made it difficult to get a consensus or impose universal changes.[10] Thus, since most empirical policy issues and debates have traditionally focused more on urban rather than rural problems, from a historical perspective at least, transformative debates have played out differently in rural as opposed to more urban communities.[11]

One of our central tasks is to understand why getting a broad consensus on health care reform has been so difficult in the NL political context. Regionalization was the only area where reform occurred. However, there was a complete lack of reform for waiting list management, drug reform, privatization, needs-based budgeting, and alternative systems of payment.

Achieving a consensus is never easy for any deeply divided society. The fact that rural areas rely more on international doctors than urban centers added further to the challenge of consensus making and communication. A number of our informants felt that getting a consensus across communities, policy fields, or even functionally designed departments was never easy, even when there were powerful external drivers and pressure for change. On the other hand, we were told that in the context of a province-centred political and media game that was historically built and sustained more by territorial ideas, interests, and institutions than functional ones, it was only logical that certain types of reforms were more easily pushed onto the agenda. In fact, some of the more functional challenges or problems (such as needs-based budgeting) only survived because they became connected with the regional and territorial power- sharing game.

Historically, at least until 2003, the Liberals tended to over-represent rural communities, while the Progressive Conservatives received stronger political support in urban areas. Smallwood sold the Canadian social welfare state as a means to break the power of urban elites and put money directly into families and communities.[12] In such a game, it has been politically difficult to generate and mobilize support for collaborative, integrated policy innovations pushed by technocrats. Regionalization was the only idea that appeared politically viable.

NL is well known for its intense internal cultural, institutional, bureaucratic divisions, decentralization and incremental traditions. The 1990s was a period of intense provincial conflict, rise of a regionalized party system, New Public Management (NPM), and various unilateral cuts in federal transfers. Seen this way, there were good reasons why the abandonment of national policies and responsibilities and push for "big bang" changes created much confusion and controversy for decision-makers and other interests who played for different audiences.

Our informants suggested that people in NL were not convinced that "big bang" policy changes (whether in health or economic development) were inevitable or even desirable. There was also much confusion and ambiguity surrounding NPM initiatives, commitment to weaken the state, while improving efficiencies and strengthening market capacity.

Our data show there were different perspectives on potential winners and losers from big bang health changes, and increasing the power of technocrats. Our interviewees clearly revealed that regionalization already had a presence and it was an easy fit for those seeking new popular alternative reforms. The other reform frameworks had fewer drivers and faced more communication challenges.

Only in the case of regionalization were there sufficient technical-political incentives, knowledge, resources and interest in mobilizing policy change across rural and urban communities and enhancing social learning. Only with regionalization was there sufficient coalition support, and leadership essential for bringing rural-urban interests together. All of this

made it possible to construct common agendas, and find ways to collaborate and effect change in a way that better reflected local values and experiences.

Regionalization proved to be a very popular notion and regional forms of community involvement and governance had already captured much attention in past debates over municipal, education, and economic development restructuring. Regionalization was seen as being very much connected with citizen and community forms of engagement and power-sharing. By design, regionalization was not perceived as an external threat, but rather was seen as a provincial compromise that was doable. The provincial state was always, according to the plan, to be in charge. But the old system of professional and market autonomy was not attacked either. As a result, regionalization was perceived as a win-win rather than winner take all proposition.

Reform in Historical-Institutional Context

The 1990s were not good times for NL. The collapse of the cod fishery, battles over Meech Lake Accord and changes to the federal unemployment insurance program all resulted in a constant outpouring of human capital from rural areas to other provinces, especially Alberta. Comparable to much of Eastern Europe in the 1990s or perhaps Quebec before the Quiet Revolution, there has been a constant struggle in NL over transformation, building and sustaining market, state and other policy instruments considered essential for success in a new regime. Nor has it been easy to effect change in a federal and party context that facilitates the construction of separate worlds, where premiers play for very different audiences. Even in NL today, Premier Danny Williams' popularity comes from being the defender of the underdog, the average citizen against the federal government, big companies, and external experts who are, by definition, often perceived as enemies and exploiters of the province. Populism remains a powerful cultural force in Newfoundland and Labrador politics.

From an historical path dependency perspective, NL did not really benefit very much by institutionalizing new frameworks or mental maps designed by external universal thinkers.[13] These are the memories that were handed down from one premier to the next and we were told by our informants that such traditions in the game worked against any outside calls for universal-technical fixes that totally ignored past historical experiences. Newfoundland and Labrador is a place where strong leadership and populist strategies have helped fill the gap. Simply put, achieving a consensus across the rural-urban divide has never been easily resolved or debated in NL. When compared with other provinces, NL lacks the kind of formal structures, knowledge networks, and policy brokers that exist in other jurisdictions. While some of this was being addressed in the 1990s, since the change of government in 2003, less emphasis has been placed on developing or building civil society capacity and new forms of engagement and social learning.

Regionalism: Case-study

The only health policy field where formal reform occurred was regionalization. The key driver for big bang change was Premier Clyde Wells' response to a fiscal crisis which threatened the future of the province. Indeed, from the start, the problem of fragmentation and the fiscal imperative was raising questions about the sustainability of the entire provincial health care

system and province-building generally. There was much at stake as key supporters of the provincial state had no choice but to defend and promote their shared territorial and jurisdictional interests against New Public Management (NPM) calls for reform and transformation. Viewed this way, regionalization was really an attempt to deal with new circumstances based on the needs and priorities of NL provincial state. It was the only reform initiative that had sufficient political and coalition support to be viable.

From the beginning of negotiations, certain powerful interests were well protected (especially drug companies and doctors who never fell under the regional orbit). On the other hand, we were told that these types of regional reforms would have been more difficult to achieve, had the media or opposition focussed more on the power of the market or private practice in health services. But this was most unlikely in an era of NPM. The combination of drug companies, doctors, and the provincial state working together in a powerful reform coalition guaranteed that regional reforms would be implemented and accepted. The pace and direction of reform stayed under provincial control but it was also constructed with key stakeholders, and communities being granted much autonomy and independence. For the most part, these regional structures and mechanisms have not encouraged much civic engagement. And as illustrated by the recent Cameron inquiry on breast cancer detection that was appointed by Premier Williams, regional health authorities in NL have not been very transparent or patient-centred.

Our informants suggested several factors influenced the push for regionalization. First, as noted above, the regional idea was very popular in 1990s and evident in campaigns for regionalizing education, municipal, and economic development services. It also helped that during the Smallwood years there was a provincially commissioned study calling for health regions. [14]

Another key driver for regional reforms was the fiscal crisis that threatened the status quo and existing provincial ideas, institutions, and powerful interests. Regionalization and provincial sustainability were also critical themes and our informants argued there was much incentive to respond and find new province-centred solutions that reflected core values. The Wells government established a Resource Committee to review the state of the health system in 1990. Members of this committee were drawn from the Newfoundland and Labrador Medical Association, the Newfoundland and Labrador Hospital and Nursing Home Association, the Association of Registered Nurses of Newfoundland, the Faculty of Medicine at Memorial University and the provincial Department of Health. The urge to embrace regionalization as a panacea for rocketing health care costs was driven primarily by fiscal concerns and pressure for shared knowledge and finding ways to respect community diversity while improving health outcomes everywhere in the province.[15]

In an effort to gain provincial control over the reform process and champion the regional cause, Health Minister Decker appointed Lucy Dobbin (a former CEO of St. Clare's Hospital in St. John's) to chair a commission to review how hospital boards could be reorganized. In March, 1993, the *Report on the Reduction of Hospital Boards* was released.[16]

In the first stage of regionalization, government established two types of health boards: institutional and integrated. The institutional boards were responsible for the delivery of medical services through hospitals and clinics in each region. Integrated boards combined the functions of the institutional boards with community and social service programs provided to

the population within the region. Beginning in 1998, a third type of board was created. Health and community service boards were created to administer health prevention, promotion, child welfare, addiction, mental health and other programs within the province. The adoption of such boards followed the make over of the Department of Health into a new Department of Health and Community Services. The new department assumed responsibility for some functions previously under the rubric of the Department of Human Resources and Employment.

When regionalization was embraced by the Wells government in 1993, the primary reasons given were to provide improved continuity of health care and to avoid costly duplication. The intent was to build regional capacity in a way that struck a balance between rural equity and urban efficiency. The main driver behind regionalization was fiscal; that is, the government wanted to reign in health spending without disruption to basic service delivery in both rural and urban communities. Health regions helped download political responsibility and accountability for health restructuring and this, according to our informants, was important to politicians.

The Department of Health and Community Services transferred responsibility for health care delivery to the boards while monopolizing policy-making. Before the boards were in place, the Department directly managed nearly twenty cottage hospitals. These were replaced or closed down entirely with the advent of regionalization. While the government did retain some degree of control over the health boards with respect to budgets and appointments, the boards were deemed to be primarily responsible for providing services to patients.

The most recent round of reforms connected to regionalization formally began in 2003 when the Progressive Conservative Party of Newfoundland and Labrador, led by Danny Williams, won the provincial election. Williams laid out his party's policy platform in the "Blue Book." Many of the proposals were targeted toward reducing the debt and deficit of the provincial government. The Department of Health and Community Services was not exempt from the desire to reduce the size and expenditure of government. Regional boundaries and structures were changed in a bid to reduce the number of health regions and to create one regional model. For the most part, regionalization was about decentralization; that is, it never threatened to impose a more integrated vision on doctors, drug companies, or other supporters of the status quo.

While regionalization was about consolidation of urban power and medical specialization, the movement also had strong appeal in a period of fiscal crisis. From a pluralist perspective, the pace and direction of change was the result of a new interplay between the provincial state and key interests such as drug companies and doctors who helped influence the pace and direction of reform. While regionalization resulted in some changes in management and rhetoric, these were hardly radical, and the power of the state, and other key stakeholders (especially doctors and drug companies) were for the most part, unaffected.

Failure of Other Health Care Reforms

According to information gleaned from informants, none of the other reform issues came close to attracting the same level of attention, resources, or consensus that regionalization did. No other movement had the capacity, political support, or autonomy required to organize and replace formal ideas, institutions, and interests.

Remarkably, much of the pressure for change in the other policy fields was perceived more as external, technical, or peripheral (a mainland problem at best). Our participants argued that waiting list reform, for example, was seen as a product of pressure by policy institutes, or insular federal-provincial meetings that were dominated by bigger provinces and their experts.

Similarly, our informants argued that other calls for reform were either too big or expensive. The problem of maintenance and recruitment, for example, made it very difficult to get too excited about new technical reforms that were unsustainable politically or economically. There was also a sense that only regionalization made sense politically while other reforms (needs-based, for-profit, and waiting list) were perceived as having an urban bias and would end up either diverting resources for urban-technological problems or ignoring rural health challenges entirely. According to decision-makers, these reforms were not seen as solutions capable of building broad coalition-support in the way that regionalization did.

Similarly, we were informed that support for privatization came primarily from private interests who operated in competitive markets. But given the more diverse, and pluralistic NL political context, building a consensus was more difficult and these reforms failed to gain political champions for the cause in quite the same way Clyde Wells stepped forward to pursue regionalization. Other than regionalization, there emerged no clear consensus on whether other health reforms were sustainable, or would likely improve patient and system outcomes.

The fact that rural areas were dominated by international, salary-based doctors, while physicians in urban areas were remunerated on a fee-for service basis, clearly made getting a consensus across competitive political parties, regions, or professions more difficult. Only in the case of regionalization (where there were entrenched traditions of territorial ideas, community interests, and institutions) was it possible to build broad support.

An underlying reform constraint was the problem of working around the urban-rural divide and finding an appropriate balance. Since most specialized services are located in St. John's, there are problems associated with spending money there and building knowledge and service-based economic capacity. Similar challenges occur in other health regions. As suggested by one informant, "I know there's competition here, there is a stress, a tension between the amount of money that goes into St. John's and the amount that goes elsewhere"[17]. There is a tradition of exploiting strong executive leadership (during times of crisis) for the purpose of striking a more reasonable political compromise.

Summary of reforms in other health policy fields

Based on our interviews, we can conclude that with the exception of regionalization, health reform was an issue that did not have much local interest or support. On the other hand, there have been informal reforms and pilot projects that were occasionally externally funded or inspired. In practice, there has never been a provincial crisis big enough to force all health reforms across all pathways or silos. Informal, incremental changes have remained a popular option available in NL and a convenient way to solve problems without invoking rural-urban or professional divisions. We review the reasons for the failure of other forms of health care reform to germinate in NL below.

Wait List Management

Newfoundland and Labrador does not have a formal system for wait list tracking and management found in other jurisdictions. There has never been an attempt to establish or erect the kind of province-centred formal policy instruments required to define the problem of waiting lists, measure it, produce a framework or guide to frame responses, or measure outcomes. Rather, the provincial government has typically relied on informal networks of physicians and surgeons to manage patient flows. Wait list management, while acknowledged as a significant concern, has not seized the attention of decision-makers. Why was there not more pressure to establish a formal waiting list system? Our informants noted that (1) interest in the issue was only triggered by external forces such as federal government reports, experimentation in other provinces and media reports on citizen frustration concerning medical procedures; (2) the issue was localized to St. John's only and (3) the ad hoc management of patient lists by physicians and surgeons reinforces separate silos, cultures and interests. What exists in NL is not only a highly decentralized, diffused, territorial system of delivery, but separate silos or systems for managing and delivering cardiac, mental health, long-term care, and other programs.

In the case of Newfoundland and Labrador, we can conclude that "one size does not fit all" when it comes to managing wait lists. With its small population, poor fiscal capacity, limited number of physicians and specialists and tertiary medical care confined to the capital region, it may simply be too expensive to create a formalized waiting list system. Besides, NL is a place with a long tradition of diffusion, decentralization, and community-silo based approaches to problem definition and resolution. Waiting list reform has never attracted much domestic attention or sense of crisis among local stakeholders, politicians, and health institutions. The opportunities for civic engagement have been limited and it is an issue that is very complex and technical, and as a result, has not attracted much media interest. There is more evidence of divergence than convergence in this area of health restructuring, and little evidence that it made sense to develop one model for waiting list reform. Currently there are no champions of waiting list reform in the province either building coalition or public support.

For Profit Delivery of Medical Services

The issue of privatizing and introducing for-profit medical and hospital services in NL has dimly pierced the policy radar. Since the 1990s, no government has passed legislation, held public hearings or commissioned research to study this issue in a formal manner. Our informants noted the main reasons for this were (1) widespread poverty and regional economic disparity within the province; (2) no groups acting as policy champions; (3) the limited policy capacity of the provincial Department of Health and Community Services and (4) the lack of support among physicians for privatization of medical and hospital services. There is not much interest in for-profit delivery of medical services for two reasons. First, it is difficult to sustain a for-profit health care system given the small population and socio-economic status of the province's people. Regime changes do not occur when there is not an alternative set of ideas, interests and institutions capable of taking over and dealing with new circumstances. Without this capacity, there would be little reason for change. Second, discussions about private, for-profit medicine in the province raise the ire of several key groups of opinion makers including physicians, health care unions, nurses, academics, and some politicians. Other than experiments with public-

private partnerships in the area of long-term care, there has not been anything approaching an Alberta-style call for health privatization.

Prescription Drug Reform

A significant factor for the lack of a universal prescription drug program in NL is cost. Currently under the province's targeted drug plan, approximately 110,000 persons are provided catastrophic coverage at a cost of $114 million (fiscal year 2005). This represents twenty percent of the population. This group consumes approximately 40 percent of all the prescription drugs purchased across the province.

A related theme concerns equity in drug coverage with respect to new therapies.

In Newfoundland and Labrador, particular "champions" have emerged to lobby government to include specific therapies in the formulary for individuals who either cannot afford them or for those persons whose private drug plans do not cover any or all of the costs. Groups such as the Cancer Society and the Arthritis Society usually rely on the mass media to publicize cases where patients are needlessly suffering because they cannot afford the necessary therapy. The kinds of policy choices made by the provincial government with respect to drug reform are largely focused on sustaining the current targeted program rather than finding ways to renew governance and build new networks.

There have not been any formal institutional or legislative acts with respect to the province's targeted drug plan. Reform, when it has occurred, has been incremental, reactive rather than proactive, and forced on government as a result of national commissions and reports and internally by the mass media on behalf of disease-advocacy groups. Lack of provincial fiscal capacity, independence and autonomy has not helped push drug reform onto the public agenda, and internal divisions within the province have undermined any chance for building coalition or social network support for a new vision for NL.

Needs-Based Budgeting

While there has been some interest in establishing a more needs-based approach to budgeting in NL, there is also a lack of political will. Needs-based discourses and frameworks offer a different approach for balancing equity-efficiency issues than market models, but there is still much confusion about how this vision would work in practice. Change or lack of change is often a product of crisis connected with new circumstances, but effective transformation depends on leadership and coalition mobilization around a clear vision. Needs-based budgeting visions lack critical details.

The fundamental reason why Newfoundland and Labrador is a "no go" with respect to budgetary reform in health care is because elected officials desire a degree of political control over how health resources are distributed. Decision-makers are reluctant to move toward a system that allocates funds based on a flexible, even ambiguous definition of need. From their perspective, since they do not have much control over drug costs, maintenance and recruitment, medical ethics, research, federal fiscal transfers and other factors that shape the pace and direction of health restructuring and agenda-setting, it is not surprising decision-makers would be reluctant to cede power and autonomy without getting some assurances that

changes would be in the public good. At this stage, there remains much ambiguity about how needs would be calculated and who the winners and losers would be.

Given what is at stake for the economy, and the rural-urban tensions involved, it is not surprising that getting a political and academic consensus over these kinds of reforms have been difficult. In many parts of rural Newfoundland, for example, ecological health is a bigger need than population health. That being said equalization and various components of the welfare state have been designed to define need on the basis of territory, not function. Since more poor people live in big cities than poor provinces, it seems logical that choice of policy instruments and patterns of discourse do influence outcomes and the course of problem definition. Under such circumstances, certain stakeholders may prefer the status quo to new patterns of transformation.

Government did not embrace a population-based funding model mainly because it would remove further political control from the funding process; government lacks the policy capacity to move forward on this issue; this particular funding method is difficult to implement; politicians are motivated by the mobilization of public opinion and not by objective indicators of health and that the province's small population and geography make a population-based model unfeasible.

Alternative Physician Payment

The model for primary care renewal in Newfoundland and Labrador evolved from the province's Strategic Health Plan in consultation with health professionals, physicians, regional health boards, community groups and government officials. The focus has been on physician recruitment and retention especially in rural areas rather than on models of payment. In fact, Newfoundland and Labrador has the highest rate of salaried doctors in Canada. In our study, payment models and primary health care intersected around 2000 due to government's interest in keeping the health care system sustainable.

We argue that the chief barrier to primary health care reform in Newfoundland and Labrador is an acceptable payment model for physician buy-in and support. Other barriers include health human resource issues (scopes of practice, opportunities for clinical and educational training, payment for emergency room services), lack of support in rural areas and the inability of government to provide adequate financial resources for project implementation.

The focus on physician recruitment and retention places government in a subordinate position vis-à-vis doctors because of labour mobility. If government fails to provide suitable compensation, incentives to practice in rural areas, opportunities to update skills and the like, then physicians will relocate to jurisdictions where they will be better compensated. Herein lays the power of the doctors and why the NL government finds itself constrained from doing anything about it. Whether in alternative systems of payment or regionalization, the power of the physician is an important constraint on public policy choices in NL.

Conclusion

With the exception of regionalization, NL is a laggard when it came to formal health policy change. It is a place known for too much geography and internal divisions. NL is also known for

its territorial competitiveness and capacity for seeing and understanding regional issues and conflicts. In the case of regionalization, a common sense of a province-centred crisis and territorially based system of organization helped push the issue onto the public agenda. Put simply, there was much territorial leadership and biases for building regional capacity across professional/community partnerships and networks. But these were carefully designed to not challenge the power or autonomy of doctors and drug interests. In the end, the bio-medical and territorial model was well defended.

In the other case-studies, there were few formal-legislation changes at all. The main difference was that there was a lack of leadership and no sense of immediate province-based crisis or conditions necessary for promoting and sustaining alternative ideas, interests, and institutions. Within a poor, divided, small province, there was little opportunity or incentive to deal with issues that tended to be viewed as an "external" problem. For the most part, internal divisions, lack of resources and public policy traditions have added much to the NL reputation as a policy laggard.

Endnotes

[1] Neil Bradford, Commissioning Ideas (Don Mills: University of Oxford Press, 1998). Pp.8-9.

[2] Ibid., 7-8.

[3] For further discussion see Alan Cairns, *Reconfigurations: Canadian Citizenship & Constitutional Change* (Toronto:McClelland & Stewart, 1995).

[4] . The comparative provincial study focused on health care policy across five provinces (Alberta; Saskatchewan; Ontario; Québec and Newfoundland and Labrador) and six fields (regionalization; needs-based management; drug reform; alternative systems of payment and privatization).

[5] For further discussion on the challenges of policy-political homogenization see Gabriel and Sidney Verba, the *Civic Culture* (Boston: Little Brown and Company, 1965); Margaret Conrad, "The Atlantic of the 1950's" in Berkely Flemming, ed., Beyond Anger and Longing: Community and Development in Atlantic Canada (Fredericton: Acadiensis, 1988); Peter and Rosemary Ommer, *Power and Restructuring: Canada's Coastal Society and Environment* (St. John's Institute of Social Economic Research); Peter Sinclair, editor, *A Question of Survival* (St. John's: Institute of Social Economic Research, 1988); David Alexander, Atlantic and Confederation (Toronto: University of Toronto Press, 1983); Raymond Blake, *Canadians at Last: Canada Integrates Newfoundland as a Province* (Toronto: University of Toronto Press, 1994); James Hillier and Peter Neary, Newfoundland in the 19th and 20th Centuries (Toronto: University of Toronto Press, 1980).

[6] For details, see Ian D.H. McDonald, edited by J.K. Hillier. *To Each His Own: William Coaker and the Fisherman's Protective Union in Newfoundland Politics, 1908-1925.* (St. John's: Institute of Social Economic Research, 1987).

[7] . This term refers to those persons born and raised in St. John's. Those born and raised in Newfoundland's outport or coastal communities are referred to as "baymen/baywomen."

[8] Tomblin. S Ottawa and the Outer Provinces. (Toronto: Lorimer Press, 1995) Chapter 3.

[9] See Stephen Tomblin, Ottawa and the Outer Provinces (Toronto: Lorimer Press, 1995). Pp67-68.

[10] John Wilson, "The Canadian Political Cultures," *Canadian Journal of Political Science 7* (1974) pp. 438-83; S.J.R. Noel, "Leadership and Clientelism," in David Bellamy et. al., editors, *The Provincial Political Systems* (Toronto: Methuen Press, 1976); David Elkins and Richard Simeon, "Regional Political Cultures in David Elkins and Richard Simeon, eds., *Small* Worlds (Toronto: Methuen Press, 1980).

[11] For further details, see David Freshwater and Stephen G. Tomblin, "Making Sense of Changing Realties in the "Uncharted Fringe," in Godfrey Baldacchino, Rob Greenwood, and Larry Felt, editors, *Remote*

Control: Governance Lessons for and from Small, Insular, and Remote Regions (St. John's: Institute of Social Economic Research (ISER), 2009).

[12] . The St. John's merchants were the traditional political and economic elites in both pre and early post-Confederation Newfoundland.

[13] See P. Pierson, *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment.* (Cambridge: Cambridge University Press, 1994).

[14] Government of Newfoundland and Labrador. *Royal Commission on Health.* Chair: Right Honourable Lord Brain. St. John's, NL: The Queen's Printer, 1966.

[15] Ingrid Botting. *Health Restructuring and Privatization from a Woman's Perspective in Newfoundland and Labrador.* St. John's, NL: Memorial University Coasts Under Stress Project, 2000.

[16] Dobbin, Lucy C. *Report on the Reduction of Hospital Boards.* St. John's, NL: Queen's Printer, 1993.

[17] . Respondent 3.