CAPACITY, COSTS, AND CONTROL:

Health Care Policy in Manitoba from 1948 to 1988

BY

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A Thesis
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DOCTOR OF PHILOSOPHY

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

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TABLE OF CONTENTS

ABSTRACT iv

ACKNOWLEDGEMENTS v

LIST OF FIGURES vi

LIST OF TABLES vi

LIST OF ABBREVIATIONS viii

1. HEALTH CARE POLICY IN CANADA 1
- The Evolution of Provincial Health Care Policy 7
  - The Era of Local Access to Hospital Care 8
  - The Era of Provincial Capacity Growth 10
  - The Era of Provincial Cost Control 19
- Capacity, Costs, and Control 33

2. THE RESEARCH FRAMEWORK 36
- The Theory Base 38
  - Conceptualizing the Policy Process 43
  - The Evaluation of Impacts 48
- The Research Questions 52
  - Goal Formation 52
  - Policy Implementation 60
  - Policy Impacts 67

3. IMPROVING ACCESS TO CARE : 1948 -1958 74
- The Post-War Policy Environment 75
- The Campbell Administration's First Term 84
  - The Second Term 100
- Changes in Capacity, Costs and Control 106

4. IMPLEMENTING INSURED SERVICES: 1958 - 1969 118
- The Roblin Administration's First Term 119
  - The Second Term 120
  - The Third Term 129
  - The Fourth Term 133
- The Weir Administration 136
- Changes in Capacity, Costs and Control 148

5. THE ERA OF PROVINCIAL CAPACITY GROWTH 160
Goal Formation 161
Policy Implementation 174
Policy Impacts 179

6. RATIONALIZING THE DELIVERY SYSTEM: 1969 -1977 188
The Schreyer Administration's First Term 190
The Second Term 212
Changes in Capacity, Costs and Control 229

7. CONTAINING HEALTH CARE COSTS: 1977 - 1981 238
The Lyon Administration 239
Changes in Capacity, Costs and Control 252

8. CONSULTATION AND COST CONTROL: 1981 - 1988 260
The Pawley Administration's First Term 261
The Second Term 273
Changes in Capacity, Costs and Control 280

9. THE ERA OF PROVINCIAL COST CONTROL 290
Goal Formation 292
Policy Implementation 310
Policy Impacts 328
Health Care Policy in Manitoba 343

APPENDIX A: Chronology of Major Policy Events A1

APPENDIX B: Manitoba's Rural Institutional Sector B1

APPENDIX C: Winnipeg's Institutional Sector C1

APPENDIX D: Supplementary Data D1

SOURCES CONSULTED SC1

ABSTRACT

The focus of this study is the evolution of health care policy in Manitoba from 1948 to 1988. The time frame covers two periods in this province's policy history: the period between the end of World War II and 1969 when the primary policy goal was increasing the capacity of the province's health care delivery system; and the period between 1969 and 1988 when the primary policy goal was containment of growth in delivery system costs. Utilizing a mix of qualitative and quantitative measures this study assesses the types of, impacts related to, and causes of health care policy change during the tenure of six government administrations in the province. The findings indicate that while policy changes at the federal level influenced the timing of provincial policy changes, the interests of and intermediation between key actors in Manitoba's health care policy community played a critical role in the way each administration approached the formation and implementation of cost control policy. In short, this study supports neo-pluralist assumptions that the interplay between executive council actors and key provider pressure groups is an important factor in the nature and direction of provincial health care policy change. It also suggests that the content of public policy debates pertaining to changes in delivery system capacity and costs are directly related to the distribution of organizational authority among key actors in a province's health care policy community.

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LIST OF FIGURES

Page

Chapter 3

3.1: The 1950 Proposal for LHU Boundaries 88

LIST OF TABLES

Page

Chapter 2

2.1: Questions and Indicators Related to Goal Formation 52
2.2: Questions and Indicators Related to Policy Implementation 60
2.3: Questions and Indicators Related to Policy Impacts 68

Chapter 3

3.1 : The 1948 Plan for Hospital Facilities 83
3.2 : The 1949 Agenda for Hospital Facilities Development 84
3.3 : Acute Care Capacity Growth between 1948 and 1950 90
3.4 : Changes in Functional Scope from 1948 to 1958 107
3.5 : LHU Growth in Rural Manitoba from 1949 to 1958 109
3.6 : LHU Growth in Metropolitan Winnipeg from 1949 to 1958 109
3.7 : Hospital Growth in Manitoba from 1949 to 1959 111
3.8 : Long-Term Care Facility Growth in Manitoba from 1949 to 1959 112
3.9 : Provincial Budgetary Changes from 1949 to 1959 114
3.10:The Campbell Administration's Impact on Functional Roles 115

Chapter 4

4.1 : Key Provincial Policy Problems and Goals in 1962 128
4.2 : Changes in Functional Scope from 1958 to 1969 149
4.3 : LHU Growth in Rural Manitoba from 1958 to 1969 150
4.4 : LHU Growth in Metropolitan Winnipeg from 1958 to 1969 151
4.5 : Hospital Growth in Manitoba from 1958 to 1969 152
4.6 : Long-Term Care Facility Growth in Manitoba from 1958 to 1969 153
4.7 : Provincial Budgetary Changes from 1959 to 1969 154
4.8: The Roblin and Weir Administration's Impact on Functional Roles 155

Chapter 5

5.1 : Changes in Functional Scope from 1948 to 1969 180
5.2 : LHU Growth in Rural Manitoba from 1949 to 1969 181
5.3 : LHU Growth in Metropolitan Winnipeg from 1949 to 1969 181
5.4 : Hospital Growth in Manitoba from 1949 to 1969 182
5.5 : Long-Term Care Facility Growth in Manitoba from 1949 to 1969 182
5.6 : Provincial Budgetary Changes from 1949 to 1969 184
5.7 : Changes in the Province's Functional Roles 187

Chapter 6

6.1 : Proposed DHSDC Service Delivery Responsibilities 205
6.2 : Policy Problems and Goals in May 1973 210
6.3: Changes in Functional Scope from 1969 to 1977 231
6.4 : Hospital Growth in Manitoba from 1969 to 1977 233
6.5 : Long-Term Care Facility Growth in Manitoba from 1969 to 1977 234
6.6 : Provincial Budgetary Changes from 1969 to 1978 235
6.7: The Schreyer Administration's Impact on Functional Roles 236

Chapter 7

7.1 : Changes in Functional Scope from 1977 to 1981 254
7.2 : Hospital Growth in Manitoba from 1977 to 1981 255
7.3 : Long-Term Care Facility Growth in Manitoba from 1977 to 1981 256
7.4 : Provincial Budgetary Changes from 1978 to 1982 257
7.5: The Lyon Administration's Impact on Functional Roles 258

Chapter 8

8.1 : Changes in Functional Scope from 1981 to 1988 283
8.2 : Hospital Growth in Manitoba from 1981 to 1989 284
8.3 : Long-Term Care Facility Growth in Manitoba from 1981 to 1989 285
8.4 : Provincial Budgetary Changes from 1982 to 1989 287
8.5: The Pawley Administration's Impact on Functional Roles 288

Chapter 9

9.1: The Policy Positions of Key Advocacy Coalition Actors 304
9.2: Policy Core Beliefs Displayed by Key Subsystem Actors 309
9.3: Issues and Responses Pertaining to DHSDC Development 314
9.4: The Cost Control Policies of Governments in Manitoba 319
9.5: Changes in Functional Scope from 1969 to 1988 329
9.6: Hospital Growth in Manitoba from 1969 to 1989 330
9.7: Long-Term Care Facility Growth in Manitoba from 1969 to 1989 331
9.8: Changes in Functional Scope between 1948 and 1988 332
9.9: Hospital Growth in Manitoba from 1949 to 1989 334
9.10: Long-Term Care Facility Growth in Manitoba from 1959 to 1989 335
9.11: Provincial Budgetary Changes from 1969 to 1989 338
9.12: Provincial Budgetary Changes from 1949 to 1989 339
9.13 :Changes in the Province's Functional Roles from 1969 to 1988 340
9.14: Changes in The Province's Functional Roles from 1948 to 1988 341

LIST OF ABBREVIATIONS

CCF	Co-operative Commonwealth Federation
CHC	Community Health Centre
CMA	Canadian Medical Association
DHSDC	District Health and Social Development Centre
DHC	District Health Centre
DSU	Diagnostic Services Unit
EPF	Established Programs Financing Act
HIDSA	Hospital Insurance and Diagnostic Services Act
LGD	Local Government District
LHU	Local Health Unit
LP	Liberal Progressive
MARN	Manitoba Association of Registered Nurses
MCD	Medical Care District
MHA	Manitoba Hospital Association
MHC	Manitoba Hospital Commission
MHO	Manitoba Health Organizations
MHSC	Manitoba Health Services Commission
MHSIC	Manitoba Health Services Insurance Corporation
MLA	Member of the Legislative Assembly
MMA	Manitoba Medical Association
MMS	Manitoba Medical Service
MMSIC	Manitoba Medical Services Insurance Corporation
NDP	New Democratic Party
PC	Progressive Conservative
PHC	Primary Health Centres
RHA	Regional Health Authority
RM	Rural Municipality
SC	Social Credit
SUDS	Single Unit Delivery System

CHAPTER 1.

HEALTH CARE POLICY IN CANADA

In the introduction to his review of health care policy in Canada, Horne argues that the policy and organizational framework for services delivery established in the late 1950s can be described metaphorically as a "joint venture" among the public, private, and voluntary sectors of the economy.[1] He observes that the establishment of this joint venture was preceded by a decade-long debate that concluded in a compromise between the supporters of a public "socialized" system for the delivery of services and those supporting a private "free enterprise" system. He also indicates that, while the policy and organizational arrangements produced by this compromise have provided Canadians with improved access to medical care since its establishment, [2] "...the fundamental tensions that fuelled the early debates remain: federal versus provincial jurisdiction; public versus private enterprise; and above all, the concern emanating from the magnitude and rapid growth of health care costs." [3]

More recent discussions of health care policy in Canada indicate that the

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[1] John Horne, "Health" in *The Canadian Economy: Problems and Options*, ed. R. Bellan, (Toronto: McGraw-Hill Ryerson, 1981), 197-221. On p. 197 he notes that the term "joint venture" is not literally applicable because the contribution that each sector makes to the functioning of the health services delivery system is specified less by formal contract than by informal accord.

[2] Ibid.,197. He describes this policy and organizational arrangement as one in which "...the public sector assumes major responsibility for financing the costs of health services, while the private (for-profit) and voluntary (non-profit) sectors together assume major responsibility for the production and delivery of health services."

[3] Ibid., 202. The remainder of Horne's article focuses on issues and policy options related to these tensions, in particular, those emanating from the growth in public sector costs related to services produced and delivered by members of the voluntary and private sectors.

tensions Horne described have remained an important feature of what is seen in this study as an ongoing debate related to three broad sets of public policy issues: a delivery system's **capacity** to provide citizens with a reasonable level of access to necessary health care services; the **costs** that the federal, provincial, and local governments should bear to fund access to these services; and the type and degree of policy and administrative **control** that the federal, provincial, and local governments should be able to exert over the utilization of public resources by the providers of these services. The content of this debate is effectively summarized in the work of Taylor and of Evans who identify a similar set of policy problems related to each of these issues.[4] With regard to a delivery system's capacity to provide access to services, both authors argue that an aging population combined with the continuous application of new medical technologies has produced a seemingly inexhaustible demand for the expansion of Canada's delivery system since the 1960s. They also indicate that provider responses to this demand have driven significant cost increases in public sector budgets related to services delivery. As a result, they suggest that, since the late 1960s, a central feature of health care policy debates in Canada has been the issue of control, more specifically, the types of policy and administrative control that the public sector has the legitimate right to implement to improve the

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[4] See Malcolm G. Taylor, *Health Insurance and Canadian Public Policy 2d ed.* (Kingston and Montreal: McGill-Queen's University Press, 1987), 463-485. Here he offers a discussion of five problem areas. A similar summary is offered by Robert G. Evans in ,"Canada: The Real Issues," *Journal of Health Politics, Policy and Law*, Vol.17, No.4 (Winter 1992): 739-762.

overall effectiveness and efficiency of delivery systems.

Taylor and Evans both indicate that public sector efforts to control health care costs since the late 1960s have taken three general forms: capacity constraints on hospital budgets and the fees paid to private providers through negotiated fee schedules; organizational rationalization initiatives designed to enhance public sector control over the flow of resources to medical care in order to re-allocate resource savings to improved primary and preventive health services capacity; and efforts to shift certain costs to citizens through user fees and limits on access of insured services.[5] They suggest that provincial governments have preferred capacity constraints and have achieved some policy success in their application. However, Evans observes that this preference has largely been due to attempts by politicians to "...avoid the very difficult and politically very dangerous task of establishing explicit priorities and protocols..."[6] to rationalize the organization of provincial delivery systems and the resultant service delivery behaviours of voluntary and private providers. This observation raises a question that is central to the research focus of this study; Why does Evans suggest that initiatives to rationalize the organization of a province's health care delivery system to control costs are likely to be "very difficult and politically very dangerous" policy exercises? As the discussion in the next section of this chapter indicates, Evans bases this suggestion on

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[5] Ibid., Taylor's discussion of all three of these types of control is offered at 464-85. Evans' discussion related to this area is offered at 751-59.

[6] Evans, "Canada: The Real Issues," 758.

research which indicates that attempts to rationalize the organizational arrangements for services delivery have presented serious policy challenges to provincial governments when they have pursued them in the context of cost control initiatives.[7] However, this discussion also indicates that the challenges have not been as great when organizational rationalization has been pursued in the context of improved access to services. This suggests that further study of the formation and implementation of initiatives to rationalize the organizational arrangements for services delivery at the provincial level is needed to better understand the role that initiatives of this type play in the broader evolution and impacts of provincial health services policy.

This study attempts to contribute to discussions of the role and impacts of these initiatives by researching provincial policy behaviour in the province of Manitoba. Manitoba has been chosen as the empirical focus of this study because an existing exploratory case study of health care policy in that province can be employed to inform the research framework. In this study Carrothers et al. argue that, while initiatives to rationalize Manitoba's delivery system in the 1970s were a sound policy response to the need for enhanced delivery system effectiveness and efficiency, implementation problems were encountered by the government administration that held office for much of this decade. They identify a number of factors that contributed to these difficulties and conclude by

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[7] Robert Evans, Morris Barer, and Clyde Hertzman, "The 20-year Experiment: Accounting for, Explaining, and Evaluating Health Care Cost Containment in Canada and the United States," Annual Review of Public Health, Vol.12 (1991): 481-518.

suggesting the need for a more systematic assessment of the evolution of health care policy in Manitoba.[8] They also suggest that an assessment of this nature should utilize a time frame that covers the evolution of Manitoba's delivery system prior to 1969, to establish an empirical context for policies initiated during and after the1970s, and that it should concentrate on three features of policy activity.[9] First, the process of policy formation to identify changes in the roles of key actors involved in the establishment of provincial health care policy goals. Second, the process of instrument implementation to determine the degree of success governments in Manitoba experienced in realizing their goals in policy practice. Third, the empirical impacts of implemented goals on the functional and geographic scope of provincial health care policy, the decentralization of the authority within the delivery system, and the rationalization of the functional roles of providers related to the day-to-day delivery of services.

Given these suggestions, this study offers a retrospective assessment of the evolution of health care policy in Manitoba between 1948 to 1988. As the theoretical and methodological discussion in Chapter 2 will indicate, its purpose is twofold. On the one hand, it will describe and assess the formation and direct impacts of the intermediate goals of policy outputs that were intended to

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[8] L.C. Carrothers, S.M. Macdonald, J.M. Horne, D.G. Fish, and M.M. Silver, *Regionalization and Health Care Policy In Canada: A National Survey and Manitoba Case Study* (Winnipeg, University of Manitoba Department of Community Health Sciences, 1991), 85-91.

[9] Ibid., 90-91.

rationalize the policy and organizational arrangements for services delivery. On the other, it will explain why provincial government actors experienced difficulties related to the implementation of their cost control initiatives. To establish the context for this discussion the remainder of this chapter offers an overview of the literature pertaining to the evolution of Canadian health care policy which gives attention to policy events in the prairie region. This overview indicates that, between 1916 and the beginning of World War II, the primary policy role of the provinces was the regulation of local initiatives to establish and fund the delivery of services. It also indicates that following World War II the federal and provincial governments became more actively involved in the funding and delivery of health care services. Between 1948 and 1966 the primary goal of this activity was improving citizen access through expansion of public health and hospital services capacity. However, beginning in the late 1960s a shift occurred which saw cost control become the dominant policy goal and organizational rationalization, through delivery system regionalization, become one of the primary instruments for its achievement. While the discussion of this period indicates that regionalization initiatives were only somewhat successful in the 1970s, it also suggests that the experience gained from efforts to implement this concept, along with efforts to implement other types of cost controls in the 1980s, has played an important role in the current provincial preoccupation with delivery system rationalization based on the regionalization concept.

THE EVOLUTION OF PROVINCIAL HEALTH CARE POLICY

The literature indicates that discussions of the evolution of health care policy in Canada can be approached in a number of ways. For example, Weller and Manga divide events into three time frames based on the nature of federal-provincial funding arrangements.[10] Taylor offers a more detailed seven category division based on the federal and provincial policy decisions that shaped the goals of, and organizational arrangements for, insured services delivery in Canada.[11] Van Loon concentrates on changes in public, voluntary, and private sector service delivery roles to define his six category time frame.[12] All of these approaches offer an effective way of framing the evolution of health care policy in Canada and have been developed by their authors in the context of a specific research interest. Given this study's empirical focus on organizational rationalization in Manitoba, this section divides the evolution of health care policy into three broad eras based on the changing nature of provincial health care policy goals in Canada's prairie region:

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[10] Geoffrey Weller and Pranlal Manga, "The Development of Health Policy in Canada," in *The Politics of Canadian Public Policy*, ed. Michael M. Atkinson and Marsha A. Chandler (Toronto: University of Toronto Press, 1983), 223-46. In this article they describe the period from 1867 to 1945 as "an era of benign neglect", the period from 1945 to 1977 as "The Era of the Shared-Cost Programs", and the period from 1977 to the present as the era of "Health Services and the Established Programs Financing Act".

[11] See Taylor, *Health Insurance and Canadian Public Policy* 2d ed.

[12] R.J. Van Loon, "From Shared Cost to Block Funding and Beyond: The Politics of Health Insurance in Canada," in *Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends*, ed. Carl A. Meilicke and Janet L. Storch (Ann Arbor: Health Administration Press, 1980), 342-366. See 353 for this time frame.

- **The Era of Local Access to Hospital Care** which began during World War I in the prairie region with a broadening of the scope of provincial policy from the regulation of public health to assisting municipal governments with the establishment and funding of local hospital services;

- **The Era of Provincial Capacity Growth** which began with the implementation of Saskatchewan's hospital insurance program in 1947 and continued with the implementation of a national health grants program in 1948, the implementation of a national hospital insurance program in 1958, and the implementation of a national medical care insurance program in 1968;

- **The Era of Provincial Cost Control** which began in the late 1960s due to provincial concerns related to potential health care cost increases following the implementation of the national medical care insurance program and continues to the present.

THE ERA OF LOCAL ACCESS TO HOSPITAL CARE : 1916-1947

While the federal government did not become actively involved in funding hospital and related medical care services outside of its established constitutional responsibilities until after World War II,[13] Taylor indicates that provincial policy in these areas can be traced to 1916. That year the Province of Saskatchewan enacted two pieces of legislation designed to improve citizen access to hospital services. The first provided rural municipal councils with the authority to levy taxes in order to pay physicians to provide hospital and clinical services to local residents who could not otherwise afford care. The second, enabled rural municipalities, villages, and towns to jointly participate in the

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[13] For an overview of federal and provincial constitutional responsibilities in the area of health services see Canada, *Review of Health Services in Canada* (Ottawa: Department of National Health and Welfare, 1976).

formation of hospital districts and to use a portion of their property tax revenues to erect and maintain hospitals.[14] The 1916 legislation was followed by the 1919 passage of another provincial Act which enabled the Lloydminster Union Hospital District to use property tax revenues to fund a pre-paid hospital services program for district residents. This program, along with the programs allowed by the 1916 legislation, was adopted by other hospital districts in Saskatchewan in the 1920s and 1930s and served to significantly increase the Saskatchewan government's involvement in the funding and regulation of local health care services during this period.[15]

Taylor also indicates that the provincial-municipal legislative and administrative framework for services delivery established by Saskatchewan was copied by other provincial governments prior to World War II. This is supported by Gelber who indicates that legislation similar to the 1916 acts were passed in Manitoba and Alberta in 1920, British Columbia in 1931, and Ontario in 1932.[16] Both authors further note that, in the late 1930s, all four of Canada's western provinces, as well as Ontario, considered the implementation of provincial hospital care subsidy programs for persons receiving public assistance. They

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[14] See Taylor, *Health Insurance and Canadian Public Policy* 2d ed., 72-73. He notes that the first piece of legislation was based on a successful pilot program in the R.M. of Sarnia started in 1914.

[15] Ibid., 74-75.

[16] Sylva M. Gelber, "The Path To Health Insurance," in *Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends*, ed. Carl A. Meilicke and Janet L. Storch (Ann Arbor: Health Administration Press, 1980), 156-165.

indicate that this interest was motivated by pressure groups representing rural municipal hospitals and physicians who, by the mid-1930s, were becoming increasingly concerned about the inability of a growing number of municipal residents affected by the economic depression to pay for local medical care. While a number of these provinces passed legislation to assist hospital districts in the funding of services to "indigents" in the late 1930s, these acts were not implemented due to concerns expressed by politicians in these provinces that the potential costs of health care for indigents would outstrip the ability to fund them as the economic depression of the 1930s continued to deepen.

THE ERA OF PROVINCIAL CAPACITY GROWTH: 1947- 1968

The end of World War II signalled the beginning of a renewed provincial interest in the organization and funding of health care services. Saskatchewan was, once again, the first province to expand its role in this area when it established a comprehensive pre-paid hospital insurance program through legislation passed in April of 1946. Taylor provides a detailed discussion of the events leading to the January 1, 1947 implementation of this program.[17] This discussion emphasizes that this program was the first of its kind in Canada to formalize direct provincial responsibility for the funding of health care services outside of the traditional provincial responsibility for institutional mental health care. The implementation of this program also provided supporters of public

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[17] See Taylor, *Health Insurance and Canadian Public Policy* 2d ed., 74-104.

hospital insurance in other provinces greater legitimacy in the decade-long debate that led to the establishment of the national joint venture for insured hospital services in the late 1950s.[18]

The dynamic nature of health care policy debates in Canada between 1947 and 1957 shaped the joint venture compromise that continues to play a role in current debates related to the issues of capacity, costs, and control. One year prior to the passage of Saskatchewan's 1946 legislation, the provinces and the federal government met in Ottawa to discuss post-war reconstruction policy. Tuohy notes that, at the time this Dominion-Provincial Conference on Post-War Reconstruction was being held, "...there existed a remarkable consensus among medical, hospital and insurance interests favourable to the establishment of a comprehensive health insurance plan in the public sector." [19] She suggests that this consensus, which had evolved prior to the War, was reflected in a federal plan for a national health care program developed in anticipation of the end of the War. This plan was proposed by the federal government at the 1945 Conference.[20] While the majority of provincial governments were favourable to

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[18] Ibid., 104. Here he notes that from its inception "...no provincial government failed to send its officials to Regina to learn at first hand how the program operated, and what policies and procedures could be adapted to their home provinces."

[19] Carolyn Tuohy, "Federalism and Canadian Health Policy," in *Challenges to Federalism: Policy-Making in Canada and the Federal Republic of Germany*, ed. William Chandler and Christian Zollner (Kingston: Queen's University Institute of Intergovernmental Relations, 1989), 141-160. See 144.

[20] For a detailed discussion of the formation of the federal hospital insurance plan and the events surrounding the Dominion-Provincial conference see Taylor, *Health Insurance and Canadian Public Policy 2d ed.*, 1-68.

the goals it defined, both Tuohy and Taylor note that a disagreement between the federal and some provincial governments over intergovernmental arrangements related to tax collection caused the Conference to end with no resolution to the issues on its agenda, including the national health plan. Both also note that, following the premature end of this conference, provincial government and health care provider pressure groups embarked on different policy paths.

Government actors continued their focus on the expansion of public sector responsibility for the funding of hospital care. In addition to the Saskatchewan government's decision to establish its health insurance program, a number of other events at the federal and provincial levels indicate the direction of this path. The first was the May 1948 announcement by Prime Minister Mackenzie King that the federal government intended to implement a system of grants to support health care delivery in the provinces. Taylor summarizes the funding and administration features of these grants and notes that they were seen by the federal government as the "first stage" in a new plan to establish a national hospital insurance program. [21] This was followed by three events at the provincial level: the implementation of a comprehensive hospital insurance program similar to Saskatchewan's in British Columbia in 1949; the implementation in 1950 of a province-wide program in Alberta to subsidize hospital districts for the care of low-income residents; and the implementation of

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[21] Ibid., 163-64.

a program similar to Alberta's in Nova Scotia in 1950. During the first half of the 1950s, the popularity of these programs in the provinces where they were implemented demonstrated to other provincial governments that demands for similar programs in their provinces should be given careful policy attention. Taylor notes that these demands were fuelled by a variety of factors including: the need to enlarge the capacity of provincial hospital systems to enhance citizen access to a growing range of new technologies and services; the rising costs of hospital care; the variable nature of the costs and coverage of private hospital care insurance plans; the growing inequity of access to services between rich and poor in the provinces lacking hospital subsidy programs; a growing public attachment to an "idea of progress" that supported an expanded role for the state in facilitating "human betterment"; and growing political support for CCF parties who supported the implementation of provincial hospital insurance programs across the country.[22] He also notes that these demands combined to produce a joint request by the provinces in early 1955 that discussions related to a national hospital insurance program be placed on the agenda of a federal-provincial conference to be held in April of that year.

At this conference the federal government indicated to the provinces that it was still willing to consider the implementation of a national hospital insurance scheme. In January 1956 it offered a plan that was more limited in scope than its 1945 proposals. This plan indicated that the federal government was

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[22] Ibid., 116.

prepared to share the costs related to insured hospital and related diagnostic services with the provinces but was no longer prepared to consider cost-sharing related to the clinical services offered by physicians or other types of institutional care provided by sanatoria, mental hospitals, and/or nursing homes. Following a year-long debate, that saw the province of Ontario decide to introduce its own hospital insurance plan, the federal parliament gave passage to the *Hospital Insurance and Diagnostic Services Act* (HIDSA) on April 12, 1957. Weller and Manga indicate that this Act formalized four policy goals that have served as the foundation of national health care policy in Canada since its passage.[23] They also note that the shared-cost funding arrangements it established contained "strong disincentives" related to the provincial imposition of direct charges on patients for hospital care.

While Weller and Manga note that HIDSA's implementation produced a variety of positive impacts,[24] its passage was not without controversy due to the policy path taken by health care providers following the premature end of the Dominion-Provincial Conference. Tuohy notes that, by the late 1940s, pressure groups representing physicians and hospitals had shifted their support to a combined system of private insurance plans, for provincial citizens who were

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[23] Weller and Manga, "The Development of Health Policy in Canada". On 228 they define these goals as: universal coverage for all citizens, accessibility to insured services unimpeded by fees; portability of benefits within Canada, and comprehensive coverage for approved medical services.

[24] Ibid., 229. Here they note that it produced a variety of negative and unanticipated policy impacts. Among these impacts the most notable is that the open-ended nature of the funding arrangements resulted in the inflation of hospital costs because "...the act did not contain any explicit incentives for cost containment."

actuarially insurable, and provincial subsidy programs for those who were uninsurable. She argues that this shift was due to the growth of private insurance plans, many sponsored by provincial medical and/or hospital associations, which "...demonstrated to the medical, hospital, and insurance communities the viability of alternatives to government-sponsored health insurance." [25] As a result, when federal-provincial negotiations for a national plan that would effectively diminish the market for these private plans began in earnest in 1956, the reaction of provider pressure groups was predictable. Taylor details the positions of these groups and their attempts to oppose the passage of HIDSA.[26] However, he indicates that their opposition was muted by the Canadian public's support for a system of publically funded insurance programs.

From National Hospital Insurance to National Medical Care Insurance

Implementation of the provisions of HIDSA in the provinces between 1958 and 1961 did not end public sector initiatives to improve the capacity of health care delivery systems to provide access to services. Once again, the implementation of new initiatives was led by provincial governments in western Canada. On December 16, 1959, Saskatchewan's Premier, Tommy Douglas, announced that his CCF government intended to establish a universal provincial

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[25] Tuohy, "Federalism and Canadian Health Policy," 145.

[26] Taylor, *Health Insurance and Canadian Public Policy* 2d ed., 189-234.

medical care insurance program to complement the province's hospital insurance program. As this announcement directly challenged the legitimacy of the network of private medical care insurance programs operated by physicians that had developed during the 1940s and 50s, the response from the Saskatchewan Medical Association was both immediate and vocal. Taylor details the political debate in Saskatchewan between 1944 and 1959 that led to this announcement and provides an extensive discussion of the passage of legislation related to the program and the ensuing physician's strike of 1962.[27] He also indicates that the Saskatchewan government's 1959 announcement triggered announcements in a number of other provinces related to their intent to develop more limited insured medical care programs. For example, in early 1960 Manitoba announced a program to fund physicians' services to indigents residing in the province's nursing homes and elderly persons hostels combined with a program to provide funding support to hospitals for patients receiving social assistance. Similar "Medi-care" programs were established in Alberta and British Columbia in 1963 and in Ontario in 1965. Taylor and Gelber both note that these programs conformed to the Canadian Medical Association's (CMA's) position that provinces intending to introduce a program designed to enhance citizen access to physician services should contract with the physician-sponsored medical insurance plan operating in the province for the administration of the program which, in turn, would ideally be limited to low-

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[27] Ibid., 239-330.

income persons who were not insurable by established private plans.[28]

At the federal level, Saskatchewan's announcement of its intent to establish a medical care insurance program contributed to the decision, in 1960, to establish a Royal Commission on Health Services chaired by Justice Emmett Hall. The Hall Commission released its report in 1964 and, as Chandler and Chandler note, it "...brought forth a stinging criticism of the existing situation and forcefully urged universal and compulsory national medical care insurance."[29] Based on the findings of this report, the federal government placed the issue of a national public medical care insurance plan on the agenda of a Federal-Provincial Conference held in the summer of 1965. While Saskatchewan and British Columbia were favourable to such a plan, the other provinces, in particular Ontario and Alberta, were opposed on the grounds that it represented an unwarranted federal incursion into an area of provincial jurisdiction. Despite this opposition, and the opposition of private insurance providers and physician pressure groups, the federal government went ahead with the passage of the *Medical Care Insurance Act* in 1966 which allowed a province to enter into an agreement with the federal government to share the costs of insured medical services delivered through a compulsory provincial insurance program.[30]

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[28] Ibid., 328. Also see Gelber, "The Path to Health Insurance," 164.

[29] Marsha A. Chandler and William M. Chandler, *Public Policy and Provincial Politics* (Toronto: McGraw-Hill Ryerson, 1979), 211.

[30] For a review of events related to the development and passage of this Act see Taylor, *Health Insurance and Canadian Public Policy* 2d ed., 331-77.

While the Canada Assistance Plan was implemented in 1966, the federal government did not begin to implement the *Medical Care Insurance Act* until 1968. On July 1 of that year Saskatchewan and British Columbia became the first provinces to enter into an agreement with the federal government to cost-share insured physician's services provided outside of a hospital. They were joined by five more provinces, including Manitoba, in 1969 and by 1971 all ten provinces were part of this national program. In her discussion of the implementation of this program, Tuohy notes that while it "...went a long way towards resolving problems of access to health services...it did nothing at the outset to contain the rising costs of health care." [31] A related criticism is offered by Van Loon who observes that in spite of ten years of experience with hospital insurance, the same lack of thought to "...the relationship of the insurer to the supplier of the service..." displayed by the organizational arrangements related to HIDSA was displayed in arrangements for the implementation of medical care insurance in 1968.[32] This observation is echoed by Vayda et al. who note that while the organizational arrangements for hospital and medical insurance established in statute by 1968 provided payments to health care providers, "...it did not mandate an organizational framework to deal with problems of efficiency

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[31] Tuohy, "Federalism and Canadian Health Policy," 147.

[32] Van Loon, "From Shared Cost to Block Funding and Beyond: The Politics of Health Insurance in Canada," 346.

or duplication of services.[33] In short, while the implementation of publically funded hospital and medical insurance programs enhanced citizen access to health care services, policy planners and their political masters at the federal and provincial levels failed to fully anticipate the resulting cost control problems that have dominated health care policy debates in Canada since the late 1960s. These problems and the public sector's response to them have dominated what this study views as the current era of health care policy in Canada.

THE ERA OF PROVINCIAL COST CONTROL: 1968-PRESENT

Carrothers et al. suggest that federal and provincial policy responses to the cost control problems produced by the implementation and growth in the capacity of hospital and medical insurance programs have evolved in three phases since the late 1960s.[34] The first phase, which spans the period from 1968 to 1977, saw eight of Canada's ten provincial governments focus on the planning and implementation of organizational change based on what they define as the regionalization concept.[35] They also note that there was a "...marked decrease in new policy initiatives..." related to this concept following

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[33] Eugene Vayda, Robert Evans, William Mindell," Universal Health Insurance in Canada: History, Problems, Trends," *Journal of Community Health* Vol.4, No.3 (Spring 1979): 217-231. See p. 219.

[34] Carrothers et al., *Regionalization and Health Care Policy in Canada*, 39-42.

[35] Ibid., 5. Here they define the regionalization concept as: "...the selective application over time of concepts contained within its decentralization, geographic and rationalization dimensions by governments, agencies, and pressure groups responsible for the planning, financing, and delivery of health and related social services."

the passage of the *Federal-Provincial Fiscal Arrangements And Established Programs Financing Act* (EPF) by the federal government in 1977.[36] For Carrothers et al, the passage of this Act began a second phase that was typified, on the one hand, by provincial efforts to consolidate and refine initiatives planned and/or implemented during the first phase and, on the other, by the implementation of other types of cost control strategies. They also indicate that passage of the *Canada Health Act* in 1984, along with federal efforts to reduce cash transfers to the provinces in the latter half of the 1980s, signalled a third phase of development which continues to the present.[37]

The First Phase of Provincial Cost Control Policy

Marmor et al. describe the shift to cost control strategies in Canada during the late 1960s as "... a startling shift in policy focus, from expanding access to care to containing its costs." [38] They note that, in the late 1960s and early 1970s, two schools of thought related to health services planning emerged among health care planners in Canada. They describe supporters of the first school as "cost controllers" who viewed the imposition of supply-side limits on

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[36] For a discussion of the passage of this Act see Taylor, *Health Insurance and Canadian Public Policy* 2d ed., 422-35.

[37] See Carrothers et al., *Regionalization and Health Care Policy in Canada*, 13-15 for this discussion.

[38] T.R. Marmor, M.L. Barer, and R.G. Evans, "The Determinants of a Population's Health: What Can Be Done to Improve a Democratic Nation's Health Status," in *Why Are Some People Healthy And Others Not?*, ed. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor (New York: Aldine De Gruyter, 1994), 217-30. See 218.

the flow of resources to voluntary and private providers as the most effective path to cost containment. On the other hand, they describe members of the second school as "health improvers" who viewed the reduction of inequalities in health status as the path to lower costs through the development of improved access to primary health and related social services coupled with the implementation of health promotion programs.[39] Both schools premised their arguments related to the need for policy changes on the recommendations of a federal-provincial Task Force established in November 1968 by the Conference of Ministers of Health to examine the types of public sector cost increases that would result from the implementation of *The Medical Care Act*.[40] Aucoin notes that one year later it presented a report, containing over three hundred recommendations, based on three central assumptions:

> - that federal and provincial resource allocations for the established insured programs concentrated almost exclusively on the delivery of curative medical care in hospital settings;
>
> - that the organizational and administrative arrangements for these established programs contained few incentives to alter the concentration on expensive hospital-based care;
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> - that the organizational and administrative arrangements for the planning, funding, and delivery of services covered by the established programs had produced a high degree of "organizational fragmentation" resulting in "...administrative complexity, confusion, competition and inefficiency." [41]

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[39] Ibid., see 221-22 for this discussion.

[40] Canada, *Task Force Reports on the Cost of Health Services in Canada*, Volumes I to III (Ottawa: Queen's Printer, 1969).

[41] Aucoin, "Federal Health Care Policy," 244-68.

In short, the recommendations of this Task Force indicated that the organizational arrangements produced by the joint venture compromise for services delivery established in the 1940s and 1950s would have to be altered to reduce serious inefficiencies in the existing arrangements for services delivery. To this end, the Task Force recommended the implementation of two related initiatives: the establishment of sub-provincial regional authorities to integrate the planning, funding, and delivery of health services; and the development of cost-effective alternatives to hospital-based services within those regions. To facilitate implementation of the latter initiative the Conference of Ministers of Health commissioned The Community Health Centre Project in 1971 under the direction of Dr. John Hastings.[42] This Project found that the creation of Community Health Centres (CHCs) to integrate the delivery of primary and preventive health services was a desirable policy alternative to further expansion of hospitals and other "in-patient" institutions.[43]

Carrothers et al. indicate that the recommendations contained in the Task Force and The CHC Project reports motivated the creation of five provincial Task Forces in the early 1970s to study how the range of health services offered by

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[42] Canada (Hastings), *The Community Health Centre in Canada, Report of the Community Health Centre Project To the Conference of Health Ministers* (Ottawa: Community Health Centre Project, July 1972).

[43] Aucoin, "Federal Health Care Policy," 253. Here he summarizes the findings of the Hastings Report and defines the CHC concept as "...an approach whereby an integrated health team is located in a community-based facility at which members of a defined community, i.e. a population of a few thousand people, receive general and specialized care for various health problems, or, if required, preliminary diagnostic services and referral to an acute-treatment hospital for "in patient" care (as opposed to "out-patient" care, i.e. services not necessitating hospitalization)."

these provinces could be integrated and delivered in a more effective and efficient fashion. While a number of these provinces, including Manitoba, implemented policies based on the recommendations of their Task Forces in the 1970s, they were resisted by provider pressure groups based on arguments that the overall quality of care provided to citizens would decline if their authority related to the production and delivery of services was diminished by changes in the original joint venture arrangements for services delivery.[44] As a result, while British Columbia, Manitoba, Ontario, and Nova Scotia were able to implement organizational changes pertaining to areas of established provincial control, notably in their public health and related community-based service delivery programs, they were unable to enhance direct provincial control over the established scope, authority, and delivery system functions of hospitals and physicians. Crichton supports this finding when she argues that, during the 1970s, provider pressure groups demanded that provincial governments focus their policy attention on increasing hospital and medical services funding "...rather than on such health care content objectives as restructuring the system towards preventive programs or improving the role delineation of hospitals."[45] Further support can be found in Tuohy who notes that provincial initiatives to

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[44] Carrothers et al., *Regionalization and Health Care Policy in Canada*, 12-13 and 21-49. They indicate that during the 1970s Quebec was the only province to successfully implement a fully regionalized delivery system and that the reasons for this success are related to factors unique to the political culture of that province.

[45] Ann Crichton, "Restructuring Health Services in Canada: Challenges for Policy Makers, Planners and Managers in the Eighties," *International Journal of Health Planning and Management*, Vol.1 (1985): 7-26. See p.19.

realign organizational arrangements for services delivery were viewed by voluntary and private providers as "peripheral" to health services policy debates during the 1970s.[46]

It is notable that Canada's policy experience during the 1970s was similar to that of other industrialized nations. In his survey of health policy trends in France, England and the United States during the 1970s and early 1980s Rodwin indicates that these nations also shifted their health care policy goals from the expansion of access to curative medical care to the control of health care costs.[47] His findings indicate that this shift involved attempts to implement three types of initiatives: supply-side rationing of public resources flowing to private sector providers; the development of health promotion programs to enhance population wellness; and the rationalization of organizational arrangements for services delivery through the regionalization of authority for services delivery.[48] They also indicate that the cost control initiatives implemented by these nation states in the 1970s produced what he describes as a "policy predicament" for health planners. On the one hand, early successes in slowing the growth of costs, through the implementation of regionalization and related supply-side cost controls, confirmed "...the need for rationalization, that

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[46] Tuohy, "Federalism and Canadian Health Policy," 152-53.

[47] Victor G. Rodwin, *The Health Planning Predicament* (Berkeley: University of California Press, 1984), 213.

[48] Ibid., 231-238.

is, for securing a more efficient allocation of resources in the health sector." [49] On the other hand, the implementation of these initiatives intensified political conflicts between the public sector and health care providers which, in turn, diminished the willingness of politicians in these nation states to more extensive organizational rationalization initiatives.

The Second Phase of Provincial Cost Control Policy

In the face of provider resistance to the rationalization of organizational arrangements for services delivery based on the regionalization concept, provincial health care planners in Canada turned their attention to other forms of cost control in the late 1970s. With regard to what Rodwin terms supply-side management, Evans indicates that "cost controllers" promoted what he describes as indirect policy responses in the form of capacity constraints.[50] He suggests that provincial governments began a concerted effort to implement these constraints in the late 1970s because: they were persuaded that health care providers would respond to them by restricting resource allocations to the areas of greatest need within the population; and they offered what, at the time, was thought to be a less controversial political alternative to delivery system rationalization. An assessment of the impact of capacity constraints by Evans et

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[49] Ibid., 2.

[50] Evans, "Canada: The Real Issues," 758. While he does not define his use of the term *indirect* policy responses, his discussion suggests that they are policies that do not directly challenge the organizational status quo.

al. indicates that while the initiatives that were implemented did constrain public sector resource allocations during the 1980s, this was largely accomplished through restrictions on the availability of capital to hospitals for construction and renovation projects. Alternatively, patterns of resource utilization by providers did not display significant change during this decade which suggests to Evans et al. that capacity constraints failed to have a positive impact on the overall effectiveness and efficiency of services delivery.[51] Based on these findings, they suggest that capacity constraints appear to require the support of related policy initiatives to be effective. To this end they note a renewed interest in "... some form of sub-provincial regionalization of priority setting, albeit with clear and binding provincial guidelines." [52] This is supported by Tuohy who suggests that the main reason for the limited success of capacity constraints was provider resistance to public sector intervention in their decisions regarding the utilization of resources.[53] She goes on to argue that a major challenge facing public sector planners in what this study views as the third phase of development is the implementation of "organizational innovations" that force significant improvements in delivery system effectiveness and efficiency.[54]

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[51] Evans, Barer, and Hertzman, "The 20-year Experiment: Accounting for, Explaining, and Evaluating Health Care Cost Containment in Canada and the United States," 507-11.

[52] Ibid., 513.

[53] Tuohy, "Federalism and Canadian Health Policy," 151-52.

[54] Ibid., 156.

The Third Phase of Provincial Cost Control Policy

The limited success with capacity constraints experienced by the provinces in the 1980s is viewed here as an important contributor to the current renewal of provincial interest in more extensive organizational rationalization initiatives. While the reasons for this renewal are not well defined in the literature, at least four can be identified that have relevance for this study. The first is indicated by Evans et al., noted above, who suggest that the provincial experience with capacity constraints in the 1980s diminished provincial government support for the assumption that those responsible for the production and delivery of services can be forced to modify their resource utilization practices within the existing joint venture arrangements. The second reason is also suggested by these researchers who note that while capacity constraints allow a government a shorter planning and implementation time frame than organizational rationalization initiatives, their long term application has proven to be politically unsustainable due to successful efforts by the critics of capacity constraints to link them with the physical and operational deterioration of hospitals. The third reason relates to the role that capacity constraints have played in forcing public sector planners to more rigorously study the relationship between medical care and its promised outcomes.[55] The research findings in this area are summarized by Roos and Roos who conclude that provincial

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[55] This point is also noted by Marmor et al. in "The Determinants of a Population's Health," on p. 226.

governments must combine capacity constraints with other types of cost control initiatives, in particular those related to the rationalization of organizational arrangements, to successfully enhance the effectiveness and efficiency of their health care delivery systems.[56]

This fourth reason for the renewal of interest in organizational rationalization flows from the inability of health improvers to realize their policy agenda which has its base in the findings of the 1974 Lalonde Report. [57] In his discussion of "the new perspective on health policy" promoted by this report, Hancock notes that while its findings have forced public sector planners to enlarge their definition of the scope of health policy, efforts to translate this definition into initiatives that significantly reduce inequalities in health status have yet to be successful.[58] His conclusions are supported by other Canadian researchers. For example, in his discussion of the need to shift public resources from sickness care to population wellness, Taylor notes that "...much remains to be done..." in the area of policy implementation.[59] Evans takes a similar position

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[56] N.P. Roos and L.L. Roos, "Small Area Variations, Practice Style, and Quality of Care," in *Why Are Some People Healthy and Others Not?*, 231-52. On 247-51 they offer a series of policy recommendations which support the need for organizational realignments that enhance public sector control over the utilization of resources by providers

[57] Canada (Lalonde), *A New Perspective on the Health of Canadians: A Working Document* (Ottawa: Ministry of National Health and Welfare, 1974).

[58] Trevor Hancock, " Lalonde and Beyond: Looking back at "A New Perspective on the Health of Canadians," *Health Promotion* Vol.1, No.1 (1986): 93-100. On 95 he argues that one reason for this is the constitutional division of jurisdictional powers for health services between the federal and provincial levels of government.

[59] Taylor, *Health Insurance and Canadian Public Policy 2d ed.*, 479.

when he observes that issues related to inequalities in the health status of Canadians "...have been honoured with much rhetoric and careful thought, but very little money...".[60] Additional support can be found in Marmor et al. who summarize the policy impact of the health improvement school in the 1970s and 1980s by suggesting that:

> The impact of the "new perspective" on modern medicine was also much less than might have been expected from the initial rhetoric. Since the policies actually implemented avoided challenging established distributions of power, medicine's expansionary dynamic largely persisted. Prevention became not a substitute for cure, but a basis for further expanding the range of services offered by medical care professionals.[61]

In summary, the experience gained by provincial governments during the first and second phases of the evolution of cost control policy indicates, as Evans notes, that they have increasingly been forced to confront a central deficiency in the existing organizational arrangements for services delivery; the public sector's inability to link technical considerations, related to what particular services actually do in the way of good or harm, with value considerations related to what actual or prospective patients want in the way of services.[62] Drawing on Evans and Stoddart's study of the linkages between health care

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[60] Evans, "Canada: The Real Issues," 759. He goes on to suggest that health planners need to expand the scope of existing health policies and carry out a wider range of interventions if they are to be effective in improving the health of Canadians.

[61] Marmor et al., "The Determinants of a Population's Health," 225.

[62] Evans, "Canada: The Real Issues," 757.

services and population health,[63] Evans argues that the public sector must respond to this deficiency in the 1990s. The literature reviewed here indicates that the public sector's ability to plan a response has been enhanced over the last two decades because: it is better prepared to challenge provider resistance to change due to its enhanced understanding of the relationship between medical care and its promised outcomes[64], and because it is better equipped to support arguments related to the types of changes that are required based on a growing body of government and independent research studies.[65] The direction that this response is intended to take during the current phase of provincial cost control policy is evident in a survey of the findings of six recent provincial health commissions by Hurley et al. [66] They indicate that all of these commissions offered similar recommendations supporting the implementation of cost control policies that link cost containment, health promotion, and organizational

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[63] See Evans and Stoddart, "Producing Health, Consuming Health Care," in *Why Are Some People Healthy And Others Not?*, 27-64. They indicate that policy changes related to one set of health determinants must be coordinated with changes related to other determinants to be effective.

[64] In addition to the findings by Roos and Roos, this point is emphasized in J. Lomas and A.P. Contandriopoulos, " Regulating Limits to Medicine: Towards Harmony in Public and Self-Regulation," in *Why Are Some People Healthy and Others Not?*, 253-83.

[65] Examples include: Sharmila Mhatre and Raisa Deber,"From Equal Access to Health Care to Equitable Access to Health: A Review of Canadian Provincial Health Commissions and Reports," *International Journal of Health Services*, Vol.22, No.4 (1992): 645-668; Canadian Medical Association, *The Language of Health System Reform* (Ottawa: 1993), 73-114; Ontario, *The Evolution of Devolution: A Brief Summary of Provincial Experiences* (Ontario Premier's Council, June 1995).

[66] Jeremiah Hurley, Jonathan Lomas, Vandna Bhatia, "When tinkering is not enough: provincial reform to manage health care resources," *Canadian Public Administration*, Vol.37, No.3 (1994): 490-514.

rationalization initiatives based on the assumption that implementation will:

> ...not only *contain costs*, but will produce and deliver services with *improved efficiency* in ways more *flexible and responsive* to community needs. It will improve *integration and coordination* of complementary and substitutive services, ensuring a full continuum of care available, whenever possible, in a community setting and evaluated according to *health outcomes*. Finally, there is to be a significant increase in *community participation* in planning decisions for health care.[67]

Hurley et al. also note that, among the organizational rationalization initiatives provincial governments are currently implementing to realize these goals, the regionalization concept continues to be prominent. The reasons for this prominence appear to be based on the assumption that regionalization:

> - offers the political means to shift the debate between the public, voluntary, and private sectors over implementation of the optimum policy balance between care, costs, and control from the provincial level of politics to the regional level;
>
> - offers the administrative means to implement and administer cost controls on a regional rather than a provincial level which, as Rodwin suggests, should enhance the public sector's ability to "...redirect demand to less expensive programs and facilities and provide the organizational leverage for extending and sharing limited health manpower and facilities..." [68].

While regionalization is assumed to offer these means in theory, the difficulties experienced by its initial implementation in the 1970s suggest that, despite the public sector's enhanced knowledge base in the 1990s, the current round of initiatives based on this concept will not go unchallenged by provider

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[67] Ibid., 494.

[68] Rodwin, *The Health Planning Predicament*, 234.

pressure groups. Further, studies which link the implementation of regionalization with its long term impacts, suggest that, while provincial governments may be doing the right thing by employing the concept, they must be careful to do things the right way for the right reasons. This point is emphasized in the literature related to the New Public Management movement in Canada. Observers of this movement indicate that some provinces have adopted its core ideas which argue that public sector administrative practices should both emulate those in the private sector and give a much greater role to the private sector in the delivery of services .[69] More specifically, Peters points out that these arguments support two broad types of change: the devolution of public sector authority through the regionalization of services delivery coupled with the development of public-voluntary/private sector partnerships; and a shift from process-oriented to results-oriented service delivery goals within provincial administrative units. He also emphasizes that the overall direction of these changes could take two very different paths. On the one hand, a movement to a more explicit "market model" of state-society relations in which members of the public are primarily viewed as the consumers of services and, on the other, to a more "participatory model" which supports enhanced citizen input into the allocation and utilization of state resources.[70]

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[69] Donald J. Savoie, "Globalization, Nation States, and the Civil Service," in *Governance in a Changing Environment*, eds. B. Guy Peters and Donald J. Savoie (Montreal and Kingston: McGill-Queen's University Press, 1995), 82-110. See 91.

[70] B. Guy Peters, "The Public Service, the Changing State, and Governance," in *Governance in a Changing Environment*, 288-320. See 301.

CAPACITY, COSTS, AND CONTROL

While the question of the path that health care delivery policy will take in the future is not central to this study, the literature reviewed in this chapter indicates that, in order to fully understand the current content of health care policy debates, one must recognize that policy initiatives flowing from all three of the eras described above have played an important role. During the first era, the primary policy focus was facilitating local improvements in the capacity for medical care through legislative support for the development of services delivered by a mix of municipal, voluntary, and private providers. While this era saw increased demand for provincial funding support, for the most part the political and economic realities of the 1930s allowed provincial politicians to legitimize limited provincial involvement in the actual delivery of services to citizens. The entry of the federal government into health policy debates following World War II, coupled with changes in public attitudes related to citizen access to medical care, produced an important shift in the content of provincial policy debates. During this second era provincial governments were forced to take a more prominent role in balancing public demands for improved access to care with the need to contain the cost implications of health care provider demands for improved delivery system capacity. Over the two decades covered by this era provincial politicians attempted to rationalize these demands by incrementally increasing their funding and regulatory roles while, at the same time, limiting their direct responsibility for the actual delivery of services to the

public. While this balance was supported by health care providers, the cost increases experienced during this era forced policy debates to shift from the relationship between capacity and costs to the relationship between costs and public sector control. As this review of the third era indicates, the need for organizational rationalization to enhance provincial administrative control over the way services are delivered has been a consistent theme in policy debates during the last three decades and has been responsible for much of the political controversy that surrounds health care policy today.

The remaining chapters in this study are devoted to a detailed description and evaluation of the evolution of public policy in Manitoba between 1948 and 1988 related to initiatives to rationalize the capacity of, costs related to, and organizational arrangements for health care delivery. This time frame has been chosen because it allows study of the way that six governing administrations in Manitoba approached health care policy during what are seen here as the second and third eras of policy development. Through study of the policy formation and implementation behaviour of these governments, as well as the impacts of the policies they implemented, the findings offered here indicate that provincial cost containment is viewed by health care researchers and politicians alike as a "very difficult and politically very dangerous" policy exercise because it requires alterations in the organizational relationship between provincial governments and key health care provider pressure groups that threaten the established interests of both parties.

The following chapter elaborates the theoretical foundation for this study and defines the research questions used to evaluate policy behaviour during each of the eras covered by the study's time frame. Chapters 3 and 4 describe key policy events in Manitoba between 1948 and 1969 and summarize changes in delivery system capacity, costs and control that occurred during this period. The policy process behaviours that contributed to these changes are evaluated in Chapter 5 based on the research questions defined in Chapter 2. Chapters 6, 7, and 8 turn to events between 1969 and 1988 which saw governments in Manitoba shift their policy goals to cost control. The changes in capacity, costs, and control described in these chapters are evaluated in Chapter 9 using the research questions. The findings in this chapter suggest that, while issues related to costs have dominated public discussions of health policy since the late 1960s, debates pertaining to these issues mask a more important set of issues that lie at the intersection between the capacity of a delivery system to provide citizens with access to necessary health care services and the capacity of a provincial government to control the allocation and utilization of public resources for the delivery of those services.

CHAPTER 2.

THE RESEARCH FRAMEWORK

Babbie emphasizes that the first formal step in the operationalization of a research study is the specification of its key features.[1] Further, he notes that the following features must be given consideration: the unit of analysis; the time frame in which the behaviour of the unit of analysis is assessed; the theory base used to inform the research framework; and the research questions that guide empirical data collection. With regard to the unit of analysis for this study, the discussion in Chapter 1 indicates that the Province of Manitoba has been chosen because Carrothers et al.'s study of policy behaviour in that province [2] can be employed in the definition of this framework's descriptive and explanatory focus, reducing the need for an extensive exploratory survey prior to specifying the research questions.[3] Turning to the time frame covered here, the four decade period, between 1948 and 1988, has been selected because it allows detailed study of the policy behaviour of six government administrations during the second and third eras of policy development discussed in Chapter 1. The Era of Provincial Capacity Growth formally began in Manitoba with the implementation of the National Health Grants Program by the Liberal Progressive (LP) Campbell administration in 1948. It continued through1958,

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[1] Earl Babbie, *The Practice of Social Research* 7d ed. (Toronto: Wadsworth Publishing Company: 1995). See 82-106 and 340-343 for a discussion of these features.

[2] Carrothers, et al., *Regionalization and Health Care Policy In Canada.*

[3] For a discussion of exploratory, descriptive and explanatory types of research see Babbie, *The Practice of Social Research*, 84-86.

with the implementation of Manitoba's insured hospital services program by the Campbell and Progressive Conservative (PC) Roblin administration, to 1969 when the Weir PC administration set the stage for the implementation of the province's insured medical services program. During this two decade period the primary public policy goal was expansion of the delivery system's capacity to provide citizens with access to hospitals and public health services. However, the June 1969 election of the New Democratic Party (NDP) Schreyer administration signalled Manitoba's entry into the Era of Provincial Cost Control. During the next two decades the Schreyer, Lyon PC, and Pawley NDP administrations attempted to implement cost control strategies that were informed by the recommendations of the 1969 Conference of Health Ministers Task Force Report[4] and the 1972 Hastings Report.[5] While the Filmon PC administration, which was first elected in 1988, has continued to pursue these cost control strategies into the 1990s, the change to a new government in 1988 is seen as a logical end point for this study.

The third feature requiring specification is the theory base for this study. The discussion of the theory base contained in the next section. This is followed by a second section, arising from the theory base, which defines the research questions and indicators that guide the descriptive and explanatory components of this study of health care policy in Manitoba.

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[4] Canada, *Task Force Reports on the Cost of Health Services in Canada.*

[5] Canada (Hastings), *The Community Health Centre in Canada, Report of the Community Health Centre Project To the Conference of Health Ministers.*

THE THEORY BASE

In his introduction to the theory and practice of policy research Pal defines policy analysis as "...the disciplined application of intellect to public problems..." [6] and argues that all public policy research "...is informed by theory, whether consciously or not." [7] His position is echoed by Peters who notes that the selection and application of a theoretical approach is frequently influenced by a researcher's intellectual predispositions rather than by a systematic evaluation of the available theoretical options.[8] These observations suggest that the theory employed to ground this study should be selected with care because, as Brooks notes, all theoretical approaches direct attention to particular features of a policy field and, therefore, play a significant role in framing research questions and methodological strategies.[9] Brooks goes on to identify three macro public policy approaches prominent in the policy literature in Canada; Public Choice theory, Marxist theory, and Pluralist theory.[10] With regard to the

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[6] Leslie Pal, *Public Policy Analysis* 2d ed. (Scarborough: Nelson, 1992), 16.

[7] Ibid., 26.

[8] B. Guy Peters, "The Policy Process: An Institutionalist Perspective," *Canadian Public Administration* Vol.35, No.2 (1992): 160-80. See 160-61.

[9] Stephen Brooks, *Public Policy in Canada* 2d. ed. (Toronto: McClelland & Stewart, 1993), 28.

[10] Ibid., 32-47. His classification scheme is that same as the classification scheme offered by Robert Jackson and Doreen Jackson in *Politics in Canada* 2d ed. (Scarborough: Prentice Hall, 1990), 585-602.

first two, the literature indicates that , with the exception of one article,[11] neither has been explicitly employed by Canadian health care policy researchers. Alternatively, pluralist approaches are common in the literature with recent research favouring a particular variant of pluralism that is generally described as neo-pluralism. Held highlights the central features of neo-pluralism by contrasting it with what he defines as the *classic version* of pluralism.[12] He notes that the latter assumes:

> Political outcomes are the result of government and, ultimately, the executive trying to mediate and adjudicate between the competing demands of groups. In this process, the political system or state becomes almost indistinguishable from the ebb and flow of bargaining, the competitive pressure of interests.[13]

In short, classic pluralism does not view state actors as playing a significant role in defining the content of policy goals since power is assumed to be widely dispersed among a plurality of competing pressure groups. However, Held points out that neo-pluralism, which is the product of Marxist critiques of the classic version, views state actors differently. Rather than assuming they are neutral or reactive mediators of pressure group demands, this approach assumes that state actors and institutions are central to the timing, content, and resultant outputs of public policy. As a result, it recognizes that, while the

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[11] See Donald Swartz, "The Politics of Reform," in *The Canadian State*, ed. Leo Panitch (Toronto: University of Toronto Press, 1977), 538-589. This article offers a Marxist interpretation of the evolution of Canadian health care policy.

[12] David Held, *Models of Democracy* (Stanford: Stanford University Press, 1987), 201-220.

[13] Ibid., 190.

interplay among pressure groups plays a role in the scope and content of policy debates, it is the interplay between state actors and dominant pressure groups in a policy field that defines the eventual content of a policy output. In the general public policy literature, the validity of the neo-pluralist approach in Canadian policy research is supported by a variety of researchers.[14] In the Canadian health policy literature, early support can be found in Weller's review of research published between 1945 and 1976.[15] It can also be found in more recent discussions by Tuohy [16], Price Boase [17], and Marmor et al.[18]

The research by Marmor et al. and Price Boase is of particular importance to this study. Marmor et al base note that health care policy debates between government actors and provider pressure groups since the early 1970s in Canada have been typified by unsuccessful government initiatives "...to redirect health policy away from curative medicine to more fundamental

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[14] For example see William D. Coleman and Grace Skogstad, *Policy Communities and Public Policy in Canada* (Mississauga: Copp, Clark, Pitman, 1990), A. Paul Pross, *Group Politics and Public Policy* 2d ed. (Toronto: Oxford University Press, 1992), and G. Bruce Doern and Richard W. Phidd, *Canadian Public Policy: Ideas, Structure, Process* 2d. ed. (Scarborough: Nelson, 1992).

[15] G.R. Weller, "From Pressure Group Politics to Medical-Industrial Complex: The Development of Approaches to the Politics of Health Care," in *Perspectives on Canadian Health and Social Services Policy*, 315-41. This article is reprinted from *Journal of Health Politics, Policy and Law* Vol.1, No.4 (Winter 1977):444-470.

[16] Carolyn Tuohy, *Policy and Politics in Canada* (Philadelphia: Temple University Press, 1992).

[17] Joan Price Boase, *Shifting Sands: Government-Group Relations in the Health Care Sector* (Montreal & Kingston: McGill-Queen's University Press, 1994).

[18] T.R. Marmor, M.L. Barer, and R.G. Evans, "The Determinants of a Population's Health: What Can Be Done to Improve a Democratic Nation's Health Status," in *Why Are Some People Healthy And Others Not?*, ed. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor (New York: Aldine De Gruyter, 1994), 217-30.

interventions...".[19] They identify the arrangements for services delivery that evolved during what is seen here as the Era of Provincial Capacity Growth as the most significant contributor to this lack of policy success.[20] In short, they suggest that the prevailing conception of health during the formative stages of this era was translated into policy and organizational arrangements for health care that have subsequently proven difficult to alter. This conception viewed curative medical services as the most important, if not the only, determinant of population health requiring public policy attention. As a result, it served as the foundation for the "joint venture" policy and organizational arrangements described by Horne.[21] Marmor et al. argue that during the development of these arrangements in the 1950s, professional health care providers demanded and were given exclusive decision-making roles related to the utilization of resources for the production and delivery of services. In addition to delegating considerable political and economic power to these providers, the formal implementation of the joint venture arrangement in the late 1950s, in the context of insured hospital services, gave provider pressure groups heightened legitimacy to resist public sector attempts to realign the organizational arrangements for services delivery when federal and provincial policy goals shifted from improving delivery system capacity to controlling health care costs

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[19] Ibid., 218-19.

[20] Ibid.

[21] Horne, "Health," 197.

in the early 1970s. Hence, they suggest that government - provider pressure group debates in Canada since the 1970s have been largely motived by public sector efforts to limit this legitimacy in order to allow enhanced state policy and administrative control.

While Marmor et al offer valuable insights pertaining to key features of this study's research focus, Boase offers additional insights into how this study should approach the interaction between state actors and provider pressure groups. In a recent article on the evolution of health policy in Canada and the United States, she argues that the different policy directions displayed by these states is the product of historic differences in the interaction between state institutions and societal interests.[22] While the nature of these interactions and their implications for this research framework are given attention later in this section, her review of the literature is important here due to her conclusion that, among the various approaches to policy research currently available, "...The assumptions of the pluralist paradigm are particularly applicable to the health policy sector...".[23] As a result, the neo-pluralist approach serves as the macro theory base for this study. The implications of this choice are elaborated in the following sub-section which discusses how the policy process and the resultant interplay between state and pressure group actors is conceptualized in the research questions that will be elaborated in the following section.

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[22] Joan Price Boase, "Institutions, Institutionalized Networks and Policy Choices: Health Policy in the US and Canada," Governance Vol. 9, No.3 (1996): 287-310. See 289.

[23] Ibid., 293.

CONCEPTUALIZING THE POLICY PROCESS

Peters observes that three process models have been employed in the general policy literature over the last three decades; Stages Models, Analytic Process Models, and The Policy Determines Politics Model.[24] He also indicates that Stages Models have been the most widely utilized in applied policy research. Based on David Easton's linkage of pluralism to systems theory in the physical sciences,[25] this model assumes that policy formation can be conceptualized as a series of sequential steps beginning with a *problem definition stage* in which pressure group and state actors interact to define the need for and direction of change on a policy system. Demands viewed as legitimate by state decision-makers then enter a *throughput stage* which defines the range of policy goals and instruments thought to be the most effective response to those demands. During this stage specific goals and instruments are formalized and move to an *outputs stage* in which policy decisions are implemented to produce desired policy *outcomes*. A *feedback loop* is often included in this model to indicate that outcomes have an impact on the behaviour of input variables.[26]

The Canadian health care policy literature reviewed for this study

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[24] Peters, "The Policy Process: An Institutionalist Perspective," 162-64.

[25] David Easton, *A Systems Analysis of Political Life* (New York: John Wiley & Sons, 1965).

[26] For a review of this model's general application to the Canadian policy process see Richard Van Loon and Michael Whittington, *The Canadian Political System* (Toronto: McGraw-Hill Ryerson, 1981).

supports Peters' argument that the stages model has been widely utilized in applied policy research. The most complete example of the empirical application of this model is offered in Taylor's monograph.[27] However, other prominent researchers also support the use of this model.[28] Given its prominence, a current variant of the stages model is employed in this study to conceptualize the policy process in Manitoba. A discussion of this variant can be found in Kernaghan and Siegel who argue that research related to the policy process can be conceptually divided into three general forms of activity:[29] the process of goal formation which focuses on definition of the policy problem(s) and the most effective response that government actors can to that problem;[30] the translation of a government's goals into strategies for implementation;[31] and the evaluation of the impacts of implemented policy goals.

While the stages model offers a useful way to conceptualize the broad features of the policy process in Manitoba, Peters notes that it is not without

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[27] Taylor, *Health Insurance and Canadian Public Policy* 2d ed. See 492-498 for a critical discussion of his application of this model.

[28] See A. Donabedian, *Explorations in Quality Assessment and Monitoring. Volume I* (Ann Arbour: Health Administration Press, 1980) and Anne Crichton, *Health Policy Making* (Ann Arbour: Health Administration Press, 1981).

[29] Kenneth Kernaghan and David Siegel, *Public Administration In Canada* 3d ed. (Toronto: Nelson Canada, 1995), 129-30.

[30] Pal, *Public Policy Analysis.* On p.10 he suggests that a government's assessment of the technical and political problems demanding a policy response guides the formation of policy goals. Therefore both types of problem should be given attention to determine if the initiative under study was flawed at the outset by the government's assessment of the policy problem(s).

[31] Gail Siler-Wells, "An Implementation Model for Health System Reform," *Social Science and Medicine* Vol.24, No.10 (1987):821-832. On p. 825-26 she argues that implementation strategies should be conceptually distinguished from the actual process of implementation.

flaws that have been given attention in the literature.[32] The central flaw is the model's failure to elaborate how interactions between state and pressure group actors should be conceptualized within the goal formation and implementation stages of the process. Researchers have responded to this problem by suggesting the use of what the literature describes as polycentric models to conceptualize these interactions.[33] A prominent Canadian contributor to the literature on polycentric models is A. Paul Pross. He argues that the decisions related to goal formation and implementation are the product of debates within established policy communities that dominate a particular policy field.[34] While his policy community concept has not been used to systematically research the evolution of health care policy in a Canadian province, it has shown promise in federal health care research and in other policy fields.[35] As a result, this study's conceptualization of each stage of the policy process in Manitoba will employ

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[32] Peters, "The Policy Process: An Institutionalist Perspective,". On p. 165 he defines four problems the model implies that must be treated with caution: that the process is driven only by inputs from the immediate environment; that the process is linear; that a problem makes a single transit through the process; and that events in the process occur in isolation from events in other policy fields.

[33] Examples an be found in Paul A. Sabatier, "An advocacy Coalition Model for Policy Change and the Role of Policy-oriented Learning Therein," *Policy Sciences* Vol.21 (1988):129-68 and A. Grant Jordan, "Policy Community Realism versus 'New' Institutionalism Ambiguity," *Political Studies* Vol.38 (1991):470-84.

[34]A. Paul Pross, *Group Politics and Public Policy* 2d ed.(Toronto: Oxford University Press, 1992). See p.114-139 for a description of the policy community concept.

[35] See Boase, *Shifting Sands Government-Group Relations in the Health Care Sector*, for an example of the application of this model at the federal level. For examples in other policy fields see J.D. Forbes, *Institutions and Influence Groups in Canadian Farm and Food Policy* (Toronto: The Institute of Public Administration of Canada, 1985) and Evert A. Lindquist, "Public managers and policy communities: learning to meet new challenges," *Canadian Public Administration* Vol.35, No.2 (1992): 127-159.

this concept to research interactions among key state and pressure group actors. It will also employ the work of a number of other neo-pluralist authors to specify the scope and nature of these interactions.[36] On the one hand, Sabatier and Jenkins-Smith's model, which offers a more detailed understanding of the interactions in a policy community than the model offered by Pross, will be employed to determine whether certain state and pressure groups actors formed a policy subsystem within Manitoba's larger health care policy community that dominated debates related to the formation and implementation of policy outputs pertaining to services delivery.[37] On the other hand, Coleman and Skogstad's research related to the existence of unique types of communications networks among actors contained in a policy community will be employed here to determine the nature of interactions within Manitoba's policy subsystem.[38]

The importance of these networks in the process of policy formation is the focus of Price Boase's research which employs Coleman and Skogstad's findings, along with the findings of other researchers interested in policy

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[36] The linkage of Pross to these two sets of authors is consistent with the discussion of policy formulation offered by Michael Howlett and M. Ramesh. See *Studying Public Policy: Policy Cycles and Policy Subsystems* (Toronto: Oxford University Press, 1995), 122-136.

[37] Paul A. Sabatier and Hank C. Jenkins-Smith, *Policy Change and Learning: An Advocacy Coalition Approach* (Boulder: Westview Press, 1993). See p.224 for their policy subsystem model. Also note that Carrothers et al.'s findings suggest that a subsystem of this type was formed and involved actors contained in the province's Executive Council, its Department of Health, and its health services commissions as well as pressure group actors representing hospitals and physicians.

[38] Coleman and Skogstad, "Policy Communities and Policy Networks: A Structural Approach," in *Policy Communities and Public Policy in Canada*, 14-33.

networks,[39] to explore the general nature of policy community interactions within Canada and the US. Based on her review of this literature she suggests that "...there are three broad types of policy networks that are particularly appropriate to describe the processes of intermediation in the health policy sector...".[40] She labels each as pressure pluralism, clientelism and corporatism and argues that the dominant type of network operating in a policy community has important implications for the types of policy outputs produced by a state.[41] While the definition of each type of network is elaborated in the following section, Price Boase's conclusions are noteworthy here.[42] First, she suggests that Canada has been more successful than the US in providing a comprehensive publically funded health care system because state institutions have been able to better withstand negative reactions from pressure groups to the redistributive policies demanded by Canada's approach to public policy in this area. In short, she argues that Canadian health care policy communities have displayed a greater capacity to resist the formation of pressure pluralist and clientelistic networks in favour of corporatist intermediation. Second, she agues that the Canadian

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[39] For example, see Klaus Schuber and Grant Jordan, "A Preliminary Ordering of Policy Network Labels," *European Journal of Political Research* Vol.21, No.1 (1992): 1-28 and Frans Van Waarden, "Dimensions and Types of Policy Networks," *European Journal of Political Research* Vol.21, No.1 (1992):29-53.

[40] Joan Price Boase, "Institutions, Institutionalized Networks and Policy Choices: Health Policy in the US and Canada," 292.

[41] Ibid., see 292-94 for her definition of these types of interest intermediation. Her definition of each type is elaborated in the discussion pertaining to Question 3 in the following section.

[42] Ibid., 303-304.

state's tendency for corporatist intermediation is rooted in the historic evolution of its organizational and institutional arrangements for health care delivery which have produced an institutional context for the ensuing health care policy debates. She notes that in contrast to the US:

> The decision to embrace public health insurance in Canada has driven all subsequent decisions and it has determined the nature of interest intermediation. Similarly, in the United States, early decisions to pursue market principles in health policy have ensured continued acquiescence to the interests of the medical/industrial complex.[43]

THE EVALUATION OF IMPACTS

The literature related to policy evaluation also offers a range of approaches that a researcher must consider in the development of a research design. For example, Howlett and Ramesh note that three types of evaluation have generally been employed.[44] Pal also offers a discussion of evaluation techniques in which he defines four general types.[45] The type that best fits the focus of this study is Pal's *direct* type which is similar to but more specific than Howlett and Ramesh's administrative type. Pal indicates that research employing this type of evaluation must recognize two important features of policy activity. The first is that all policy outputs combine ultimate goals, which are

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[43] Ibid., 303.

[44] Howlett and Ramesh, *Studying Public Policy: Policy Cycles and Policy Subsystems*. On 170-75 they define these three general types as; administrative evaluation, judicial evaluation, and political evaluation.

[45] Pal, *Public Policy Analysis*. On 183-93 he defines the central features of Direct, Political, Economic, and Social types of impacts evaluation.

"...the final end states to which a policy is directed...", and intermediate goals related to "...the erection or establishment of means to achieve those end states." [46] Based on this distinction he argues that, while ultimate goals are important motivators in the effort to implement intermediate policy goals, a direct impacts evaluation should concentrate on intermediate goals because governments in Canada focus their resources on the achievement of this type of goal.[47] Pal's distinction between ultimate and intermediate goals is supported by other policy researchers who suggest that policy goals related to organizational rationalization initiatives should be viewed as intermediate means to an ultimate end. For example, Lindquist argues that, while organizational rationalization is often presented as an ultimate response to a range of technical problems in a service delivery system, it is usually an intermediate technical solution to an ultimate political end; enhancement of a government's legitimate ability to implement and administer policies intended to increase the long-term efficiency and effectiveness of the delivery system.[48]

The second feature relates to Pal's position that the formation of policy

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[46] Ibid., p.185.

[47] Ibid., On p.185-86 he indicates that this is the case because the empirical realization of ultimate goals is mediated by a complex of variables that are beyond the authority of Canadian governments to control through the range of policy instruments currently available to them.

[48] Evert A. Lindquist, "Recent Administrative Reform in Canada as Decentralization: Who is Spreading What Around to Whom and Why?," *Canadian Public Administration* Vol.37, No.3 (1994): 416-430. On 416 Lindquist notes that while stated public sector rationales for organizational rationalization are often based on the need to respond to specific technical problems in a delivery system, their implementation is ultimately motivated by "...the twin imperative of controlling government deficits and reducing debt....".

goals and the implementation of instruments to achieve those goals are two different, albeit related, forms of policy activity.[49] His discussion of both types of policy activity indicates that the successful formation of a policy does not necessarily mean its goals will be realized empirically because they may be altered during the implementation process. He argues that this is likely to occur when a government interested in implementing an administratively rational response to a perceived policy problem overlooks or ignores political and administrative barriers that may be placed in its path.[50] Siler-Wells and Rodwin offer empirical support for this position. In her article, Siler-Wells notes that the public sector's inability to effectively manage instrument implementation has been the primary reason for the failure of what she defines as positive health care reforms.[51] Similarly, Rodwin concludes his survey of the evolution of health care policy in four states by noting that all were "...unable to alter significantly the allocation of health care resources in conformance with health plans...due to problems encountered during the implementation of those plans."[52] In short, both suggest that the instrument implementation phase of a health services rationalization initiative is vital to its empirical realization because it is during this

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[49] Pal, *Public Policy Analysis 2d ed.* See 98-170 for his discussion of policy formation and 171-98 for his discussion of policy implementation in Canada.

[50] Ibid., 10.

[51] Siler-Wells, "An Implementation Model for Health System Reform,". On 821 she suggests that an emphasis on care and cure of the sick represents negative health policy while promoting and maintaining good health represents positive health policy.

[52] Rodwin, *The Health Planning Predicament,* 219.

phase that barriers to change are likely to be encountered.

In summary, the literature reviewed here supports the division of the research questions, defined in the following section, into three groups which describe and evaluate: the process of goal formation in Manitoba's health care policy community across the defined time frame; the process of implementation pertaining to policy outputs developed during this time frame; and the impacts of implemented policies on the capacity and costs of the province's delivery system, as well as the distribution of policy and administrative control. The responses to these questions, contained in Chapter 5 and 9, are based on a mix of qualitative and quantitative indicators operationalized through a case study of the six governing administrations covered by this study's time frame.[53] The data base for these indicators is grounded on a survey of documents produced by state actors, provider pressure groups, and independent researchers during this time frame.[54]

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[53] This mixed approach to research design is supported by Catherine Marshall and Gretchen Rossman in *Designing Qualitative Research* (Newbury Park: Sage Publications, 1989). Also see Robert K. Yin, *Case Study Research: Design and Methods* (Newbury Park: Sage Publications, 1989) for a detailed discussion of the application of case study techniques in this context.

[54] See Tomas Klassen and Suzanne LeBlanc, "Methodological Issues in Sociological Research on Public Policy: Utilizing Government Documents," *Society*, February 1993, 9 - 13. Based on this article's findings, every effort was made to cross-reference all data using multiple sources to ensure that the data was not contaminated by the political interests of the party in power.

THE RESEARCH QUESTIONS

This section defines nine questions that are asked in the context of the empirical data gathered for this study. They are discussed in the following three subsections which are based on this study's application of the stages model of the policy process discussed in the previous section. Each subsection begins with a Table that summarizes the questions and their potential indicators.

GOAL FORMATION

Table 2.1: Questions and Indicators Related to Goal Formation

Question	Indicators
1. What forms of policy initiatives did executive council actors in each administration attempt to pursue in their interactions with other actors in the province's health care policy community, in particular, the subsystem actors responsible for services delivery?	The initiatives each administration attempted to pursue in the health care policy community subsystem responsible for services delivery related to: a) price and supply constraints; b) organizational rationalization; c) cost-shifting.
2. How did actors in the policy subsystem respond to the agenda of executive council actors in each administration and were advocacy coalitions evident in these responses?	The response of subsystem actors to each administration's agenda, in particular, the geographic, decentralization, and rationalization dimensions of agenda items.
3. What type of communications network did Manitoba's health care services delivery subsystem display and what kinds of normative assumptions were expressed by subsystem actors?	Whether the subsystem displayed: a) pressure pluralist; b) clientelistic; c) corporatist tendencies in its intermediation behaviours and/or the normative positions taken by key actors in policy debates.

Question 1: What forms of policy initiatives did executive council actors in each administration attempt to pursue in their interactions with other actors in the province's health care policy community, in particular, the subsystem actors responsible for services delivery ?

As noted in the previous section, this study's conceptualization of the policy process assumes that key actors involved in the formation of health policy in Manitoba can be found in a policy community that, in turn, contains a subsystem of government and pressure group actors that network to debate the formation and implementation of policies pertaining to the delivery of health care services. Based on the findings of Carrothers et al, this subsystem appears, at minimum, to contain the following group of actors: political actors in the executive council branch; political actors in the opposition parties; bureaucratic actors in the Department of Health and the province's hospital/health services commissions; pressure group actors representing the interests of hospitals and other institutional providers; and pressure group actors representing the interests of private sector providers, in particular, physicians. The response to this question will assess the types of initiatives that these subsystem actors, along with any other actors identified in the study, debated over the time frame of the study. These initiatives will be categorized based on Tuohy's observation that provincial governments may exert "three types of policy leverage" in the management of their health care delivery systems:[55]

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[55] Tuohy, "Federalism and Canadian Health Policy," 148-155. Tuohy's findings are supported by similar findings related to other industrialized nations. For example, see Martin Harrop, "Health Policy," in *Power and Policy in Liberal Democracies*, ed. Martin Harrop (Cambridge: Cambridge University Press, 1992),150-73, which indicates that in the four countries he studied the policy options Tuohy enumerates were also the "main strategies" that have been employed.

a) price and supply constraints which can include limits on the budgets of institutional providers, limits on increases in negotiated medical fee schedules, attempts to constrain the number and/or distribution of practising physicians, and attempts to constrain the volume and mix of services provided by physicians;

b) organizational rationalization which can take a number of forms including the regionalization of services administration, revision of professional legislation to alter the service delivery functions of professionals, and the development of alternative service delivery mechanisms in the form of Community Health Centres (CHCs) and Health Maintenance Organizations (HMOs);

c) the cost-shifting of services funding responsibility to citizens which can take the form of third party co-payments and/or direct charges to citizens.

In Chapters 5 and 9 the response to this question will identify the mix of options pursued by executive council actors during each era of policy development. The findings related to each era will be used to assess the argument made by Evans, noted in the introduction of Chapter 1, related to provincial cost control policy preferences. His argument suggests that the following hypothesis should be the focus of this assessment:

Hypothesis 1: That during the time frame of this study executive council actors in Manitoba preferred price and supply constraints over the other available cost control policy options.

Question 2: How did actors in the policy subsystem respond to the agenda of executive council actors in each administration and were advocacy coalitions evident in these responses?

This question will assess how actors in Manitoba's health care delivery subsystem responded to the policy agenda of executive council actors in each administration. The indicators employed to assess this response, which are re-

employed in the impacts evaluation, are based on Carrothers et al.'s finding that provincial cost control strategies, in particular those related to organizational rationalization, contain three dimensions:[56]

> a) a geographic dimension which involves strategies to alter the way the public sector resources for services delivery are distributed within the province;
>
> b) a decentralization dimension which involves strategies to alter the way authority for the governance and administration of the delivery system are distributed within the province;
>
> c) a rationalization dimension which involves strategies to alter the way services are delivered to citizens through the delivery system.

The response to this question will describe similarities and differences in the policy positions related to each dimension taken by key actors in Manitoba's subsystem. With regard to the first dimension, this description will be sensitive to Carrothers et al.'s finding that, prior to the 1970s, provincial policies related to the funding of public health and the construction of institutional facilities favoured more affluent regions of Manitoba.[57] Turning to the second dimension, this study will give particular attention to their finding that, beginning in the 1960s, the re-allocation of administrative authority for services delivery began to emerge as a policy issue. In this area they note that, on the one hand, the supporters of improved delivery system efficiency favoured the creation of

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[56] Carrothers et al., *Regionalization and Health Care Policy In Canada.* On 5 they define regionalization as: "...the selective application over time of concepts contained within its decentralization, geographic and rationalization dimensions by governments, agencies, and pressure groups responsible for the planning, financing, and delivery of health and related social services."

[57] Ibid., see 51-55 for their discussion of the development of local health care services.

regional authorities to centralize the planning and administration of services at the sub-provincial level. On the other, the supporters of improved effectiveness favoured realignments in the administrative roles of existing local units to enhance their responsiveness to local needs.[58] By the early 1970s municipal governments were willing to have their delegated authority for public health services returned to the province so that it could be re-delegated to new regional units. However, hospitals operated by municipal, religious, and lay boards were unwilling to give up any of their delegated authority based on fears that this would result in the closure of their facilities. As a result, Carrothers et al. indicate that policy debates in Manitoba since the early 1970s have focussed on two aspects of this dimension: the centralization of local administrative authority at the provincial/regional level to reduce delivery system fragmentation and enhance the co-ordination of services delivery; and the decentralization of provincial administrative authority to regional/local units to enhance provider responsiveness to the health care needs of local populations.[59] Turning to the

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[58] Their findings mirror Badgley's observation that policy initiatives related to this dimension have been typified by the inability of key actors to define a consensus "...about how the boundaries of a region should be established, which components of services should be included under the authority of different branches of government, or whether local or national priorities take precedence." See Robin F. Badgley, "Regionalization of Health Services in Canada," *Israel Journal of Medical Sciences* Vol.18:375-83 on 375.

[59] Support for this finding can be found in Canadian Medical Association, *The Language of Health System Reform* (Ottawa: Canadian Medical Association, 1993),17-20 and A. Mills et al, *Health System Decentralization* (Geneva: World Health Organization, 1990), 15-24. Both studies indicate that a contributor to policy problems related to this dimension has been the inconsistent and sometimes contradictory positions taken by policy actors related to the centralization and/or decentralization of authority. Both also note that decentralization can take four different forms; deconcentration, delegation, devolution, and privatization.

third dimension, Carrothers et al. indicate that provider pressure group resistance to initiatives pertaining to the first two dimensions in the 1970s limited the ability of executive council actors to implement realignments in the delivery system roles of professional providers.[60] They do, however, note that experimentation in this area was undertaken in the 1970s based on a Single Unit Delivery System (SUDS) concept.

In Chapters 5 and 9 the response to this question will utilize the study findings to describe how subsystem actors responded to the policy agenda of executive council actors during each era and will give particular attention to their response to rationalization initiatives. It will also explore Sabatier and Jenkins-Smith's argument that pressure group actors in a policy subsystem form advocacy coalitions to enhance their ability to support or resist government policy initiatives that impact on their interests .[61] This argument forms the basis of the second hypothesis in this study:

> Hypothesis 2: That during each era actors in Manitoba's services delivery subsystem formed advocacy coalitions to support or resist the initiatives of executive council actors which, in turn, affected the scope and content of these initiatives.

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[60] Carrothers et al., Regionalization and Health Care Policy In Canada, 88-90. For a discussion of these functional roles, which are elaborated later in this chapter see A. Mills et al., ibid., 25.

[61] Sabatier and Jenkins-Smith, *Policy Change and Learning,* 212-13. They also suggest that bureaucratic actors will likely take centrist positions relative to the positions taken by government and pressure group coalitions.

Question 3: What type of communications network did Manitoba's health care services delivery subsystem display and what kinds of normative assumptions were expressed by subsystem actors?

This question extends the response to Question 2 by moving from a description of the policy positions of key actors in Manitoba's health care delivery subsystem to an assessment of the structure and content of subsystem interactions. The assessment of the structural features of this subsystem during each era will be based on Boase's argument, noted in the previous section, that health care policy networks can display three different types of intermediation which, in turn, impact on the scope and content of policy outputs:[62]

> a) pressure pluralism which is based on classical pluralist assumptions that policy outputs are the products of competition among pressure groups which, in turn, are implemented by a responsive state acting as a neutral mediator of the opposing interests represented in policy debates;
>
> b) clientelism which is based on critiques of classical pluralism that suggest state agencies can become dependent on the support and expertise of particular pressure groups for policy success and, in turn, become part of an institutionalized network in which the interests of these pressure groups dominate policy debates;
>
> c) corporatism which is accepted by some neo-pluralist and neo-marxist theorists as an arrangement in which state actors have clear interests in the content of policy debates that are autonomous of pressure group interests and are expressed in the decisions of these actors related to "...who will have access to policy debates and how they will participate in policy development." [63]

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[62] Boase, "Institutions, Institutionalized Networks and Policy Choices: Health Policy in the US and Canada," 292-293.

[63] Ibid., 293.

In addition to assessing the structural features of subsystem interactions in Manitoba based on these categories, the content of these interactions is also of interest. This area will be assessed based on Manzer's argument that the normative assumptions of key actors related to the proper balance between public-private sector control over a public good plays an important role in Canadian public policy debates.[64] Sabatier and Jenkins-Smith extend Manzer's argument by suggesting that the positions displayed by actors in a policy subsystem are the product of the linkage of three related types of beliefs:[65]

> a) deep core beliefs which pertain to normative assumptions about the general role of the state in the society;
>
> b) policy core beliefs which pertain to normative assumptions about the role of the state in a specific policy area;
>
> c) secondary aspects which pertain to the linkage of deep and policy core beliefs in responses to a policy initiative.

They note that, while deep core beliefs are rarely, if ever, contained in the policy statements of subsystem actors, policy core beliefs are sometimes displayed in the pattern of secondary belief systems displayed by these actors. As a result, this question will, whenever possible, utilize the findings related to Question 2 to identify whether subsystem actors displayed consistent secondary

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[64] Ronald Manzer, *Public Polices and Political Development in Canada*, (Toronto: University of Toronto Press, 1985). On 19 he argues that public sector in Canada has always been required to balance demands in Canada's political culture produced by the "...fundamental contradiction between economic and ethical liberalism." This contradiction is important to health care policy debates because it favours the assumption that private sector actors can always deliver services more efficiently and effectively than public sector actors.

[65] Sabatier and Jenkins-Smith, *Policy Change and Learning*, 220-21.

positions that suggest deeper policy core beliefs. The response to it in Chapters 5 and 9 will, in turn, give attention to the role that these beliefs played in health care delivery subsystem's ability to establish a consensus on how policy initiatives should be implemented. This response will contribute to a test of the following hypothesis related to this question:

> Hypothesis 3: That during each era the structure and content of interactions between key actors in Manitoba's health care delivery subsystem affected the scope and content of the public policy initiatives that were produced.

POLICY IMPLEMENTATION

Table 2.2: Questions and Indicators Related to Policy Implementation

Question	Indicators
4. What types of initiatives were actively pursued by executive council actors in Manitoba's health care delivery subsystem into the implementation stage?	Whether executive council actors attempted to implement initiatives related to: a) price and supply constraints; b) organizational rationalization; c) cost-shifting.
5. Were pressure group and/or opposition party barriers to the implementation of these initiatives encountered by executive council actors?	The barriers, if any, that these actors attempted to erect to limit the ability of executive council actors to implement initiatives flowing from the policy formation process.
6. Were bureaucratic barriers to the implementation of these initiatives encountered by executive council actors?	The barriers, if any, that these actors attempted to erect to limit the ability of executive council actors to implement initiatives flowing from the policy formation process.

Question 4: What types of initiatives were actively pursued by executive council actors in Manitoba's health care delivery subsystem into the implementation stage?

In Chapters 5 and 9 the response to this question will summarize the scope and content of the policy initiatives that executive council actors in Manitoba's health care delivery subsystem attempted to implement utilizing the indicators defined in Question 1. These responses will re-employ the arguments made by Evans[66] to test the following hypothesis:

> Hypothesis 4: That during the time frame covered by this study executive council actors in Manitoba preferred to implement price and supply constraints over the other available cost control policy options.

Question 5: Were pressure group and/or opposition party barriers to the implementation of these initiatives encountered by executive council actors?

In discussions of their research findings, Rodwin and Siler-Wells both identify three areas where barriers to the implementation of health care policy initiatives may reside: [67]

> a) among members of the general public who are likely to resist an initiative that challenges dominant ideas about what health policy is and the services that define its successful realization;
>
> b) among provider pressure groups who are likely to attempt to convert what they view as a "top-down" implementation process into a "bottom-up" political debate legitimized by the need to protect the public interest;
>
> c) among bureaucratic actors who may not support a government's policy goals or, even if they do, may fail to properly co-ordinate the implementation of those goals.

The first two barriers they identify are the focus of this question while the

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[66] Evans, "Canada: The Real Issues," 758.

[67] See Rodwin, *The Health Planning Predicament,* 221-232 and Siler-Wells, "An Implementation Model for Health System Reform," 824-25.

last is the focus of the next question. With regard to the first barrier, Siler-Wells and Rodwin both suggest that public resistance to policy change in the health field is the product of structural constraints within a state's political culture. This is supported by Marmor et al. who argue that Canada's political culture is dominated by a "health paradigm" which supports a perception that medical care is the primary, if not the only, contributor to population health and, therefore, should be the central focus of public policy.[68] They suggest that if executive council actors are not sensitive to this paradigm during the formation of an initiative's goals and/or do not develop effective strategies to respond to it during the implementation stage, then the initiative is likely to be resisted by those who view it as residing outside of the established boundaries of legitimate state policy activity. Support for this argument can be found in Rodwin's discussion of efforts to implement supply-side rationing in the states he surveyed. He argues that these initiatives met with limited success because government actors failed to link implementation with a campaign to inform the public of the empirical relationship between means, in the form of growing public sector resource inputs for medical services, and ends in the form of a plateau in population health improvement. In short, these governments failed to challenge dominant perceptions in the political culture that expanding access to medical services is the moral and political equivalent of doing good.[69] As a result, the opponents of

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[68] Marmor et al., "The Determinants of a Population's Health," 219.

[69] Rodwin, *The Health Planning Predicament*, 221-23.

these initiatives were able to cast them as an attempt to restrict the public's access to health care which, in turn, allowed them to construct barriers based on the argument that limiting access is the moral and political equivalent of doing harm.

Turning to the second barrier, Marmor et al. suggest that the resistance to policy change displayed by provider pressure groups in Canada has been an important check on the formation and implementation of new policy initiatives. They argue that this resistance has its base in the organizational arrangements for services delivery established in the late 1950s which produced and continue to reinforce an organizational culture among health care providers that views any initiative that negatively affects a provider's ability to offer what the culture defines as "necessary medical services" as a threat to the public's interest in improved population health.[70]

In Chapters 5 and 9 the response to this question will describe whether opposition party or provider pressure group resistance to the implementation of cost control initiatives during both eras were a barrier to policy implementation. It will also test arguments made by Rodwin, Siler-Wells, and Marmor et al. related to the ability of these actors to affect the implementation process. All three are critical of an assumption made by some health care policy researchers that opposition party and/or provider pressure group resistance to policy change is the single most significant barrier to the implementation of cost control

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[70] Marmor et al., "The Determinants of a Population's Health," 219.

initiatives.[71] They argue that because these actors tend to be reactive to the initiatives of executive council actors, their ability to successfully construct barriers is directly related to the ability of executive council actors to anticipate these barriers and develop strategies to overcome them. Hurley et al.'s survey of provincial health policy studies indicates that executive council actors are aware of this problem. However, they note that the six commissions they studied recommended two potentially conflicting strategies to facilitate the implementation of their recommendations: persuading the public that organizational rationalization is politically legitimate because its allows opportunities to make providers more accountable for resources utilization through the enhancement of citizen participation in the administration of services delivery; and persuading the public that it is scientifically legitimate because it allows opportunities for public resources to be redeployed to services that should have the most significant positive impacts on population health. They note that the potential for conflicts between these strategies flows from the need to implement instruments based on the first strategy, which decentralize administrative authority, and the need to implement instruments based on the second strategy which demand the centralization of that authority.[72]

Given these arguments, this question will test them through the following

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[71] See Rodwin, *The Health Planning Predicament*, 225-26. Here he argues that this assumption has its base in the normative assumptions made by classical pluralists which are not empirically valid. For a critique of these normative assumptions see Held, *Models of Democracy*, 186-220.

[72] Hurley, et al., "When Tinkering is Not Enough: Provincial Reform to Manage Health Care Resources," 509.

hypothesis:

> Hypothesis 5: That during the time frame of this study executive council actors in Manitoba were unable to fully implement their cost control initiatives when they failed to anticipate and develop strategies to overcome opposition party and/or pressure group barriers.

Question 6: Were bureaucratic barriers to the implementation of these initiatives encountered by executive council actors?

This question extends the above discussion by focussing on the role that bureaucratic actors play in the implementation of executive council initiatives. While the health care literature in Canada does not give a great deal of attention to the interactions between executive council and bureaucratic actors in the implementation process, Hancock and Siler-Wells both hint at the importance of this relationship. Hancock notes that the failure of governments in Canada to implement initiatives suggested by the Lalonde Report since the mid-1970s has been due to the inability of political and bureaucratic actors at both levels of government to develop an implementation strategy for the policy changes suggested by this report.[73] Siler-Wells supports Hancock's findings by suggesting that an important barrier to the implementation of what she describes as "health improvement" initiatives in Canada has been the failure of executive council actors to provide bureaucratic implementors with an adequate level of political and budgetary support.[74]

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[73] Hancock, "Lalonde and Beyond: Looking Back At 'A New Perspective on the Health of Canadians' ", 95.

[74] Siler-Wells, "An Implementation Model For Health System Reform," 823.

Given these hints, this question explores relations between executive council and bureaucratic actors in the implementation process based on Sabatier and Jenkins-Smith's discussion of the "guidance instruments" used by government actors to influence bureaucrats during the implementation process. In this discussion they divide these instruments into two groups:[75]

> a) direct instruments which are used by executive council actors to affect the internal dynamics of an implementing agency such as changes in the organization of the agency, changes in the agency's senior management, and public comment on the performance of agency staff;
>
> b) indirect instruments which are used by executive council actors to affect the dynamics around the implementing agency such as changes in the agency's political appointees, changes in the legislative authority of the agency, changes in the agency's budget, an agency mandate review, and attempts to influence public opinion related to the implementation of the initiative.

In Chapters 5 and 9 the response to this question will describe the observed interactions between executive council and bureaucratic actors in an effort to assess the role these interactions played in the implementation process and whether direct or indirect guidance instruments were employed by executive council actors to influence the course of policy implementation. This description will be based on the following hypothesis:

> Hypothesis 6: That during the time frame of this study executive council actors in Manitoba encountered bureaucratic barriers to their cost control initiatives when they failed to anticipate these barriers and employ guidance instruments to overcome them.

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[75] Sabatier and Jenkins-Smith, *Policy Change and Learning*, 226-27.

POLICY IMPACTS

While the health sciences literature offers a range of indicators that could be applied to the study of policy impacts, it does not specify how they should be operationalized in the context of organizational rationalization research.[76] The reason for the literature's limited guidance in this area can be found in a Task Force report sponsored by the Ontario Premier's Council on Health, Well-being and Social Justice. In a discussion of its literature review, the Task Force notes that, while the available literature was helpful in identifying potential evaluation questions and indicators related to cost control policy, "...there was no literature that reported specific examples of actual evaluation projects...".[77] As a result, the impacts of interest in this study are based on the linkage of Carrothers et al.'s findings with those of the Task Force. While the impacts of potential research interest identified by the Task Force are specific to organizational rationalization within a region, they are more broadly employed here because the research model defined by the Task Force:

> - is consistent with this study's approach to cost control initiatives as intermediate policy goals intended to realign a health services delivery system to enhance its efficiency and effectiveness;[78]

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[76] For a description of the range of indicators and a discussion of their application in the literature see Avi Yacar Ellencweig, *Analysing Health Systems A Modular Approach* (Oxford: Oxford University Press, 1992).

[77] Ontario, *A Framework for Evaluating Devolution* (Toronto: Task Force on Devolution, Premier's Council on Health, Well-being and Social Justice, October 1994) 3. A summary of the findings of the Task Force's literature review is offered on p.B-3-B-11.

[78] Ibid., 13. Here the Task Force indicates that the model is grounded on the assumption that "...a change in where power resides will have an impact on the accountability for and performance of the health and social services system...".

- employs a causal chain to define evaluation modules that is consistent with this study's use of the stages model to conceptualize the process of policy formation, implementation and evaluation of the direct impacts of intermediate policy goals.[79]

As a result, the following questions link three types of impacts defined in the third module of this model, related to the scope, authority and functions of key actors in Manitoba's cost control policy network, with Carrothers et al.'s definition of the three dimensions of regionalization.

Table 2.3:Questions and Indicators Related to Policy Impacts

Questions	Indicators
7. How did implemented policy initiatives alter the functional and geographic scope of Manitoba's health care delivery system?	a) Observed changes in the functional scope of provincial health care policy; b) Observed changes in the geographic distribution of services within the province.
8. How did implemented policy initiatives alter administrative authority in Manitoba's health care delivery system?	a) Observed changes in the planning and administrative roles of key actors; b) Observed changes in the distribution of budgetary resources to key actors.
9. How did implemented policy initiatives alter functional roles in Manitoba's health care delivery system?	Observed changes in the functional roles of key actors based on a nine category list of functional roles defined by Mills et al.

Question 7: How did implemented policy initiatives alter the functional and geographic scope of Manitoba's health care delivery system?

Two groups of indicators are utilized in the response to this question.

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[79] Ibid., the first two modules are designed to evaluate the formation and implementation of policy goals while the third and fourth modules define indicators of *immediate* and *ultimate* impacts. The Task Force's use of the term immediate is consistent with Pal's use of the term intermediate goals and its approach to impacts assessment is consistent with Pal's direct impacts form of evaluation.

The first group focuses on the functional scope of health care policy and is based on a continuum offered in the Ontario Task Force which defines how policy change could expand the scope of a delivery system. One end of this continuum is occupied by traditional medical services, the middle areas are occupied by a broader range of community-based health and social services, and the other end of the continuum includes services such as public housing, economic development programs and environmental protection.[80] In Chapters 5 and 9 the impact of policy changes implemented during each era will be assessed by comparing the scope of the province's functional responsibilities at the beginning of the era with its scope at the end of the era. The second group of indicators focuses on the geographic distribution of public health, acute care, and long-term care services in Manitoba and is based on Carrothers et al.'s geographic dimension of regionalization. The response to this part of the question will utilize data contained in the appendixes of this study to describe observed changes in the geographic distribution of these services. The impact of policy change will be assessed by comparing their distribution at the start of the era with their distribution at the end of the era. The following null hypothesis guides the initial research assumptions related to this assessment.

> Hypothesis 7: That policy initiatives implemented to realign the functional and geographic scope of Manitoba's health care delivery system did not produce significant policy impacts.

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[80] Ibid., p.21-22.

Question 8: How did implemented policy initiatives alter administrative authority in Manitoba's health care delivery system?

The response to this question is also based on two groups of indicators. The first group is informed by Carrothers et al.'s findings related to the decentralization dimension of regionalization and involves an assessment of changes in the planning and administrative authority of key actors during each era. The importance of this type of assessment is supported by the Canadian Medical Association's Working Group Report on Regionalization and Decentralization. This report argues that realignments in authority roles can take two distinct forms; they can be centralized at the local, regional, or provincial level and/or they can be decentralized at the sub-provincial level in four possible ways:[81]

- the deconcentration of providers to a regional or local unit with the province retaining planning and administrative authority for their service delivery functions;

- the delegation of provincial administrative authority for service delivery functions to a regional or local unit or some other sub-provincial agency;

- the devolution of provincial planning and administrative authority for service delivery functions to a regional or local unit or some other sub-provincial agency;

- the privatization of provincial planning and administrative authority for service delivery functions to a private person or agency.

Carrothers et al. indicate that government administrations in Manitoba undertook the implementation of a variety of initiatives to alter the planning and

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[81] Canadian Medical Association, *The Language of Health System Reform*, 15-20.

administrative authority of key actors in the delivery system through the centralization and/or decentralization of authority. They also suggest that while these initiatives expanded provincial authority, they did not have a significant impact on the authority roles of other actors in the delivery system. To test this suggestion this group of indicators will compare the authority of key actors at the beginning of an era with their authority at the end of the era.

The second group of indicators have their base in the Ontario Task Force's argument that changes in the distribution of budgetary resources among key actors in a delivery system also provide an indication of changes in their authority roles. As a result, this group of indicators utilizes provincial budgetary data, detailed in Appendix D, to assess changes in the allocation of resources to key actors during each era. The measurement of changes in this area will be based on a comparison of the percentage of the province's health care budget captured by various providers at the start and end of each era. The following null hypothesis guides the initial research assumptions related to this assessment

> Hypothesis 8: That policy initiatives implemented to realign planning and administrative authority in Manitoba's health care delivery system did not produce significant policy impacts.

Question 9: How did implemented policy initiatives alter functional roles in Manitoba's health care delivery system?

The response to this question is informed by the linkage of Carrothers et al.'s discussion of the rationalization dimension of regionalization with a discussion of functional service delivery roles offered by the Ontario Task Force

Report.[82] It will assess changes in these functional roles during the tenure of each administration. However, rather than using the seven category list of roles defined in the Ontario Task Force as indicators, this question will apply a broader nine category list defined by Mills et al. in their discussion of functions that are frequently the targets of health care policy change.[83] This list includes:

- legislative functions pertaining to the governance of the delivery system;

- inter-sectoral collaborative functions with other jurisdictions to facilitate the funding of services delivery;

- revenue-raising functions related to the funding of services;

- planning and resource allocation functions related to services delivery;

- policy-making functions related to the licensing of and standards for service providers;

- inter-agency coordinative functions related to services delivery;

- regulatory functions related to the resource utilization practices of professional providers;

- training functions related to the education and placement of professional providers;

- management functions related to the day-to-day administration of services delivery.

In the final chapter the response to this question will offer a comparative assessment of cumulative changes related to these indicators over the time

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[82] Ontario, *A Framework for Evaluating Devolution*, 27-30. For related discussions of the realignment of functional roles see Canadian Medical Association, *The Language of Health System Reform*, 119-125 and Jeremiah Hurley, Stephen Birch, John Eyles, *Information, Efficiency And Decentralization Within Health Care Systems* (Hamilton: The Centre For Health Economic and Policy Analysis Working Paper Series No.92-21, 1992) 11-12.

[83] Mills, et al., *Health System Decentralization Concepts, Issues and Country Experience*, 25.

frame of the study. The following null hypothesis guides initial assumptions related to this assessment.

> Hypothesis 9: That policy initiatives implemented to alter functional administrative roles in Manitoba's health care delivery system did not produce significant policy impacts.

As the final section of Chapter 1 indicates, the questions and indicators described here are utilized to systematically assess the evolution of health care policy in Manitoba between 1948 and 1988 contained in the next seven chapters. Chapters 3 and 4 describe The Era of Provincial Capacity Growth which is assessed in Chapter 5. The Era of Provincial Cost Control is described in Chapters 6, 7, and 8 and is assessed in Chapter 9 which also compares policy behaviour during both eras covered by this study. Chapter 9 concludes with an assessment of the role that factors related to the process of goal formation and implementation played in the observed policy impacts, and the implications of the study findings for future health care policy research at the provincial level of government in Canada.

CHAPTER 3.

IMPROVING ACCESS TO CARE: 1948 - 1958

As the discussion in Chapter 1 indicates, the focus of health care policy in Canada following World War II was the expansion of provincial delivery systems to enhance citizen access to medical care. This chapter is the first of two that focuses on Manitoba's efforts to improve citizen access to care services. It begins with a discussion of three policy outputs produced between 1945 and 1948 that established the foundation for delivery system growth throughout much of the 1950s. The second section turns to a discussion of the policy initiatives of Premier Douglas Campbell's administration which governed Manitoba between 1948 and 1958. This discussion indicates that the Campbell administration utilized revenues from a 1948 taxation agreement and the National Health Grants Program, which began the same year, to enlarge and modernize the delivery of community-based public health and institutional acute care services in the province. The concluding section of the chapter summarizes the makeup of Manitoba's health care delivery subsystem and the impacts that it had on the province's delivery system capacity and its health care budget.

THE POST-WAR POLICY ENVIRONMENT

When World War II ended in 1945, Manitoba was governed by a coalition of political parties dominated by the Liberal Progressive (LP) party led by Stuart Garson.[1] Morton describes this coalition's approach to governing as "non-partisan" and indicates that policy formation was the product of a "partnership" between the cabinet and senior civil servants. He also notes that "...the unintended result of this partnership of able civil servants and non-political ministers was, not a theory of government, but a habit of administration..." [2] During the immediate post-war era this partnership produced a number of policy initiatives that had a significant impact on health care delivery in the province. The first was the April, 1945 passage of *An Act to Provide for the Improvement of the Health of the Citizens of the Province.* This Act, the short title of which was *The Health Services Act*, was the first major legislative redefinition of the province's health care delivery role in seventeen years and was given Royal Assent six months prior to the October 15 general election.[3] It contained four sections which defined provincial and local government roles related to the administration and delivery of the following services.

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[1] This coalition had governed Manitoba under the leadership of John Bracken since 1922. In 1943 Bracken left the Premiership to lead the federal Progressive Conservative Party. Garson replaced Bracken in 1943 as the leader of the coalition and won his first election as Premier in October of 1945.

[2] W. L. Morton, *Manitoba: A History* 2d. ed. (Toronto: University of Toronto Press, 1967), 460.

[3] The last major redefinition was in 1928 when the Ministry of Health and Public Welfare was established. Prior to 1928 provincial health care policy, which was largely defined by *The Public Health Act* of 1911, was the responsibility of The Provincial Board of Health. This Board was part of the Municipal Commissioner's administrative mandate.

- Preventive Medical Services which were to be delivered through Local Health Units (LHUs) responsible for services defined by *The Public Health Act*. These units were to be governed by an advisory board made up of one or two appointees from each of the municipalities participating in the Unit, one or two provincial appointees, a physician practicing in the area, and the Unit's Medical Director. Funding for these Units was shared with two-thirds of the costs provided by the province and the other third provided by the participating municipalities.

- Diagnostic Services which were to be delivered through Local Laboratory and X-Ray Units. To set up a Unit of this type a Local Health Unit had to be established as the LHU board was required to assume responsibility for its administration. The cost-shared funding arrangements for these Units were the same as those for LHUs.

- Clinical Medical Care Services to indigents residing in municipalities that were not able or willing to participate in LHUs. These services were to be delivered by local physicians who would be paid by a Medical Care District Board made up of municipal appointees. These District Boards replaced those responsible for the Municipal Doctor program, established in 1916, and were to be funded on a 50-50 cost -shared basis by the participating municipality and the province.

- Acute Care Hospital Services which were to be delivered by two types of institutions: District Hospitals and smaller Medical Nursing Units. The governing boards of both types of institution were to be composed of appointees from the municipalities participating in the District or Unit. Funding for the construction and/or renovation of these institutions was to be shared on a 75/25% basis by the participating municipalities and the province. The participating municipalities were responsible for the costs related to the services delivered by these institutions and could generate income by billing patients and/or their third party private insurers for the services they provided.

Following the passage of *The Health Services Act,* the Garson administration announced that its implementation would be based on a plan developed in anticipation of the Act's passage. It was titled *The Manitoba Health Plan* and was distributed throughout the province in the summer and fall of 1945

by Manitoba Pool Elevators Ltd. who paid its printing and distribution.[4] In addition to explaining the intent of the four sections of the Act, this Plan divided the southern half of the province, which contained the majority of Manitoba's one hundred and eighty-five cities, towns, villages, and rural municipalities, into three large regions which, in turn, were sub-divided into a total of thirty-three district units and seventy-eight local units. The intent of this geographic division was to facilitate municipal proposals for the establishment of LHUs and three types of acute care facilities.

> - Regional Base Hospitals providing a full range of specialized medical services. Under the plan the Winnipeg and the St. Boniface General Hospitals were designated to serve the Eastern region of the province with the Brandon General Hospital serving the Western region and the Dauphin General Hospital serving the Northern region.[5]
>
> - District Hospitals based in larger rural communities providing surgical, medical nursing, and diagnostic services. Under the plan thirty-three such facilities were proposed based on the conversion of existing and construction of new facilities.
>
> - Medical Nursing Units (MNUs) which were to serve as satellite facilities for District Hospitals providing emergency care and out-patient services to persons in communities that could support a physician. Under the plan the conversion or construction of seventy-eight such facilities were proposed.

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[4] For a discussion of the role of this co-operative in supporting the government's plan see F.W. Hamilton, *Service At Cost* (Saskatoon: Modern Press, 1977), 205 -06.

[5] To facilitate the development of one of the Winnipeg base hospitals the Garson administration passed another legislative Act during the session in which *The Health Services Act* was proclaimed. *The Manitoba Medical Centre Act* ordered the creation of a seven member Council made up of the administrators of five facilities located in central Winnipeg between William and Notre Dame streets. These facilities included; The University of Manitoba Medical School, The Winnipeg General Hospital, The Children's Hospital, The Sanatorium Board of Manitoba Hospital, and The Cancer Treatment and Research Foundation Centre. Under this Act the Centre's Council was mandated to co-ordinate the planning and delivery of the specialized services and training offered by these facilities.

By early 1946 the Garson administration had received proposals from forty-one municipal governments interested in participating in a LHU and thirty proposals for the development of District Hospitals and MNUs. However, many of these proposals indicated that their implementation could not be undertaken until the participating municipalities had lessened their debt load accumulated during the depression and war years. They also indicated that if the province wanted rapid improvements in the health care delivery system, it would have to relieve the municipal sector some of its cost-shared responsibilities and/or its accumulated debt load so that new revenues could be raised for local improvements.[6] The Garson administration responded by indicating that it would study the situation during the summer and fall of 1946. It is apparent that this response was due to the completion of a five year taxation agreement between the province and the federal government on March 31, 1946. Under this agreement the province had allowed the federal government to collect personal and corporate income taxes from its citizens, as well as succession duties, in exchange for an annual twelve dollar per capita subsidy. Its completion resulted in a series of federal-provincial meetings that produced a new five year agreement in November 1946 effective April 1, 1947. Under this agreement, the province undertook to continue to allow the federal government to collect personal/corporate income taxes and succession duties in exchange for a minimum annual federal subsidy of $13.5 million. Morton notes that this

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[6] Hamilton, *Service At Cost*, 206.

agreement increased provincial revenues by at least $5.5 million annually over the previous agreement, which had remained in effect during the 1946-47 fiscal year.[7] He also indicates that the Garson administration opted to distribute one-half of this new income to municipalities on an annual basis, beginning in the 1947-48 fiscal year, provided they utilized these funds to improve local health and educational services.

In anticipation of the impact that new revenues from the 1946 tax agreement would have on local health care initiatives, the Garson administration also established a Special Select Committee of the Manitoba Legislature in the fall of 1946 to make recommendations related to implementation of The Manitoba Health Plan. This Committee was headed by the Minister of Health and Public Welfare, Ivan Schultz, and reported in April 1947. Its findings concentrated on three features of the province's delivery system: the reorganization of public health services delivered by the Department of Public Health and Welfare; the expansion of public health services delivered by LHUs; and the distribution of hospital facilities and physicians in the province.[8] With regard to the first feature, the Committee found that the reorganization of the Department of Health and Welfare, initiated in 1945, was largely completed and that the only outstanding problem areas related to staffing some of the more specialized positions in the Department's Division of Health Services. Turning to

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[7] Morton, *Manitoba: A History*, 461.

[8] Manitoba (Schultz), *Report of Special Select Committee of Manitoba Legislature on Health* (Winnipeg: King's Printer, April 1947).

the second feature, the Committee found that the pace of LHU development was increasing. Its report notes that four municipal health departments established in the 1930s had been converted to LHU status by 1946 and that nine new LHUs were in the process of being established. As a result, the Committee projected that, by the end of the 1947-48 fiscal year, the total population covered by LHUs would increase from seventy thousand to over two hundred and fifty five thousand persons.[9] When combined with Winnipeg's population of two hundred and twenty nine thousand persons who were served by the City of Winnipeg Health Department, this would provide more than one-half of the province's citizens with access to public health services by April 1948.

With regard to the third feature, the Committee indicated that the situation was more problematical. Its report indicates that demand for the construction or expansion of local hospitals was evident throughout the province and cites a number of general and geographically specific reasons for this demand.[10] The general reasons were seen to pertain to:

> - advances in the medical sciences, in particular the development of antibiotics, which had produced new hospital-based treatments that encouraged citizens to seek care in these facilities;
>
> - growing participation in voluntary and private pre-paid hospitalization plans, such as the Blue Cross Plan, which further increased the demand for access to the new treatments available in hospitals;

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[9] Ibid., 5.

[10] Ibid., 9-14.

- a growing preference among physicians to treat patients in a hospital because they provided the necessary facilities "...for proper diagnosis and treatment..." and, therefore, provided a "...more satisfactory and less time consuming...." setting for patient care.

The geographically specific reasons were seen to pertain to:

- the "greatly overcrowded" conditions in Winnipeg hospitals due to the need for "...the provision of beds for the care of chronic disease and for convalescent patients.";

- the "very unevenly distributed" location of hospital beds in rural areas of the province;[11]

- the inability of rural communities to attract or retain physicians due to the lack of a District Hospital or MNU.

The Committee's recommendations assumed that provincial funding approval for the construction and/or expansion of facilities should be based on a seven beds per one thousand population target. Given this target, the Committee recommended that up to seven hundred new general hospital beds should be planned for Winnipeg to bring the total number of beds to approximately twenty- eight hundred. In rural Manitoba it recommended that nine hundred new beds were needed, with five hundred contained in MNUs, to bring the total number of beds to approximately twenty-three hundred. However, it also noted there was no legislative mechanism in place which allowed the province to formally control the type or bed capacity of a facility that a local government might opt to construct. Based on a concern that local governments

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[11] Ibid., 9-10. The Committee found that while citizens in the south central parts of the province were "fairly well supplied", citizens in the south western, interlake, and south eastern parts of the province were, in some cases, required to travel over sixty miles (one hundred kilometers) to a hospital.

would favor the construction of larger and more expensive District Hospitals over MNUs, the Committee further recommended that *The Health Services Act* be amended to give the province "...wider powers for making regulations in respect to the establishment, voting and operation of hospital districts."[12]

The Garson administration did not formally adopt the Committee's recommendations during the 1947-48 fiscal year because it anticipated that the federal government was going to implement a cost-shared program to assist the provinces with the delivery of health care services. This anticipation ended in May 1948 when the federal government announced the National Health Grants Program. It provided Manitoba with ten types of grants to facilitate improvements in general public health programs, tuberculosis control , venereal disease control, cancer control, research related to public health, mental health care, the care of crippled children, the capacity of acute care hospitals, the training of professional providers, and province-wide health care planning. The hospital construction grant was the largest of the ten grants and allowed the province to implement a formal plan for the development of Manitoba's hospitals which had been finalized in early 1948. The key features of this plan are summarized in Table 3.1 below.[13]

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[12] Ibid., 15.

[13] The implementation of this plan is detailed in Manitoba Department of Health and Public Welfare, *Annual Report For the Calendar Year 1948* (Winnipeg: King's Printer, 1949), 157-60.

Table 3.1: The 1948 Plan for Hospital Facilities

Planned Changes in Regional Capacity	Winnipeg- St. Boniface Urban Region	Rural Regions
Bed Capacity in 1948	2,044	944
Beds Per 1,000 Pop in 1948	6 per 1,000	2.5 per 1,000
Planned Bed Capacity	2,862	1,722
Planned Beds Per 1,000 Pop	8.5 per 1,000	4.6 per 1,000
Planned Percentage Increase	40%	82.4%

While this planned increase in hospital capacity was informed by the recommendations of the Select Committee, the province opted for a larger increase in the Winnipeg region's capacity based on the assumption that six to seven percent of the patients in Winnipeg hospitals would come from rural regions of the province for specialized services. In addition, it did not act on the Committee's recommendations related to increased provincial regulatory control over local government hospital construction based on the assumption that the province's enhanced funding role would allow the degree of control necessary to meet the planned targets. Following the June announcement of this plan, Premier Garson resigned his position having accomplished his goal of "establishing Manitoban revenues on a sound base...".[14] He joined the federal Liberal cabinet as the Minister of Justice in the summer of 1948 and was replaced as party leader by a member of his provincial cabinet, Douglas Campbell.

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[14] Morton, *Manitoba: A History*, 462.

THE CAMPBELL ADMINISTRATION'S FIRST TERM

When Douglas Campbell assumed the post of Premier in 1948, Manitoba's health care delivery system was poised to begin a period of unprecedented growth. As noted above, during the 1948-49 fiscal year the number of Local Health Units (LHUs) increased from four to thirteen which more than tripled the number of citizens with access to a comprehensive range of public health services. In addition, the number of rural general hospital beds increased by sixty and the number of Medical Nursing Unit (MNU) beds by ten. However, this seventy-bed increase was small relative to the number of beds that would be opened or brought under construction in the following fiscal year. Table 3.2 below summarizes the Campbell administration's agenda for the development of hospitals during the 1949-1950 fiscal year.

Table 3.2: The 1949 Agenda for Hospital Facilities Development[15]

Regional Area	Winnipeg-St. Boniface Region	Rural Regions of the Province
Hospital Beds opened in 1948-49	208 at Princess Elizabeth Hospital	72 in 2 communities
Hospital Beds under construction in 1948-49	132 at the Winnipeg General Hospital	144 in 6 communities
MNU Beds opened in 1948-49		52 in 6 communities
MNU Beds under construction in 1948-49		53 in 7 communities
Totals	340	321

[15] Source Manitoba Department of Health and Public Welfare, *Annual Report For the Calender Year 1948*, 157-60.

Following the implementation of this agenda, Premier Campbell opted to affirm his administration's mandate and, in early October 1949, announced that a general election would be held on November 10. Peterson notes that the Liberal-Progressive Party's traditional supporters, who he describes as an alliance of opinion leaders made up of "...southwestern British farmers and south Winnipeg British businessmen...",[16] were favourable to the new Premier's policy agenda. This agenda, which was based on what Serfaty describes as a "...pay-as-you go philosophy...", [17] featured plans for further improvements in local health and educational services, the upgrading of the province's roadways, and the continuation of a rural electrification program announced in 1946. The Manitoba electorate was also favourable to this agenda as Campbell's coalition government was returned with fifty of the legislature's fifty-seven seats. It is notable that LP candidates were successful in holding twenty-seven of the fifty government seats with the remainder held by Independent and Progressive Conservative Party (PC) candidates.[18] A further indication of the popularity of Campbell's agenda is suggested by the fact that eight of the LP party's candidates ran unopposed and were elected by acclamation.

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[16] Thomas Peterson, "Manitoba Ethnic and Class Politics," in *Canadian Provincial Politics 2d ed.*, Martin Robin ed. (Scarborough: Prentice-Hall, 1978). 61-119. See 88-89.

[17] Meir Serfaty, "Electoral Behaviour in Manitoba," in *The Geography of Manitoba*, John Welsted, John Everitt, Christoph Stadel eds. (Winnipeg: The University of Manitoba Press, 1996) 177-194. See 182.

[18] Manitoba, *Statement of Votes* (Winnipeg: Report of the Chief Electoral Officer for the Thirty-Third Provincial General Election, March 18, 1986) 258-59. This information can be found in any *Statement of Votes* following the 1949 provincial election.

The first major health care policy event following the 1949 election campaign came in January 1950 when Manitoba received a National Health Grants Program health survey grant for $38,797. The Campbell administration utilized this grant for two purposes. On the one hand, it hired Dr. Carl Buck to undertake a "restudy" of public health services delivery.[19] On the other, it established the twenty-four person Manitoba Advisory Health Survey Committee to make recommendations related to future health care delivery planning in the Province.[20] Dr. Buck presented his report in April 1950. It described *The Health Services Act* as "...perhaps the broadest and soundest public health legislation to be found anywhere on the North American continent."[21] However, it also noted that the "...tremendous growth of the Department of Health and Public Welfare which has taken place in the past few years has brought about a complexity of administrative problems which have not been completely solved as far as delineating them in terms of clear cut policies and procedures."[22] The administrative problems noted by Dr Buck related to:

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[19] Dr. Buck was a public health consultant who had studied the province's delivery system in the early 1940s. His original study is contained in Manitoba, *Public Health in Manitoba 1941* (Winnipeg: King's Printer, 1941).

[20] This Committee was made up of representatives from the province, professional health care providers, unions representing non-professional providers, and Manitoba's urban and rural municipalities. For a list of the representatives see Manitoba, *Manitoba Health Survey Report* (Winnipeg: Queen's Printer, 1953), i-ii.

[21] See Manitoba, *Public Health in Manitoba 1950* (Winnipeg: Department of Public Health and Welfare, 1950), 4.

[22] Ibid.

- the inconsistent implementation of the intent of *The Health Services Act* related to the establishment of LHUs due to disputes between the province and participating municipalities over funding and administrative responsibility for the delivery of certain services;

- the voluntary nature of municipal participation in the Act which had produced a situation where regions with the greatest need for service improvements did not have the resources to realize those improvements.

Dr. Buck elaborated the second point by suggesting that, while implementation of *The Health Services the Act* had improved the quantity and quality of services for residents in urban and southern rural areas, those in the less affluent eastern and northern regions of the province had not experienced similar improvements because they did not live within the boundaries of an incorporated municipality or, if they did, their municipality do not have the funds available to participate in a LHU.[23] He also suggested that implementation of the National Health Grants Program would likely do little to ease this problem due to growing demands on the province from rural communities to utilize funds for the construction of hospitals and MNUs rather than the expansion of access to public health services.

The province's response to Dr. Buck's findings came in the fall of 1950 in the form of alterations to The Manitoba Health Plan, which had originally proposed the establishment of twenty-one LHUs. These alterations indicated that fifteen Units would ultimately be established to serve the whole of southern

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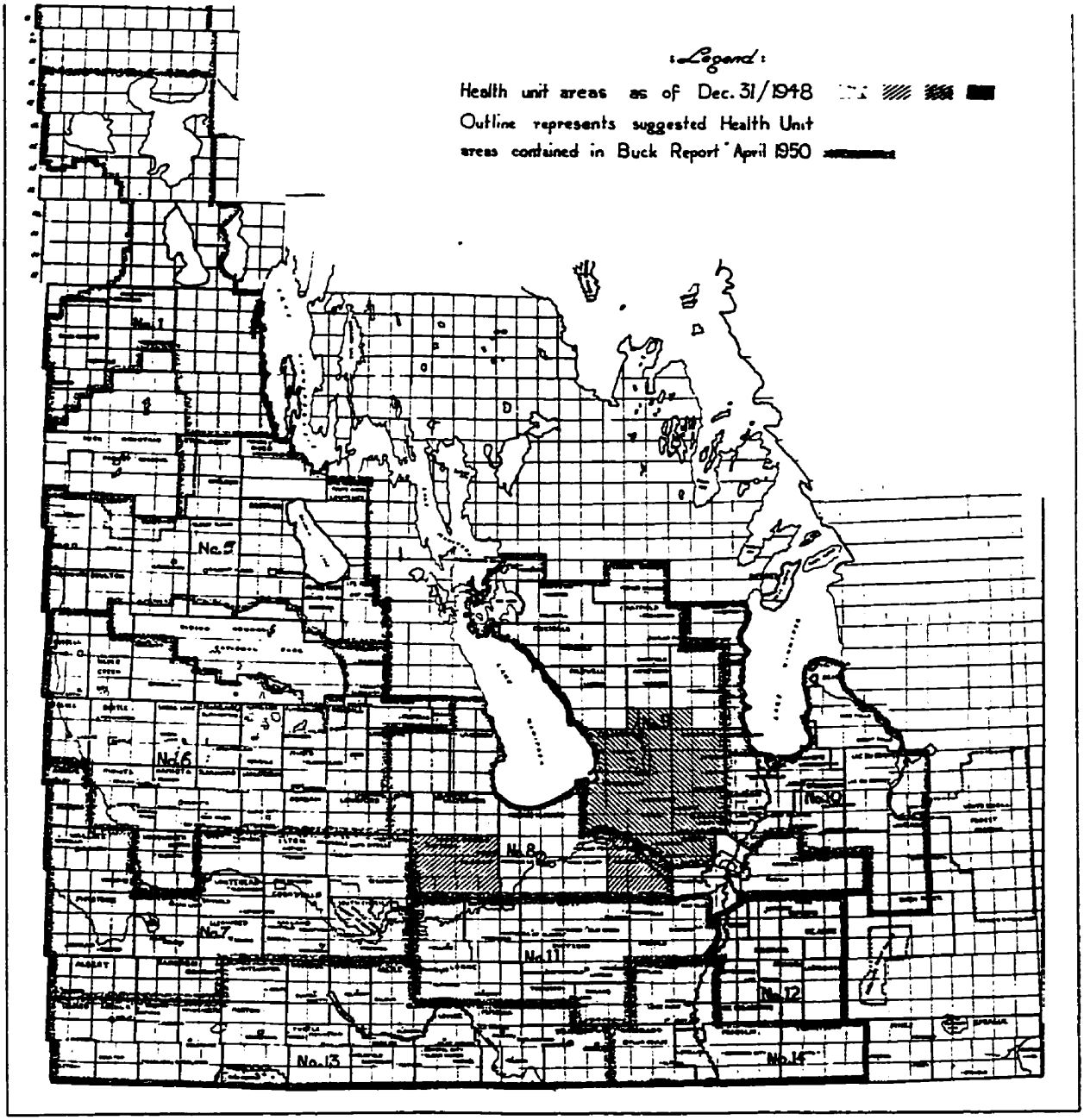
[23] Ibid. Here Dr. Buck notes that while the staff of the Department of Health and Social Welfare had increased by 157% and its budget had grown by 334% since 1941, the resultant increase in access to the services provided by Local Health Units had been concentrated in the urban and more affluent south central and western rural areas of the province.

Manitoba by enlarging the boundaries of the thirteen existing units and adding two new units. The boundaries established by these of alterations can be seen in Figure 3.1 below.

Figure 3.1: The 1950 Proposal for LHU Boundaries[24]



[24] Manitoba, *Manitoba Health Survey Report*, 33.

While the number of LHUs remained at thirteen at the end of 1950, the boundaries of three of the existing thirteen Units were enlarged raising the total rural population served from 255,000 to 267,617 persons, an increase of approximately five percent.[25] However, this incremental growth in LHUs was concentrated in the south central and western regions of the province and did not improve citizen access in the eastern and northern regions. The 1950 Annual Report of the Department of Health and Public Welfare notes the need for services improvements in these regions when it observes that eight northern and eastern communities containing over 30,000 residents had no regular access to public health services. It also indicates that an interim response to this problem had been implemented by giving medical officers of health the authority to dispatch air transport to these communities when services were urgently required.[26]

In contrast to the incremental growth in access to public health services, acute care capacity improved rapidly during the first two years of the Campbell administration's first full term in office. This improvement is evident in Table 3.3 below which compares the capacity of Manitoba's acute care delivery system in December 1948 with its capacity at the end of December 1950.[27]

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[25] Department of Health and Public Welfare, *Annual Report for the Calender year 1950* (Winnipeg: King's Printer, 1951), 106.

[26] Ibid., 104-05.

[27] Source Manitoba, *Manitoba Health Survey Report*, 55-58.

Table 3.3: Acute Care Capacity Growth Between 1948 and 1950

Time Frame and % Increase	Dec.1948	Dec.1950	% Increase
# Winnipeg Public Hospitals	9	10	11.1
# Winnipeg Beds (Existing & Planned)	1967	2,796	42.1
# Rural Hospitals/MNUs	35	71	102.9
# Rural Beds (Existing & Planned)	1,092	1,584	45.1
Total Beds (Existing & Planned)	3059	4380	43.2
Estimated Population in thousands	757.0	795.0	5.0
Total Beds per thousand population	4.0	5.5	37.5

The construction of new hospital beds continued throughout 1951 and the majority of the planned construction projects was completed by the end of the 1951-52 fiscal year. In May of 1952, the Advisory Health Survey Committee made its report to the Minister of Health and Public Welfare, Ivan Schultz, and offered sixty-three recommendations.[28] The majority of these recommendations concentrated on the future development of hospitals and LHUs as well as on policies to improve citizen access to private practice physicians, enhance services for the aged and infirmed, and to expand the availability of prepaid health insurance.

With regard to hospital services, the Committee offered three observations. First, it suggested that with the pending completion of the current hospital construction program "...there may be very little need to extend the program any further in the immediate future."[29] This suggestion was based on

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[28] Ibid., see 103-10 for a summary of the recommendations made by the Committee.

[29] Ibid., 58.

the Committee's finding that, with the completion of the current program, bed ratios would be 7.8 beds per thousand in Winnipeg and 3.7 in rural Manitoba which were close to the targets established in 1948. Second, the Committee expressed a concern that some of the recently constructed Medical Nursing Units (MNUs) were being utilized to perform surgical and related diagnostic procedures of a non-emergent nature. As a result, it recommended that the province consider regulations to restrict patient admissions to MNU's for these procedures because they "...should be confined to the larger, more adequately staffed and equipped general hospital, within the patients' hospital district, or elsewhere."[30] Finally, it observed that, even with restrictions on MNU admissions, the majority of rural general hospitals were not large enough to support the full-time services of surgical specialists, pathologists, radiologists, dietitians, or even a trained hospital administrator. As a result, it recommended that the province consider the development of regional "Hospital Divisions" governed by a board made up of representatives of the Hospital District boards included in the Division. This board would be responsible for employing specialized personnel "...who would allot an adequate proportion of their time and services to the various larger general hospitals within the subscribing districts."[31]

Turning to the issue of Local Health Unit (LHU) development, the

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[30] Ibid.

[31] Ibid., 59.

Committee supported the province's intent to assist in the establishment of fifteen LHUs to cover the whole of southern Manitoba. It also recommended that the province consider three changes in its current LHU policies.[32] First, that minimum staffing levels and salary scales be increased to ensure that existing units would be able to cope with the demands of enlarged boundaries and the proposed units would be able to attract staff. Second, the Medical Director of a LHU should be provided with the authority to contract with private practice physicians to provide services to persons in remote rural areas within the LHU. This recommendation was based on the Committee's view that the Medical Care District (MCD) concept had not proven effective in meeting the needs of residents in municipalities that could not afford to participate in a LHU. As a result, the Committee felt that one component of the expansion in LHUs to the whole of southern Manitoba should be increased provincial funding to allow all LHUs to provide citizens in remote rural areas with access to physician services. Finally, the Committee recommended that the province give the governing boards of LHUs greater control over the planning and administration of the services they provided. This recommendation was based on Dr. Buck's 1950 finding that the province's administrative policies and practices limited the ability of LHUs to respond to unique local needs. As a result, the committee called for administrative changes that would "...bring about local programs balanced to

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[32] Ibid., see p. 34-36 for these recommendations.

meet local needs."[33]

In addition to suggesting that improved access to physicians for persons in remote rural areas could be realized through changes in LHU policies, the Committee also studied the more general issue of citizen access to private practitioners. Its survey of the distribution of physicians in Manitoba indicated that four hundred and seventy-five of the province's six hundred and sixty "active" private practice physicians resided in Winnipeg with the remainder in southern rural Manitoba.[34] This survey also found that one hundred and eighty-six of the physicians in Winnipeg held specialists certificates while only eight rural physicians, all located in Brandon, held these certificates. While the findings related to the urban-rural distribution of physicians were expected by the Committee, those related to the distribution within rural Manitoba produced unexpected results. The Committee notes that it "...theorized that the denser the population the more concentrated the doctor population would be: in rural Manitoba at least, there was no evidence to substantiate this."[35] Rather, the Committee found that the most important variable in the distribution of physicians was the economic status of the population contained within the hospital district in which the physician resided. Hence, districts containing populations with higher levels of what Committee describes as "financial

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[33] Ibid., 36.

[34] Ibid., 71. On 79 the Committee notes that the northern region containing the communities of The Pas and Flin Flon "...may be considered as almost without doctors."

[35] Ibid., 73.

security", displayed a significantly higher number of resident physicians regardless of their population density. As a result, the Committee's main recommendation in this area was that the province consider the development of an income subsidy program for general practitioners to increase the number of resident physicians in twenty of the province's thirty-three rural hospital districts.

Turning to the issue of services for the aged and infirm, the Committee based its recommendations on survey research related to population trends in the province. The findings of this survey indicated that, between 1937 and 1950, the number of persons aged 65 years or older increased by 55.8 per cent, from 5.2 per cent of the total provincial population to 8.1 per cent.[36] It also indicated two related trends in the province's ability to care for this demographic cohort.[37] First, approximately thirteen hundred beds were available in the province's homes for the aged and infirm and that these voluntary and private sector homes were both overcrowded and had combined waiting lists containing over four hundred persons. Second, that during 1950 a further four hundred persons who could be accommodated in a home for the aged were occupying general hospital beds. As a result, the committee recommended that the province develop new regulatory and funding policies for homes for the aged and infirm to control overcrowding and increase the number of available long-term care beds by at least seven hundred. As a result, the Committee urged the province to

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[36] Ibid., 3.

[37] Ibid., 67.

undertake a more extensive study of the future needs of what it described as "...a rapidly aging population..." to ensure that the province was prepared to respond to the long-term needs of this population effectively.

The fifth issue that the Advisory Committee concentrated on was citizen access to prepaid services. With regard to the general concept of state involvement in the provision of prepaid services, the Committee endorsed the principles contained in the federal health insurance plan, related to the need for state support of prepaid programs to facilitate improved access to medical care, presented at the Dominion-Provincial Conference on Reconstruction in 1945.[38] However, it viewed Saskatchewan's implementation of a state-managed hospital insurance program as potentially too costly for Manitoba. As a result, the Committee made four recommendations which suggested that Manitoba's policies should be limited to ensuring that:[39]

- prepaid health care insurance was made available to citizens on a voluntary basis;

- non-profit voluntary agencies were responsible for the collection of premiums and the administration of payments to providers;

- provincial subsidization was available for the medically indigent to safeguard the program costs of voluntary insurers;

- provincial subsidization concentrated on those services that promoted health and prevented disease within the population.

These recommendations were the product of the combined interests of

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[38] Ibid., 99.

[39] Ibid., see 100 for these recommendations.

three key actors on the Advisory Committee: the province, represented by its Medical Director, Dr. M. R. Elliott; the Associated Hospitals of Manitoba, represented by Dr. O.C. Trainor; and the Manitoba Medical Association (MMA) represented by one rural and two Winnipeg physicians. The province's support for these recommendations was based on its interest in limiting the government's direct funding role for services to patients to areas it was already statutorily responsible for under the provisions of *The Health and Public Welfare Act* of 1940, *The Hospital Aid Act* of 1944, and *The Health Services Act* of 1945. These Acts required the province and participating municipalities to jointly fund, on a two-third one third basis, prepaid public health services and grants to hospitals for the costs of up to three months of care for the medically indigent.[40] An analysis by the Committee indicated that the total cost to the province and participating municipalities for the administration and delivery of these services was approximately $5 million in the 1950-51 fiscal year.[41] It also indicated that, if the public sector expanded its direct funding responsibility to all residents through a prepaid program covering hospital and medical care, provincial and municipal costs would double to approximately $10 million per year.[42]

Given the three month limit on public support for the medically indigent,

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[40] Ibid., 77-78. Under the provisions of these Acts the province was fully responsible for indigents residing in unorganized territories. Further, while the hospital grants covered basis care they did not cover the costs of therapeutic drugs. As the Committee notes, "Thus, the general hospital which accepts the indigent receives no repayment for therapy."

[41] Ibid., 85. This calculation does not include contributions by the Federal Health Grants Program which contributed another $1 million to the province's health budget.

[42] Ibid., 99.

the primary interest of the Associated Hospitals of Manitoba was the development of a prepaid program that provided its member facilities with the ability to collect on the billings generated by "long-stay" indigents requiring therapeutic drugs and/or care for more than three months. While the MMA was also concerned with the need to fund the care for long-stay patients, its primary interest was facilitating the future growth of the Manitoba Medical Service (MMS). The MMS was created in early 1942 when the MMA, the Manitoba College of Physicians and Surgeons, and the Winnipeg Medical Society agreed to jointly establish a prepaid physician-managed insurance program. It was formally incorporated through the passage of *An Act to Incorporate Manitoba Medical Service* the same year. Throughout the remainder of the 1940s, the services covered by the MMS were administered by the largest non-profit voluntary health care insurer in the province; the Manitoba Blue Cross Plan.[43] While enrollments in the MMS plan had grown to eleven percent of Manitoba's population by 1950, the Advisory Committee found that more extensive participation in the plan had been limited by two factors.[44] On the one hand, the requirement that residents enrolled in the plan had to be enrolled in the hospital services plan offered by Blue Cross made the costs of MMS coverage too great for lower income residents. On the other, the participation of physicians in the plan was limited because it paid an average of seventy-five percent of the

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[43] Ibid., on 77 the Committee notes that in 1952 more than 50 non and for-profit organizations offered some form of hospital or medical care insurance in the province.

[44] Ibid, on 76 Table IX indicates that 87,733 persons participated in the MMS plan in 1950.

established MMA fee schedule.

The Campbell administration tabled the findings of the Advisory Committee in the legislature in May 1952 but did not act on them during the remainder of the year. The government's more limited public attention to health and related social policy matters was, in large part, the product of events in the early 1950s that had produced concerns within Campbell's cabinet about his government's future electoral success. The first of these events was a flood that devastated parts of Winnipeg in the spring of 1950, Dyck notes that this was "...a disaster for which the provincial government was totally unprepared."[45] In addition to forcing unexpected budgetary expenditures on the province, the Campbell administration's perceived lack of financial generosity and political leadership during and immediately following the flood created serious rifts in the governing coalition which resulted in the withdrawal of seven of its nine Progressive Conservative Party (PC) members in the fall of 1950. With this withdrawal, the PC party displaced the CCF as the official opposition and, under the leadership of Errick Willis, it embarked on a campaign to challenge the Campbell administration's legitimacy.

Morton indicates that the PCs focussed on two broad issues related to the governance of Manitoba.[46] The first involved the urban-rural distribution of seats in the legislature, a distribution that had not been substantively altered since

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[45] Rand Dyck, *Provincial Politics in Canada* (Scarborough: Prentice Hall, 1996), 404.

[46] Morton, *Manitoba: A History*, 463.

1907. Between 1907 and 1951 Manitoba's urban population had grown by 244 per cent, from 138,090 to 337,331, while the rural population had risen from 227,598 to 389,592 persons, an increase of 171 per cent. Morton notes that "...the consequence was a steadily increasing over-representation of the rural element and a corresponding under-representation of the urban."[47] The PCs emphasized this issue in their campaign to gain support among Winnipeg's business leaders. They also argued that the lack of representational balance was the cause of a second issue; the Campbell administration's lack of political leadership. Morton summarizes the nature of this argument when he notes:

> The constriction of the representative system was one indication that the pragmatic mind which had governed Manitoba for a generation, and served it well in hard and trying times, was now revealing its inherent limitations. Parliamentary and responsible government had been seriously, if not fatally, impaired by the persistent confusion of government with administration. The task of democratic government, to lead, inform, and inspire, had been deliberately neglected by ministers who...largely trained in municipal affairs, reduced provincial government to municipal administration...The long stifling of debate on political principle, the long insistence on administration rather than politics, had ended in a groove of routine, an incapacity to comprehend opposing points of view, or to envisage new opportunities and new lines of advance.[48]

Confronted with these issues, the Campbell administration began the legislative session in January 1953 with a Speech from the Throne promising to act on the findings of the Advisory Health Survey Committee, further expand rural electrification, and introduce new legislation to regulate the future

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[47] Ibid., 463.

[48] Ibid., 464.

distribution of electoral seats. These promises proved to be the central planks in the government's platform during an election campaign which ended June 8. During the May and June election campaign Campbell's LP party once again drew on its traditional rural support to achieve a majority government with thirty-one seats. The PC party formed the official opposition with nine seats. Notably, only one LP candidate was elected by acclamation.

THE SECOND TERM

The first health care policy change undertaken by the Campbell administration during its second term came in April 1954 with the passage of amendments to *The Public Health Act, The Municipal Act,* and *The Health Services Act.* These amendments relieved municipalities of their one-third funding responsibility for some LHU services by making the province solely responsible for the funding and administration of maternal and child hygiene, community health education, communicable disease control, case management for the chronically and mentally ill, community sanitation programs, and food inspection. The provision of nursing care to patients discharged from District Hospitals and physicians services to indigents remained a shared responsibility. These amendments were followed, in early 1955, by amendments to *The Health Services Act* to allow Hospital Districts the option of enrolling residents within their boundaries as subscribers to the MMS without requiring them to first be subscribers to Manitoba Blue Cross. They were an attempt by the Campbell

administration to improve access to medical care and provide a more stable income base for physicians in rural areas by increasing the number of persons with insurance coverage. They appear to have been effective because, by the end of 1956, subscriptions to the MMS had more than doubled, bringing over half of the province's population under the umbrella of this physician-sponsored insurance program.

Two related policy events that occurred in 1955 had little immediate impact on health services delivery in Manitoba but would play a more significant role later in the 1950s. The first involved Premier Campbell's response to the PC opposition's criticisms of Manitoba's unequal system of electoral representation. It came in the form of passage of *The Electoral Redistribution Act* which established an independent commission to oversee the future boundaries of provincial electoral divisions. The second was a federal-provincial conference held in Ottawa in October of 1955. Taylor offers a detailed account of the events leading up to the conference and indicates that the federal government was motivated to pursue an arrangement for a cost-shared health insurance program at this conference for two reasons.[49] On the one hand, agreements it had with the provinces related to the collection of personal and corporate income taxes were due to expire in 1957. Taylor notes the federal government recognized that the negotiations related to new agreements would produce provincial fiscal demands that, if unmet, would threaten the status quo

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[49] Taylor, *Health Insurance and Canadian Public Policy*, 173-211.

related to federal control of income tax collection. [50] On the other hand, the Dominion Bureau of Statistics had, since 1953, been releasing analyses of data collected during a year-long sickness survey conducted in 1950-51. Taylor describes the findings related to the volume of long-term illness as "staggering" and also notes that "...equally striking was the statistical confirmation of the inequity among citizens in the distribution of the burden of both physical and mental illness and the financial impact of their costs."[51] These findings had been given extensive coverage by the media and by 1955 public opinion was supportive of a new national policy to further improve access to health care services. As a result, the October conference produced an agreement to establish a committee made up of federal and provincial health and finance ministers to give further consideration to the development of a national insurance program. This committee met in January 1956 and produced a policy proposal in which federal government would pay one-half of provincial costs related to the provision of diagnostic services and in-patient hospital care.[52]

Taylor notes that, over the period between the January 1956 release of the policy proposal and the April 1957 passage of the federal Hospital Insurance and Diagnostic Services Act (HIDSA), "...the hospital insurance offer never

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[50] Ibid., 206.

[51] Ibid., 173.

[52] Ibid., see p. 217 for a review of the key features of this proposal.

ceased to arouse controversial comment."[53] The Campbell administration, while supportive of the main features of the federal proposal, was critical of the proposal's lack of coverage for mental hospitals and tuberculosis sanatoria. The PC opposition supported the government's concerns in these areas. However, it was also critical of the proposal's failure to account for the potential impacts of the proposed program on the voluntary and private health insurance industry in Manitoba. The Campbell administration did not respond to this criticism. Rather, it began 1956 with the passage of *The Elderly Persons' Housing Act.* This Act represented a further response to the recommendations of the Advisory Health Survey Committee by enabling the province to provide construction grants to municipalities and voluntary organizations for hostels to house the elderly and infirmed. In addition, it provided additional funding to the thirteen existing LHUs for a poliomyelitis immunization program and crippled children's clinics.

Following the passage of the HIDSA in April 1957, the federal government began negotiations with each province regarding their entry into the insurance program. These negotiations were interrupted following a June 10 national election in which the governing Liberal Party was defeated by a minority PC government lead by John Diefenbaker. On November 25,1957 Prime Minister Diefenbaker chaired his first federal-provincial conference. At this conference the provinces called for a variety of changes in the proposed arrangements with

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[53] Ibid., 218.

Premier Campbell requesting the inclusion of mental health and tuberculosis care coverage in the program.[54] His request was successful and, in early April, amendments to the HIDSA were introduced to the federal parliament to allow participating provinces to include such services in their insurance programs. However, they also allowed the federal government to deduct its contribution for these services from any funding increases related to tax-sharing arrangements with the province.[55]

In Manitoba, the introduction of these amendments resulted in the passage of *The Hospitals Act* and *The Hospital Services Insurance Act* in late April. These Acts established the legislative framework for Manitoba's entry into the national hospital insurance program, which was scheduled to take place on July 1. With the pending introduction of insured hospital services, Premier Campbell determined that the time was right for a provincial election. In May he announced that a general election would take place on June 16 based on his government's need for a mandate to implement what he termed The Manitoba Hospital Services Plan. This plan was popular among an electorate that, as Morton notes, supported the assumption that health care should "...cease to be a matter of private means and private action and become a public benefit universally available and maintained as a public necessity, like roads and

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[54] Ibid., 232.

[55] Ibid., 233. These amendments came into force on June 26, 1958.

water."[56] However, he also notes that while this Plan was popular, the Campbell administration was no longer the dominant political force it once was. While the leader of the PC party, Duff Roblin, supported the introduction of the Manitoba Hospital Services Plan during the election campaign, he was critical of the Campbell administration's lack of leadership regarding other health care issues. Roblin focussed on the Campbell administration's failure to carry out its plan to expand LHUs to cover all of Manitoba. He indicated that, if his party became the government, access to public health services would be provided to citizens in all regions regardless of the ability of their municipality to fund those services.[57] This focus was effective as citizens in the less affluent eastern and northern regions of the province, in addition to those in Winnipeg, provided enough support to elect a minority PC government. Minority rule was sustained by elected members of the Co-operative Commonwealth Federation (CCF) who informally agreed to support the PC minority government based on Roblin's commitment to implement The Manitoba Hospital Services Plan and expand public health services to poorer areas of the province.[58]

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[56] Morton, *Manitoba: A History*, 476.

[57] Peterson, "Manitoba: Ethnic and Class Politics." On 92 he notes that this position was shaped by the PC party candidate from the interlake region of the province, Dr. George Johnson, who resided in Gimli.

[58] For a discussion of the CCF's position see Nelson Wiseman, *Social Democracy in Manitoba* (Winnipeg: The University of Manitoba Press, 1983), 70-73.

CHANGES IN CAPACITY, COSTS AND CONTROL

The following summary of the Campbell administration's tenure in office describes the changes in provincial health care delivery system capacity, costs, and control between 1984 and 1958. It indicates that, while this administration was successful in enhancing citizen access to health care, its policy initiatives were largely guided by the combined impacts of federal government policy changes, which enhanced provincial revenues, and the demands of citizens, municipal governments, and professional health care providers interested in expanding provincial hospital capacity.

CAPACITY CHANGES

The discussion in Chapter 2 pertaining to Question 7 indicates that this study utilizes two types of indicators to assess changes in delivery system capacity. The first focuses on changes in the functional scope of the province's health care delivery roles. As the discussion in the first section of this Chapter indicates, the passage of *The Health Services Act* in 1945 significantly expanded the province's functional scope by shifting the policy focus of the Department of Public Health and Welfare from a regulatory role to that of a participant in the shared-cost delivery of public health and diagnostic services, the construction of hospitals, and the direct funding of services for the medically indigent. The responsibilities established by this Act, which serve as the starting point for Table 3.4 below, were further altered in 1954 when legislative amendments to it

and *The Public Health Act* established the Department as wholly responsible for the funding and administration of a range of services delivered by LHUs. This was followed by the 1956 passage of *The Elderly Persons' Housing Act* which expanded the scope of provincial shared-cost responsibility to the construction of facilities for the elderly and infirmed. The final major expansion occurred in 1958 with the passage of legislation to allow implementation of The Manitoba Hospital Services Plan. This legislation established the province's responsibility for funding insured hospital and diagnostic services prescribed by the HIDSA and further expanded its planning, funding, and regulatory roles in four functional areas noted below.

Table 3.4: Changes in Functional Scope from 1948 to 1958

Functional Area	Status in 1948	Status in 1958
Public Health Services	The shared-cost funding of LHU services with local governments and the direct delivery of public health nursing to municipalities and unorganized territories not included in a LHU.	The direct funding and delivery of preventive services to all citizens, the shared-cost funding of LHU services, and the direct delivery of public health nursing to areas not included in a LHU.
Acute Care Hospital Facilities	Delivery system planning and the provision of construction grants as well as grants for up to three months for the care for indigents.	The administration of insured hospital services for all citizens[59] combined with expanded planning and regulatory roles related to the services provided by Hospital Districts.

[59] It is noteworthy that under the Manitoba Hospital Services Program local governments were responsible for the payment of premiums for resident indigents while the province paid the premiums of indigents in Local Government Districts (LGDs) and unorganized territories.

Institutions for the Aged and Infirmed	The regulation of private and voluntary facilities.	The regulation of these facilities combined with enhanced planning roles based on the provision of construction grants to voluntary providers.
Services Provided by Physicians	The shared -cost funding, with local governments, of the services provided by a MCD.	The facilitation of medical care insurance through the MMS based on support for prepaid local government programs.

The second set of indicators in Question 7 focus on changes in the geographic scope of the delivery of services. The findings, summarized in Tables 3.5 to 3.8, also suggest a consistent pattern of expansion that was, in two of three areas, favourable to rural areas of the province. Tables 3.5 and 3.6 identify LHU growth between1949 and 1958 in rural areas of the province and metropolitan Winnipeg. Table 3.5 lends support to opposition criticism in the 1950s, that the Campbell administration failed to expand LHU services to the whole of rural Manitoba, given that the number of rural LHUs remained at ten and the population they served only increased incrementally, from forty-two to fifty-four per cent of the rural population. The service boundaries of these LHUs are graphically presented in Figure D.1 in Appendix D which indicates that portions of southern and eastern Manitoba were not included in LHU boundaries at the end of the Campbell administration's second term. On the other hand, Table 3.6 indicates that the rapidly growing population of metropolitan Winnipeg was able to access a full range of public health services through the three urban LHUs and the City of Winnipeg's Health Department.

Table 3.5: LHU Growth in Rural Manitoba from 1949 to 1958 [60]

LHU	Pop Served 1949	Pop Served 1958
Brandon	20500	32000
Dauphin	15200	17800
Neepawa	19600	24600
Northern	14900	19600
Portage	18300	25000
Red River	17700	22500
Selkirk	24000	32400
Stonewall	12300	21300
Swan Valley	17600	16800
Virden	19500	21900
Total	179600	233900
Total Provincial Pop	757000	876000
Total Rural Pop	427000	432000
% of Rural Pop Served	42.06%	54.14%

Table 3.6: LHU Growth in Metropolitan Winnipeg from 1949 to 1958 [61]

LHU	1949	1958
Kildonan	24000	47000
St. Boniface	25000	44000
St. James	40000	76000
City of Winnipeg HD	236000	277500
Total Pop. Served	325000	444500

A review of changes in the geographic scope and capacity of public

[60] Source 1949 and 1958 Annual Reports of the Department of Public Health and Welfare. Data from the 1949 Annual Report is used here because LHU service populations were not reported in 1948. All population totals have been rounded to the nearest hundred.

[61] Ibid. All population totals have been rounded to the nearest hundred.

general hospitals indicates that the Campbell administration was committed to increasing the geographic scope of medical services, at least in rural areas. This is evident in Table 3.7 below which offers a summary of Table D.1 contained in Appendix D which details the geographic and capacity growth of hospitals and long-term care facilities at the end of the 1948/49 and 1958/59 fiscal years.[62] With regard to rural Manitoba, this table indicates that, while the total population increased by less than two percent, the total capacity and number of beds per one thousand persons increased by over eighty percent. In addition, it indicates that three regions experienced capacity growth of over ninety percent; the Westman, Central, and Eastman regions. It is notable that the first two of these regions consistently elected LP candidates during the tenure of the Campbell administration. Turning to the Winnipeg region, this table indicates that capacity growth was incrementally consistent with the region's population growth. The linkage of this finding to those related to the rural regions lends support to an indication that the Campbell administration favoured rural Manitoba in its policy decisions. Further support can be found in a comparison of the findings in this table with those in Table 3.1 which indicates that, while the Campbell administration exceeded its planned target of 4.6 beds per thousand for rural Manitoba, it fell well short of realizing its target of 8.5 beds per thousand for the Winnipeg region.

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[62] To facilitate comparison throughout this study, the regional headings used here are those established by the province in 1974. A graphic indication of these boundaries is offered in Figure D.3 contained in Appendix D.

Table 3.7: Hospital Growth in Manitoba from 1949 to 1959

Region	1948/49	1958/59	% Increase
Central: # of Communities with Facilities	7	13	85.7
: Rated Bed Capacity	182	349	91.8
Eastman: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	76	151	98.7
Interlake: # of Communities with Facilities	4	7	75
: Rated Bed Capacity	118	162	37.3
Norman: # of Communities with Facilities	2	4	100
: Rated Bed Capacity	131	238	81.7
Parkland: # of Communities with Facilities	6	9	50
: Rated Bed Capacity	178	283	59
Westman: # of Communities with Facilities	13	27	107.7
: Rated Bed Capacity	407	851	109
Total Rural Capacity	1092	2034	86.3
Total Rural Population (in thousands)	427	432	1.2
Rural Beds Per 1000 population	**2.6**	**4.7**	**80.8**
Winnipeg: # of Facilities	9	10	11.1
:Rated Bed Capacity	1967	3303	67.9
Total Winnipeg Population (in thousands)	325	444.5	36.8
Winnipeg Beds Per 1000 population	**7.2**	**7.4**	**2.8**

Turning to changes in the geographic scope and capacity of long-term care facilities, a comparative analysis cannot be offered in this chapter because reporting related to these facilities did not take place until 1959. Based on the findings of the Advisory Health Survey Committee, it is known that approximately thirteen hundred beds were available in the province in 1949. However, the only indication of their regional distribution was that approximately half of the beds

were located in Winnipeg.[63] The following table presents the known data related to the capacity of these facilities.

Table 3.8: Long-Term Care Facility Growth in Manitoba from 1949 to 1959

Region	1948/49	1958/59	% Increase
Central: # of Communities with Facilities		5	
: Rated Bed Capacity		218	
Eastman: # of Communities with Facilities		3	
: Rated Bed Capacity		94	
Interlake: # of Communities with Facilities		2	
: Rated Bed Capacity		240	
Norman: # of Communities with Facilities		1	
: Rated Bed Capacity		96	
Parkland: # of Communities with Facilities		2	
: Rated Bed Capacity		54	
Westman: # of Communities with Facilities		9	
: Rated Bed Capacity		563	
Total Rural Capacity (approximation 1949)	700	1265	80.7
Total Rural Population (in thousands)	427	432	1.2
Rural Beds Per 1000 population	**1.6**	**2.9**	**81.3**
Winnipeg: # of Facilities			
Rated Bed Capacity	700	1883	169
Total Winnipeg Population (in thousands)	325	444.5	36.8
Winnipeg Beds Per 1000 population	**2.2**	**1.2**	**-54.5**

[63] A later survey of facilities in Manitoba conducted by the Roblin administration in the late 1950s, which is cited in the next chapter, offered greater detail and its findings are contained in Table D.1

Given the available data, this table offers further support for an argument that the Campbell administration favoured rural Manitoba over Winnipeg in the allocation of provincial resources. While rural LTC capacity increased by over eighty per cent between 1949 and 1959, metropolitan Winnipeg's beds per thousand ratio dropped by almost fifty-five per cent.

COST CHANGES

The changes in the province's functional scope noted above indicate that the Campbell administration altered the province's administrative authority in two important ways. First, expansion of the province's responsibilities for the provision of preventive public health services moved it from a shared-cost participant to sole responsibility for the delivery of community-based preventive public health programs. Second, the scope of its administrative role changed from that of a regulator and provider of grants to the institutional sector, to a full partner in the planning, construction, and delivery of institutional services. In short, these changes centralized some of the authority delegated to local governments and voluntary providers prior to World War II at the provincial level. This increased centralization is reflected in changes in the budget of the Department of Health and Public Welfare during the tenure of the Campbell administration. The following table contains a summery of Table D.2 in Appendix D which compares Manitoba's audited financial statements for the 1948-49 and 1958-59 fiscal years.

Table 3.9: Provincial Budgetary Changes from 1949 to 1959

Budget Line	1948-49	1958-59
Total Provincial Budgetary Expenditures	37522214	85356800
Provincial Health Care Expenditures	3749949	10839427
Health Dept. Expenditures as % of the Province's Total Expenditures	10%	12.7%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	4.72%	4.02%
Psychiatric Services Division	48.03%	36.67%
Public Health Services Division	32.44%	23.61%
Hospitals and Related Institutional Services	14.81%	35.69%
Totals	100%	100%

As this table indicates, the allocation of provincial resources shifted from psychiatric and public health services to acute care hospitals and long-term care facilities during the tenure of the Campbell administration. The detailed review of the Public Health and Hospitals Division expenditures offered in Table D.2 indicates that, while hospital construction grants dropped from 33 percent to 14 percent of the Hospitals Division budget, allocations for hospital services rose from 67 percent to 83 percent of this Division's budget. Further, allocations to LHUs declined from 21 percent to 12 percent of the Public Health Division's budget. While 3.5 percent of the decline in LHU allocations was due to increased allocations to provincial disease control programs, the remainder was largely due to the Campbell administration's increased emphasis on hospital services and the construction of long-term care facilities.

CONTROL CHANGES

As the discussion in Chapter 2 pertaining to Question 9 indicates, the response to this question is based on a nine category list of functional roles that Mills et al. suggest are the frequent targets of government intent on policy changes. Table 3.10 below summarizes the impact of the Campbell administration on each of these categories.

Table 3.10: The Campbell Administration's Impact on Functional Roles

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	No change. However legislative scope and authority did expand due to the changes related to public health, hospitals, and insured services.
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased with the federal government and hospital districts, due to the introduction of the National Grants Program and Manitoba's entry into the national hospital insurance program.
Revenue-Rasing Functions related to the funding of services.	Increased due to the introduction of the premium-based Manitoba Hospital Services Plan.
Planning and Resource Allocation Functions related to services delivery.	Increased due to expansion of the province's scope and authority.
Policy-Making Functions related to the licencing of and standards for services providers.	Increased for LTC facilities in 1956 and for hospitals in 1958.
Inter-Agency coordinative Functions related to services delivery.	Increased due to the introduction of National Health Grants Program allocations for delivery system surveys and the delivery of specialized services related to TB and Polio.
Regulatory Functions related to the resource utilization practices of professional providers.	Increased with LTC providers in 1956 and with hospitals in 1958.

Training Functions Related to the education and placement of Professional Providers.	Increased with the introduction of professional training grants through the National Health Grants Program.
Management Functions related to the day-to-day administration of services delivery.	Increased in the area of public health due to the province's takeover of preventive health programs from LHUs.

This table provides a further indication of the general policy trend noted above; an increasing provincial role in the planning, funding, and administration of health care services delivery. In total, the findings indicate that three sets of factors were major contributors to this trend. The most important was the changing nature of federal-provincial relations which both increased the province's ability to fund the delivery of health care services and influenced pubic perceptions related to the province's role in the provision of services. Taylor argues that this impact was felt in all provincial capitals during the 1950s and notes that an important "spin-off effect" of increased federal policy involvement in health care delivery was the regularization of information gathering and sharing at the federal-provincial level.[64] The second set of factors relates to the Campbell administration's "pay-as-you go" administrative philosophy. This philosophy supported increased provincial funding for services delivery in the late 1940s and placed implicit cost controls on growth for much of the 1950s, particularly in the area of public health services. The combination of slower provincial revenue growth in the 1950s with the application of this philosophy to shared-cost programs with local governments, appears to have

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[64] Taylor, *Health Insurance and Canadian Public Policy*, 164.

been a critical factor in the uneven distribution of services noted in this section which contributed to the electoral defeat of the Campbell administration in the late 1950s. The third set of factors involves the types of demands that were placed on the cabinet by key actors in the province's health care policy community. These demands were led by health care providers who called for increased provincial contributions to expand the delivery system's functional and geographic scope. However, differences in the priorities of this expansion were evident. The findings indicate that the interests of supporters of enhanced access to medical care services were more fully realized in policy community outputs than were the interests of those supporting improved access to public health services. As the discussion in the following chapter indicates, the substantial improvements in Manitoba's hospital capacity produced during this 1940s and 1950s came with a price as the Roblin administration was forced to increasingly focus on the policy challenges generated by the budgetary demands of the medical care component of Manitoba's delivery system.

CHAPTER 4.

IMPLEMENTING INSURED SERVICES: 1958 - 1969

This chapter turns to the activities of the Progressive Conservative (PC) party administrations that held office in Manitoba between 1958 and 1969; the Roblin and Weir administrations. It is divided into three sections that describe how these administrations responded to demands within the province's health care policy community for capacity increases to further enhance citizen access to health care services. The first section describes the activities of the Roblin administration with particular attention to this government's expansion of its policy role in an effort to contain the costs of insured hospital services. The second section turns to the Weir administration and concentrates on its role in debates related to the implementation of medical care insurance in the late 1960s. The third section summarizes changes in capacity, costs, and control during the tenure of these PC administrations. The findings in this section indicate that these administrations were successful in improving access to health care through expansion of the province's planning and funding roles. However, the resistance to further expansion of the province's funding responsibilities role for medical care insurance by the PC party in the late 1960s, due to a combination of concerns about the potential costs of this program and the resistance of provider pressure groups, contributed to its electoral defeat in the province's 1969 general election.

The Roblin Administration's First Term

On June 24, 1958 one of the first acts of the newly elected minority Roblin administration was to approve a regulation authorizing implementation of the Manitoba Hospital Services Plan. This was followed, on June 27, by the signing of a formal agreement with the Government of Canada to provide funding for insured hospital services. As the previous chapter indicates, the implementation of this Plan, on July 1, increased the scope of the province's responsibilities to the administration of payments for all medically necessary hospital services provided to persons registered with the Plan. Administrative authority for the plan followed the model established in Saskatchewan by placing day-to-day control in the hands of a provincially appointed Commissioner of Hospitalization.[1] Members of the province's health care policy community were given a voice in the plan's administration through provisions in *The Hospital Services Insurance Act* which required the establishment of an independent advisory council to assist the Commissioner in the formation of policies and practices pertaining to the Plan. This council was formed in October 1958 as The Manitoba Hospitals Council and was composed of appointees representing municipal and professional provider interests.

Further changes in Manitoba's health care policy framework anticipated by the Roblin administration's electoral agenda were interrupted in April 1959

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[1] Taylor notes that this arrangement was established in Saskatchewan based on concerns by provider pressure groups that management of that province's plan should be "at arm's length" from the cabinet. See Taylor, *Health Insurance and Canadian Public Policy*, 82-97.

when the CCF withdrew its legislative support for the Roblin minority government. This resulted in the government's defeat during a vote in the legislature.[2] At the time of this vote the government held twenty-six seats, with Campbell's LP party holding nineteen and the CCF holding eleven seats. When Roblin returned from the May 14 election to begin his second term as Premier it was with a majority government of thirty-six seats. Morton notes that the foundation of Roblin's political success in the 1959 election campaign was his advocacy of "social investment" in areas such as education, health care, and economic development. He also notes that the balance of "....idealism with hard-headed restraint..." that Roblin brought to the Manitoba legislature "...was to be the explanation of both the success and the failures of the Roblin regime."[3]

THE SECOND TERM

The Roblin administration began its second term by introducing a number of health care policy initiatives. The first followed the July 1959 release of a study of living conditions among Manitoba's northern population initiated by the Department of Public Health and Welfare in 1956. It found that living conditions and the ability to access provincial health and social services in the north were

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[2] Nelson Wiseman, *Social Democracy in Manitoba* (Winnipeg: University of Manitoba Press, 1983), 72. Wiseman argues that Roblin engineered his government's defeat in the legislature in order to force another election in the hope of obtaining a majority government.

[3] Morton, *Manitoba: A History*, 485.

below the standards enjoyed by citizens in southern Manitoba.[4] The government's response to this finding came in September with the establishment of a Northern Health Services Branch in the Department of Health and Public Welfare to provide an improved range of public health and social services to persons in unorganized territories north of the 53rd Parallel. At the same time, the government announced that it was also embarking on a program to fund the expansion of public health services in southern Manitoba beginning with the extension of the service boundaries of the Dauphin and Portage LHUs. The second initiative came in October with the establishment of the Manitoba Hospital Survey Board to assess the supply and distribution of services offered by hospitals in the province. This Board's mandate was to make recommendations related to how the organization and growth of Manitoba's institutional care sector could be optimized to meet the needs of citizens during the next decade.[5] One month later a third initiative took the form of a new Office of Alternative Care in the Department of Public Health and Welfare. This Office was given responsibility for the province's regulatory role related to long-term care institutions and was charged with the promotion of improved treatment protocols and living conditions for the residents of these institutions.

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[4] Manitoba, *Annual Report of the Department of Public Health and Public Year for the Calender Year 1959* (Winnipeg: Queen's Printer, 1960), 2.

[5] The mandate of this Board is defined in the first chapter of its report. See Manitoba, *Manitoba Hospital Survey Board Report Vol. 1* (Winnipeg, Department of Health and Public Welfare, 1961), 7. This three person board was chaired by a federal public servant, Dr. J.W. Willard, who was Director of Research and Statistics in the Department of National Health and Welfare.

The 1960-61 fiscal year began with four additional initiatives. First, the Department of Health and Public Welfare established an Elderly Persons' Housing Branch based on the March repeal and re-enactment of *The Elderly Persons' Housing Act*. This Branch was responsible for the payment of billings generated by elderly indigents in the province's hospitals and long-term care institutions as well as the development of alternatives to hospital care for elderly persons who were not able to function independently. Second, the province attempted to further improve living conditions in northern regions by creating a Community Development Branch in the Department charged with enhancing the social and economic security of northern citizens. Third, the funding for LHUs was increased to allow the creation of the Birtle-Shoal Lake LHU and the expansion of the boundaries of the Selkirk and Virden LHUs.[6] Fourth, the ability of indigents to access physician's services was improved through an agreement between the province, the MMS, and representatives of rural and urban municipalities to establish a medi-care program to replace the Medical Care District (MDC) program. Under this agreement the MMS agreed to administer provincially funded payments to physicians for services to citizens receiving assistance under the province's *Social Allowances Act*. Peterson notes that these changes fulfilled many of the Roblin government's election promises in the area of health care and were particularly popular among low income residents in

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[6] The *Annual Report of the Department of Public Health and Welfare for the Calender Year 1960* indicates that these changes increased the total population served by LHUs to 418,287 persons.

Winnipeg and those residing in the eastern, interlake, and northern regions of the province.[7]

A less popular policy initiative occurred two months later when the Premier announced that Manitoba Hospital Services Plan premiums would increase effective January 1, 1961. This announcement was the product of a study of hospital costs completed in May by the Commissioner of Hospitalization. The findings of this study, which were summarized in an *Information Guide* published by Commissioner of Hospitalization in September, indicated that premium increases to $3.00 a month for single persons and $6.00 a month for a family were necessary for two reasons.[8] On the one hand, hospital budgets had risen an average of 20percent since the Hospital Services Plan had begun operation on July 1, 1958. The Commissioner's study found that these increases were due to three factors: demands from communities seeking the construction and/or expansion of a hospital; increased salary and drug costs in hospitals; and a decrease in the work week of hospital staff from 44 to 40 hours which had forced staffing increases in existing facilities. On the other hand, the province had determined that it was unable to further subsidize premiums due to its decision to take full responsibility for the costs of hospital

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[7] Peterson, "Manitoba Ethnic and Class Politics," 93-94. Here Peterson notes that in 1960 it was estimated that over 17,000 families in metropolitan Winnipeg still lived in "extreme poverty" and that incomes in the eastern, interlake, and northern areas of the province were "markedly lower, than those in south western and south central Manitoba.

[8] Commissioner of Hospitalization, *Information Guide to Manitoba Hospital Services Plan Premiums* (Winnipeg: Office of the Commissioner of Hospitalization Pamphlet. September 1960).

and long-term care services to elderly indigents which had previously been a shared responsibility with local governments. As a result, the Commissioner's findings argued that the only recourse was to increase the Plan's revenues and work with hospital boards to contain the growth of their budgets.

There were no further major health care policy announcements in 1960 and the Roblin administration entered 1961 under criticism from opposition parties and the media for the premium increases announced the previous year. It deflected these criticisms by indicating that it was awaiting the findings of the Manitoba Hospital Survey Board report prior to initiating further policy changes. The Board released its report in March 1961 and, given the research focus of this study, the recommendations contained in its concluding chapters are of particular interest. The focus of Chapter XII is organizational fragmentation in the province's delivery system. It gives particular attention to the administrative separation of public health services from institutional medical services delivered by Hospital Districts and opens by noting that "...care of the sick and disabled is an integral problem; it cannot be fragmented into a series of unrelated compartments." [9] It goes on to offer eight recommendations related to the need to establish an integrated continuum of services.[10] Chapter XIII offers three

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[9] Manitoba, *Manitoba Hospital Survey Board Report Vol. 1*, 493.

[10] Ibid., All eight recommendations are detailed at 501-504. In summary these recommendations include: the development of home care programs as an alternative to hospital care; enhancement of community-based health services along with improved co-ordination of these services with existing hospital and public welfare services at the local level; and, as the Report notes on 503, the establishment "...of more effective liaison between hospitals and provincial and community health and welfare agencies..." on a province-wide basis.

additional recommendations related to the need for organizational rationalization. The first supports the creation of a new provincial advisory agency responsible for the planning, financing, and construction of hospitals to enhance the co-ordination of policy formation and implementation.[11] The second calls for the consolidation of all provincial legislation pertaining to hospitals to centralize the province's authority in this area within a single Act.[12] The third echoes the 1952 Advisory Health Survey Committee's support for regional Hospital Divisions based on the Board's assumption that:

> There are obvious advantages in enlarging the hospital districts to include perhaps five or six hospitals within one area with a governing board planning and co-ordinating services available in the region as a whole. There would be further advantages if the local health unit, laboratory and x-ray unit areas and the hospital district could be altered to coincide. This should set in play a measure of planning regionally which, in turn, would facilitate planning for the Province as a whole.[13]

The Roblin administration tabled the Board's report in the legislature and indicated that a response to it would be forthcoming later in the year. In the interim it continued its program of increasing access to LHU services by expanding the boundaries of the Neepawa and Selkirk LHUs in April. Based on these boundary changes, the government estimated that 440,344 persons or 72

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[11] Ibid., 516-17. At the time two advisory agencies played what the Board describes as overlapping roles in this area; The Manitoba Hospitals Council established under the *Hospital Services Insurance Act* and, and an Advisory Commission to the Minister established under the *Health Services Act*.

[12] Ibid., 514-15.

[13] Ibid., 514.

74 percent of the population residing outside of the City of Winnipeg were now within the boundaries of the fourteen established LHUs.[14] More importantly, it responded to opposition criticisms related to the January premium increases in three steps during the fall of 1961. First, the government placed restrictions on hospital budgets for the 1962-63 fiscal year by having the Commissioner of Hospitalization write to all hospital boards in September requesting that they limit their budget increases to 3 percent over the 1961-62 fiscal year. Second, it completed an agreement with the federal government in October which altered the method used to determine the amount of federal transfer payments to the province.[15] Third, it combined the October 26 announcement of the signing of this agreement with an announcement that, effective January 1,1962, Hospital Services Plan premiums would be reduced to $2.00 a month for a single person and $4.00 for a family. This reduction was due to the province's enhanced ability to fund the Plan through increased revenues from the federal government.

The announcement of premium reductions was followed, two days later, by a cabinet shuffle which saw the Department of Health and Welfare broken into two separate Departments; the Department of Health and the Department of Welfare. The former Minister of Health and Public Welfare, Dr. Johnson,

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[14] Manitoba, *Annual Report of the Department of Public Health and Welfare for the Calender Year 1961* (Winnipeg: Queen's Printer, 1962), 132.

[15] Prior to this agreement a portion of the federal transfers for health care had been based on the number of registrants in the Manitoba Hospital Services Plan. Under this new agreement, calculation of the amount of the annual transfer was now based on a formula that included the annual average family size defined by the Dominion Bureau of Statistics.

retained the Health portfolio and began the formulation of his response to the findings of the Hospital Survey Board. This response began in January 1962 with the Roblin administration's introduction of amendments to *The Hospital Services Insurance Act* to allow the creation of the Manitoba Hospital Commission (MHC). These amendments were given Royal Assent in April and came into force on July 1 when the responsibilities of the Commissioner of Hospitals, the Manitoba Hospital Council, and the Advisory Commission were transferred to the newly established MHC. To ensure a stable funding base for the MHC, the Roblin administration also assigned a portion of provincial income tax revenues to the Commission's annual revenue budget. The introduction of these amendments was followed by Dr. Johnson's presentation of a submission to the federal Royal Commission on Health Services outlining the policy problems faced by the Roblin Administration and the goals it and the federal government should pursue to respond to these problems.[16] The four key problem areas defined by this submission and the proposed responses to these problems are summarized in Table 4.1 below.

During the spring and summer of 1962 the only major health care policy event was the announcement that a cabinet committee had been established in May to review the need for changes in the MHC's mandate, legislative powers, and future policy roles.

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[16] Manitoba, *Submission by Hon. George Johnson, M.D., Minister of Health on behalf of The Government of Manitoba to the Royal Commission on Health Services* (unpublished: January,1962).

Table 4.1: Key Provincial Policy Problems and Goals in 1962

The Policy Problem	The Proposed Response
LHU Development: the decline in federal health grants between 1955 and 1960, from 31% to 27% of the costs of their operation, had limited the province's ability to fund immediate LHU expansion to the whole of Manitoba.	Increased federal health grants to allow the province to expand LHUs combined with a new grant to allow LHUs to offer home care medical programs for persons discharged from a District Hospital or MNU.
Hospital Facilities: the need to further expand the capacity of and access to acute and chronic care hospitals in the province while, at the same time, containing the costs of hospital services	Revision of the federal hospital grant to ensure that 80% of hospital construction costs were equally shared coupled with an additional grant to facilitate the establishment of home care programs in Winnipeg
Long-Term Care Facilities: the need for new construction based on the findings of a survey which indicated that approximately two-thirds of the three thousand available beds "...were not suitable for modern long term accommodation."	The development of a low interest long-term loan program through the Central Mortgage and Housing Corporation for charitable groups interested in the construction of long-term care facilities in the province.
Physicians: the growing imbalance between Winnipeg and rural regions with 1.8 physicians per one thousand population available in Winnipeg (76% of the total number of licensed medical practitioners in the province) and only .6 per one thousand in rural Manitoba (24% of the total).	The development of a shared-cost incentive program to attract physicians to rural Manitoba coupled with the establishment of regional treatment centres large enough to support the purchase of specialized equipment and support staff not currently available to rural physicians.

The pace of events in Manitoba increased in September 1962 with the announcement that hospital budget increases for the1963-64 fiscal year would be limited to 4 percent over 1962-63 levels. This was followed by the announcement that three new hospital, two new long-term care facility, and three existing hospital expansion projects had been approved by the Commission. This, in turn, was followed by the November announcement of a December 14 provincial election which saw the re-election of a majority PC government. A

review of newspaper reports of the election campaign indicates that while health policy was not a major issue, Premier Roblin made a number of commitments regarding the further expansion of LHUs, the construction of long-term care beds, and the initiation of a study of the relationship between the provincial and local governments related to the need for changes in the funding and administration of services delivered by both levels of government.

THE THIRD TERM

When Roblin returned to the legislature in January 1963 his new government's health care policy agenda paid particular attention to his December 1962 campaign promises. As a result, during 1963, four major policy changes were announced. The first was the February creation of a Royal Commission on Local Government Organization and Finance to study the funding and administrative arrangements for the delivery of all provincial and municipal public services including public health services. This was followed by the April announcement of budgetary increases to LHUs which allowed four of the fourteen Units to enlarge their service boundaries.[17] One month later a Care Services Division was created in the Department of Health charged with responsibility for the development of services for elderly and infirm persons not requiring hospital care, the co-ordination of early discharges from hospitals, and

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[17] Manitoba, *Annual Report of the Department of Health for the Calendar Year 1963* (Winnipeg: Queen's Printer, 1963), 65-66.

the regulation of personal care homes and hostels in the province.[18] Finally, in September, Premier Roblin announced that MHC staff had been asked to assist the Royal Commission in its study of the feasibility of establishing larger hospital districts to increase the efficiency of hospital services and attract physicians to rural areas.

The Royal Commission on Local Government and Finance reported to the cabinet in April 1964. With regard to health care policy, it recommended that authority for public health and related social services delegated by the province to municipal governments should be returned to the province. Given exclusive provincial responsibility for these areas, the Commission further recommended that the province establish eleven regional units for the integrated delivery of these services.[19] While municipal governments were not adverse to having full responsibility for these services placed in the hands of the Department of Health, the Roblin administration did not immediately act on these recommendations. Morton suggests that this was due to the realization that undertaking significant organizational changes related to the delivery of health and education services at the same time would place demands on the province's expenditure budget that would greatly exceed revenues.[20] As a result, the cabinet determined that it would first act on the Commission's recommendations related to the

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[18] Ibid., 113-155.

[19] Manitoba, *Report of the Manitoba Royal Commission on Local Government Organization and Finance*, (Winnipeg: Queen's Printer, 1964) 28-35.

[20] Morton, *Manitoba A History*, 499-500.

consolidation of local school districts, which required considerable expansion of the province's funding and regulatory authority, prior to reorganizing the health care delivery system. The primary impact of this decision on health care policy was to slow the pace of policy change in 1964 to the passage of two pieces of legislation in April. The first involved amendments to *The Elderly and Infirm Persons' Act* which allowed the province to increase its support for elderly persons' housing through the implementation of a construction grant program. The second involved amendments to *The Public Health Act* to provide the province with enhanced regulatory control pertaining to the construction and operation of these facilities.

The pace of health policy change did not increase in 1965 as the Roblin administration focussed on the changes in its education policies. In April, the government imposed a provincial sales tax, along with fuel tax increases, to assist in the funding of provincial services. During the remainder of the fiscal year major health care announcements were limited to the creation of the South-West LHU, located in Killarney, and the expansion of the boundaries of three of the established LHUs. These changes increased the population served by 32,889 persons and brought the total rural population served to 530,893 or 87 percent of the population outside of the boundaries of the City of Winnipeg.[21]

The Roblin administration's focus on organizational realignments in the

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[21] Manitoba, *Annual Report of the Department of Health for the Calendar Year 1965* (Winnipeg: Queen's Printer, 1966), 103.

province's education system continued in 1966 with the April announcement that a series of referenda on the consolidation of local school districts, intended to take place in the fall of 1966, would give citizens an opportunity to determine whether they supported the regionalization of school districts. One month later, in May 1966, Premier Roblin determined that his administration needed a new mandate to implement any changes that might be produced by these referenda and called a provincial election for the following month. Newspaper reports of the campaign indicate that the pending introduction of a federal Bill to implement a national medical insurance program, popularly described as medicare, was the only health services policy issue that received attention during the election campaign. However, it did not play a significant role in the results of the June election, which saw the re-election of a majority PC government, albeit with five fewer seats. The reason for this is that Premier Roblin and the leaders of the two major opposition parties took similar positions in their general support for a province-wide medical care insurance program funded, at least in part, by the state. In addition, because the province and the federal government were still negotiating the funding and administrative details of the proposed medicare program, there was little opportunity for debate among the three major parties on substantive issues related to the specific features of its implementation in Manitoba. [22]

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[22] For a review of the federal-provincial negotiations leading to the introduction of this Act and the debates following its passage related to implementation see Taylor, *Health Insurance and Canadian Public Policy* , 331-378.

THE FOURTH TERM

The July 1966 introduction of the *Medical Care Act* to the federal parliament for first reading forced the Roblin administration to respond to two health services policy issues that it had managed to avoid debating during the June election campaign. The first was implementation of the recommendations of the 1964 Royal Commission related to the realignment of funding and organizational arrangements for public health services. The government's response to this issue came in the fall of 1966 with the establishment of a government-wide planning exercise titled Operation Productivity. This exercise required all provincial departments to study how the services they administered could be administratively integrated and decentralized on a regional basis. The second issue involved the pending implementation of medicare which was fostering growing concern among physicians that their professional autonomy related to the delivery of services would be eroded through a provincial role in the negotiation of fee schedules. This concern took the form of resistance to any realignment in their established authority and accountability roles. Esuke indicates that, in September 1966, the MMA made an informal presentation to Premier Roblin indicating that plans related to the future implementation of a provincial medical insurance program should recognize two concerns of the Association's membership.[23] The first involved the need to avoid provincial

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[23] A. Arthur Esuke, *The Issues That Led to Development of Medicare in Manitoba*, (M.A. thesis, University of Manitoba, 1978), 44-51.

intrusion into traditional areas of professional autonomy related to clinical practices. The second involved the need to give the MMS a continuing role in the provision of medical insurance. The Premier's response to these concerns came in a speech to the MMA's membership on October 13.[24] In this speech he proposed that his alternative to the federal government's implementation proposals, in particular its position that ninety percent of a province's population be enrolled in a compulsory public insurance plan prior to release of the federal share of annual funding for medicare, involved:

> - the establishment of a voluntary public insurance plan in Manitoba to cover the thirty percent of the province's population not already covered by the MMS or other private insurance companies;
>
> - the inclusion of the sixty percent of Manitoba's population currently enrolled with the MMS in the federal enrollment calculation thereby bringing the province to the ninety percent threshold for federal funding.

While the MMA was favourable to Roblin's position, the federal government was not. As a result, when the government introduced Bill 68 on March 16, 1967, to establish the legislative foundation for the implementation of *The Medical Care Act* in Manitoba, the provisions of this Bill allowed the province to implement a compulsory public plan consistent with the requirements of the federal government for shared-cost funding.[25] *The Medical Services Act* received Royal Assent in May and, one month later, the province established the

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[24] Manitoba, "Medicare by July 1 if Ottawa Agreeable," Department of Provincial Secretary Press Release, October 14, 1966.

[25] The title of Bill 68 was *An Act Respecting Insurance of Residents of the Province in Respect to the Cost of Medical Service.* Its short title was *The Medical Services Act.*

Manitoba Medical Services Insurance Corporation (MMSIC) to administer the provisions of new Act if the federal government brought *The Medical Care Act* into force. However, a June 12 press release announcing the directors of the MMSIC indicates that the Roblin administration was continuing its efforts to implement a policy compromise that would satisfy the MMA. This release indicates that one of the first goals of the MMSIC would be "...to undertake discussions with the Manitoba Medical Services with respect to utilizing the staff, experience and facilities of the doctor-run service to the greatest degree possible."[26] This statement is of particular interest given an announcement by the MMA two months earlier that premium increases of between 12.5 and 18 percent for the more than six hundred and twenty thousand subscribers to the MMS would take effect on July 1. Esuke indicates that the MMA undertook these increases based on an informal understanding with the Premier that, if the federal government prevailed in its demands for a compulsory public system, the province would allow physicians to retain the fee schedule increases that were the rationale for these premium increases. Further, the province would purchase the MMS in return for the MMA's agreement to participate in the provincial plan.[27]

In August 1967 Roblin attended a provincial premiers' conference which saw renewed provincial criticism of the federal government's medicare

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[26] Manitoba, "Medical Insurance Directors Named," Department of Provincial Secretary Press Release June 12, 1967.

[27] Esuke, *The Issues That Led to Development of Medicare in Manitoba*, 44.

implementation plans for a national medicare program. Criticisms of the federal plan were again voiced at a November federal-provincial finance ministers' meeting in Ottawa following a presentation by the federal Finance Minister which indicated that the total cost of the proposed medicare program would be significantly higher than previous estimates.[28] Based on the growing national controversy over medicare, Premier Roblin suspended all preparations for medicare's implementation in Manitoba on November 17 based on what he termed "...the uncertainty as to whether Ottawa will go ahead with the compulsory medicare scheme."[29] On November 27 he resigned as Premier to pursue a career in federal politics and was replaced by a member of his cabinet, Walter Weir, at a Progressive Conservative Party convention in December.

The Weir Administration: 1967-1969

During the first two months of his tenure, Premier Weir's did not alter Roblin's decision to suspend preparations for medicare's introduction.[30] On February 1, 1968 he outlined his government's position on medicare by releasing a copy of a telegram he had sent to Prime Minister Pearson earlier that day. It stated that his administration would defer medicare's implementation for

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[28] For a discussion of events at the federal level during 1967 see Taylor, *Health Insurance and Canadian Public Policy,* 368-74.

[29] *The Winnipeg Tribune*, November 17, 1967, 6.

[30] In *The Winnipeg Tribune*, January 4, 1968, 1, Weir is quoted as stating that Manitoba's preparations for medical insurance were "...still in limbo."

at least one year during which the federal government would have the opportunity to negotiate "more favourable" arrangements which would allow the province to implement a voluntary plan that included the participation of private insurers such as the MMS in the calculation of the number of persons participating in the plan.[31]

The release of this telegram to the media generated considerable public and opposition party criticism of the Weir administration's resistance to entry into the federal medicare scheme. Faced with daily opposition party accusations in the legislature that the MMA was dictating the terms of Manitoba's entry into medicare, the government argued that the provincial health care budget could not sustain the funding demands placed on it by the provisions of the federal *Medical Care Act*. It maintained this position throughout March and April and, on May 1, introduced amendments to the *Manitoba Medical Services Insurance Act* to allow the province to set up a voluntary medicare program and to enter into agreements with third parties to manage the program.[32] To support the legitimacy of these amendments, the Weir administration tabled a study on hospital insurance costs in the legislature when they were introduced for first reading. This study had been prepared by the MHC in April. It indicated that while per capita shareable in-patient costs in Manitoba were the seventh lowest among the ten provinces and in-patient demand had stabilized since 1964 at

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[31] *The Winnipeg Tribune*, February 2, 1968, 1-2.

[32] Manitoba, "Medical Insurance Measure Amended," Public Information Branch May 27, 1968.

slightly over 1,900 patient days per thousand population, the total cost to the province related to the operations of the Manitoba Hospital Services Plan had risen an average of 11.5 percent a year since 1960.[33] Due to this increase direct provincial contributions for the financing of the Plan had doubled from 10 percent of the total cost in 1960 to 20 percent in 1967 and were expected to increase to almost 23 percent by 1971.[34] Based on these findings, the Weir administration argued that the province could not finance a universal medicare program but might be able to finance a more limited program in which the province paid the premiums of indigents and "near indigents" estimated to make up approximately 30% of the province's total population. However, in order to finance a program of this nature, the government also indicated that Manitoba Hospital Services Plan premiums would have to be increased for the first time since 1961 and would rise to $3.60 per month for a single person and $7.20 per month for a family effective January 1, 1969.

The Weir administration was successful in passing the amendments to *Manitoba Medical Services Insurance Act* on May 26. However, their passage took place amid a political controversy related to the Weir administration's health care policy agenda that had grown since the release of Premier Weir's February telegram. On April 19 this controversy had been fuelled by the resignation of the

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[33] Manitoba Hospital Commission, *Forecast of Costs and Financial Requirements For the Years 1968 through 1971* (Winnipeg, Queen's Printer, April 1968), 3. It is noteworthy that the calculation of cost increases does not appear to have been adjusted for inflation.

[34] Ibid., 2.

PC MLA for Churchill constituency, Gordon Beard, who had resigned his seat based on what he described as the Weir administration's indifference to the findings of a report prepared for the government by a public health consultant. This report indicated that living conditions in Northern Manitoba were "...among the most wretched in Canada..." and suggested that the existing system of public health services delivery system had contributed to these conditions by excluding persons who did not live within the boundaries of the province's Northern Health Services Unit.[35] A second event, on May 6, added further fuel when the MMA announced that MMS premiums would increase by a further 23 per cent on July 1, 1968 and that MMS coverage would only pay seventy-five percent of the physician's fee for persons with taxable incomes of over $1000 per year.[36] The response to this announcement by opposition parties was to argue that these premium increases in combination with the premium increases of the previous year, Mr. Beard's resignation, and the Hospital Services Plan premium increases supported their position that the Weir administration was out of touch with the public and that the province's health care policy agenda was really being controlled by the MMA in the interests of its members.

Weir countered these criticisms throughout this period by arguing that his

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[35] Winnipeg Free Press, April 20, 1968, 1. The report, by Murray V. Jones and Associates Ltd., attributed its findings to the lack of health and related social services in northern areas of the province. Mr. Beard's action focused attention on differences in the delivery of health and social services between northern and southern areas of the province.

[36] Winnipeg Free Press, May 7, 1968, 1. For persons with an income of over $1000 per year this resulted in a real increase of 48 percent in the cost of physician's services.

primary health care policy goal was to defend Manitoba's interests against what he viewed as an unwarranted incursion by the federal government in an exclusive area of provincial jurisdiction. However, this position appears to have been a stalling tactic based on the hope that events at the national level would alter the federal government's implementation plans for medicare. The same month Weir became Premier, Prime Minister Pearson announced his resignation and the scheduling of a leadership convention for April 1968. This convention saw Pierre Trudeau assume the leadership of the federal Liberal Party and mantle of Prime Minister on April 22. Three days later Trudeau announced that a general election would take place on June 25. Premier Weir appears to have hoped that if the Liberal Party was unsuccessful in the June election, Manitoba would be able to negotiate more favourable terms for the implementation of a medicare program under a federal PC party government. However, as the date of the federal election drew closer and the controversy over his handling of health care policy continued to grow, Weir appears to have recognized that his own interests related to re-election would be served by accepting the existing terms for entry into the national medicare program. As a result, on June 19 Premier Weir announced that Manitoba would re-open negotiations with the federal government. Six days later the Trudeau administration was elected with a majority government.

The negotiations with the federal government related to Manitoba's entry into the national medicare program were completed in September 1968 and, on

the 27th of that month, Premier Weir announced that his government would implement a compulsory medicare program beginning April 1, 1969.[37] He also announced a cabinet shuffle and reorganization of the government's departmental structure the same day.[38] While the Premier argued that the changes in his cabinet were based on the findings of Operation Productivity, the return of Dr. Johnson to the new Health and Social Services portfolio appears to have been an attempt to enhance the legitimacy to the government's health care policy agenda as Dr. Johnson was an experienced and respected MLA. Dr. Johnson re-entered the health portfolio with four policy problems at the top of his agenda. The first was the implementation of a provincial medicare program which he began through the initiation of negotiations with the MMA over the future role of the MMS. The second related to opposition criticism of the government's failure to expand LHU services to the whole of Manitoba, in particular to residents in northern regions. To respond to this problem Johnson commissioned a Departmental study related to the feasibility of implementing the 1964 Royal Commission recommendation that the province develop a regional health and social services delivery. The third related to growing criticism of the MHC's approach to administration of the Manitoba Hospital Services Plan by the Manitoba Hospital Association (MHA). These criticisms were contained in an

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[37] Manitoba, "Manitoba To Enter Medicare April 1," Public Information Branch, September 27, 1968.

[38] Manitoba, "Major Shifts In Department Duties," Public Information Branch, September 25, 1968.

earlier brief presented to Health Minister Witney which indicated that since the introduction of the Plan there as been "...a disturbing trend..." in the province's health care the delivery system in the form of "...the gradual erosion of the responsibility and authority of governing boards and their Association."[39] The brief called on the Minister to shift the province's administrative authority for hospitals to an independent health services planning board that would be responsible for policy and planning related to the province's institutional care sector. The fourth problem faced by Dr. Johnson related to the funding of the province's health care delivery system. Prior to leaving for a November Federal-Provincial Health Ministers conference, he issued a statement indicating that:[40]

> - the province was experiencing difficulties having "...meaningful negotiations..." with the MMA related to the implementation of medicare due to the Association's assumption that the federal government's implementation planning for medicare could be altered;
>
> - the federal government had announced that it was phasing out a number of the National Health Grants due to the introduction of its medicare program and would not extend its commitment to fund preventive and local health services programs after the 1973 fiscal year;
>
> - the provinces were being unfairly blamed by Ottawa for recent increases in the costs of insured hospital services programs which had averaged seven percent above the rate of inflation in the previous three years.

Upon his return from this meeting Dr. Johnson expressed his disappointment that these matters had not been discussed and noted that he

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[39] Manitoba Hospital Association, "Brief to the Honorable C.H. Witney, Minister of Health," (unpublished, September, 1968), 1.

[40] Manitoba, "Manitoba To Press For Clear Medicare Statement," Public Information Branch, November 1, 1968.

was "extremely uneasy" with Ottawa's announcement that it would withdraw all of its cost-sharing guarantees with the provinces after 1973 and replace them with a "fiscal equivalent".[41] On a more positive note, he indicated that his provincial and federal counterparts had agreed to fund a one year study related to the costs of health care services and that his department would participate in this study.

In early 1969 Dr. Johnson completed negotiations with the MMA regarding the implementation of medical care insurance and, on January 27, announced the results of these negotiations.[42] Beginning on April 1 the MMS would serve as the province's agent for the processing of claims made by physicians and would be absorbed by the MMSIC on April 1, 1970 based on the terms of a tentative purchase agreement with the MMA. In an effort to counter opposition claims that the government had let the MMA dictate the terms of Manitoba's implementation plan, Dr. Johnson also indicated that the schedule of payments to physicians would be fifteen percent less than the MMA's 1967 fee schedule and that no extra-billing would be allowed under the new program. The government's efforts to counter the opposition party critics can also be seen in its February 27 Speech from the Throne in which the government committed to begin medicare coverage on April 1, expand public health services to all

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[41] Manitoba, "Federal Health Intentions Disappointing Says Johnson," Public Information Branch, November 8, 1968.

[42] Manitoba, "Medicare April 1 With $9.80 Family Premium," Public Information Branch, January 29, 1969.

regions of the province, improve home care services for the elderly; and embark on a public housing program for low income families.[43] These commitments served to define the Weir administration's health policy platform in a provincial election campaign that began in late May. Peterson notes that the central theme of the government's campaign was Weir's continuing determination to restrain public spending which was "...was substantially conveyed by broadcast testimonials from average citizens who endorsed his firmness in resisting claims on the public treasury."[44] The most prominent critic of the Weir administration's policy agenda during the election was the NDP under the leadership of Edward Schreyer. Carrothers et al. indicate that the NDP's 1969 election platform contained three planks related to health services: an immediate cut in the medicare premiums with their elimination by 1973; the centralization of funding and administrative responsibility for public health and social services at the provincial level; and increases in provincial funding to voluntary groups for the construction of long-term care facilities and low-rental housing for the elderly and disabled.[45]

The NDP's first plank differed from the Weir administration's position that

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[43] Manitoba, "Throne Speech Unveils Wide-Ranging Programs," Public Information Branch, February 28, 1969. Note that when medicare was introduced on April 1 the name of the MMSIC was changed to the Manitoba Health Services Insurance Corporation (MHSIC).

[44] Peterson, "Manitoba Ethnic and Class Politics", 98.

[45] Carrothers et al., *Regionalization and Health Care Policy in Canada*, 55-56. Also see T. Peterson and P. Barber, "Some Factors in the 1969 NDP Victory in Manitoba," *Lakehead University Review* Vol.3 (1970):120-133.

health insurance premiums were necessary because they acted as a deterrent to the over-utilization of services. Esuke argues that the PC position was motivated by political concerns as premiums allowed the government to finance approximately half of the province's cost of providing insured services outside of its general revenue base thereby minimizing the need to increase taxes.[46] During the election campaign Schreyer challenged this position by arguing that the existing system of premium collection and bill payment was administratively inefficient and that premiums could ultimately be eliminated by establishing a single payer for all insured services funded by the province's general revenues.[47] Further, he argued that a premium-based system was politically inconsistent with the principles of medicare related to equity of access. To support this argument he pointed out that the MMS premium increases in 1968 and 1969 had been driven by physician's fee schedules, not increased patient utilization, and had impacted negatively on the ability of low and average income citizens to access health services.[48]

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[46] Esuke, *The Issues That Led to the Development of Medicare in Manitoba*, 95-96. Support for this point is offered in the 1969 MHC *Annual Report* . On p. 8 this report indicates that the federal government contributed approximately 46 percent of the costs of the Commission's operations, premiums accounted for another 28 percent, and grants from the province accounted for 24 percent of the costs.

[47] In 1969 three separate organizations were responsible for the payment of insured services. They included: The MHC which was responsible for hospital services; the MMS which paid for insured physician's services; and the MHSIC which paid for physician's services not covered by the MMS as well as certain optometric and chiropractic services.

[48] The NDP used the findings of a study conducted by the Manitoba Association of Social Workers in 1968 to argue that the increases in premiums had placed over 200,000 citizens at risk of losing their medical insurance benefits. See Winnipeg Tribune, February 13, 1968 for a review of the results of this study.

With regard to the second plank, Weir argued that provincial funding for rural LHUs had been consistently expanded in the1960s and that the establishment of the Southern LHU in April was proof that LHUs would continue to expand if his government was re-elected. Schreyer countered that LHU expansion under the Roblin and Weir administrations had concentrated on southern Manitoba where the municipal tax base allowed more opportunities for LHUs to increase their service boundaries. Citing the recommendations of the 1964 Royal Commission, Schreyer argued that a shift to full provincial responsibility for public health and social services was necessary to ensure that all regions of the province were provided with an equivalent range of services. Peterson notes that this position was of particular importance to the NDP's electoral success because the majority of its rural seats came from eastern, interlake, and northern constituencies.[49] It is also noteworthy that Schreyer's concerns related to the unequal distribution of public health services was similar to the position taken by Roblin in the 1958 general election when the PC party defeated the Campbell administration.

The NDP's third plank, which related to the needs of the elderly and disabled, also differed somewhat from the Weir administration's position. Based on the findings of the Manitoba Hospital Survey Board,[50] the Roblin and Weir

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[49] Peterson, "Manitoba Ethnic and Class Politics," 99-100.

[50] See Manitoba, *Manitoba Hospital Survey Board Report Vol. 1*, Chapters XI and XII which contain recommendations related to the expansion of extended care beds and the development of alternatives to hospital care including home care.

administrations had implemented four related initiatives in this area: the development of home nursing programs delivered through rural LHUs and public general hospitals in Winnipeg; the construction of low-rental housing units for elderly persons funded by the Manitoba Housing and Renewal Corporation; the expansion of provincial regulatory controls on private personal care facilities coupled with increased grants to non-profit organizations for the construction of new facilities; and the expansion of extended care beds in General Public Hospitals.[51] Schreyer acknowledged the positive features of these initiatives but argued that an NDP government would improve on them by increasing the level of provincial funding for elderly persons' housing and establishing a provincial home care program to serve citizens throughout the province.

The election took place on June 25th and resulted in the election of twenty-eight NDP candidates. The PC party fell to twenty-two seats while the Liberal Party declined to five seats. The Social Credit party and an independent candidate each retained one seat. Peterson notes that the NDP's election victory was the result of the voter polarization along geographic and economic lines with the more affluent southern rural constituencies, along with those in south Winnipeg, supporting Weir and the less affluent constituencies in north Winnipeg and rural Manitoba supporting the NDP.[52]

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[51] See Manitoba, *1969 Annual Report* (Winnipeg: Department of Health and Social Services, 1970) for a review of the range of public health and social services funded by the province.

[52] Peterson, "Manitoba Ethnic and Class Politics," 99-101. He notes that following the election Weir attempted to stay in office by proposing a coalition government with the Liberal Party. However, the Liberal MLA for St. Boniface, Larry Desjardins, chose to sit with the NDP caucus.

CHANGES IN CAPACITY, COSTS, AND CONTROL

This assessment of the Roblin and Weir administrations indicates that the policy changes displayed by Manitoba's health care delivery system between 1958 and 1969 were, like those produced during the tenure of the Campbell administration, influenced by three broad sets of factors: federal policies related to the implementation of medical care insurance and pending changes in cost-shared funding; the Roblin administration's idealistic support of "social investment" in the province which continued to foster capacity growth; and demands from hospitals and physician's for continued expansion of medical care albeit with no additional expansion of the province's administrative authority.

CAPACITY CHANGES

As Table 4.2 below indicates, a number of changes in the functional scope of the province's health care delivery role occurred during the tenure of the Roblin and Weir administrations. The most significant was Manitoba's entry into the national medicare program on April 1, 1969. This expanded the province's delivery system role to the payment of billings for insured physicians services. However, as this table indicates, its increased role in the funding and administration of public health services, its increased regulatory role in the provision of institutional services for the elderly and infirmed, and the establishment of the MHC were also important in incrementally expanding the province's role in the delivery of services.

Table 4.2: Changes in Functional Scope from 1958 to 1969

Functional Area	Status in 1958	Status in 1969
Public Health Services	The direct funding and delivery of preventive services to all citizens, the shared-cost funding of LHU services, and the direct delivery of public health nursing to areas not included in a LHU.	The addition of care services for the elderly and infirmed coupled with expansion of responsibility for services delivered in the northern region.
Acute Care Hospital Facilities	The administration of insured hospital services for all citizens combined with an expanded regulatory role related to the services provided by Hospital Districts.	The centralization of provincial planning, regulatory, and funding authority related to hospitals within the MHC
Institutions for the Aged and Infirmed	The regulation of these facilities combined with enhanced planning roles based on the provision of construction grants to voluntary providers.	The expansion of regulatory control over institutional care coupled with the expansion construction grants to include elderly persons housing.
Services Provided by Physicians	The facilitation of medical care insurance through the MMS based on support for prepaid local government programs.	The funding and administration of the province's medical care insurance program.

In addition to the incremental expansion of the province's functional role, the geographic scope and capacity of the services delivery system also expanded between 1958 and 1969. With regard to public health services, Tables 4.3 and 4.4 detail LHU growth during this period.

Table 4.3: LHU Growth in Rural Manitoba from 1958 to 1969 [53]

LHU	Pop Served 1958	Pop Served 1969
Brandon	32,000	38,000
Birtle-Shoal Lake	established 1960	21,500
Dauphin	17,800	28,600
Neepawa	24,600	27,800
Northern	19,600	30,900
Portage	25,000	38,000
Red River	22,500	25,400
Selkirk	32,400	43,800
Southern	established 1969	43,600
South-West	established 1965	20,100
Stonewall	21,300	28,900
Swan Valley	16,800	16,000
Virden	21,900	25,200
Total	233,900	387,800
Total Provincial Pop	876,000	979,000
Total Rural Pop	432,000	452,300
% of Rural Pop Served	54.14%	85.7%

This table indicates that, under the Roblin and Weir administrations, LHU coverage increased by 31.6 percent, from 54.1 to 85.7 percent of the total rural population. When the population totalling 25,200 in 1969 covered by the province's Northern Health Services Branch is included, the total population covered increases to 91.3 percent. In short, this Table indicates that significant gains in access to public health services were achieved under the Roblin and

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[53] Source: 1958 Annual Report of the Department of Public Health and Welfare and the 1969 Annual Report of the Department of Health and Social Services. All population totals are rounded to the nearest hundred.

Weir administrations despite NDP claims to the contrary. Turning to Table 4.4 below, the most interesting feature is the large gain in suburban Winnipeg's population relative to the population in the city's core area.

Table 4.4: LHU Growth in Metropolitan Winnipeg from 1949 to 1958 [54]

LHU	Pop Served 1958	Pop Served 1969
Kildonan	47,000	69,000
St. Boniface	44,000	63,000
St. James	76,000	119,800
City of Winnipeg	277,500	274,900
Total Pop. Served	444,500	526,700

Table 4.5 below indicates changes in the geographic scope and capacity of public general hospitals in Manitoba. Based on the data contained in Table D.3 in Appendix D, this table suggests that the Roblin administration continued to increase access to medical services in the rural regions. However, while the total rural population increased by less than five per cent, the total capacity, based on the number of beds per thousand persons, increased by over twenty-eight percent with the eastern, northern, and parkland regions experiencing the largest increases in bed capacity. On the other hand, while Winnipeg's population grew by over eighteen per cent, the number of beds per thousand population declined by slightly over eight percent.

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[54] Ibid. All population totals are rounded to the nearest hundred.

Table 4.5: Hospital Growth in Manitoba from 1959 to 1969

Region	1958/59	1968/69	% Increase
Central: # Communities with Facilities	13	13	0
: Rated Bed Capacity	349	474	35.8
Eastman: # Communities with Facilities	7	7	0
: Rated Bed Capacity	151	226	49.6
Interlake: # Communities with Facilities	7	7	0
: Rated Bed Capacity	162	199	22.8
Norman: # Communities with Facilities	4	7	75
: Rated Bed Capacity	238	344	38.7
Parkland: # Communities with Facilities	9	9	0
: Rated Bed Capacity	283	423	49.4
Westman: # Communities with Facilities	27	27	0
: Rated Bed Capacity	851	941	9.4
Total Rural Capacity	2034	2607	28.2
Total Rural Population (in thousands)	432	452	4.6
Rural Beds Per 1000 population	**4.7**	**5.8**	**25.5**
Winnipeg: # of Facilities	10	11	10
Rated Bed Capacity	3303	3584	7.8
Total Winnipeg Population (in thousands)	444.5	526.7	18.4
Winnipeg Beds Per 1000 population	**7.4**	**6.8**	**-8.1**

Table 4.6 below, which is also based on data contained in Table D.3, indicates that changes in the geographic scope and capacity of long-term care facilities in rural Manitoba mirrored those related to hospitals with the eastern, northern, and parkland regions experiencing the largest capacity increases. Total rural capacity in the form of beds per thousand grew by almost 65 percent compared to a 14.2 percent increase in Winnipeg's bed capacity.

Table 4.6: Long-Term Care Facility Growth in Manitoba from 1959 to 1969

Region	1958/59	1968/69	% Increase
Central: # of Communities with Facilities	5	7	40
: Rated Bed Capacity	218	400	83.4
Eastman: # of Communities with Facilities	3	3	0
: Rated Bed Capacity	94	196	108.5
Interlake: # of Communities with Facilities	2	3	50
: Rated Bed Capacity	240	338	40.8
Norman: # of Communities with Facilities	1	1	0
: Rated Bed Capacity	96	203	111.4
Parkland: # of Communities with Facilities	2	3	50
: Rated Bed Capacity	54	137	153.7
Westman: # of Communities with Facilities	9	12	33.3
: Rated Bed Capacity	563	893	58.6
Total Rural Capacity	1265	2167	71.3
Total Rural Population (in thousands)	432	452	4.6
Rural Beds Per 1000 population	**2.9**	**4.8**	**65.5**
Winnipeg: # of Facilities		35	
Rated Bed Capacity	1883	2520	33.8
Total Winnipeg Population (in thousands)	444.5	526.7	18.4
Winnipeg Beds Per 1000 population	**4.2**	**4.7**	**14.3**

COST CHANGES

The changes in the province's functional scope indicated above suggest that, despite NDP criticism in the late 1960s, the Roblin and Weir administrations had a significant positive impact on increased access to pubic

health and institutional services in all regions of the province. This impact was facilitated by three changes in provincial authority: increased provincial funding authority and service delivery roles in the area of public health services; increased provincial budgetary relief for municipalities through the transfer of responsibilities for the costs related to medical indigents to the province; and the centralization of planning and funding authority for hospitals within the province's hospital commissions. Table 4.7 below, which is based on Table D.4 in Appendix D, indicates how this expansion impacted provincial budgets during the 1960s.

Table 4.7: Provincial Budgetary Changes from 1959 to 1969

Budget Line	**1958-59**	**1968-69**
Total Provincial Budgetary Expenditures	85,356,800	357,331,901
Provincial Health Care Expenditures	10,839,427	43,943,443
Health Dept. Expenditures as % of the Province's Total Expenditures	12.7%	12.3%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	4.02%	2.08%
Psychiatric Services Division	36.67%	29.46%
Public Health Services Division	23.61%	19.57%
MHC/ Other Institutional Services	35.69%	48.89%
Totals	100%	100%

This Table, which does not include provincial expenditures on social services, indicates that, without factoring for inflation, total provincial expenditures increased by 418.6 percent and total health care expenditures increased by 405.4 percent between April 1 1959 and March 31,1969. It also

indicates that the relative share of budgetary resources captured by the major divisions in the Department of Health declined with the exception of the Institutional Services division which increased its relative share of the Department's budget by 13.2 percent.

CONTROL CHANGES

Table 4.8 below summarizes this chapter's observed changes in the province's functional roles based on the nine category list of administrative roles that Mills et al. suggest are frequently targeted by health care policy changes.

Table 4.8: The Roblin and Weir Administration's Impact on Functional Roles

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	No change. However legislative scope and authority did expand from eighteen Acts in 1958 to a total of thirty-one by 1969;[55]
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased due to the need to maintain national standards imposed by the funding provisions of HIDSA and the *Medical Care Act* and develop agreements with other provinces related to the portability of hospital insurance
Revenue-Raising Functions related to the funding of services.	Increased due to the need to re-assign income-tax revenues to the Manitoba Health Services Plan and increases in provincial funding for public health services.

[55] For a listing of these Acts see Manitoba, *Annual Report for the Calender Year 1958*, ii and Manitoba, *1969 Annual Report*. (Department of Health and Social Services, Queen's Printer, 1970), ii-iv.

Planning and Resource Allocation Functions related to services delivery.	Increased with the creation of the MHC in 1962 and the passage of legislation related to insured medical care in 1968.[56]
Policy-Making Functions related to the licencing of and standards for services providers.	Increased through expanded regulatory and licencing authority related to providers funded by the MHC and the Housing and Agency Division of the Department of Health.
Inter-Agency coordinative Functions related to services delivery.	Increased through centralization of the the Department of Health's responsibility for a range of voluntary Boards and Commissions.[57]
Regulatory Functions related to the resource utilization practices of professional providers.	Increased regarding hospitals through the MHC's implementation of limits on budgetary increases.
Training Functions Related to the education and placement of Professional Providers.	Increased through the creation of a Health Sciences Co-ordinating Council reporting to the MHC and the Department of Education's Universities Grants Commission
Management Functions related to the day-to-day administration of services delivery.	Increased in the area of public health services due to the creation of the Northern Health Services, the Care Services Branch and the Office of Alternative Care in the Department of Health.

In summary, this table supports the finding in the previous chapter that the era of provincial capacity growth saw a marked increase in the provincial government's planning, funding, and administrative roles related to health care delivery. At the beginning of 1959 the primary responsibilities of the province were: the payment of billings for insured hospital services; the administration of

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[56] On January 1, 1969 the Chair of the MHC also became the Chair of the MHSIC which signalled the first step in the administrative integration of these agencies.

[57] At 1969 the Department was responsible for twenty-one Boards and Commissions including the MHC, The Manitoba Cancer Treatment and Research Foundation, The Sanatorium Board of Manitoba, and The Alcoholism Foundation of Manitoba.

National Health Grants for hospital construction and related care services;[58] the delivery of institutional mental health care; the shared-cost funding of local nursing, diagnostic, and physicians services offered through LHUs; and the provision of public health services to persons residing outside of the boundaries of an LHU. [59] At the time of the 1969 election the province was responsible for: the financing of the province's medical care insurance program; the regulation of all long-term care institutions and the funding of capital grants for the construction of non-proprietary personal care homes; a range of new public health services delivered by province and/or LHUs such as home nursing and dental/nutritional programs for school age children; and an environmental health program administered by the Clean Environment Commission.[60]

While Manitoba's functional roles continued to expand under the Roblin and Weir administrations, administrative responsibility for the delivery of services remained divided between the Department of Health, the various Commissions and Corporations established by the province in the 1960s to fund insured services programs, and health care providers. The maintenance of this

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[58] Of the nine types of grants-in-aid three were used to fund provincial public health programs; the Mental Health Grant, the General Public Health Grant, and the Child and Maternal Health Grant. The remaining six were paid to other service providers and included: the Professional Training Grant, the Hospital Construction Grant, the Tuberculosis Control Grant, the Public Health Research Grant, the Cancer Control Grant, and the Medical Rehabilitation and Crippled Children Grant.

[59] This list is based on a review of Manitoba, *Annual Report for the Calender Year 1958*, (Department of Health and Public Welfare, Queen's Printer, 1959).

[60] These responsibilities are detailed in Manitoba, *1969 Annual Report*. (Department of Health and Social Services, Queen's Printer, 1970) .

division appears to have been the product of two related sets of concerns among key actors in the province's health care policy community. On the one hand, the ongoing concerns expressed by executive council actors that the province should minimize its direct responsibility for services delivery to limit the legitimacy of public and provider demands for further increases in the capacity of and attendant costs related to services delivery. These actors displayed their concerns through their support for a premium-based health insurance system and their efforts to keep responsibility for provider funding at arm's length from the cabinet through the MHC. On the other hand, provider pressure groups displayed increasing concern about the province's growing administrative authority which was viewed by these groups as a potential threat to their established professional autonomy. They displayed this concern by resisting attempts by the MHC to initiate voluntary regional administrative arrangements despite the recommendations of the Hospital Survey Board and the Royal Commission and general cabinet support for regional administrative arrangements. Executive council support for regional administrative arrangements is evident in government outputs related to other policy sectors notably the creation of metropolitan Winnipeg and the consolidation of school districts during the 1960s.[61]

In short, each of the above sets of concerns worked in tandem to produce little change in the organizational arrangements for services delivery that

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[61] For a discussion of these events see Morton, *Manitoba A History*, 486-488.

evolved during the 1950s. As a result, organizational responsibility for health care services delivery in Manitoba remained fragmented between three groups of policy actors when the Schreyer administration assumed office on July 15, 1969:

- the provincial government which was responsible for the regulation and administration of programs offered through the Department of Health and Social Services and the Commissions and Corporations established during the period to administer health insurance programs;

- public sector and voluntary actors responsible for the delivery of health care services at the local level including the boards of municipal, lay, and religious public general hospitals, the members of LHU boards, the members of voluntary boards responsible for institutional care of the elderly, and voluntary boards and agencies responsible for the provision of specialized institutional services for TB and polio patients;

- private sector actors who were responsible for clinical medical care, some personal care institutions, and third party medical insurance programs.

CHAPTER 5

THE ERA OF PROVINCIAL CAPACITY GROWTH

This assessment of the evolution of provincial health care policy in Manitoba between 1948 and 1969 is divided into three sections based on the division of the research questions, defined in Chapter 2, into three groups. Each section offers a response to the questions in each group in the context of the hypothesis pertaining to each question. By way of introduction, the findings in this chapter suggest that the observed policy and capacity changes in Manitoba's health care delivery system between 1948 and 1969 were broadly motivated by three sets of factors. First, federal policy changes that increased the province's ability to fund increases in the capacity of its health care delivery system. Second, the administrative philosophies of the administrations that governed during this time frame which supported delivery system growth through consensus-based rational planning. Third, the demands of health care providers and the public for increased delivery system capacity at the local level. The findings also suggest that a subsystem of actors were prominent in policy debates and that intermediation between these actors played a role in the formation and implementation of policy outputs. In short, while the province's delivery system capacity was enhanced during this period, the rapid growth in delivery system costs, coupled with provider resistance to changes in the organizational arrangements for services delivery, saw this era end with an increased level of conflict among actors in the health care delivery subsystem.

GOAL FORMATION

Question 1: What forms of policy initiatives did executive council actors in each administration attempt to pursue in their interactions with other actors in the province's health care policy community, in particular, the subsystem actors responsible for services delivery ?

While the Campbell administration did not initiate an explicit program of delivery system cost controls, its general approach to public administration resulted in the utilization of all three of the approaches to cost control defined by Tuohy. As Morton notes, the Liberal-Progressive governments of the 1940s and 1950s viewed partnerships with other policy actors as necessary for the achievement of their policy goals.[1] Given that consensus-based planning played a central role in facilitating these policy partnerships, it is not surprising that a feature of the Campbell administration's first term was implementation of the Manitoba Health Plan developed by the Garson administration in partnership with health care providers to rationalize capacity growth in the province's delivery system. As the observations in the last section of Chapter 3 indicate, the implementation of this Plan resulted in significant capacity growth during the late 1940s and early 1950s as new revenues were made available through the 1947 tax agreement and the introduction of the National Health Grants Program in 1948. However, when the Campbell administration was confronted with unexpected budgetary demands following the flood of 1950 and the beginning of an economic recession a few years later, it moved to reduce the pace of delivery

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[1] Morton, *Manitoba: A History*, 460.

system expansion after the 1953 general election.[2] To legitimize this reduction the Campbell administration turned to implicit price and supply constraints by emphasizing what Serfaty describes as its "pay-as-you-go" approach to public administration during its second term in office.[3]

Cost-shifting was also part of the Campbell administration's approach to health care policy. While the province expanded its shared-cost funding role during the immediate post-war era, it also maintained that responsibility for the delivery of public health services within municipal boundaries was local and not provincial in nature. While this position allowed municipal ratepayers equal opportunity of access to these services, it did not provide equitable access as it excluded citizens residing in municipalities lacking the revenue base to participate in a LHU. Also, those located in "unorganized territories" were dependent on the more limited range of services offered by the province. Turning to acute and long-term institutional care, the Campbell administration expanded provincial responsibility by providing grants for the construction of facilities, subsidizing the costs generated within these facilities by the medically indigent, and facilitating access to third-party prepaid health insurance. However, with the exception of mental health care, it viewed the day-to-day funding and administration of institutional services as a local and/or voluntary responsibility and the payment of billings for medical care as an individual

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[2] Ibid., see 475 for a discussion of the impacts of this economic recession.

[3] Serfaty, "Electoral Behaviour in Manitoba," 182.

and/or municipal responsibility. While it did finally accept the need for a broader provincial role in the area of funding for the medically indigent, when it initiated the Manitoba Hospital Services Plan, in 1958, this Plan maintained the assumption that the costs of insured services delivery should remain an individual responsibility through the payment of premiums.

The discussion in Chapter 4 indicates that the Roblin administration's electoral successes in 1958 and 1959 were facilitated by PC party criticism of Campbell administration's failure to extend LHU boundaries to citizens in less affluent regions of the province, despite promises to do so throughout the 1950s. However, the policy goals and implementation strategies of this administration did not differ significantly from those of the post-war LP administrations. As a result, PC governments in the 1960s also utilized all three of the approaches to cost control defined by Tuohy. Organizational rationalization is evident in the commissioning of the Hospital Survey Board at the beginning of Roblin's tenure. The recommendations of this Board supported a broad range of realignments in the organization of the province's delivery system premised on the need for centralized planning to reduce delivery system fragmentation. The rationales for this premise were based on the Board's finding that implementation of the Manitoba Hospital Services Plan had increased demands from District Hospital and MNU Boards for capital grants to expand their bed capacity and range of services. The Board found that these demands were, for the most part, being generated by smaller hospitals interested in retaining and/or increasing their

physician complement. As a result, it argued that centralized planning and administrative control was necessary to contain future delivery system costs and minimize the risks to patients who might be subjected to specialized procedures in facilities ill-equipped to perform these procedures. This argument was supported by a 1959 study of rural hospital utilization conducted for the Survey Board by Dr. Carl Buck. It found that Manitoba's rural hospital sector displayed three related trends:[4]

> - the "dangerous misuse" of smaller facilities to perform procedures that should be performed in larger, better equipped hospitals employing more experienced professional providers;
>
> - a decline in rural populations which did not support the demands of many rural hospitals for expansion of their rated bed and service capacity;
>
> - growing problems related to physician retention in rural communities which Dr. Buck viewed as the primary reason for the demands by rural hospitals boards for capital grants to facilitate expansion.

Turning to the other types of cost control, price and supply constraints are evident in Roblin's approach to insured hospital services funding. When the legislation enabling the Manitoba Hospital Services Plan was brought into force in 1958, the intent was to limit the province's direct funding responsibility for the Plan to approximately ten percent of its total annual cost.[5] However, hospital budget increases of over twelve percent in 1960 and 1961 forced the Roblin

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[4] Manitoba, *Manitoba Hospital Survey Board Report Vol. 1.* Dr. Buck's presentation to the Survey Board is detailed on p. 505-508.

[5] See Manitoba, *Forecast of Costs and Financial Requirements*, p. 2 which indicates that in 1959 federal contributions made up 50 percent of the total costs of the program, premium income provided 40 percent of the costs, and the province contributed the remaining 10 percent which amounted to $3 million in 1959.

administration to impose price and supply constraints on the allocation of resources.[6] The implementation of these constraints was the responsibility of the MHC and took the form of three to four percent limits on annual increases to hospital budgets beginning in 1962. Cost-shifting is evident in Roblin's position on health insurance premiums and public health services funding. While the introduction of a medi-care program in 1960 relieved local governments of responsibility for the payment of premiums for the medically indigent, the explicit assumption that individuals were ultimately responsible for funding most of the province's share of the hospital services plan is evident in the decision to increase premiums in 1961. When this decision proved to be politically unpopular, the government was forced to return premiums to their 1960 levels and pursue other initiatives such as the rationalization of organizational arrangements in the province, evidenced in the mandate of the 1964 Royal Commission on Local Government Organization and Finance. While this Commission supported realignments of the existing organizational arrangements for health care services delivery, the Roblin administration's decision to first pursue the education reforms recommended by this Commission resulted in the continuation of cost-shifting for local services delivery to the municipal level.

In short, the above findings indicate that the hypothesis related to this question was not supported during The Era of Provincial Capacity Growth. While executive council actors in Manitoba utilized price and supply constraints

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[6] Ibid., see Table 1 p. 3.

and cost-shifting during this era, their preference appears to have been the utilization of organizational rationalization grounded on consensus-based planning among key actors in the health care delivery subsystem. Further, the discussion in Chapters 3 and 4 indicates that price and supply constraints were generally employed by provincial governments as a reactive measure when the behaviour of the delivery system deviated from the behaviour anticipated by the planning exercises undertaken during this era

Question 2: How did actors in the policy subsystem respond to the agenda of executive council actors in each administration and were advocacy coalitions evident in these responses?

The discussion in Chapters 3 and 4 indicate that two coalitions of actors dominated the policy health care delivery subsystem during the 1950s and 1960s. The first was led by the members of the official opposition parties in the province's legislature. As the discussion in Chapter 3 indicates, the Campbell administration did not encounter significant political opposition to its health care policy agenda until after the 1953 election. During the election campaign of that year, PC party candidates accused the government of failing to facilitate the expansion of LHUs to the less affluent eastern and northern regions of the province. While the Campbell administration did implement policy changes following the 1953 election that relieved municipalities of some of their shared-cost responsibilities for public health services, these changes did not produce significant alterations in the geographic scope of the province's health care

delivery system. This was supported by a 1955 "restudy" of health services delivery in Manitoba by Dr. Buck that continued to emphasize the need for limits on the growth of institutional facilities in favour of the further expansion of public health services to the less affluent regions of the province.[7] The release of this study fuelled PC party criticism of the government during the late 1950s. The validity of its attack, combined with Roblin's promise to extend LHU services to the whole of Manitoba during the 1958 general election, appears to have contributed to the defeat of rural LP candidates in 1958, in particular, those in the eastern, interlake, and northern regions.

The Roblin administration's tenure was similar to that of the Campbell administration in that it did not experience serious opposition party criticism until the mid point of its tenure. Following the passage of *The Medical Care Act,* Roblin began to face growing opposition from NDP members of the legislature. Like the PC party of the 1950s, the NDP gave attention to the geographic dimension of health care policy by criticising the government for failing to enhance citizen access to public health services throughout the province. Its critique in this area was given considerable support in 1968 when the government's study of living conditions in the north, which resulted in the resignation of a government MLA, found that the health status of this population

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[7] Manitoba, *Public Health in Manitoba: 1955* (Winnipeg: Department of Public Health and Welfare, 1955). See p.2-3 for Dr. Buck's conclusions related to the continued expansion of public health services.

had not improved during the 1960s.[8] Unlike the PC opposition parties of the 1950s, the NDP also critiqued the government's policy agenda based on the other two dimensions of health care policy. With regard to the decentralization dimension, it utilized the findings of the 1964 Royal Commission on Local Government Organization and Finance to call for the development of regional units responsible for the delivery of provincially funded health and social services. With regard to the rationalization dimension it was critical of the Roblin and Weir administration's support of a premium-based system to fund most of the province's share of its hospital insurance program. However, its most vocal criticism in this area related to the effort by Roblin and Weir to accommodate the interests of the MMA pertaining to a continuing role for the MMS in the implementation of the province's medical care insurance program. While the relative impact of the NDP's critique related to each of the three dimensions is difficult to assess, it is evident that the combined impact of this critique facilitated the party's electoral success in 1969. It is also notable that the NDP's electoral gains came from the same eastern, interlake, and northern regions that facilitated the Roblin administration's electoral success in 1958.

The second coalition of subsystem actors in Manitoba's health care policy community was led by provider pressure groups representing hospitals and

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[8] The need to improve health care services delivery in the north was established in an unpublished study of living conditions in Northern Manitoba presented to the cabinet following the 1959 election. The 1959 *Annual Report* of the Department of Health and Public Welfare indicates on p. 4 that this study found the health of northern residents, in particular those of aboriginal persons, was "below acceptable standards" and recommended that the province expand public health services to all persons residing in "unorganized regions" of the province.

physicians. The participation of this coalition in policy formation during the 1950s can be seen in the recommendations of the 1952 Manitoba Advisory Health Survey Committee report reviewed in Chapter 3. On the one hand, this report supported delivery system rationalization in the form of expanded provincial funding for: the construction of acute and long-term care facilities; the costs generated by care of the medically indigent; expansion of the range of services provided by Hospital Districts, and subsidization of the incomes of rural general practitioners. On the other hand, it was not supportive of changes in the established organizational arrangements for services delivery which supported the "joint venture" partnership between District Hospitals and MNUs, voluntary institutional providers, and private practice physicians. The most notable feature of this coalition's response to government policy during the 1960s was its increasingly public defence of the authority for services delivery, formally and informally delegated to its members during the 1950s. This is evident in the Manitoba Hospital Association's (MHA's) brief to the Hospital Survey Board which argued that:

> ...the optimum level of patient care in and about hospitals can be attained and maintained by preserving and strengthening the present voluntary and local character of ownership and operation of the hospitals of Manitoba. No action of Government, or other agency, or indeed the Association itself which will weaken the concept of local authority and responsibility should be tolerated nor be permitted to grow.[9]

The MHA's defence of its autonomy throughout the decade is also evident

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[9] Manitoba, *Manitoba Hospital Survey Board Report Vol. 1*, 517.

in the brief it presented to the Health Minister in September 1968. As the discussion in Chapter 4 indicates, this brief expressed the Association's concern that the Manitoba Hospital Commission (MHC) was eroding the autonomy of hospital boards and called on the Minister to establish an independent planning board composed of representatives for the various health care provider pressure groups. The MMA supported this position and also played a more public role in health care policy debates following the 1966 federal announcement of a bill to establish *The Medical Care Act* would be introduced to the House of Commons. The Association campaigned for the inclusion of MMS subscribers in the federal requirement that ninety percent of a province's population be enrolled prior to the initiation of federal shared-cost funding.[10] Because the Roblin and Weir administrations supported inclusion of the MMS in the federal calculation, the Association did not publically attack the provincial government until June 1968 when Premier Weir agreed to enter the national program under the federal government's compulsory enrollment requirements. However, given wide-spread public support for the program in the late 1960s, this attack was unsuccessful and the MMA's only option was to negotiate favourable conditions for its membership related to the sale of the MMS to the province and the implementation of its current fee schedule.

In conclusion, this discussion indicates that the study findings support the

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[10] Examples of the MMA's position can be found in newspaper articles published during March and April of 1967. For example, see the *Winnipeg Free Press*, March 15, 1967, 4 and *The Winnipeg Tribune*, April 26, 1967, 33.

hypothesis related to this question. They show that during The Era of Provincial Capacity Growth two advocacy coalitions in Manitoba's services delivery subsystem, an opposition party coalition and a provider pressure group coalition, affected the scope and content of executive council initiatives.

Question 3: What type of communications network did Manitoba's health care services delivery subsystem display and what kinds of normative assumptions were expressed by subsystem actors?

Based on arguments by Boase noted in Chapter 2, related to the three different types of intermediation that can be displayed in a health care policy subsystem, it appears that the network of policy actors in Manitoba largely operated on pressure pluralist assumptions. Support for this position can be seen in three related features of the policy subsystem's behaviour. First, policy planning was largely based on provincial government efforts to develop a consensus among key actors by including their representatives on the various planning and advisory boards and commissions noted in Chapters 3 and 4. With regard to this point it is notable that these actors were not represented on the 1964 Royal Commission on Local Government Organization which failed to see its recommendations related to realignments in the health care delivery system enter subsystem policy debates. Second, it is evident that goal formation and implementation in Manitoba attempted to accommodate two types of demands for enhanced service delivery capacity: the general public's demands for improved access to local services; and provider demands for facilities that would

allow them to offer an ever expanding range of medical technologies. As the response to the final group of questions in this section suggests, the demands of providers were, in many respects, better represented than those of the general public in provincial policy outputs.

The third feature relates to the normative assumptions that were displayed by key actors in Manitoba's health care delivery subsystem. During much of the era of provincial capacity growth no fundamental differences in policy core beliefs and the translation of those beliefs into the secondary aspects of health care policy was evident among these actors. In short, they generally supported incremental growth in the capacity of the health care delivery system within an organizational arrangement containing shared funding and administrative roles among key actors in the delivery system. However, it is notable that during the 1960s differences began to emerge between pressure group and government actors and between these actors and the opposition coalition. While executive council and provider pressure groups continued their general support of incremental capacity growth, the province's efforts to deal with rising costs forced subsystem actors to confront the issue of organizational authority in their policy debates. The response of provider pressure groups was to argue that their authority should be increased through the establishment of an independent planning agency representing the interests of providers and the general public. On the other hand, the province used the findings of the 1961 Hospital Survey Board and the 1964 Royal Commission to support its position

that that the authority of the MHC should be enlarged to improve the province's ability to centrally plan the allocation of public resources.

The opposition coalition represented by the NDP brought a new set of issues to this debate. This coalition's belief system was based on the assumption that provincial policy goals should be designed to promote citizen equality and equity of access to all services funded by the province.[11] The translation of this assumption into its position on health care policy suggested that because the province provided most of the funds for the delivery of services, it should retain ultimate authority to allocate those resources to the areas of greatest need. As the following chapter indicates, this assumption produced new initiatives for the realignment of Manitoba's delivery system during the tenure of the Schreyer administration which, in turn, generated heightened levels of conflict in the province's health care delivery subsystem.

In conclusion, the findings pertaining to this question also support the hypothesis related to it. As a result, it can be suggested that, during the era of provincial capacity growth, the structure and content of interactions between key actors in Manitoba's health care delivery subsystem affected the scope and content of provincial policy initiatives.

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[11] For a discussion of the NDP's core beliefs see James McAllister, *The Government of Edward Schreyer* (Kingston and Montreal: McGill-Queen's University Press, 1984) 4-6.

POLICY IMPLEMENTATION

Question 4: What types of initiatives were actively pursued by executive council actors in Manitoba's health care delivery subsystem into the implementation stage?

The discussion pertaining to Question 1 above indicates that the LP and PC administrations reviewed in Chapters 3 and 4 pursued all three of the approaches defined to Tuohy into the implementation stage. However, due to the more explicit nature of the Roblin/Weir administration's implementation practices, this government's policy behaviour is the primary focus of the response to this and the next two questions. With regard to price and supply constraints, Chapter 4 indicates that the Roblin administration's failure to implement premium increases in 1961 forced it to respond to delivery system cost control problems in two ways. On the one hand, it increased the province's annual contribution to the Manitoba Hospital Plan in 1962 from $3 to $10 million by re-assigning a portion of the province's income tax revenues to the Plan's annual budget. On the other, it placed a three percent limit on increases in hospital budgets which was increased to four percent in 1963 and remained at that level throughout the remainder of the Roblin/Weir administration's tenure.

Turning to cost-shifting, the Roblin administration persisted in its support of health insurance premiums to finance a portion of the province's funding responsibility for the Hospital Services Plan based on the view that premiums acted as a deterrent to over-utilization. Further, while it acknowledged the need for increased public health services funding, it maintained the shared cost

approach to LHU development that had limited their growth in the 1950s. As a result, the response to Questions 7 and 8 below indicate that while policy changes related to public health services implemented in the 1950s and 1960s enhanced the ability of municipalities to fund the creation of LHUs and/or expand the capacity of existing units by relieving them of some funding responsibilities,[12] the overall allocation of budgetary resources to public health services fell during this period relative to institutional services.

With regard to organizational rationalization, it is notable that the 1959 Survey Board recommendations called for limits on the growth of small hospitals in favour of better equipped regional facilities and organizational realignments that allowed the development of an integrated continuum of community-based and institutional services. These recommendations were reiterated in the 1964 Royal Commission on Local Government Organization which called for enhanced provincial control over the delivery of all provincially funded services. However, Roblin determined that challenging the professional provider coalition's position on the independence of hospital boards by expanding the province's planning and administrative authority would negatively affect his political support in rural areas of the province. As a result, he employed two related strategies to contain costs while, at the same time, maintaining his

[12] The most significant changes took place in the late 1950s and early 1960s and included: the 1958 funding increases to LHU budgets;: the establishment of a provincial "medi-care" program delivered by the MMS in 1960 which relieved municipalities of the payment of insurance premiums for indigents; and the creation of the Office of Alternative Care to assist in the funding of services to the elderly and infirmed.

electoral support base. On the one hand, he created the MHC in 1962 which centralized planning and funding authority for hospitals within a Commission that was "at arms length" from the Cabinet and the Department of Health. This enhanced the province's ability to coordinate policy planning and implementation while, at the same time, offering provider pressure groups inputs to the policy process through committees established by the Commission's board. On the other hand, it opted to preempt the unplanned growth of institutions for the elderly by expanding the province's regulatory authority through the passage of *The Elderly and Infirm Persons' Act* in 1960.

These findings suggest that the study hypothesis related to this question was not supported given that executive council actors did not prefer price and supply constraints relative to the other available cost control policy options. Rather, they attempted to utilize all three types of cost control and showed a marked interest in organizational rationalization as their preferred approach to the management of the province's health care delivery subsystem.

Question 5: Were pressure group and/or opposition party barriers to the implementation of these initiatives encountered by executive council actors?

In general, no evidence of the erection of specific barriers to the implementation of government cost control initiatives by opposition parties could be found beyond their ongoing legislative efforts to diminish the legitimacy of government health care policy initiatives. The same can be said of pressure

group actors. With regard to the tenure of the Campbell administration, the findings indicate that, during the 1940s and 1950s, provider pressure groups publically accepted this government's "pay-as-you go" philosophy. While they were dissatisfied with the pace of capacity growth by the late 1950s, they did not erect observable barriers to the implementation of this administration's policy agenda. This does not suggest that implementation of the province's hospital insurance program was unopposed by provider pressure groups. Rather, that their opposition to this program focussed on attempts to stop the federal government's passage of the HIDSA rather than the implementation of the provisions of this Act in Manitoba.[13]

With regard to the Roblin and Weir administrations, the findings indicate that the MHA was the pressure group most directly affected by the province's cost control initiatives during the 1960s. However, this Association did not publically resist the province's efforts to control hospital budgets until 1968 when the MHC's study of hospital costs, released in April of that year, indicated that compliance to provincial policy was problematic. This study found that the immediate impact of implemented budget limits was an average drop in hospital budget increases to ten percent in 1963 and just under five percent in 1964. However, the average began to increase in 1965 and, by 1967, had reached a new high of fourteen percent over the previous year.[14] As a result, in 1967 the

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[13] For a detailed review of national pressure group opposition to this program see Taylor, *Health Insurance and Canadian Public Policy*, 188-98.

[14] Manitoba Hospital Commission, *Forecast of Costs and Financial Requirements*, 3.

province was once again forced to increase its direct contribution to the MHC, from $10 million to $21 million annually. Further evidence of compliance problems among the MHA's membership can be seen in the context of the MHC's voluntary shared services program initiated in 1963. The response to this program, which was designed to encourage hospitals to enter into agreements to share specialized services, focussed almost exclusively on the development of regional laundry services throughout the 1960s.

In conclusion, the hypothesis related to this question is supported by the study findings. However, it is notable that the inability of executive council actors to fully implement explicit cost control initiatives was due to a particular type of failure: the failure to anticipate the non-compliance of key provider pressure groups to provincial policy outputs.

Question 6: Were bureaucratic barriers to the implementation of these initiatives encountered by executive council actors?

With regard to this question, no evidence of explicit bureaucratic barriers to the implementation of government cost control initiatives could be found in the data surveyed for this study. As a result, the hypothesis pertaining to this question does not appear to be supported.

POLICY IMPACTS

Question 7: How did implemented policy initiatives alter the functional and geographic scope of Manitoba's health care delivery system?

The discussion in Chapter 2 related to this Question indicates that two types of indicators are utilized here to assess changes in Manitoba's delivery system. The first focuses on changes in the functional scope of the province's health care delivery role. As the discussion in Chapter 3 indicates, the passage of *The Health Services Act* in 1945 significantly expanded the province's functional scope by shifting the policy focus of the Department of Public Health and Welfare from a regulatory role to that of a participant in the shared-cost delivery of public health and diagnostic services, the construction of hospitals, and the funding of services for the medically indigent. The responsibilities established by this Act, serve as the starting point for Table 5.1 below.

The second set of indicators related to Question 9 focus on cumulative changes in the geographic scope of services delivery. Here the findings, which are contained in Tables 5.2 to 5.5 below, summarize the scope of capacity growth between 1948 and 1969. With regard to public health services, Tables 5.2 and 5.3 identify LHU growth between1949 and 1969. In addition, Tables 5.4 and 5.5 summarize the findings pertaining to the geographic scope and capacity of public general hospitals and long-term care facilities.

Table 5.1: Changes in Functional Scope from 1948 to 1968

Functional Area	Status in 1948	Status in 1969
Public Health Services	The shared-cost funding of LHU services with local governments and the direct delivery of public health nursing to municipalities and unorganized territories not included in a LHU.	The funding and delivery of preventive and northern services, the shared-cost funding of LHU services, the delivery of public health nursing to areas not included in a LHU, and the delivery of care services to the elderly and infirmed.
Acute Care Hospital Facilities	Delivery system planning in consultation with provider pressure groups, the provision of hospital construction grants, the provision of grants for up to three months for the care for indigents.	The centralized regulation, and funding of hospital services through the province's hospital insurance program.
Institutions for the Aged and Infirmed	The regulation of private and voluntary facilities.	The regulation of private and voluntary facilities coupled with increased planning control through the provision of construction grants to voluntary elderly persons housing projects.
Services Provided by Physicians	The shared -cost funding, with local governments, of the services provided by a MCD.	The centralized funding of physician's services through the province's medical care insurance program.

Table 5.2: LHU Growth in Rural Manitoba from 1949 to 1969 [15]

LHU	Pop Served 1949	Pop Served 1969
Brandon	20500	38,000
Birtle-Shoal Lake	established 1960	21,500
Dauphin	15200	28,600
Neepawa	19600	27,800
Northern	14900	30,900
Portage	18300	38,000
Red River	17700	25,400
Selkirk	24000	43,800
Southern	established 1969	43,600
South-West	established 1965	20,100
Stonewall	12300	28,900
Swan Valley	17600	16,000
Virden	19500	25,200
Total	179600	387,800
Total Provincial Pop	757000	979,000
Total Rural Pop	427000	452,300
% of Rural Pop Served	**42.1%**	**85.7%**

Table 5.3: LHU Growth in Metropolitan Winnipeg from 1949 to 1969

LHU	1949	1969
Kildonan	24000	69,000
St. Boniface	25000	63,000
St. James	40000	119,800
City of Winnipeg HD	236000	274,900
Total Pop. Served	**325000**	**526,700**

[15] All population totals have been rounded to the nearest hundred.

Table 5.4: Hospital Growth in Manitoba from 1949 to 1969

Region	1948/49	1968/69	% Increase
Central: # of Communities with Facilities	7	13	85.7
: Rated Bed Capacity	182	474	160.4
Eastman: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	76	226	197.3
Interlake: # of Communities with Facilities	4	7	75
: Rated Bed Capacity	118	199	68.6
Norman: # of Communities with Facilities	2	7	250
: Rated Bed Capacity	131	344	162.5
Parkland: # of Communities with Facilities	6	9	50
: Rated Bed Capacity	178	423	137.6
Westman: # of Communities with Facilities	13	27	107.6
: Rated Bed Capacity	407	941	131.2
Total Rural Capacity	1092	2607	138.7
Total Rural Population (in thousands)	427	452	5.9
Rural Beds Per 1000 population	**2.6**	**5.8**	**123.1**
Winnipeg: # of Facilities	9	11	22.2
:Rated Bed Capacity	1967	3584	82.2
Total Winnipeg Population (in thousands)	325	526.7	62.1
Winnipeg Beds Per 1000 population	**7.2**	**6.8**	**-5.5**

Table 5.5: Long-Term Care Facility Growth in Manitoba from 1949 to 1959

Region	1948/49	1968/69	% Increase
Central: # of Communities with Facilities		7	
: Rated Bed Capacity		400	
Eastman: # of Communities with Facilities		3	
: Rated Bed Capacity		196	

Interlake: # of Communities with Facilities		3	
: Rated Bed Capacity		338	
Norman: # of Communities with Facilities		1	
: Rated Bed Capacity		203	
Parkland: # of Communities with Facilities		3	
: Rated Bed Capacity		137	
Westman: # of Communities with Facilities		12	
: Rated Bed Capacity		893	
Total Rural Capacity[16]	700	2167	209.5
Total Rural Population (in thousands)	427	452	5.9
Rural Beds Per 1000 population	**1.6**	**4.8**	**200**
Winnipeg: # of Facilities		35	
Rated Bed Capacity	700	2520	260
Total Winnipeg Population (in thousands)	325	526.7	62.1
Winnipeg Beds Per 1000 population	**2.2**	**4.7**	**113.6**

The hypothesis related to this question, that policy initiatives implemented to realign the functional and geographic scope of Manitoba's health care delivery system did not produce significant policy impacts, is not supported by the findings in these tables. They indicate that the population served by LHUs in rural regions increased by 103.6 percent, from 41.2 to 85.7 percent of the rural population, while the LHUs in metropolitan Winnipeg, along with the Winnipeg Health Department, expanded to meet the City's population increase of 62.1 percent. Turning to changes in the capacity of hospitals, rural regions of the province experienced a 123.1 per cent increase in beds per thousand population

[16] While provincial reports indicated the total number of rural beds available in 1949, no indication of their regional distribution could be found in the data surveyed.

due, in part, to an average increase in the number of communities with facilities in each region of 116.9 percent. On the other hand, capacity growth in metropolitan Winnipeg failed to keep pace with the City's increasing population and the beds per thousand ratio fell by 5.5 percent. Winnipeg did experience a 113.6 percent increase in the number of long-term care beds per thousand population, but this increase was not as great as the 200 percent increase in the number of long-term care beds per thousand experienced in rural Manitoba.

Question 8: How did implemented policy initiatives alter administrative authority in Manitoba's health care delivery system?

The following table compares Manitoba's audited financial statements for the 1948-49 fiscal year with those for the 1968-69 fiscal year.

Table 5.6: Provincial Budgetary Changes from 1949 to 1969

Budget Line	1948-49	1968-69
Total Provincial Budgetary Expenditures (in all areas)	37,52,2214	357,331,901
Provincial Health Care Expenditures	3,749,949	43,943,443
Health Dept. Expenditures as a % of the Province's Total Expenditures	10%	12.3%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	4.72%	2.08%
Psychiatric Services Division	48.03%	29.46%
Public Health Services Division	32.44%	19.57%
Hospitals and Related Institutional Services	14.81%	48.89%
Totals	100%	100%

This table shows that the allocation of provincial resources shifted between 1949 and 1969 with the relative share of the province's expenditure budget for psychiatric and public health services dropping by an average of 39.2 percent. On the other hand, the allocation for acute care hospitals and long-term care facilities increased by 230.1 percent across this two decade period. Given these findings, the hypothesis pertaining to this question was not supported as provincial initiatives did produce changes in the health care delivery system's capacity. These findings also suggest that marked differences existed in the province's planning and administrative authority for services delivery. In short, the relative share of resources allocated to the service delivery functions under direct provincial control, psychiatric care and public health services (where municipalities contributed one-third of the costs), dropped an average of 2 percent per year. Alternatively, the relative share of resources allocated to medical care providers increased an average of 11.5 percent per year. This supports the point made in the discussion pertaining to Question 1 above that provincial efforts to increase delivery system capacity to enhance access were influenced and perhaps led by the special interests of health care providers relative to the broader interests of the general public. This also assumes that the interests of the general public differed from those of health care providers. The election results of the 1958 and 1969 general elections suggest that there were differences in that promises to enhance access to public health services, as opposed to institutional medical care,

contributed to the electoral success of the Roblin and Schreyer administrations. This is also evident in the lack of public support for the Weir administration's protection of the MMA's interests related to a continued role for the MMS in Manitoba's health insurance programs.

Question 9: How did implemented policy initiatives alter functional roles in Manitoba's health care delivery system?

As the discussion in Chapter 2 indicates, the response to this question is based on a nine category list of functional roles. Table 5.7 below summarizes the impact of the Campbell, Roblin, and Weir administrations on each of these categories. It provides a further indication of the province's increased role in the planning, funding, and administration of health care services delivery between 1948 and 1969. However, with regard to the hypothesis for this question, that policy initiatives implemented to alter functional administrative roles in Manitoba's health care delivery system did not produce significant policy impacts, the findings mirror those related to the previous question. In short, while functional administrative changes had a positive impact on the delivery system's capacity, they concentrated on improving institutional medical care at the expense of community-based public health and mental health services.

Table 5.7: Changes in the Province's Functional Roles

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	Increased as legislative scope and authority expanded from seven major Acts in 1948 to a total of thirty-one by 1969.
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased with the federal government due to the introduction of insured services programs and with the other provinces due to federal demands for portability between the provinces related to health insurance.
Revenue-Raising Functions related to the funding of services.	Increased with the introduction of the premium-based Manitoba Hospital Services Plan and with new forms of taxation that were implemented by the province to augment its general revenues.
Planning and Resource Allocation Functions related to services delivery.	Increased due to expansion of the province's scope and authority related to delivery system funding.
Policy-Making Functions related to the licencing of and standards for services providers.	Increased with regard to providers in hospitals and long-term care facilities.
Inter-Agency coordinative Functions related to services delivery.	Increased in the 1940s due to the introduction of the National Health Grants Program and in the 1950s and 1960s due to the implementation of insured services programs.
Regulatory Functions related to the resource utilization practices of professional providers.	Increased in the areas of mental health and public health care as the province attempted to contain growth in its health care expenditures.
Training Functions Related to the education and placement of Professional Providers.	Increased with the introduction of professional training grants through the National Health Grants Program.
Management Functions related to the day-to-day administration of services delivery.	Increased in the area of public health with the province's takeover of preventive health programs offered by LHUs. Increased in the area of insured health care services with the establishment of the MHC.

CHAPTER 6.

RATIONALIZING THE DELIVERY SYSTEM: 1969 -1977

This chapter reviews the tenure of the Schreyer administration which governed Manitoba from July 15, 1969 to October 11, 1977. As the previous chapter suggests, this administration brought a new perspective to debates in the province's health care policy community based on the NDP's philosophy of "social democracy." The first section of this chapter reviews how the Schreyer administration translated this philosophy into policy planning during its first term. The second section turns to the implementation and budgetary challenges that it encountered during its second term in office. In addition, this section notes a shift in the NDP's health care planning priorities from a rural to a Winnipeg focus. The final section summarizes changes in capacity, costs, and provincial control during the tenure of this administration. It indicates that the NDP had a positive impact on citizen access health care services through the removal of health insurance premiums, the province's takeover of full administrative responsibility for public health services delivery, and the expansion of long-term care capacity. However, these policy initiatives produced increased demands on the province's budget and brought the Schreyer administration into open conflict with provider pressure groups in the province's health care policy community.

THE SCHREYER ADMINISTRATION'S FIRST TERM

When the NDP assumed office, Premier Schreyer appointed Sidney Green as the Minister of Health and Social Services. While Green's tenure as the health minister lasted only through the Fall session of the legislature, he was responsible for implementing what the government's August 14 Speech From The Throne described as a "substantial reduction" in health insurance premiums.[1] This reduction was facilitated by the November 1969 passage of an amendment to *The Medical Services Insurance Act* which allowed hospital and medical insurance premiums to be combined in a single payment. Following the passage of these amendments, Premier Schreyer announced that as of January 1, 1970 the total monthly cost of health insurance premiums would drop from $8.50 for a single person and $17.00 for a family to $4.15 for a single person and $8.30 for a family.[2] At the same time he indicated that his government was initiating the administrative integration of all health insurance programs within a single agency to enhance the efficient and effective management of these programs.

The Fall session was followed by a cabinet shuffle that saw Rene Toupin

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[1] Manitoba, "Throne Speech Forecasts Wide Government Agenda," Information Services Branch, August 15, 1969, 1.

[2] Manitoba, "New Health Insurance Premiums Effective January 1," Information Services Branch, November 26, 1969, 1.

replace Sidney Green as the Minister of Health and Social Services.[3] Toupin's tenure as the health minister, which continued into the administration's second term, saw provincial health planners focus on three major policy initiatives: the administrative integration of insured health services programs; expansion of the province's funding and delivery roles in the area of public health services; and the development of a new model for the delivery of an integrated continuum of health services at the local level based on the Community Health Centre (CHC) and Single-Unit Delivery System (SUDS) concepts. The following sub-sections review the government's efforts to implement these initiatives during the Schreyer administration's first term.

The Administrative Integration of Insured Programs

As the previous chapter notes, the administrative integration of insured hospital and medical care programs was initiated by the Weir administration in early 1969. This initiative began with the January 10 announcement that the Manitoba Hosptial Commission (MHC) Chair would assume the Chair of the Manitoba Medical Services Insurance Corporation (MMSIC) board. This was followed, on January 27, with an announcement that the Manitoba Medical Service (MMS) would administer the medical insurance program under contract during the program's first year of operation and would then be absorbed by the MMSIC on April 1, 1970. On April 1, 1969 a third announcement indicated that

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[3] Manitoba, "The Manitoba Cabinet," Information Services Branch December 19, 1969, 1.

the name of the MMSIC would be changed to the Manitoba Health Services Insurance Corporation (MHSIC). Three events, which were noted in the previous chapter, contributed to these announcements. The first was the September 1968 completion of Operation Productivity which found that the administrative integration of similar service delivery activities would, in general, enhance their efficiency and effectiveness. The second was the MHA's September presentation of its brief to Minister Witney expressing the Association's concerns related to the erosion of the authority of hospital boards. The third was the federal government's November announcement that it was considering replacing shared-cost funding for insured hospital and medical care services in 1973 with a single transfer that it described as a "fiscal equivalent" to the existing arrangements. While this announcement did not indicate what form a new funding mechanism would take, the Weir administration assumed that a single block grant for all health services was the likely instrument and that a single agency would be the most efficient way to administer this grant.

While no further progress related to the creation of a single agency occurred during the remainder of the Weir administration's tenure, the election of the Schreyer administration brought new political momentum to this policy change. This was given further momentum through the November release of the Conference of Health Ministers Task Force report on the costs of health

services.[4] As noted in Chapter 1, the Task Force argued that the realignment of what it described as the fragmented organization of provincial health care delivery systems was necessary to improve the cost-effective utilization of public resources. In addition, it offered recommendations which suggested that the provinces should expand their regulatory authority over professional providers to enforce consistent planning, administrative, and service delivery practices. The Schreyer administration employed these arguments to legitimize the February 1970 introduction of a bill to establish a single health services commission. On July 21 this bill received Royal Assent as *The Health Services Insurance Act. On* October 21 the act came into force with the establishment of the Manitoba Health Services Commission (MHSC) which was responsible for the programs previously administered by the MHC and the MHSIC.[5]

While the Task Force report played a role in the timely establishment of the MHSC, a series of events between 1970 and 1973 resulted in significant growth in the Commission's planning and administrative authority. When *The Health Services Insurance Act* was presented to the legislature, a Winnipeg surgeon, Dr. David McQueen, responded publically to its introduction by suggesting that the teaching hospitals in Winnipeg were restricting admissions

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[4] Canada, *Task Force Reports on the Cost of Health Services in Canada*, Volumes I to III (Ottawa: Queen's Printer, 1969). See Volume II which offers a range of recommendations related to the need for consistent practices related to the way services were delivered by hospitals as well as their construction, management, and human resources policies.

[5] On April 1, 1970 the MMS ceased to be the agent for processing medical insurance claims in Manitoba and was absorbed by the MHSIC.

to the patients of physicians who held active staff privileges within these facilities and that their admissions and staffing policies should be investigated by the government. Further, he suggested that the proposed MHSC should be mandated to ensure that equitable access to the specialized services these hospitals provided would become available to all residents of the province. The Schreyer administration responded to Dr. McQueen's arguments by establishing The Commission of Inquiry Into Hospital Admissions on March 26, 1970. It was chaired by Mr. Justice J. M. Hunt who was empowered to investigate the staffing and admissions practices of all of the province's hospitals with particular attention to the teaching hospitals in Winnipeg.[6] The Hunt Commission reported one year later with a report containing forty-two recommendations.[7] While it supported the continued administrative autonomy of hospital boards, it recommended that the granting of staff privileges and the admissions/discharge practices in hospitals be standardized and centrally regulated. It also recommended that facility planning be centrally managed by the MHSC to ensure that alternatives to acute care accommodation, in the form of extended and personal care beds, would become more readily available in the province.

The Schreyer administration's response to these recommendations came

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[6] Manitoba, *Report Of The Commission of Inquiry Into Hospital Admissions*, March 26, 1971. See p. 7 for the Commission's Terms of Reference.

[7] Ibid., 66-70. These recommendations relate to the structure of hospital boards, medical staff privileges in the teaching hospitals, admissions and discharge practices in the province's hospitals, the future development of health care facilities in Winnipeg, the role of general practitioners, and the role of the College of Physicians and Surgeons.

in four steps which progressively expanded the administrative authority of the MHSC. The first step occurred in March 1971 with the introduction of amendments to *The Health Services Insurance Act*. They came into force in August and expanded the Commission's mandate from the administration of health insurance programs to "...in-depth examinations of proposals relating to long-range health care planning."[8] The second step occurred in April 1972 when the government transferred two responsibilities held by the Department of Health and Social Development to the MHSC: planning responsibility for the construction of personal care homes; and responsibility for the administration of Diagnostic Services Units (DSUs) in rural Manitoba. The third step, which occurred one year later, is discussed below in relation to the establishment of CHCs and provided the MHSC with primary responsibility for the implementation of provincial delivery system reforms. The final step took place on July 1, 1973 when the Commission was given responsibility for the government's new insured services program for personal care homes along with regulatory responsibility for all long-term care facilities in the province.[9]

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[8] Manitoba Health Services Commission, *1971 Annual Report* (Winnipeg, MHSC, 1972), 13. These amendments had three specific impacts on the structure and role of the Commission's board. First, they allowed the Commission's Chair to become a part-time, rather than a full-time administrative position, through the establishment of an Executive Director's position to serve as the Commission's CEO. Second, they expanded the size of the Commission's board from seven to nine appointed members. Third, they expanded the board's mandate from the management of health insurance programs to the planning and regulation of the province's health care services delivery system.

[9] Note that in response to the creation of an insured services program for personal care homes the MHA changed its name to Manitoba Health Organizations, Inc (MHO) at its annual meeting in November 1973.

The Regionalization of Public Health Services

Policy changes in this area were also initiated by the Roblin/Weir administrations. They began two months after the September 1968 release of Operation Productivity's findings when the Department of Health and Social Services announced a new organizational structure that included a Social Services Division mandated to deliver services through eleven regional offices based on the SUDS concept.[10] Throughout 1969 and 1970 the Department was occupied with the establishment of this Division and the only major announcement pertaining to public health services came in May 1970 when the Department's name was changed to the Department of Health and Social Development. However, six events during 1970 indicated that more significant changes were being planned:

> - the March 22 announcement by the Industry and Commerce Minister that the province was initiating a study to determine how provincial and municipal services could be administered on a regional basis;[11]
>
> - an August 26 submission to cabinet by Mr. Toupin which proposed the transfer of all administrative responsibility for public health and social services to his department, the development of coterminous regional boundaries for the integrated administration of public health and social services by the province, and the introduction of the SUDS concept to all of the public health services that would delivered by the Department;[12]

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[10] Department of Health and Social Services, *1968 Annual Report* (Winnipeg: Queen's Printer, 1969). A discussion of the Department's mandate and new organizational structure is offered on p. 1-5.

[11] Manitoba, "Planning Emphasis For Regional Bodies", Information Services Branch, March 26, 1970.

[12] Manitoba, "Submission To Cabinet by The Minister of Health and Social Development," August 26, 1970. Following cabinet a working group was established in September to explore the feasibility of a regional SUDS- based system for services delivery.

- a September speech by the Municipal Affairs Minister to a meeting of the Manitoba Urban Municipalities Association which advocated the establishment of regional government units to administer policy areas that extended beyond the jurisdictional boundaries of municipalities;[13]

- the November passage of amendments to *The Municipal Act* which enabled the province to release local governments from their administrative obligations related to provincial-municipal shared-cost programs;

- the December departure of Mr. Toupin and senior members of his Department on a fact-finding visit to the Scandinavian states to determine whether new models for community-based health care delivery developed by them could be applied to Manitoba's delivery system;

The final event was the release of a Discussion Paper by Mr. Toupin following his return from the Scandinavian states. It defined the need for Departmental reorganization based on the view that implementation of the SUDS concept in all service areas was necessary for two reasons. First, it was assumed that the concept's implementation would increase delivery system efficiency and effectiveness due to its focus on providing services through integrated teams of professional providers and its emphasis on the needs of the client/patient, rather than those of service providers. Second, it was assumed that implementation of the concept would alter the Department's relationship with citizens by enhancing citizen support of, and participation in, health care policy issues. This is emphasized in the opening pages of the paper which note that:

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[13] Manitoba, "Pawley Advocates Regional Approach," Information Services Branch, September 25, 1970. The provision of hospital care, public health and social services, and seniors housing were among the issues cited by the Minister in his speech.

> Through the Single Unit Delivery System we hope to create that sense of concern which will show the individual that this is a Department and a Government that is totally committed to meeting his or her total needs...We feel that this development of a one to one relationship with the citizen will encourage greater citizen participation in the affairs of the provincial government. By doing this, we are attempting to restore belief in the government process and show to the average individual that he or she is the centre, the focus and the ultimate reason for our existence as a Department and Government.[14]

The combined impact of these events on the government's policy agenda became evident in the Schreyer administration's April 1971 Speech From the Throne which stated that the government would "...adopt new concepts and take new directions in the delivery of health and social development services..." including: the regional integration of services delivery; the development of alternatives to hospital care in the form of CHCs and personal care homes; and the introduction of a new program to reduce prescription drug costs for the elderly and infirm.[15] This speech was followed by five events in 1971 related the regionalization of services delivery:

> - the April 30 announcement by the Minister of Industry and Commerce that his department was initiating study of regional models for the administration of all provincial services;[16]

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[14] Manitoba, A Re-Organization Concept for the Department of Health & Social Development (unpublished discussion paper, December 1970), 3.

[15] Manitoba, "Health, Welfare Changes Outlined," Information Services Branch April 8, 1971 p.1.

[16] Manitoba, "Regional Analysis Program Announced," Information Services Branch, April 30, 1971.

- the July 2 announcement by Mr. Toupin of a Departmental reorganization to facilitate the administrative integration of public health and social services;[17]

- the August initiation of a pilot project in two rural social service regions to assist implementation planning related to the SUDS concept;[18]

- the October 22 announcement by Premier Schreyer that a second phase in the study of regional governance models would begin in January 1972;[19]

- the December 29 formation of a Task Force responsible for defining new regional boundaries to facilitate the implementation of a SUDS- based health and social services delivery system across the province.

The following year saw two additional changes related to public health services. In March, the Minister of Industry and Commerce announced the completion of his study of regional government models and the beginning of the next phase of implementation based on a series of planned meetings with the representatives of municipal governments in the province.[20] Two months later the Task Force appointed the previous December to study public health and social services delivery reported to cabinet.[21] It recommended the establishment of seven regional units in rural Manitoba based on what it defined

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[17] Manitoba, "Service Integration Outlined by Toupin," Information Services Branch, July 2, 1971.

[18] Donald E. Vernon, "Integrated Social Services in Manitoba," *Public Welfare*, Summer 1973, 3.

[19] Manitoba, Regional Analysis Caravan Announced, Information Services Branch, October 22, 1971.

[20] Manitoba, "Regional Analysis Briefings Completed," Information Services Branch, March 17, 1972.

[21] Manitoba, *Final Report Of The Task Force On Regional Boundaries*, (Winnipeg: Department of Health and Social Development, May 1972). See 2-3 for the discussion on boundaries and the need for new legislation to facilitate "more perfect" boundaries.

as "interim boundaries" created through an amalgamation of the province's sixteen established LHUs and eleven social services regions. Further, it indicated that "more perfect boundaries" could be defined following the completion of provincial- municipal meetings related to a regional government system and the subsequent passage of new legislation to enable the formation of regional government units.

The provincial-municipal meetings announced in March continued throughout the remainder of 1972. While the municipalities were resistant to the establishment of regional government units with wide-ranging administrative authority, they supported a transfer of their responsibility for LHUs to the province if the province was willing to offer them the same relief from funding responsibility that it had when their responsibility for DSUs was transferred to the MHSC in 1971. As a result, the Department of Health and Social Development began formal negotiations with LHU boards in the fall of 1972 related to the transfer of their authority to the province. As negotiations with the boards in each region were finalized, the Department appointed a regional director to administer services delivery. While all regional directors were appointed by April 1, 1973, it is notable that the Schreyer administration viewed this regional delivery system as a temporary organizational arrangement. This is emphasized in the 1972 *Annual Report* of the Department of Health and Social Development which indicates that the creation of these regions was the first of two stages in the planned reorganization of public health care delivery. It goes

on to note that "...A second stage of development foresees the establishment of District Health and Social Services boards with jurisdiction over an integrated system of services."[22]

As noted above, provincial-municipal meetings held during the first half of 1972 did not produce support for the province's regional government model. As a result, during the four month period leading up to the June 1973 provincial election, the Schreyer administration made two additional announcements related to health care delivery. First, it used the February 22 Speech From the Throne to announce that it government would expand its responsibility for health care through extension of the province's insured services program to all types of long-term institutional care, expansion of the insured home care services program to all regions of the province, and the introduction of a program to pay eighty percent of the drug costs incurred by elderly and chronically-ill persons.[23] The intent to implement these commitments on July 1 was announced by the Premier during the March 30 presentation of the budget speech. This speech also indicated that the Province would eliminate the collection of all premiums for insured health services on June 1.[24] Second, it abandoned its plan for the development of large regional government units in favour of a model based on

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[22] Manitoba, *Annual Report 1972*, (Winnipeg: Department of Health and Social Development, 1972) 15.

[23] Manitoba, "Major Health, Social Aid Program Unveiled," Information Services Branch, February 23, 1973..

[24] Manitoba, "No Health Premiums After June First," Information Services Branch, March 30, 1973.

district units that more closely approximated established administrative relationships between incorporated towns or villages and their adjacent rural municipalities. This new approach to regionalization was detailed in the March 1973 release of *Guidelines For the Seventies*, a two volume statement of the government's future plans for policy change in rural Manitoba based on the "stay option" concept.[25]

The Introduction of CHCs

The introduction of the Community Health Centre concept to Manitoba's health care policy community represents the beginning of what the 1972 *Annual Report* of the Department of Health and Social Development describes as the "second stage" in the Schreyer administration's effort to rationalize the organization of health care delivery in Manitoba. The introduction of this concept began in 1970 with Mr. Toupin's December visit to the Scandinavian states to study their CHC model. This trip was followed by the following events in 1971:

> -an indication in the April 8 *Speech From The Throne* that the government was "exploring" the CHC concept;[26]

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[25] Manitoba, *Guidelines For the Seventies*, Volumes I & II, (Winnipeg: March 1973). On p.9 of Volume II the "stay option" is defined as the administrative integration of all public sector services at the community level to "...provide those economic opportunities and social amenities in our rural areas which will permit the choice to move into the city to be one of preference, and not a decision determined only by economic necessity."

[26] Manitoba, "Health, Welfare Changes Outlined," Information Services Branch April 8, 1971.

- an April 12 announcement that the government had appointed a study group based on the Hunt Commission's recommendation for "...a full study of community health care needs with emphasis on alternative care facilities that could release the pressure on hospital beds and services";[27]

- the May establishment of the Hastings Task Force by the Conference of Health Ministers which included Dr. Ted Tulchinsky as one of Manitoba's two representatives.

- the June hiring of Dr. Cecil Sheps as a consultant to the government on the development of CHCs;[28]

- the August 3 approval of a submission to cabinet by Dr. Tulchinsky requesting funding for study of the role of CHCs in the reorganization of the province's health and social services delivery system;[29]

- the September 24 announcement that the government planned to create CHCs in the northern communities of Churchill and Leaf Rapids responsible for "...social development, public health, and allied medical services...". [30]

The MMA responded to the last of these announcements with a demand that Mr. Toupin meet with its executive to discuss the government's future plans

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[27] Manitoba, "Govt. Studying Hospital Report," Information Services Branch, April 12, 1971 p.2. The members of this study group included the Chair of the M.H.S.C., the Deputy Minister of Health and Social Development, and Dr. Ted Tulchinsky who had been hired as a special consultant to Mr. Toupin in March. Dr. Tulchinsky had begun his career as a physician in The Saskatchewan Community Clinic and had come to Manitoba after serving as the medical director of the St. Catherine's Community Group Health Centre and the executive director of the Ottawa and District Community Health Foundation.

[28] Dr. Sheps was the husband of Dr. Mindel Sheps who was the first secretary of the Saskatchewan Health Commission. He was active in the supporting the Dougal administration's establishment of hospital insurance in that province and in 1946 served as the Commission's chair.

[29] This submission is discussed in an October 7, 1971 letter to Dr. Tulchinsky from Dr. Sheps discusses its contents. In this letter Dr. Sheps agrees with Dr. Tulchinsky's assumption that changing the roles of existing facilities would act "...as a lever to help change the system around." However, Dr. Sheps goes on to express reservations related to Dr. Tulchinsky's expectation that the governing boards of District Hospitals will to co-operate with his plan to convert them to CHCs.

[30] Manitoba, Health, Social Dev. Centre For Churchill," Information Services Branch, September 24, 1971.

for delivery system reorganization. This meeting, which took place less than a week later, included the presentation of a MMA Discussion Paper critical of the government's initiative to implement the CHC concept in Manitoba. Mr. Toupin responded to its content in an October 12 letter which defined the reasons why the government would continue to pursue the development of CHCs including the need to: contain increases in provincial health services costs; reduce organizational fragmentation, over-specialization, and the discontinuity in the delivery system; and reduce the "over-dependence on acute care hospitals" so that resources could be re-allocated to other programs designed to improve population health.[31] The Schreyer administration's intent to pursue implementation of the CHC concept despite MMA opposition was further confirmed in January 1972 when Dr. Tulchinsky assumed the post of secretary to the Health, Education, and Social Policy (HESP) subcommittee of the new cabinet Planning Secretariat chaired by a senior cabinet minister, Mr. Saul Miller. On January 31 Premier Schreyer, Mr. Miller, and the HESP subcommittee met with Dr. Sheps to discuss planning goals for the upcoming year. The minutes of this meeting indicate that the following agreements were reached;[32]

> - that the province undertake the development of "...a major public presentation on health policy in the context of the evolving health scene in North America..." based on the integration of public and institutional health services at the community rather than at the regional level;

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[31] Manitoba, Letter from the Honourable Rene Toupin, Minister of Health and Social Development to the MMA Board, October 12, 1971, p.8-9.

[32] Manitoba, Minutes of the HESP Subcommittee Planning Meeting, January 31, 1972.

- that this presentation avoid discussion of the role of private health care providers due to the current lack of support for the CHC concept among the membership of the MMA;

- that "decisive action" be taken by taken by the government to limit the flow of capital for the construction of acute hospital beds until long-range policy goals had been fully defined.

The development of the public presentation agreed to at this meeting was the focus of the HESP subcommittee's activities over the next five months. On July 12, Mr. Miller tabled the product of this activity in the form of *The Manitoba White Paper on Health* in the legislature.[33] The government's announcement of the release of the White Paper describes it as "a prelude to reform" [34] and summarizes three central problems in the province's delivery system that it hopes citizens will consider in their review of the Paper's recommendations:

- the "alarming" increase in hospital and medical costs and the even more alarming cost projections for the future which were viewed by the White Paper as a threat to the long term quality and quantity of services;

- the unequal distribution of hospital and medical services within the various regions of the province evidenced by the fact that regional populations with the highest health service needs had the fewest services available to them within their region;

- the fragmented organization of the delivery system, in particular, the lack of administrative integration between acute, long-term , and community-based health services.

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[33] Manitoba, *White Paper on Health Policy*, (Winnipeg: Cabinet Committee on Health, Education, and Social Policy, July 1972. See Chapter II p.7-36 for a discussion of the Paper's definition of the primary problems in Manitoba's delivery system.

[34] Manitoba, "Govt White Paper on Health Policy Tabled," Information Services Branch, July 14, 1972. In this Release Mr. Miller describes the White Paper as "...a prelude to reform, but also an open invitation to Manitobans in discussing how reform is to proceed."

The Paper's solution to these problems focussed on the establishment of District Health and Social Development Centres (DHSDCs) which were based on the CHC model developed in the Hastings Commission report released a week prior to the release of the White Paper. These Centres were intended to integrate administrative authority for services delivery under an elected board comprised of residents in the Centre's service area. The services that a Centre's board members would be responsible for are defined in Table 6.1 below.

Table 6.1: Proposed DHSDC Service Delivery Responsibilities [35]

Area of Service Delivery	Actor(s) Currently Responsible
Public Health Services	Shared between the Province and LHU boards.
Acute Care Hospital Services	District Hospital Boards.
Long-term Care Facilities	Not-For Profit voluntary organizations and private for-profit organizations.
Clinical Physician's Services	Private practitioners and physicians employed by LHUs and/or the province to serve persons in remote areas.
Allied Services	Private practitioners offering dental, optometric and chiropractic services.

The release of the White Paper was followed by the September formation of the Health White Paper Working Group which was responsible for planning the implementation of the White Paper's recommendations. It began this process by assuming responsibility for: the development of the Churchill and Leaf Rapid DHSDCs initiated in 1971; the establishment of DHSDCs in the rural

[35] Ibid., See Chapter III p.37-46 for this discussion.

communities of Gladstone, Hamiota, and Lac du Bonnet; and the redevelopment of the Mount Carmel Clinic in Winnipeg initiated earlier in the year. On December 2 Dr. Tulchinsky and the members of the Working Group met with Dr. Bill Bicknell, the Health Commissioner for the State of Massachusetts, to discuss his experience related to the establishment of CHCs in that state. The minutes of this meeting include a summary by Dr. Tulchinsky which notes that the Working Group's implementation plans should pursue the following:[36]

> - a focus on "small unit" services regionalization because "...it is at the local level that fragmentation is most pronounced";
>
> - the administrative consolidation of all health and social services in these small units through the transfer of municipal and provincial responsibility for these services to the elected Centre boards;
>
> - the development of a capitation-based global funding system for these centres, rather than maintaining or blending the existing funding mechanisms, to ensure that professional providers would work together to serve the needs of patients served by the unit.

The Schreyer administration entered 1973 with two responses to the White Paper from members of the province's health care policy community. On January 20 the MMA released a position paper containing nineteen recommendations which indicated that the Association:[37]

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[36] Department of Health and Social Development, Minutes of Meeting Held with Dr. Bill Bicknell, Health Commissioner, State of Massachusetts, Winnipeg (unpublished, December 2, 1972. This summary is offered on p.13.

[37] Manitoba Medical Association, *Health Care In Manitoba As of Today and Tomorrow*, (Winnipeg: February, 1973). While this position paper was approved in January, copies were not made available until February. The principle recommendations are contained on p. 8-10.

- supported the administrative regionalization of hospital and community-based services through an implementation plan that was "...sensitive to existing patterns of medical practice and patient utilization of services";

- supported the development of hospital-based home care programs to relieve the demand on acute care beds as well as the development of home care programs based in physician's offices;

- did not support the administrative integration of health and social services within the DHSDC concept, in particular, the integration of physician's services with those of other professional providers;

- did not support changes in the fee-for-service method of remunerating physicians suggested by the DHSDC concept.

This was followed by the January 25 release of a position paper by the MHA which indicated that the Association:[38]

- supported the government's assumption that the demand on hospital beds could be decreased through the addition of personal care services to the list of insured services if new personal care facilities were located adjacent to hospitals and managed by them;

- supported the creation of a province-wide home care program as long as it was managed by local hospital boards;

- supported the development of DHSDCs as long as the Association's membership was involved in the planning and management of these centres;

- did not support the elimination of fee-for-service payments to physicians but did agree that fee schedules should be reviewed to provide more incentives for preventive activities.

With a number of pilot DHSDC projects already in various stages of development, the mixed reaction of these provider pressure groups, combined with the conclusions reached at the December meeting with Dr. Bicknell,

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[38] Manitoba Hospital Association Inc., *Position Statement on the White Paper on Health Policy and the Hasting Report*, (Winnipeg, January, 1973).

suggested the need for clarification of the Working Group's mandate. This was initiated in February through a series of discussions between Dr. Tulchinsky and another health policy consultant retained by the province, Dr. E. Vayda. They first dealt with the need for a formal process for the formation of a DHSDC. This process was outlined in a February letter from Dr. Tulchinsky to Dr. Vayda and contained five steps.[39]

> - First, initial consultations between Health White Paper Working Group staff and interested District Hospital and community clinic boards to facilitate the development of a proposal to establish a DHSDC.
>
> - Second, the formal submission of a proposal to the Health White Paper Working Group for review and approval.
>
> - Third, approval of the proposal by the HESP subcommittee.
>
> - Fourth, approval of the proposal by cabinet through an Order-In-Council defining regulations pertaining to the roles of the DHSDC board.
>
> - Fifth, the forwarding of these regulations to the Community Operations Division of the Department of Health and Social Development as well as the MHSC who were jointly responsible for co-ordinating the establishment of the Centre and the definition of its funding.

The senior staff in the Department of Health and Social Development did not fully support this proposed process. The minutes of a February 21 meeting between Dr. Tulchinsky and the Department's Deputy Minister, Mr. H. Schneider, indicate that the Department's position was that its lack of involvement in the initial steps of the formation process left it unable to anticipate staffing and funding demands that might arise during the budget year. As a result, Mr

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[39] Manitoba, Letter to Dr. E. Vayda from Dr. Ted Tulchinsky, February 2, 1973.

Schneider made two requests. First, that Dr. Tulchinsky "...draw some specific parameters around what he expects to undertake in the next year or at the very least the next six months...". Second, that the Department be given the right to authorize the assignment of staff to projects initiated by the White Paper Working Group.[40] Dr. Tulchinsky responded to these requests in an April 5 submission to cabinet which contained the following recommendations.[41]

> - First, that the province integrate all health care and social services in Districts governed by DHSDC boards responsible for the delivery of "a progressive care system" within their District.
>
> - Second, that a target of 12.0 beds per thousand population be established in a District consisting of 4.0 acute care beds, 4.0 extended care beds, and 4.0 personal care beds per thousand population.
>
> - Third, that a province-wide freeze on the construction of proprietary personal care beds be instituted and that attempts be made to purchase existing proprietary facilities when a DHSDC was established in a District.
>
> - Fourth, that the MHSC be given full responsibility for the implementation of all health care delivery system reforms in the province including the establishment of DHSDCs.

The last of these recommendations indicates that Dr. Tulchinsky favoured the centralization of implementation responsibility in one agency. While this was being considered by the cabinet, the Health White Paper Working Group completed a Discussion Paper titled *Framework-- District Health System.*[42]

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[40] The issues discussed in this meeting are summarized in a February 22, 1973 Memorandum from Mr. Schneider to Donald Vernon the Assistant Deputy Minister in charge of the Department's, Community Operations Division.

[41] Manitoba, "Submission To Cabinet by The Health, Education, and Social Policy Committee of Cabinet," April 5, 1973.

[42] Manitoba, *Framework--District Health System* (Winnipeg: White Paper Working Group, HESP Subcommittee of Cabinet, May 8, 1973), 1-2.

This Paper outlined the Working Group's position on the most pressing health care delivery problems, the goals that should be pursued to respond to these problems, and the "major mechanisms" that should be utilized to facilitate goal implementation. The problems and goals defined by this Paper are summarized in Table 6.2 below.

Table 6.2: Policy Problems and Goals in May 1973

Policy Problem	Policy Goal
The "rapid escalation of costs" related to insured hospital and medical services.	The development of incentives for health care providers to "use scarce resources effectively."
The "waste in funds and resources through fragmentation and inadequate organization of services".	Reductions in "inequality and fragmentation" through the establishment of DHSDCs.
The "inequitable distribution of services" coupled with "inequality of access and use of services".	The evolutionary establishment DHSDCs with delegated authority for "a comprehensive range of health and social services".
The "gaps in insurance coverage and in-service programs" for health and social development programs.	The development of "requisite mechanisms for rationalization of programs" at the provincial level.

With regard to the implementation of these goals, the Paper defined the six "major mechanisms" to facilitate this process:

- reduction of the "over-usage of institutional services" to make funds available for "less costly and more effective services";

- public promotion of the benefits of an integrated progressive care system with an emphasis on "promoting the individual's ability to retain the maximum degree of independent functioning possible in the situation";

- the evolutionary development of District Health Boards based on a Stage I to Stage IV approach;

- the consideration of proposals for the "construction, expansion or renovation of all health facilities on the basis of satisfactory functional programming";

- enforcement of the maximum norms for institutional beds per thousand population at the regional and district level approved by the cabinet;

- the establishment of a new system for the licensing of health care facilities and professional providers.

In summary, this description of events indicates that the enhancement of citizen access to health care services was an important goal during the Schreyer administration's first term. This discussion indicates that this goal was based on the implementation of the DHSDC and SUDS concepts. However, when Schreyer called a provincial election in May 1973, the realignment of the health care delivery system based on these concepts, as well as the broader organizational realignments suggested in *Guidelines for the Seventies*, were not prominent in the government's election platform. Newspaper reports of the election campaign indicate that Schreyer opted for a more cautious approach which focussed on the popular policy changes his government had implemented during the latter part of its first term including the June 1 elimination of health insurance premiums and the promised July 1 implementation of insured personal care, home care, and pharmacare programs. While this platform contributed to in an increase in the NDP's majority, from 28 to 31 seats, Peterson notes that the regional distribution of votes in 1973 "...closely followed the pattern set in 1969...".[43] As a result, the NDP did not realize any increase in its seats from rural southern Manitoba with all of its gains coming from north Winnipeg and constituencies to the north and east of the city.

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[43] Peterson, "Manitoba: Ethnic and Class Politics," 104.

THE SECOND TERM

The post-election Schreyer cabinet saw Rene Toupin retain the Health and Social Development portfolio. His first major announcement of the second term followed a September 1973 provincial health ministers meeting in Charlottetown. It indicated that the provincial health ministers had endorsed Manitoba's proposal for a review of health care costs that included study of the "over-supply of physicians in major centres in Canada..." and the development of new payment mechanisms for physicians.[44] While Manitoba's proposal was supported by the other provinces, it was not well received by the MMA. Esuke notes that during the Schreyer administration's first term the MMA had increasingly perceived the NDP as "...a radical party which offered proposals that appeared to aim at the destruction of professional autonomy." [45] The acceptance of Mr. Toupin's Charlottetown proposal furthered this perception and spurred the MMA to a new level of opposition to the government's efforts to rationalize the province's health care delivery system. This is evident in the events surrounding fee schedule negotiations in the fall of 1973. They began on September 7 and broke down on December 5 when the MMA released a letter to the media addressed to Mr. Toupin. It indicated that the Association viewed Mr. Toupin's September 28 announcement as an attempt by the government to

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[44] Manitoba, "Toupin Terms Health Meet "Most Productive"," Information Services Branch, September 28, 1973.

[45] Esuke, *The Issues That Led To Development of Medicare in Manitoba*, 75.

eliminate fee-for-service as the principal method of physician payment. Further, it demanded that the province appoint a cabinet committee to negotiate an agreement with the Association by January 15,1974 or the Association's membership would be forced to consider withdrawing their services. The major areas of dispute in the negotiations included:

> - the release of statistical information by the MHSC that the Association viewed as important in the process of fee schedule negotiations;
>
> - the need for agreement that the MHSC's Medical Appointments Review Committee, which had held its first meeting on November 8, would not attempt to limit the right of physicians to determine where they could practice through its control of the medical staff appointments process;
>
> - the need to provide the Association with what it viewed as "reasonable opportunities" to make representations to the cabinet prior to the introduction of health care policy changes.

On December 14, Mr. Toupin responded to this letter through a press release that included a declaration of the government's position on health policy along with a copy of a December 12 policy statement he had forwarded to the MMA's executive.[46] The press release stated that the government had already agreed to the MMA's demand for the creation of a cabinet committee and that this committee was prepared to meet with the Association any time to discuss the concerns detailed by the Association in its December 5 letter. The declaration attached to the press release questioned the MMA's motives in making its dispute with the government public. In the closing paragraphs it notes

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[46] Manitoba, "Declaration of Government Health Policy is Issued," Information Services Branch, December 14, 1973.

that the government has "...sole jurisdiction in declaring and administering..." health services policy and that "...if a breakdown in discussion occurs, it will be because the Association wishes to adopt a role in policy matters which is not available to any other group of citizens in society."[47]

As the Schreyer administration's dispute with the MMA entered 1974 with no resolution, other provider pressure groups in the province's health care policy community began to voice their concerns about the government's management of health policy. An example is contained in a January 7, 1974 letter to Premier Schreyer from the MHO Board of Directors critical of the way initiatives flowing from the White Paper on health policy were being implemented. This letter focussed on what the MHO viewed as a the lack of co-ordination among the agencies responsible for implementation; the White Paper Working Group, the Community Operations Division of the Department of Health and Social Development, and the MHSC. It notes that, "...each of these agencies has varying expertise and influence, and each must be approached by health provider organizations wishing to implement the intent of integrated health and related social services." It goes on to describe this situation as "...both confusing and frustrating to us and our members...".[48]

The Premier's response to growing provider pressure group criticism of his government's policies came in four steps between January and July 1974.

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[47] Ibid., see p.3 of the attached policy statement by Hon. Rene E. Toupin dated December 12, 1973.

[48] Manitoba Health Organizations Inc., Letter to the Hon. Edward Schreyer, January 7, 1974, 3.

The first involved the replacement of two key government actors. On January 28, Saul Miller was named the new Minister of Health and Social Development following Mr. Toupin's resignation from the portfolio. At the same time Hans Schneider resigned as the Chair of the MHSC and was replaced by the Minister of Tourism, Recreation and Cultural Affairs, Larry Desjardins. This announcement appears to have broken the deadlock in negotiations. In a February 7 press release, the MMA announced that it had reached an agreement with the government on a new fee schedule and had agreed to the establishment of a joint MHSC - MMA consultative committee that was expected to meet monthly to discuss policy issues of interest to both parties.[49] The second step came later in February when Saul Miller announced the allocation of $5,000,000 for the first phase in a series of improvements to the Health Sciences Centre (HSC) in Winnipeg. This announcement also indicated that Dr. G Clarkson and Dr. E Vayda had been hired by the government to study the future development of the HSC in the context of the overall health facility and program needs of the province.[50] The third step occurred in March with the release of a position paper on implementation planning related to the White Paper.[51] This four page paper, which had been ordered by the Premier in early

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[49] Manitoba Medical Association, "Association Reaches Agreement with MHSC," MMA Press Release, February 7, 1974. The joint committee noted in this release held its first meeting the following month.

[50] Manitoba, "Health Sciences Centre Study To Be Launched," Information Services Branch, February 15, 1974.

[51] Manitoba, *Implementation of the White Paper on Health Policy in Manitoba* (Winnipeg: MHSC - HESP White Paper Working Group, March 1974).

February, was jointly authored by the White Paper Working Group, the MHSC, and the Department of Health and Social Development. It defined the province's intent to establish a system of progressive care in the context of its DHSDC program. It also outlined what the document describes as an "evolutionary approach" to the implementation of this program containing three stages:

> - an initial stage related to the establishment of a Type I centre in which acute and personal care facilities in a District would be integrated and new services related to personal care, seniors' housing, home care, and day care would be developed and linked to other programs pertaining to recreation, public housing, and environmental protection;
>
> - a second stage which would see a Type I centre move to a Type II designation through the addition of existing public health and social services administered by the province and/or voluntary agencies in the district which would be delivered based on the single unit delivery system (SUDS) concept;
>
> - a third stage which would see a Type II centre convert to a Type III designation in which salaried medical and dental care providers would be added to the centre's SUDS - based delivery team.
>
> In late March this document was forwarded to the MHO Board for review.

The response came in a May 6 letter from the MHO's Board to Saul Miller which indicated that "...There are a large number of our members who are now ready to abandon their present organizational framework, name, and role, in favour of the District Health Board concept." The letter goes on to enquire whether the government was considering legislation to enable the creation of these boards. Mr. Miller's response was contained in a June 5 letter to the MHO's Board which indicated that "...while no new legislation is planned for the present session, we intend, at the next session of the legislature, to introduce new legislation now

being developed which will more adequately allow for district health systems development." This letter goes on to note that while the new legislation was being prepared, the existing legislative framework could be employed to create a DHSDC board and cites the establishment of the Seven Regions and Hamiota Health Centre Boards as examples of DHSDCs created under this framework.

The fourth step came with the June 1 expansion of the MHSC's policy planning and implementation authority which reduced the number of government agencies responsible for implementation from three to two.[52] This expansion was facilitated through transfer of the HESP's responsibilities to the MHSC. In turn, the Commission added a Planning Division to its organizational structure which contained the staff of the former White Paper Working Group. With this change the Schreyer administration entered the fall of 1974 assuming that it had answered the concerns of institutional health care providers and could now begin the implementation of its plans for the establishment of a province-wide system of DHSDCs. However, September brought a renewal of MMA opposition to the government's policy agenda. This is evident in the minutes of a September 9 meeting between Dr. Tulchinsky and the President of the MMA, Dr. Peter Lommerse. At this meeting Dr. Lommerse listed four concerns related to the government's DHSDC initiative:[53]

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[52] Manitoba, "Health Services Re-Structured," Information Services Branch, November 8, 1974. This press release describes the completion of the re-structuring that was began on June 1.

[53] Manitoba, Minutes of the Meeting between Dr. T. Tulchinsky, Deputy Minister of Health and Social Development, and Dr. P. Lommerse, President, MMA, September 9, 1974. 2.

- that the creation of these Centres would restrict patients to the services offered in their district thereby limiting their ability to obtain services offered outside the district's geographic boundaries;

- that physicians wishing to practice in a DHSDC would be forced to become part of the Centre's SUDS - based delivery team because District Boards would give preference to team members in the granting of hospital privileges;

- that the employment of salaried physicians in the Centres would lead to an attempt by the government to impose this method of payment on all physicians practising in a district;

- and that the SUDS - based delivery teams would disrupt the relationship between private practitioners and their patients if the needs of physicians already practising in a district were ignored by DHSDC staff.

In an October 4 letter to Dr. Lommerse, Dr. Tulchinsky responded to these concerns by noting that:[54]

- the government expected some degree of patient "cross haul" between districts due to geography, therefore, patients would not be held to a geographic area in order to receive services;

- while the government was committed to implementation of the SUDS concept, the process of granting hospital privileges would not be altered with the establishment of DHSDC boards;

- while the Type III district favoured salaried physicians, this form of payment would not implemented in Type I and II districts;

- that the implementation of the district system would be "evolutionary" through a process of conversion initiated by an existing Hospital Board, not by the province.

This response was prominent in Dr. Lommerse's presentation to the MMA's membership during a tour of the province he undertook in early October

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[54] Manitoba, Letter to Dr. P. Lommerse, President, MMA from Dr. T. Tulchinsky, October 4, 1974.

and appears to have been satisfactory to the Association's membership as no further statements of concern related to the issue were issued by the MMA during the remainder of the year. However, two other health policy events in 1974 are noteworthy. The first was an October announcement by Mr. Miller that the Seven Oaks General Hospital would be built to serve citizens residing in north west Winnipeg. The construction of this hospital had been a stated goal of Mr. Miller's since 1967 when he was elected the Mayor of the then City of West Kildonan (which became a part of metropolitan Winnipeg in 1970). The second involved Mr. Miller's resignation as the Minister of Health and Social Development to return to his pre-1974 Urban Affairs portfolio. He was replaced by the Chair of the MHSC, Larry Desjardins, who had become a member of the NDP caucus in November after winning a by-election in the St. Boniface constituency.

Mr. Desjardins' tenure as the Minister of Health and Social Development during the remainder of the Schreyer administration's second term, was dominated by three issues: first, federal-provincial negotiations related to new funding arrangements for health services; second, implementation of the DHSDC concept in rural Manitoba, and, third, the realignment of institutional services delivery in Winnipeg based on the findings of the Clarkson and Vayda study commissioned in February 1974. His role in the process of policy change related to the first issue began in January 1975 when he attended a federal-provincial health minister's conference in Ottawa. At this conference he

supported the need for a new cost-shared arrangement that provided the provinces with greater flexibility to fund alternatives to the existing range of insured medical services.[55] Mr. Desjardins' role related to the second issue also began in January with the introduction of Bill 48 to establish *The District Health and Social Services Act*. The primary intent of this bill was to provide the province with a new legislative mandate to allow the creation of DHSDC boards and, in anticipation of the bill's passage, a number of changes in the Department Health and Social Development's senior staff were announced in March. These changes were intended to provide Dr. Tulchinsky with more time to concentrate district health system development and the redevelopment of the HSC.[56] *The District Health and Social Services Act* was given Royal Assent on June 19, 1975 and was brought into force on the same day.[57] A review of the content of this Act by Carrothers et. al. indicates that it reflected the incremental approach to rural delivery system realignment established by the government during its first term.[58] Further, while it was consistent with the government's stated policy goals and did not radically alter local authority and accountability roles established by *The District Hospital Act* of 1945, it met with opposition from provider pressure groups

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[55] Manitoba, "More Equitable Health Cost-Sharing Is Urged," Information Services Branch, January 17, 1975.

[56] Manitoba, "Changes in Health-Social Department Are Announced," Information Services Branch, March 14, 1975.

[57] Manitoba, Bill Eases Formation of District Health Centres," Information Services Branch, June 20, 1975.

[58] Carrothers et. al, *Regionalization and Health Care Policy in Canada*, 65.

following its passage. This is reflected in the minutes of a July 4 meeting between Mr. Desjardins, senior MHSC staff, and members of MHO executive. At this meeting the MHO indicated that meetings among member institutions during May and June had produced three concerns related to the Act's implementation:[59]

> - that it was the beginning of a politically-motivated plan to eliminate local control of the delivery of health services (the minutes note that the strength of this concern was related to "...which political party the MLA for that area belonged to.");
>
> - that the formation of a District would require adjoining communities to integrate existing services resulting in the potential loss of some services in a particular community (here the minutes note that ".... community rivalry persists in many areas of the province.");
>
> - that upon the formation of a District the province was not required to repay a participating municipality for the ten percent equity it was required to hold in existing Hospital District facilities.

To assist the province in its response to these concerns the MHO proposed the establishment of a joint Departmental, MHSC, and MHO Task Force to formulate regulations for the establishment of District boards. In addition, it suggested that the MHO be provided a permanent consultative role with the MHSC's Planning Division to facilitate implementation of the district health centre plan. Mr. Desjardins' response was to order the MHSC's Planning Division to develop a new implementation plan for the district system in an effort to accommodate the MHO's concerns. In addition, he promised the MHO that

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[59] Manitoba, "Minutes of the July 4, 1975 Meeting with the MHO Executive," (unpublished Department of Health and Social Development document, July 5, 1975.

while this study was being conducted, the province would not attempt to establish district boards under the provisions of Bill 48.

The concerns raised by the MHO were not the only reason Mr. Desjardins' placed a moratorium on the realignment of Manitoba's rural health services delivery system. Less than a week after the June 1975 passage of Bill 48 the federal Finance Minister, John Turner, had announced that, beginning in the 1976-77 fiscal year, he would impose limits on the federal share of health care funding to the provinces and that he was considering ending the present system of shared-cost funding by 1980. While this announcement was viewed by the provinces as an attempt to pressure negotiations for a new federal-provincial funding arrangement, Mr. Desjardins recognized that, if the federal government carried out its threat to reduce funding, he would be forced to limit further policy changes to ensure that the province could finance its existing responsibilities. At the time of Mr. Turner's announcement, Mr. Desjardins already had two major initiatives on his Department's expenditure budget agenda. These were the development of DHSDCs and the completion of Seven Oaks General Hospital. In addition, he was aware that other demands on his Department's budget would arise following completion of the Clarkson and Vayda study, commissioned in February of the previous year, and fee schedule negotiations with the MMA for a contract beginning in 1976. Faced with these pending demands, on the one hand, and rural opposition to DHSDC concept on the other, Mr. Desjardins' moratorium on the establishment of District Health Centres appears to have

been a strategic political decision. This interpretation is supported by an announcement in October that the province was prepared to act on the findings of the Clarkson and Vayda study which had been completed in early July.[60] This study's recommendations supported improvements in the province's health care delivery system through a $64.8 million two phase redevelopment of the HSC over a ten year period. The first phase, which was budgeted at $32.3 million, called for a reduction of 270 acute care beds at the HSC and the redistribution of those beds to the Seven Oaks and Concordia Hospitals. The second phase, which was budgeted at $32.5 million, involved a major capital construction and renovation program at HSC to improve the Centre's specialized and extended care capacity. Implementation of the first phase began in February 1976 with the approval of capital budgets for the 1976-77 fiscal year totalling $26.5 million.

With the HSC redevelopment underway, Mr. Desjardins turned his attention to the province's fee schedule negotiations with the MMA. On December 29 he proposed a total fee schedule income increase of no more than 9.15 per cent over 1975 levels.[61] The MMA rejected this proposal in early January 1976 based on its position that the province was attempting to impose arbitrary controls on physicians' incomes. As a result, on January 14, Mr. Desjardins unilaterally imposed his proposal for a 9.15 per cent total increase.

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[60] Manitoba, "Health Sciences Centre Redevelopment Detailed," Information Services Branch, October 17, 1975.

[61] Manitoba, Revised Fee Proposal to Doctors," Information Services Branch, December 29, 1975.

While the MMA did not support this action, it did not erect barriers to the implementation of the proposal. This was likely due to general public acceptance of the concept of wage and price controls which had been instituted by the federal government the previous year as part of its strategy to control the rate of inflation in Canada.

In any event, the lack of immediate MMA resistance allowed Mr. Desjardins to once again turn his attention to the DHSDC initiative. In June he released a policy paper completed by the MHSC's Planning Division in March containing four changes in the government's policy position.[62] First, it removed the requirement that the creation of a new board was needed to establish a DHSDC, thereby allowing established District Hospital boards to take responsibility for the conversion process. Second, it gave municipal councils that were willing to participate in a DHSDC responsibility for the appointment or election of all of the members on a DHSDC board, thereby ensuring that the province would not demand the right to appoint board members. Third, it made a commitment to a block funding formula for the delivery of particular services, rather than the global funding formula supported by provincial planners, thereby ensuring that funding levels for services delivered prior to a facility's conversion to a DHSDC would remain the same. Finally, it stated that the province would relieve municipalities participating in a DHSDC of their responsibility for ten

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[62] MHSC, *Policy Paper District Health Systems (*unpublished Planning Division paper, March, 1976) 2.

percent of the costs related to any construction or renovation of facilities in their district arising from the conversion process and would make this relief retroactive to all construction completed following the passage of Bill 48.

The release of this paper was followed by a mid-September statement of the goals of the Department of Health and Social Services over the next five years which included:[63]

- the establishment of DHSDCs in rural regions of the province through the conversion of existing hospital districts;

- the establishment of appointed Regional Health and Social Service Councils in all regions of the province to facilitate the planning and promotion of service integration at the district level;

- the redevelopment of laboratory and diagnostic services in rural areas of the province as part of the district health system initiative;

- the transfer of authority for the delivery of health and social services from the City of Winnipeg Health Department and the various Children's Aid Societies to the province's health regions;

- the formation of a city-wide SUDS - based health and social services delivery system following the above transfer;

- the development of affiliation agreements between acute and long- term care facilities in Winnipeg to enhance the coordination of patient care.

These policy statements were followed by an October 18 meeting attended by Mr. Desjardins which resulted in an agreement that "...A joint MHSC/MHO approach would be taken to get local municipal councils to support

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[63] Manitoba, *Health Planning in Manitoba 1976-1981*, unpublished presentation by Dr. T. Tulchinsky to the MHSC Board made in Brandon on September 15, 1976.

District Health Systems." [64] This agreement, which also defined a total of thirty District Hospital boards that would be targeted by this approach, was followed by the passage of a resolution at the November 1976 MHO Annual Meeting supporting the prompt establishment of regulations related to the conversion of Hospital Districts to DHSDCs.[65] Given this support of its DHSDC plan, along with the MMA's acceptance of a new fee schedule negotiated in December, the Schreyer administration entered 1977 assuming that it could now move forward with the implementation of its health care policy agenda. It publically formalized the October agreement with MHO in a February announcement that the province would relieve rural municipalities of $14 million in debt resulting from their owner's equity contribution to the construction of existing health care facilities.[66] This announcement cited the passage of Bill 48 as the reason for the elimination of the owner's equity contribution and, in addition to serving as a public commitment to the MHO, it appears to have been part of an attempt by the Schreyer administration to enhance rural political support in anticipation of a provincial election.

The February announcement was followed by the March completion of an MHSC study of the province's rural health care delivery system. It focussed on

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[64] This agreement is contained on p.3 of the minutes of an October 18, 1976 meeting between the MHO Board Executive, MHSC staff, Department of Health and Social Development staff, and representatives of The Management Committee of Cabinet.

[65] Ibid., p.4.

[66] Manitoba, "$14M Provincial Relief for Health Facilities," Information Services Branch, February 4, 1977.

the distribution of primary care services in the province and offered a variety of recommendations including:[67]

> - the need to develop regional referral centres for primary care as part of the reorganization of the rural delivery system;
>
> - the need to establish model DHSDCs in each region of the province as soon as possible to demonstrate their viability as alternatives to small district hospitals;
>
> - the need to clarify provincial authority related to primary care facilities and the distribution of this authority between the MHSC and the Department of Health and Social Development.

In April the MHSC Board initiated consultations with the MHO related to the findings of this study. While the MHO continued to support the establishment of DHSDCs, it brought a new issue to the district health system debate. This issue was emphasized in a May 1976 exchange of letters in between the MHSC Chair, T.R. Edwards, and the MHO executive. In summary, these letters indicate that the MHO was concerned that Sections 28 and 35 of *The District Health and Social Services Act* would require participating municipalities to take responsibility for service delivery costs not included in established MHSC and Department and Health and Social Development funding mechanisms. Internal correspondence within the MHSC indicates that, while the Commission was sympathetic to this concern, it could not respond to it until the province's Finance Department had completed its study of the budgetary implications related to the April 1 implementation of the Federal-Provincial Fiscal

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[67] MHSC, *Primary Care Facilities Study (* unpublished Planning & Construction Division document, March 3, 1977) 12.

Arrangements and Established Programs Financing Act (EPF).[68]

The issue of DHSDC funding was not resolved in September when the Schreyer administration called a provincial election for October 11. As a result, the establishment of DHSDCs was not part of the NDP's health care policy platform. Rather, the Schreyer administration focussed this area of its platform on a promise to expand pharmacare coverage and introduce an insured program for dentures and eye-glasses. On the other hand, the Progressive Conservative opposition, under the leadership of Sterling Lyon, focussed on the overall growth of the provincial budget during the Schreyer administration's tenure and its lack of success in managing the province's public enterprises. Lyon committed to cut provincial taxes through an overall reduction in government spending. As Peterson notes, "...the election was fought amid signs of imminent economic crisis: prices continued to rise at a rate of over 8 percent a year; unemployment rose to almost 6 per cent; and the exceptionally cold wet autumn severely damaged crop prospects."[69] These conditions combined with a traditional rural distrust of the Schreyer administration's policy agenda to produce a thirty-three seat majority for the PC party on October 11. Much of this majority came from the NDP's loss of eight seats from the rural eastern and northern regions of the province.

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[68] For a discussion of the negotiations related to the establishment of this Act see Taylor, *Health Insurance and Canadian Public Policy*, 422-28.

[69] Peterson, "Manitoba: Ethnic and Class Politics," 105.

CHANGES IN CAPACITY, COSTS, AND CONTROL

This assessment of the Schreyer administration's tenure follows the pattern established in Chapters 3 and 4 and is divided into three sub-sections. It suggests that policy and resultant organizational changes displayed by Manitoba's health care delivery subsystem 1969 and 1977 were, like those produced during the tenure of the Campbell, Roblin, and Weir administrations, influenced by three broad sets of factors: federal policies related to health care cost containment which supported organizational rationalization at the provincial level; the Schreyer administration's concern with increasing the equity and equality of citizen access to health care services through realignments in administrative authority for services delivery; and the policy positions taken by key provider pressure groups in the policy subsystem. The impact of these factors on health care policy outputs during the 1970s are detailed below. This discussion appears to support Wiseman's general conclusion that, while the Schreyer administration "...permanently etched its mark on the province through various legislative acts, it certainly did not transform or radically alter the social and economic fabric of the province...".[70]

CAPACITY CHANGES

As Table 6.3 below indicates, the tenure of the Schreyer administration saw a number of important changes in the functional scope of the province's

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[70] Wiseman, *Social Democracy in Manitoba*, 139.

health care delivery role. These changes, which continued the incremental trend started in the late 1940s related to increasing provincial control over the delivery system, included: the termination of shared-cost funding for the delivery of public health services through the centralization of authority for services delivery in the Department of Health; the implementation of provincial home care and child dental care programs; the establishment of alternatives to Hospital Districts in the form of DHSDCs; the inclusion of long-term care facilities and pharmacare in the province's insured services program; and the creation of a single Commission for the planning and administration of the province's insured services programs.

The second approach to this question focuses on changes in the geographic scope of services delivery. Here the most notable change was the establishment of the province's regional administrative units for the administration and delivery of public health and related social services. The range of services provided by these regional units, along with the City of Winnipeg's Health Department, ensured that all citizens in Manitoba had the right to access primary and preventive services regardless of their place of residence. However, the Schreyer administration also intended to improve citizen access to community-based services through implementation of the DHSDC and SUDS concepts. While this intent was implemented through the establishment of five Type III DHSDCs in rural Manitoba and five CHCs in Winnipeg, Table D.6 in Appendix D, and the review of Winnipeg CHCs in

Appendix C indicates that they served a small number of rural communities and citizens in neighbourhoods in the core and northern areas of Winnipeg.

Table 6.3: Changes in Functional Scope from 1969 to 1977

Functional Area	Status in 1969	Status in 1977
Public Health Services	The shared-cost funding of LHUs coupled with the province's public health nursing, care services program for the elderly and infirmed, and its northern health services program.	All services are under the direct funding and administrative control of the province including the new home care, child dental health, and pharmacare programs.
Acute Care Hospital Facilities	The centralization of provincial planning, regulatory, and funding authority related to hospitals within the MHC	The creation of the MHSC further expands provincial regulatory authority. In addition, the 1975 passage of *The District Health and Social Services Act* allows the conversion of Hospital Districts to DHSDCs. By late 1977 5 Type III and 5 Type I Centres are in operation.
Institutions for the Aged and Infirmed	The expansion of regulatory control over institutional care coupled with the expansion construction grants to include elderly persons housing.	The inclusion of services provided by these institutions in the province's insured services program coupled with increased MHSC regulatory control over the construction and operation of these facilities.
Services Provided by Physicians	The funding and administration of the province's "medi- care" insurance program.	The expansion of provincial authority related to the definition of insurable services, fee schedules pertaining to those services, and policies related to the granting of hospital privileges.

Turning to changes in the geographic scope of institutional services, Table 6.4 offers a summary of the data from Table D.6 in Appendix D. The most notable change is that the Schreyer administration was the first post-World War II government in Manitoba to see overall capacity growth decline relative to the province's population. While the overall rate of growth in beds per thousand population during the Campbell administration averaged 41.8 percent and dropped to an average of 8.7 percent under the Roblin/Weir administrations, due to negative growth in Winnipeg's bed capacity, the Schreyer administration experienced a negative growth rate of slightly over 6.1 percent. The changes that contributed to this decline are detailed in Table 6.4 below.

Negative hospital capacity growth during the Schreyer administration's tenure was produced by the conversion or phase out of acute care beds and their replacement with long-term care beds. A review of the data in Table D.6 indicates that the MHSC's 6/20 model played a role in this process as many of the rural communities that saw their acute capacity drop also experienced improvements in their long-term care capacity.[71] These capacity changes are detailed in Table 6.5 below which is based on Appendix D's Table D.6. In short, this table indicates that the overall growth in long-term beds per thousand population averaged 41.2 percent during the tenure of the Schreyer administration with most of this increase occurring in the Winnipeg region. By

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[71] This model involved the reduction of acute bed capacity in smaller rural centres to six beds for every twenty long-term care beds in the community. In effect, this model supported the development of DHSDCs by suggested that small rural centres should assume the role of extended treatment facilities for the larger hospitals in a region.

comparison, the Roblin/Weir administration experienced an average growth of 39.9 per cent with much of it occurring in rural regions of the province. As a result, the parity between rural regions and Winnipeg established by the late 1960s shifted in favour of the Winnipeg region in the 1970s.

Table 6.4: Hospital Growth in Manitoba from 1969 to 1977

Region	1968/69	1976/77	% Increase
Central: # Communities with Facilities	13	13	0
: Rated Bed Capacity	474	502	5.9
Eastman: # Communities with Facilities	7	7	0
: Rated Bed Capacity	226	231	2.2
Interlake: # Communities with Facilities	7	7	0
: Rated Bed Capacity	199	211	6
Norman: # Communities with Facilities	7	8	14.3
: Rated Bed Capacity	344	423	23
Parkland: # Communities with Facilities	9	9	0
: Rated Bed Capacity	423	373	-11.8
Westman: #Communities with Facilities	27	27	0
: Rated Bed Capacity	941	970	3.1
Total Rural Capacity	2607	2710	4
Total Rural Population (in thousands)	452	481.8	6.6
Rural Beds Per 1000 population	**5.8**	**5.6**	**-3.4**
Winnipeg: # of Facilities	11	9	-18.2
Rated Bed Capacity	3514	3647	3.8
Total Winnipeg Population (in thousands)	526.7	596.8	13.3
Winnipeg Beds Per 1000 population	**6.7**	**6.1**	**-8.9**

Table 6.5: Long-Term Care Facility Growth in Manitoba from 1969 to 1977

Region	1968/69	1976/77	% Increase
Central: # of Communities with Facilities	7	9	28.6
: Rated Bed Capacity	400	601	50.25
Eastman: # of Communities with Facilities	3	5	66.6
: Rated Bed Capacity	196	329	67.9
Interlake: # of Communities with Facilities	3	5	66.6
: Rated Bed Capacity	338	468	38.5
Norman: # of Communities with Facilities	1	2	100
: Rated Bed Capacity	203	102	-49.8
Parkland: # of Communities with Facilities	3	5	66.6
: Rated Bed Capacity	137	277	102.2
Westman:# of Communities with Facilities	12	13	8.3
: Rated Bed Capacity	893	1212	35.7
Total Rural Capacity	2167	2989	37.9
Total Rural Population (in thousands)	452	481.8	6.6
Rural Beds Per 1000 population	**4.8**	**6.2**	**29.2**
Winnipeg: # of Facilities	35	36	2.9
Rated Bed Capacity	2520	4275	69.6
Total Winnipeg Population (in thousands)	526.7	596.8	13.3
Winnipeg Beds Per 1000 population	**4.7**	**7.2**	**53.2**

COST CHANGES

While the Schreyer administration was successful in containing capacity growth measured in beds per thousand population at or below the levels experienced in the 1960s, the data related to budgetary changes during the 1970s contained in Table 6.6 below indicates that health care costs continued

to increase.

Table 6.6: Provincial Budgetary Changes from 1969 to 1978 [72]

Budget Line	1968-69	1977-78
Total Provincial Budgetary Expenditures	357,331.901	1,077,980,917
Provincial Health Care Expenditures	43,943,443	301,977,827
Health Care Expenditures as % of Total	12.3%	28%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	2.08%	1.44%
Psychiatric Services Division	29.46%	12.65%
Public Health Services Division	19.57%	11.31%
MHSC/Other Hospital Services	48.89%	74.60%
Totals	100%	100%

This Table is based on Table D.7 in Appendix D which utilizes Manitoba's public accounts from fiscal 1968-69 and fiscal 1977-78.[73] This Table indicates that the relative share of the province's budget allocated to the Department of Health more than doubled during the Schreyer administration, increasing by 128 percent. While the relative share of budgetary resources captured by the psychiatric services and public health services divisions declined by 57.1 percent and 42.2 percent respectively, the relative share for the MHSC's budget and the funding of speciality hospitals increased by 52.6 percent. Table D.8 in

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[72] The budget amounts detailed in this Table only include budget line expenditures directly related to the health care services components of the Department of Health and Social Development's operations. Service functions pertaining to social services, community development and corrections administered by the Department are not included.

[73] Table D.8, which follows this Table, utilizes MHSC data from the 1978-79 fiscal year because the Commission's 1977-78 fiscal year was fifteen months long to accommodate a conversion from calender year to fiscal year reporting.

Appendix D indicates that growth in the MHSC's budget, due largely to the addition of the province's medical care insurance program and the province's insured personal care home program, was a major contributor to this funding increase.

CONTROL CHANGES

Table 6.7 below summarizes changes in the province's functional roles during the Schreyer administration's tenure.

Table 6.7: The Schreyer Administration's Impact on Functional Roles

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	Increased with the centralization of delegated legislative authority for public health services at the provincial level.
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased with the federal government in 1969 with the implementation of medical care insurance followed by the negotiations leading to the April 1, 1977 with the implementation of the EPF Act. Also increased with other provinces to ensure the portability of medical care insurance.
Revenue-Raising Functions related to the funding of services.	Increased in areas related to general revenues due to the elimination of health insurance premiums.
Planning and Resource Allocation Functions related to services delivery.	Increased with the creation of the MHSC and the HESP subcommittee of cabinet as well as the expansion of the Department's role for regional health and social services delivery.
Policy-Making Functions related to the licencing of and standards for services providers.	Increased in the area of long-term care, through expansion of the Department's and MHSC's funding and regulatory authority in this area, as well as with local facility boards due to the passage of *The District Health and Social Services Act*

Inter-Agency coordinative Functions related to services delivery.	Remained largely unchanged.
Regulatory Functions related to the resource utilization practices of professional providers.	Increased with institutional providers though expansion of the MHSC's planning and administrative roles and with physicians due to the need to negotiate fee schedules.
Training Functions Related to the education and placement of Professional Providers.	Remained largely unchanged.
Management Functions related to the day-to-day administration of services delivery.	Increased in the area of public health services due to the creation of the province's regional delivery system.

In short, at the time of the 1969 election, the province's responsibilities encompassed: the financing of the province's hospital and medical care insurance program; the regulation of long-term care institutions and the funding of capital grants for the construction of non-proprietary personal care homes; the shared funding and delivery of public health services; and an environmental health program administered by the Clean Environment Commission. At the time of the 1977 election the province's responsibilities had grown to encompass: the expanded range of public health services administered and delivered by the province; an expanded range of insured services that included home care, prosthetic/orthotic services, and pharmacare; and local diagnostic services and patient transportation programs administered by the MHSC.

CHAPTER 7.

CONTAINING HEALTH CARE COSTS: 1977 - 1981

In his discussion of the 1977 election campaign in Manitoba, Dyck notes that the Progressive Conservative (PC) party's election platform was based on two central themes.[1] On the one hand, PC candidates accused the NDP of financial irresponsibility in its management of the province's budget and its administration of crown agencies, in particular, Manitoba Hydro. On the other, these candidates promoted an approach to governing based on a philosophy of "acute protracted restraint" reestablish the province on a sound financial footing. As a result, when the Lyon administration took office it was expected that price and supply constraints and cost shifting would be the dominant policy strategies utilized by this government to limit growth in the province's health care sector. While the former was utilized, the latter was not. Rather, this chapter indicates that, following an initial freeze on delivery system development, the Lyon administration continued the Schreyer administration's focus on organizational rationalization strategies to control future health care costs. As a result, this period saw the number of Type I District Health Centres in rural Manitoba increase combined with a more conciliatory and pragmatic approach to government-pressure group relations in the province's health care policy community.

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[1] Dyck, "Manitoba," 411.

THE LYON ADMINISTRATION

As the discussion in Chapter 6 related to the 1977 election campaign indicates, the PC party was largely silent on how its approach to the implementation of "acute protracted restraint" would affect the province's health care budget. The appointment of Louis "Bud" Sherman as the Minister of Health and Social Development on October 19, 1977 did not provide an immediate indication of the Lyon administration's direction in this area as Mr. Sherman did not bring an extensive health care background to his portfolio. However, during October and November of 1977, two events hinted at the Lyon administration's general policy direction. The first occurred less than a week after the appointment of the cabinet. It involved an announcement by Premier Lyon that, during his administration's first year in office, the budgets of all government departments would be frozen pending the findings of the newly created Task Force on Government Organization and Economy which had been mandated to review the structure and operations of government departments.[2] The second event occurred on November 22 when Mr. Sherman presented his first speech as the Minister of Health to the annual meeting of the MHO. In this speech, he identified expenditure budget costs as the government's most pressing health care policy problem and announced that, as part of the government-wide cost containment program, he would freeze all new construction projects until a

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[2] Manitoba, "Task Force To Probe Organization, Economy," Information Services Branch, October 14, 1977. This Task Force was headed by the Minister Without Portfolio, Sidney Spivak.

review of his Department's expenditures was completed by the Task Force. In addition, he noted that the future direction of health policy in Manitoba would emphasize greater personal responsibility for health as an alternative to "...the current and vast dependency on governments to do all our health repair jobs for us."[3]

There were no further health care policy announcements until February 1978 when a subcommittee of the MHSC's Medical Manpower Committee responded to the findings of the Planning and Construction Division's study of primary care facilities completed in March 1977.[4] Its review of the planning and implementation process related to DHSDCs emphasized the MMA's continued resistance to the establishment of Centres beyond the Type I level. This review also noted the MHO's support for the establishment of the Type II model as well as the general lack of provider pressure group support for implementation of the Type III model. Given this resistance to the Type III model, the subcommittee recommended the consideration of other policy options related to delivery system realignment but did not identify them. However, it did focus on the study's recommendation related to the development of regional referral centres for primary care. It suggested that an informal and incremental implementation process would be the most effective strategy in this area.

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[3] Manitoba, "Health Care Cost Control Essential," Information Services Branch, November 25, 1977.

[4] Manitoba, Report by the Medical Manpower Subcommittee on Rural Manitoba (unpublished, Manitoba Health Services Commission, February 6, 1978).

> "...because of the political aspects of actively phasing out smaller facilities. An alternative would be to identify and actively develop the "obvious" regional Centres and allow nearby smaller facilities to phase out gradually by attrition." [5]

While the MHSC considered the subcommittee's findings, three events occurred in March 1978 that influenced the Lyon administration's health care policy agenda. The first took place on March 8 when the MHO board forwarded a discussion paper to Mr. Sherman containing eight recommendations for the Task Force on Government Organization and Economy which, in summary, called for: continued administrative control of institutional services at the district level by local boards; clarification of the government's implementation plans related to the *District Health and Social Services Act* in order to allow existing hospital boards to convert to Type I or II health districts; and the expansion of the province's insured services program in the areas of ambulatory care and hospital managed home-care.[6]

The second event occurred on March 29 when Finance Minister Don Craik announced the Lyon administration's fiscal 1978-79 budget.[7] In this budget Department of Health and Social Development expenditures were increased by $21.7 million over the previous fiscal year, from $632.1 to $658.8

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[5] Ibid., p.3.

[6] Manitoba Health Organizations Inc, *Discussion Paper on Methods of Cost Reductions in the Delivery of Health and Related Social Services to Manitobans* (Winnipeg: MHO, March 8, 1978).

[7] Manitoba, "Manitoba Spending To Health Increases 2.9 Per Cent," Information Services Branch, March 31, 1978.

million. Much of this increase was allocated to the MHSC budget line, which rose from $426 million to $444.7 million.

The third event took place on March 31 when the Task Force on Government Organization and Economy released its three volume report.[8] With regard to the administration of health care services, the Task Force recommended dividing the Department of Health and Social Development into two departments. One would be called the Department of Community Services and would be responsible for the administration and delivery of community-based public health, social, and related services such as legal aid and consumer assistance services. The other would be called the Department of Health Care Institutions and would be responsible for the administration of the province's insured services programs through the "disestablishment" of the MHSC and the transfer of its functions to this Department. Following the release of this report Premier Lyon indicated that he would study its findings prior to implementing any of the recommended changes.[9]

While the government studied the Task Force report, the protracted negotiations between the MHSC and the MHO related to implementation of the DHSDC model, which was now being termed the District Health Centre (DHC) model, continued. Changes in the MHSC's view of this model are evident in an

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[8] Manitoba, *Report of the Task Force On Government Organization and Economy* Vol I - III, (Winnipeg: Queen's Printer, April 1978).

[9] Manitoba, "Immediate Scrutiny of Task Force Report Set," Information Services Branch, April 7, 1978.

April 3 letter from the Commission's Chair and Executive Director, Reg Edwards, to Mr. Sherman. This letter offers Mr. Edwards' response to the March 8 MHO discussion paper. In it he makes three observations:

> 1. That while he is prepared to give cautious support to the conversion of Hospital Districts to Type I and II DHCs, the conversion to a Type II District would involve increased budgetary expenditures. On this issue he notes " ...there should be no doubt in anybody's mind that transfer of services now provided by the government to these boards will result in extra program costs." As a result, he suggests that the cabinet should only approve an application for conversion if it demonstrates that the goal of the DHC would be to reduce costs by shifting resources from acute care to less expensive alternatives.[10]
>
> 2. That he is not prepared to support increasing the service delivery role of hospitals and DHCs by expanding the scope of the insured services program because "...this would increase overall costs in the absence of improved organizational controls over the utilization of delivery system resources."[11]
>
> 3. That it is his perception that throughout the 1970s the MHO has attempted to obtain greater authority related to the administration and delivery of insured services in the interest of its membership. On this issue he notes that the twenty-member MHO Board contains eleven paid hospital or nursing home administrators who "...could hardly be considered to be a group without vested interest."[12]

A further indication of the MHSC's perspective on the DHC concept can be seen in a May memorandum from Mr. F.C. Bell, Co-ordinator of Special Projects for the MHSC, to Mr. Edwards. In this memorandum Mr. Bell notes that if the MHO is successful in obtaining Mr. Sherman's support for implementation

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[10] MHSC, Letter from Mr. Reg Edwards, Chair to the Hon. Mr. Sherman, Minister of Health, April 3, 1978, 3.

[11] Ibid., p.3.

[12] Ibid., p.2.

of a province-wide Type II District Health Centre program funded by global budgets, it would be "the kiss of death" for community-based programs. He goes on to note that: "There is no doubt that facilities oriented to direct patient care respond to the immediate crisis situations and would, therefore, over time, channel more and more of their physical and financial resources to in-patient care as opposed to a home care program or other outreach programs."[13] A more detailed elaboration of the MHSC's perspective can be seen in a July memorandum from Mr. A. Getz, the Commission's Director of Planning & Construction, to Mr. D.B. Nelson, the Commission's Secretary. This memorandum offers Mr. Getz's analysis of a July 6 letter from the MHO's Executive Director, Mr. H. Crewson, to Mr. Edwards. In his opening comments Mr. Getz notes that Mr. Crewson's "uncritical enthusiasm" for the District Health System concept:

> "...is only slightly less than was our own five years ago. And I believe still that there is no question of the potential benefits of this type of organization. However, in the absence of other incentives and controls...mere reorganization by itself does not guarantee performance. These controls principally involve reducing the flow of real resources (ie. doctors, hospital beds) into the system and restraining their potential to generate costs once they are committed to the system."[14]

Mr. Getz also observes that Manitoba's inability to implement an effective strategy for the realignment of the province's delivery system is due to a lack of

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[13] MHSC, Memorandum from Mr. F.C. Bell to Mr. Reg Edwards, May 17, 1978, 1.

[14] MHSC, Memorandum from Mr. A. Getz to Mr. D.B. Nelson, July 26, 1978, 1.

agreement among key actors as to whether the system should evolve based on the District model or on a "...fully developed public utility model which would have a regional board completely responsible for all health and social services and responsible to provincial authorities for overall budgets and standards."[15] Mr Getz favours the latter option for two reasons. First, because a large regional authority will be better able to "...challenge the power of physicians..." and, second, because it will lessen "....the unwillingness or inability of politicians to close hospital beds or impose deterrents large enough to be meaningful to efforts to control costs...".[16]

Despite Mr. Getz's support for a regional "public utility" model, a series of meetings between Mr. Sherman and the MHO during the fall of 1978 were successful in persuading the Minister to allow the implementation of a province-wide DHC system based on the conversion of Hospital Districts to the Type I model. While the Lyon administration never publicly announced that it was moving forward with implementation, no doubt because the initiative was the product of planning during the Schreyer administration's tenure, it did announce in the February 15, 1979 Speech from the Throne that the freeze on health facilities construction had been lifted and thirteen new projects, mostly involving the construction of long-term beds attached to rural hospitals, would begin in the new fiscal year. In addition, the Throne Speech indicated that the province's

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[15] Ibid, 2.

[16] Ibid.

insured services program was being expanded to include adult day care and respite programs offered through hospitals and personal care homes.

It is noteworthy that just prior to the Throne Speech the government also announced the division of the Department of Health and Community Services into two operational groups.[17] This division was informed by the recommendations of the Task Force on Government Organization and Economy Report and created a "social services and community health group" and an "institutional services group" in the Department. In addition, the announcement of this division indicated that a five member management team had been formed to advise Mr. Sherman on policy matters.[18]

With the government's policy agenda related to the continued realignment of the province's rural delivery system and the reorganization of the Department and the MHSC now in the implementation phase, Mr. Sherman turned his attention to other policy issues. On June 19, 1979 he announced the approval of a $138 million budget for the construction projects related to the redevelopment of the HSC.[19] Then, on September 20 he returned from a Federal-Provincial Health Ministers meeting in Ottawa and announced the province's support for the establishment of a federal task force, chaired by Mr.

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[17] Manitoba, "Health Department is Re-organized," Information Services Branch, February 9, 1979.

[18] Ibid., this management teams included Mr. Ron Johnstone, the Department's Deputy Minister, the Assistant Deputy Ministers responsible for both of the groups in the Department, the MHSC Chair, Mr. G. Pollock, and former health minister Dr. George Johnson.

[19] Manitoba, "Health Sciences Centre Major Redevelopment Set," Information Services Branch, June 22, 1979.

Justice Emmett Hall, to review the national health insurance program. In this announcement Mr. Sherman noted that Manitoba's support was based on the Lyon administration's concern that the professional climate for physicians needed to be improved because "Doctors are the very foundation of our health care system....We owe them consideration of their concerns."[20] In addition, he indicated that the province planned to conduct its own study of the challenges related to medical practice in Manitoba, through the appointment of a Standing Committee of the Legislature on Medical Manpower, and that the government has entered into negotiations with the MMA to establish a new fee schedule by April 1, 1980.

During the remainder of the year, three other events are also noteworthy. The first took involved the separation of the Department of Health and Community Services into two Departments on November 1 with Mr. Sherman retaining the health portfolio.[21] At this time a former health minister in the Roblin administration, Dr. George Johnson was appointed the Acting Deputy Minister of Health. The second involved a statement of the government's policy agenda to members of the province's medical community. It was offered by Mr. Sherman in a November 7 speech to a meeting of the Winnipeg Medical Society. In this speech he noted the growing national concern related to the financing of health

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[20] Manitoba. "Medicare Principles Re-Endorsed At Meeting," Information Services Branch, September 21, 1979.

[21] It is noteworthy that this division required staff in the province's health regions to report to senior staff in the Department of Health and Department of Community Services as the funding for regional services delivery now flowed from both Departments.

services as well as physician dissatisfaction related to the climate for medical practice in Canada. Further, he indicated that the Lyon administration would try to deal with these concerns by supporting improved planning and policy co-ordination between the government and the physician community.[22] The third event occurred on December 14 when Mr. Sherman spoke to a MHO seminar on facilities management. In this speech he indicated that his Department was exploring the implementation of "...economic incentives in the hospital field to improve the efficiency of allocation of hospital-based resources..." and that these incentives would be based on "...consideration of the distribution of facilities on the basis of size and type of care provided...." While he was not specific as to the nature of these incentives, he suggested that they would be designed to facilitate "responsible economic management on a regional basis."[23] In this presentation Mr. Sherman also noted his concerns related to the climate for medical practice and observed that "For Manitoba, a central portion of this challenge lies in restoring our physicians' pride in the practice of medicine."[24]

Mr. Sherman's efforts to forge a more cooperative relationship with provider pressure groups appear to have facilitated the February 1980 announcement that the government and the MMA had reached a two year

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[22] Manitoba, "Health Care System Facing Challenges," Information Services Branch, November 9, 1979.

[23] Manitoba, "Health Care Economy Incentives Are Urged," Information Services Branch, December 14, 1979.

[24] Ibid., p.2.

agreement on fee schedules beginning April 1. This agreement provided an overall increase of 8.9 percent for each of the two years as well as a 10 percent differential for physicians delivering services north of the 53rd parallel. In June the Standing Committee on Medical Manpower reported to Mr. Sherman with three recommendations: that a Physician Placement Bureau administered by the MHSC be established to facilitate the hiring of physicians in rural communities; that this Bureau administer an incentive program to attract physicians to medically under serviced areas of the province; that medical training in speciality areas where there were physician shortages be promoted by the province.[25] Mr Sherman's response to these recommendations was to order the MHSC to formulate an implementation plan for these recommendations that would begin in the next fiscal year.

During the remainder of 1980 there were no further major health policy announcements. However, in September the Chairpersons of Winnipeg's Hospital Boards met with Mr. Sherman to discuss the shortage of acute care beds in the City. The Minister asked the MHSC to respond to these concerns and, in October, Mr. Edwards wrote to the Minister indicating that the bed shortage was largely due to a backlog of elective procedures that had resulted from summer staff vacations and a shortage of long-term care beds. That month the Commission implemented a new personal care home (PCH) admissions

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[25] Manitoba, Standing Committee on Medical Manpower Report (unpublished, Department of Health , June, 1980), 2.

policy designed to ensure that persons discharged from Winnipeg's hospitals were given priority for PCH placement. It also authorized the temporary opening of 115 personal care beds at HSC (63 beds), Deer Lodge Hospital (32 beds), and Victoria General Hospital (20 beds). These beds were to be closed in the fall of 1981 when three new personal care homes were scheduled to open in the City.[26]

With the beginning of the new year a series of events suggested that the government was preparing for a provincial election. The first occurred on January 7,1981 when The Manitoba Health Research Council was established to fund and co-ordinate health services research in the province including research related to delivery system efficiency and effectiveness. This was followed, on March 13, by Mr. Sherman's presentation of his Department's budget estimates to the legislature. In his speech presenting these estimates Mr. Sherman indicated that the government's primary health care policy goal was "...to shift the health care system over to a much greater emphasis on day hospitals, adult day care, respite care, home care and the training of specialists in gerontology."[27] This goal was to be realized through:

> - further expansion of the province's long-term care bed capacity to respond to the shortage of acute care beds in Winnipeg as well as the high number of what the Department defined as "substandard beds" in operation in rural Manitoba;

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[26] For a discussion of this plan see Manitoba Health Services Commission, *Annual Report* 1980-81(Winnipeg, MHSC, 1981), 14.

[27] Manitoba,"Health Initiatives Outlined By Sherman," Information Services Branch, March 13, 1981.

- implementation of a new incentive program designed to encourage physicians to locate in rural areas of the province;

- implementation of an ambulance attendant training program combined with increased ambulance grants to municipalities in order to improve patient transportation services in rural Manitoba;

- expansion of the programs offered by The Alcoholism Foundation of Manitoba through the construction of new treatment facilities in Portage la Prairie and Swan River;

- expansion of the training programs for nurses at H.S.C. and St. Boniface General Hospital to counter the growing shortage of nurses and enhance the number of specialized nursing professionals.

The Lyon administration began the implementation of these programs in April following the approval of its budget. There were no further major changes in the government's health care policy agenda when, on October 11, Premier Lyon called a provincial election for November 17. During the election the government campaigned on its record of fiscal restraint and the dangers to the province's future financial stability related to the election of an NDP government. With regard to health care services, Premier Lyon emphasized his administration's efforts to improve the delivery system, in particular in the area of services for the province's aging population. The NDP, now under the leadership of Howard Pawley, campaigned on the negative impacts of Lyon's fiscal restraint program. In the area of health services, Mr. Pawley accused the Lyon administration of planning to privatize the delivery of some services if it was re-elected. Further, he promised to expand the province's insured services program in areas such as home care, dental services for children, and eyeglasses for the elderly. The provincial election took place on November 17

and reduced the PC party to twenty-three seats relative to the NDP's thirty-four seats in the province's 57 seat legislature.

CHANGES IN CAPACITY, COSTS, AND CONTROL

This assessment of the Lyon administration's single term in office follows the pattern established in previous chapters and is divided into three sub-sections. It also indicates that the changes in capacity, costs, and control displayed by Manitoba's health care delivery system between 1977 and 1981 were influenced by three sets of factors. The first set relate to federal policy changes through the implementation of the EPF Act in 1977. As noted in Chapter 6, while this Act restricted the growth of federal health care transfers, it also gave the provinces greater flexibility in the way they allocated delivery system resources. As the findings in this section indicate, the Lyon administration utilized this increased flexibility to enlarge the province's long-term care capacity, establish twelve new Type I Health Districts, and expand its insured services program in the area of ambulatory and out-patient services. The second set of factors relate to Lyon's application of his philosophy of "acute protracted restraint" to the province's health care sector. While the PC party's 1977 election campaign suggested that price and supply constraints would

dominate the Lyon government's cost containment strategies, following its first year in office, the government loosened its budgetary freeze and turned to the rationalization of Manitoba's delivery system in an effort to shift resources from institutional to community-based care. The third set of factors pertain to the government's relationship with provider pressure groups which, to a large degree, saw a return to the status quo of the Roblin administration. As a result, it is not surprising that the MMA enhanced its legitimacy in the province's health care policy community under the Lyon administration. Nor is it surprising that the MHO was more successful in its demands related to the development of DHCs despite suspicions on the part of the MHSC's senior staff regarding the ultimate goals of this pressure group.

CAPACITY CHANGES

As Table 7.1 below indicates, the tenure of the Lyon administration did not produce much in the way of changes in the functional scope of the province's health care delivery role. The only notable changes were the expansion of the insured services program, in the areas of ambulatory and out-patient care, and the division of the Department of Health and Community Services into two separate departments. The primary impact of the latter event was to formally separate the budget lines for services delivered by the province at the regional level.

Table 7.1: Changes in Functional Scope between 1977 and 1981

Functional Area	Status in 1977	Status in 1981
Public Health Services	Responsibility for health and social funding and delivery is centralized in the Department of Health and Social Development.	Funding responsibility for regional health and social services delivery is divided between two provincial departments.
Acute Care Hospital Facilities	Funding and regulatory control is centralized in the MHSC.	No changes in this area with the exception of expansion of insured services in the area of ambulatory and out-patient care.
Institutions for the Aged and Infirmed	Funding and regulatory control is centralized in the MHSC.	No changes in this area.
Services Provided by Physicians	Funding and regulatory control is centralized in the MHSC.	No changes in this area.

The lack of change in the province's functional scope is also reflected in the lack of significant changes in the geographic scope of public health services delivery. However, there were some changes in the geographic scope of institutional services delivery related to the balance between rural and urban regions which are noted in Table 7.2 below. This Table, which summarizes the data in Table D.9 in Appendix D, indicates that, during the tenure of the Lyon administration, rural bed capacity decreased by 1.1 percent. However, due to rural population decreases, the beds per thousand ratio grew by 7.6 percent. Winnipeg's population also dropped slightly during this period resulting in a beds per thousand ratio increase of 8.2 percent which was largely due to the opening of Seven Oaks General Hospital.

Table 7.2: Hospital Growth in Manitoba from 1977 to 1981

Region	1976/77	1981/82	% Increase
Central: # Communities with Facilities	13	13	0
: Rated Bed Capacity	502	480	-4.4
Eastman: # Communities with Facilities	7	7	0
: Rated Bed Capacity	231	213	-7.8
Interlake: # Communities with Facilities	7	7	0
: Rated Bed Capacity	211	211	0
Norman: # Communities with Facilities	8	8	0
: Rated Bed Capacity	423	398	-7.9
Parkland: # Communities with Facilities	9	9	0
: Rated Bed Capacity	373	388	1.0
Westman: # Communities with Facilities	27	26	-7.7
: Rated Bed Capacity	970	946	-7.5
Total Rural Capacity	2664	2636	-1.1
Total Rural Population (in thousands)	481.8	458.8	-1.8
Rural Beds Per 1000 population	**5.5**	**5.7**	**7.6**
Winnipeg: # of Facilities	9	10	11.1
Rated Bed Capacity	3647	3946	7.2
Total Winnipeg Population (in thousands)	596.8	594.1	-7.5
Winnipeg Beds Per 1000 population	**6.1**	**6.6**	**8.2**

The data contained in Table D.9 of Appendix D indicates that as some rural communities acquired or increased their long-term care capacity, the number of rated hospital beds declined. The increases in long-term care capacity are noted in Table 7.3 below which is also based on the data in Table D.9. This Table indicates that rural capacity, measured in beds per thousand population, increased 22.6 percent during the tenure of the Lyon administration.

On the other hand, the ratio of beds per thousand in Winnipeg declined by 4.2 percent.

Table 7.3: Long-Term Care Facility Growth in Manitoba from 1977 to 1981

Region	1976/77	1981/82	% Increase
Central: # of Communities with Facilities	9	10	11
: Rated Bed Capacity	601	718	19.5
Eastman: # of Communities with Facilities	5	5	0
: Rated Bed Capacity	329	390	18.5
Interlake: # of Communities with Facilities	5	5	0
: Rated Bed Capacity	468	428	7.5
Norman: # of Communities with Facilities	2	2	0
: Rated Bed Capacity	102	132	29.4
Parkland: # of Communities with Facilities	5	6	20
: Rated Bed Capacity	277	378	36.5
Westman:# of Communities with Facilities	13	16	23.1
: Rated Bed Capacity	1212	1426	17.7
Total Rural Capacity	2989	3472	16.2
Total Rural Population (in thousands)	481.8	458.8	-1.8
Rural Beds Per 1000 population	**6.2**	**7.6**	**22.6**
Winnipeg: # of Facilities	36	34	-5.5
Rated Bed Capacity	4275	4074	-4.7
Total Winnipeg Population (in thousands)	596.8	594.1	-7.5
Winnipeg Beds Per 1000 population	**7.2**	**6.9**	**-4.2**

COST CHANGES

While the Lyon administration did not alter established functional roles in Manitoba's health care delivery system, this government's tenure did see further

changes in the allocation of delivery system resources. These changes are noted on Table 7.4 below which is based on Table D.10 in Appendix D.

Table 7.4: Provincial Budgetary Changes from 1978 to 1982

Budget Line	1977-78	1981-82
Total Provincial Budgetary Expenditures	1,077,980,917	2,431,863,998
Provincial Health Care Expenditures	301,977,827	525,490,464
Health Care Expenditures as % of Total	28%	21.6%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	1.44%	.11%
Psychiatric Services Division	12.64%	5.48%
Public Health Services Division	11.31%	3.42%
MHSC/Other Hospital Services	74.6%	90.98%
Totals	100%	100%

This table indicates that the Department of Health's relative share of the provincial budget declined. However, this decline was largely due to the Lyon administration's transfer of key components of the Department's Public Health and Psychiatric Services Divisions to the new Department of Community Services. The detailed breakdown of the MHSC's budgets offered in Table D.11 of Appendix D indicates that the relative allocation of expenditures within the MHSC remained largely the same throughout the Lyon administration's tenure. This suggests that the primary reason for MHSC budget increases during this period was rising costs related to the delivery of the province's established insured services programs.

CONTROL CHANGES

With regard to changes in the province's functional roles, Table 7.5 below supports the findings noted above which indicate that the Lyon administration's overall impact on Manitoba's delivery system was more limited than the impact of earlier administrations.

Table 7.5: The Lyon Administration's Impact on Functional Roles

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	No substantive changes.
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	No substantive changes.
Revenue-Raising Functions related to the funding of services.	No substantive changes.
Planning and Resource Allocation Functions related to services delivery.	No substantive changes.
Policy-Making Functions related to the licencing of and standards for services providers.	No substantive changes.
Inter-Agency coordinative Functions related to services delivery.	No substantive changes.
Regulatory Functions related to the resource utilization practices of professional providers.	No substantive changes.
Training Functions Related to the education and placement of Professional Providers.	No substantive changes.
Management Functions related to the day-to-day administration of services delivery.	No substantive changes. However, facilities were given greater flexibility in the allocation of resources to ambulatory and out-patient services.

In summary, the most prominent change in Manitoba's health care delivery system produced by the Lyon administration was to return government-provider pressure group relations to something resembling the pre-1969 status quo. While this played a role in reducing observable conflict in the province's health care delivery subsystem, it did little to alter the capacity and costs of, as well as the distribution of policy and administrative control within, the province's health care delivery system.

CHAPTER 8.

CONSULTATION AND COST CONTROL: 1981 - 1988

This chapter turns to the policy behaviour of Howard Pawley's NDP administration which replaced the Lyon government in 1981. When this administration entered office it embarked on a policy path similar to that of earlier provincial administrations. In short, it initiated further study of the province's health services delivery system to determine where organizational changes could be implemented to contain costs. However, while the Schreyer and Lyon administrations conducted much of their health care delivery planning behind the doors of executive council offices, the Pawley administration undertook to engage provider pressure groups and other interests in a process of public consultation. The discussion in this chapter indicates that this process was fairly quickly overshadowed by a return to conflict between the province and the MMA. While a plan for delivery system organizational change was nearing finalization two years into the Pawley administration's second term, the government's unexpected defeat during a vote in the legislature in 1988 precluded the announcement and implementation of this plan. Nevertheless, the changes in capacity, costs, and control described in the second section of this chapter indicate that this government enjoyed some success in containing provincial expenditure budget growth, in the area of insured services programs, and used the savings to expand funding for community-based public health services.

THE PAWLEY ADMINISTRATION'S FIRST TERM

The election of the Pawley administration saw Laurent Desjardins return as the Minister of Health when the cabinet was announced on November 28, 1981. In December Mr. Desjardins appointed Mr. Reg Edwards as the Deputy Minister of Health. As Mr. Edwards retained his position as the Executive Director of the MHSC, his appointment effectively centralized the planning and management of services provided by the Department of Health and the Commission within the Minister's office. The first major health services policy event in the Pawley administration's tenure came in January 1982 when the government began negotiating with the MMA for a new fee schedule that was to become effective on April 1, 1982. At the first meeting between the two parties Mr. Desjardins indicated that he was not prepared to reach a settlement with the Association until the government's budget was completed. As a result, talks between the two parties ended after the first meeting and did not reopen prior to Mr. Desjardins presentation of his Department's budget estimates to the legislature on April 23. These estimates contained a 26 percent expenditure increase over the previous year with 93 percent of this expenditure increase allocated to the MHSC.[1] The remainder of this increase was allocated to: renovations to the Selkirk and Brandon mental health centres; the addition of 27 staff positions in the province's health and social services regions to improve

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[1] Manitoba, "26% Increase In Health Care Spending Projected," Information Services Branch, April 23, 1982.

public and mental health nursing care; the Northern Patient Transportation Service; the City of Winnipeg to upgrade its emergency response system; and to the Department to create a Planning Secretariat responsible for long-term Departmental and MHSC program planning.

Following the passage of the government's budget bill in May, Mr. Desjardins presented the Pawley administration's position on health care policy at a federal-provincial conference of health ministers in Ottawa. His May 26 opening speech was critical of federal funding policies which he noted had declined from 50 percent of insured services costs in 1979 in Manitoba to an estimated 39 percent for the current fiscal year. Based on this decline, Mr. Desjardins called for a review of the EPF Act to determine its impact on health services delivery in the provinces.[2] There were no other health care policy announcements during the remainder of the spring and the summer of 1982 except for a June announcement that, beginning on July 1, the province would expand the insured services program to include medically-required frames and/or lenses for persons over the age of 65.

In October preparations for the winter legislative session resulted in a number of announcements including: the re-organization of senior staff at the MHSC to relieve Mr. Edwards of some of his day-to-day administrative responsibilities; the creation of the position of Provincial Gerontologist in the

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[2] Manitoba, "Greater Federal Share of Health Costs Urged," Information Services Branch, May 28, 1982.

Department of Health; the appointment of Mr. David Pascoe as the Director of Research and Planning for the Department and the Commission; and the formation of a Working Group on Mental Health to examine this component of the province's delivery system. In addition, Mr. Desjardins wrote the executive of the MMA on October 22 indicating that the government was willing to agree to binding arbitration with the Association for a contract covering a two year period commencing April 1, 1983 if the MMA was prepared to accept limits on extra-billing by its membership.[3] On November 19 the MMA rejected this offer and called on the government to re-enter negotiations for a fee schedule increase retroactive to April 1, 1982. In addition, it asked its membership to withdraw their participation from all provincial and Commission planning and management committees. Mr. Desjardins responded on November 29 by once again offering to enter into binding arbitration.[4] In a letter to the MMA he indicated that the government was willing to bring legislation into force that would establish the MMA as the exclusive bargaining agent for all fee-for-services physicians if the Association accepted his binding arbitration proposal. Once again, the MMA rejected this offer. However, one week later it returned to the bargaining table and in early January an agreement was reached that gave the MMA's membership an average fee schedule increase of three percent in the 1982-83

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[3] Manitoba, "Binding Arbitration Trial Offered Manitoba Doctors," Information Services Branch, October 22, 1982.

[4] Manitoba, "Doctors Get Modified Offer of Arbitration," Information Services Branch, November 29, 1982.

and 1983-84 fiscal years.

With the issue of fee schedules settled, the Pawley administration turned to other health care policy issues. On April 1 Mr. Desjardins announced another reorganization of the Department of Health.[5] It saw the creation of a three Division structure: an Administrative Services Division responsible for Departmental support services; a Community Health Operations Division responsible for Departmental services offered in the health regions and the Selkirk and Brandon Mental Health Centres; and a Community Health Programs Division which contained a Health Promotion Directorate, a Communicable Disease Control Directorate, a Dental Health Services Unit, an Office of Hearing Conservation, a Maternal and Child Health Directorate, and the Office of Continuing Care. This reorganization included the creation of The Office of Chief Provincial Psychiatrist. It was followed by the presentation of the Department's spending estimates to the legislature for the 1983-84 fiscal year on April 8. The estimates called for an 11.6 percent increase over the previous year. In addition to a 9.9 percent increase in the MHSC's budget, the remainder of the expenditure budget was allocated to: further expansion of the services provided by the Department's Continuing Care Services Division through a 20.4 percent budget increase; a 20.1 percent increase in the budget for the Home Care Assistance program; the construction of a new adolescent treatment facility

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[5] Manitoba, "Long-Range Health Planning Stressed," Information Services Branch, April 8, 1983.

in Winnipeg; renovations to the Brandon and Selkirk Mental Health Centres; and new preventive programs in the area of maternal and child health. During his presentation of these estimates to the legislature, Mr. Desjardins also announced a new policy related to hospitals by indicating that hospital budget deficits would "no longer be tolerated, unless occasioned by some unforeseen emergency...".[6] There was no immediate reaction to this policy change from the MHO and no additional health care policy changes were announced during the summer of 1983.

In the fall of that year Mr. Desjardins attended a meeting of provincial health ministers in Halifax. In his opening speech he called on the federal government to return to the pre-1977 cost-sharing formulas in an effort to solve the current health care funding problems faced by the province.[7] On October 14 he reiterated this position in a letter to federal Health Minister Monique Begin requesting a federal-provincial health ministers' meeting to discuss more equitable funding arrangements. While Mr. Desjardins continued to pressure the federal government for more funding, five other events in late 1983 and early 1984 indicate that the Pawley administration was also becoming more interested in implementing changes in the organization of the Manitoba's delivery system. The first was the September release of the Working Group on Mental Health report which recommended the expansion of community-based services in all

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[6] Ibid., p.3.

[7] Manitoba, "Desjardins Urges Return To Federal Cost-Sharing," Information Services Branch, September 9, 1976.

regions of the province.[8] Mr. Desjardins responded to the recommendations of this group by establishing a Mental Health Advisory Committee in October to receive feedback on the study from interested agencies and individuals. The second involved the establishment of a Health Services Review Committee to study the organization and behaviour of the province's delivery system. This committee was made up of senior Health Department officials along with representatives from the MMA, the College of Physicians and Surgeons, the MHO, and the Manitoba Association of Registered Nurses (MARN). The third event was the initiation of an internal Department of Health study related to the development of Primary Health Centres (PHCs) that would be funded by the province to provide targeted disease prevention and health promotion programs to sectors of the population at high risk of hospitalization. The fourth was the January 1984 establishment of a Nursing Review Committee to examine the supply and utilization of nursing professionals in the province. The fifth was the establishment, also in January, of an MHSC Task Force to study the viability of Community Health Centres (CHCs) for the delivery of primary care services.

While the Pawley administration awaited the findings of these studies, there was little in the way of significant health policy announcements during the remainder of 1984. However, three events during the year are notable. The first occurred in April when the MHSC approved a $16 million interim financing

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[8] Manitoba, *Mental Health Services In Manitoba*, (Winnipeg: Mental Health Working Group, September 1983).

agreement with the City of Winnipeg for the redevelopment of the City's Municipal Hospitals. The first phase of this redevelopment, which was expected to cost $28 million, involved the construction of a new 205 bed facility. The second was August implementation of The Manitoba Home Care Orderly Service which provided an expanded range of services to home care clients in the province's health regions. The third was a joint Provincial-MMA announcement in December which indicated that the Association had agreed to begin conducting assessments of its membership's practice patterns to "...identify and control unwarranted annual increase in the utilization of medical services, and to determine the cost-effectiveness of new high technology services on the health-care system."[9] In exchange, the province committed to provide a further two percent fee schedule increase for the 1984-85 fiscal year. More importantly, both parties agreed to enter into binding arbitration related to fee schedule negotiations for a three year period beginning April 1, 1986.

In January 1985 the first of the studies commissioned the previous year was released by the government. On January 21 the MHSC Task Force presented its recommendations related to Community Health Centres to the Commission's Board. Its recommendations were based on the general finding that the establishment of CHCs would improve access to primary health care

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[9] Manitoba, "Province, MMA Announce Problem-Solving Accord," Information Services Branch, December 28, 1984.

services.[10] The Task Force's report was followed by the release of the Department of Health study group's report in February which recommended that the PHC concept should guide provincial policy related to the delivery of services to three high risk groups in the province; the children of urban cultural minority groups, elderly persons living in urban area, and first nations persons in remote and northern communities.[11] Also in February, an interdepartmental task force on disabled persons in personal care homes, established in January 1983, released its report which supported the provision of a wider range of lifestyle options in the form of assisted independent living accommodations.

In early March a special study of the province's health care delivery system commissioned by the Health Services Review Committee the previous year was released. Authored by Dr. Robert Evans, Mr. Denis Roch, and Mr. David Pascoe, it presented a detailed picture of resource utilization behaviour related to Manitoba's insured services programs between the 1971 and 1982 fiscal years.[12] This study's comparison of Manitoba's programs with the national averages indicated that the province's per capita bed capacity was larger than the national average and was significantly more expensive to operate. The study's findings in this area indicated that Manitoba displayed a thirty percent

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[10] Manitoba Health Services Commission, Submission To The Health Services Commission Board (unpublished MHSC Facilities Division Task Force Report, January 21, 1985).

[11] Manitoba, *Manitoba Primary Health Care* (Winnipeg: Department of Health, February 1985).

[12] Manitoba, *Manitoba and Medicare 1971 To the Present* (Winnipeg: Manitoba Health, March 1985).

higher rate of Personal Care Home (PCH) spending than the national average due to the inclusion of PCH services in the insured services program. The study observed that expenditures related to PCH services appear to have been an "add-on" cost to the delivery system, rather than an alternative to acute care facilities. As a result, it suggested that the province explore further realignments to its delivery system based on the Health Maintenance Organization (HMO) concept.[13]

The findings of the studies noted above had a direct impact on the content of the Pawley administration's March 7, 1985 Speech from the Throne. In this speech the government indicated that during the 1985-86 fiscal year the Department of Health would emphasize "...preventive services and development of alternatives to more expensive hospital and institutional treatment."[14] To this end the government indicated that it would: establish CHCs in all regions of the province to deliver primary care services; expand outpatient and day surgery at hospitals in Winnipeg and at the Brandon General Hospital; establish regional chemotherapy programs in rural hospitals; expand community-based services to the elderly; expand provincial regulatory control over private laboratories and related diagnostic facilities; and introduce legislation banning extra-billing by physicians in conformance with the demands of *The Canada Health Act* passed by the federal government in 1984.

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[13] Ibid., see Chapter IX p.236-49.

[14] Manitoba, "Extra-Billing Ban Forecast in Speech," Information Services Branch, March 8, 1985.

Following the Speech from the Throne the cabinet approved new budget guidelines for hospitals which restricted them to 2 percent budget increases during the next fiscal year. On March 20 Mr. Edwards began forwarding letters to all hospitals in the province informing them of the province's new budget limits. This letter indicated that, in the upcoming fiscal year, no budgetary increases would be provided by the MHSC for salaries and that the maximum two percent increase over the previous fiscal year would be provided for supplies only. Needless to say, the MHO was critical of the government's new policy and called on the government to withdraw these limits in a public statement to the media.[15]

In April, the Nursing Review Committee established the previous year presented its report to Mr. Desjardins. This Committee offered a variety of recommendations related to the future training of nurses and the need to expand their role in the province's delivery system.[16] Mr. Desjardins did not offer an immediate response to these recommendations as his attention was focussed on national policy issues. On May 16-17 he hosted a Federal-Provincial Health Ministers meeting held in Winnipeg. At this meeting he urged the federal government to develop new funding mechanisms designed to meet current and pending provincial needs related to the provision of services for Canada's aging

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[15] Winnipeg Free Press, "Hospital budget limits assailed," March 21, 1985 p.4.

[16] Manitoba Nursing Review Committee, *Report Of The Manitoba Nursing Review Committee To the Minister of Health*, (Winnipeg: Department of Health, April, 1985). See Chapter VII, p.34-35 for the report's conclusions.

population.[17] Less than a month later, on June 9, Mr. Desjardins travelled to Ottawa to protest federal amendments to the EPF Act, passed the previous fall in the form of Bill C96, which allowed the federal government to link increases in federal transfers to increases in the gross national product.[18] While his protest was not successful, Mr. Desjardins continued his campaign against the federal health care policy changes by releasing a letter he had written to federal Health Minister Jake Epp expressing Manitoba's concerns related to the private management of health facilities.[19] No immediate response was forthcoming from Mr. Epp.

During the remainder of 1985 two additional health care policy events occurred that played a role in Manitoba's health care policy agenda. The first was the August 1 implementation of a ban on physician extra-billing based on the passage of amendments to the *Health Services Insurance Act* in May. The second was the release of the final report of the Health Services Review Committee on December 16.[20] The many recommendations offered by the Committee were based on two central assumptions related to the future development of the province's delivery system: :

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[17] Manitoba,"Common Health Concerns Addressed At Conference," Information Services Branch, May 24, 1985.

[18] Manitoba, "Manitoba Calls For Bill C-96 Withdrawal," Information Services Branch, June 13, 1986.

[19] Manitoba, "Privatizing Health Care Management Is Opposed," Information Services Branch, July 19, 1985.

[20] Manitoba, *Report of the Health Services Review Committee* Vol. I-IV (Winnipeg: Manitoba Health , December 1985).

- that no further construction of institutional beds was required within the province, rather, there was a need for improved ambulatory care and other alternatives to institutional care;

- that while no new funding was needed for health care delivery, monitoring of existing resource allocations should be improved to enhance effective and efficient resource utilization.

Mr. Desjardins responded to this report by indicating that the Health Services Review Committee would be designated as a permanent advisory body to his Department. He also indicated that the Committee's next task would be to solicit responses to its findings from health service providers in the province.

The government entered 1986 with a February 11 announcement by Premier Pawley that he was calling a provincial election for March 18. During the election campaign, the NDP's approach to health policy issues was reminiscent of its opposition to the Lyon administration in that it was based on expressions of concern that the election of a PC party government would result in the privatization of some public health care services. The PC party, now under the leadership of Garry Filmon, responded by denying any interest in the privatization in the health services and expressed concerns about the Pawley administration's management of the province's health care services budget and the deterioration of the climate for medical practice in the province. Election day saw the NDP retain its majority with 30 seats while the PC party held 26 seats with one seat held by the Liberal Party.

THE SECOND TERM

Mr. Desjardins retained the health portfolio when the Pawley administration's new cabinet was announced one week after the election. However, it would be another month before he began a series of announcements related to changes in the organization of the province's delivery system. The first was a mid-April, 1986 announcement that the 2 percent limit on hospital budgets, introduced during the government's first term, would be continued. In addition, hospital boards were asked to meet with MHSC staff over the next four months to develop plans for further budgetary reductions in the next fiscal year. The second announcement came in mid-May when Mr. Desjardins and the Minister of Community Services, Muriel Smith, announced that the Winnipeg Health and Social Services region would be divided into three regional units so that services could be provided in a manner more sensitive to the unique character of neighbourhoods in the City.[21] This announcement also indicated that departmental lines of reporting for the Directors of the seven existing and three new regions had been integrated to reduce administrative fragmentation.

In July Mr. Desjardins made two further announcements. The first was the appointment of Dr. Nick Poushinsky to assist the government in the development of an implementation plan for the realignment of the province's

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[21] Manitoba, " Restructuring in Health, Community Services Set," Information Services Branch, May 16, 1986.

health care delivery system based on the recommendations of the Health Services Review Committee and the other Task Forces and Advisory Groups that had reported to the government over the previous year.[22] The second indicated that the government was now in receipt of the plans for budget reductions developed by the province's hospitals and that the first of a series of changes flowing from these plans would be implemented. These changes included: the closure of twenty-nine beds at Brandon General Hospital with conversion of the space occupied by these beds to a day surgery area; the closure of 98 beds in Winnipeg at the HSC, St. Boniface Hospital, and the Victoria General Hospital; and the initiation of a joint pilot project by the emergency departments at St. Boniface General Hospital and Grace General Hospital designed to prevent admissions by providing emergency patients with appropriate home care alternatives where possible.

There were no other major announcements until early December when Mr. Desjardins retained the services of Michael Decter, a former staff member of the Pawley government's executive council, to review the operational mandate of the MHSC relative to the mandate of the Department of Health. The stated goal of Mr. Decter's review was to assess the feasibility of amalgamating the Commission's operations with the Department. At the same time Mr. Desjardins issued a request for proposals for health care demonstration projects intended to

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[22] Manitoba, "Health Care Reform Action Plan Sought," Information Services Branch, July 4, 1986.

reduce the province's dependency on institutional services. This was followed, on December 23, by the release on a ruling by the arbitrator responsible for fee schedule negotiations between the province and the MMA. This ruling proposed a 6.5 percent fee schedule increase retroactive to the start of the 1986-87 fiscal year. Mr. Desjardins immediately rejected this proposal based on his position that a new contract with the MMA would have to include a commitment by the Association to impose controls on the volume of medical services utilized by its members. The situation remained at an impasse into 1987 when, on January 23, Mr. Desjardins suggested to the media that he was prepared to terminate the government's agreement with the MMA to utilize binding-arbitration to resolve fee disputes.[23] Following a cabinet meeting on February 3 Mr. Desjardins softened his position by indicating that he had instructed the MHSC to provide a 5.6 percent increase in fee schedule payments retroactive to April 1, 1986 based on the arbitrator's recommendations.[24]

With yet another confrontation with the MMA behind him, Mr. Desjardins released the findings of the Decter report commissioned the previous December. It indicated that the separation of services delivery administration between the Department of Health and MHSC had contributed to the Pawley administration's inability to shift resources from curative to primary and preventive care. As a result, Decter's recommendations mirrored those of Lyon administration's Task

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[23] Winnipeg Free Press, "Province ends arbitration pact with doctors," January 23, 1987 p.1.

[24] Winnipeg Free Press, "Province pays up to MD's," February 4, 1987 p.3.

Force On Government Organization and Finance by suggesting the "disestablishment" of the MHSC and the integration of its functions within the Department of Health to improve the planning and administration of services delivery.[25] The government gave no indication that it was planning to act on the recommendations of this report when it presented the health department's expenditure budget to the legislature on April 10. These estimates indicated that the only changes in resource allocations were a 9.5 percent increase in the MHSC's budget and a 2 percent increase in the province's home care services program. [26]

In May the only major policy announcement was the establishment of a program to control the spread of HIV infection. It was not until June 1987 that Mr. Desjardins indicated planning was underway to amalgamate the functions of the MHSC with the Department of Health.[27] However, he never formally announced the implementation of this plan because, on August 26, he resigned as the Minister of Health and was replaced by Wilson Parasiuk. Mr. Parasiuk began his tenure as the Minister of Health by attending a September 9-10 provincial health ministers meeting in Saint John, New Brunswick. At this meeting he called on the federal government to alter funding arrangements with

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[25] The October Partnership, *Review of Manitoba Health Services Commission*, January, 1987.

[26] Manitoba, "$1.3 Billion Health Spending Is Proposed," Information Services Branch,April 10, 1987.

[27] Winnipeg Free Press, "Desjardins ducks details of health department plan," June 19, 1987 p.11.

the provinces to allow the development of new insured programs for the delivery of services at the community level. Upon his return from this meeting Mr. Parasiuk spent much of September responding to public and pressure group criticism of the Pawley administration's management of health services due to a series of cuts to hospital services undertaken by urban institutions in Winnipeg and Brandon to control their budgets.

The MMA was one of the most vocal critics of the government during the fall of 1987and, on October 3, it issued a public letter suggesting that the Department of Health's failure to properly co-ordinate the implementation of the cost containment plans of hospitals developed the previous year had negatively affected the ability of physicians to deliver care to their patients. Based on the positive response of its membership to the release of this letter, the MMA began an advertising campaign in late October designed to increase public opposition to the Pawley administration's management of the province's health care delivery system. Throughout November this campaign was augmented by almost daily stories in the media pertaining to the negative impacts of hospital budget cuts on patients and providers. In an effort to counter this campaign, Mr. Parasiuk began a series of announcements intended to show that the government was responding to the need for policy changes. The first came on December 10 when he announced that the province had approved $1.1 million in grants to fund demonstration projects designed to reduce the health care

delivery costs.[28] This was followed by a December 22 announcement that the Department of Health was planning a series of delivery system realignments that would include changes in the role of physicians.[29] A third announcement was contained in the government's February 12, 1988 Speech from the Throne which indicated that it would implement a new program to establish Community Health Centres in all parts of the province based on the conversion of existing hospitals and health centres. This announcement was followed by the presentation of the province's budget on February 26.

The Health Department's 1988-89 budget estimates included a $111 million allocation to finance the implementation of programs designed to realign the delivery of health care services.[30] Almost one-half of this allocation was intended to fund the provisions of Bill 2, *An Act to Establish The Health Services Development Trust Fund*, which had been placed on the legislature's order paper by Mr. Parasiuk on February 23. The goal of the trust fund intended by this Bill was to provide transitional funding to communities that agreed to convert their District Hospitals and Type I District Health Centres into Community Health Centres that were similar to Type III DHSDC model implemented in five communities during the Schreyer administration's tenure. However, Bill 2 was never passed by the legislature which was dissolved on March 9, 1988 when the

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[28] Winnipeg Free Press, "Health-care cost reduction plan launched," December 11, 1987.

[29] Winnipeg Free Press, "MDs target of health-care reform," December 26, 1987 p.1.

[30] Manitoba, "$1.4 Billion To Ensure Quality of Health Care," Information Services Branch, February 26, 1988.

Pawley administration was unable to gain a majority vote for its budget bill and was forced to resign. A provincial election was called by Premier Pawley for April 26 after which he resigned as Premier in advance of an NDP leadership convention. The election campaign was not an easy one for the NDP who faced constant criticism for their handling of health care policy. In an effort to respond to this criticism, the new leader of the NDP, Gary Doer, announced a six-point health services platform on April 7 which included budget increases for community-based programs, the development of CHCs, the expansion of health promotion programs, and the implementation of a home renovation program for elderly persons that would allow them to stay in their homes rather than living in an institutional setting.[31] The PC party countered this platform by promising to halt the closure of hospital beds. In addition, Mr. Filmon ruled out any possibility that he would implement user fees if his party was elected .[32] This proved to be an effective strategy because on April 26 the election results gave the PC party minority government status with twenty-five seats. The Liberal Party formed the official opposition with twenty seats while the NDP was reduced to twelve seats in the province's fifty-seven seat legislature.

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[31] Winnipeg Free Press, "Doer targets health care," April 8, 1988 p.16.

[32] Winnipeg Free Press, "Filmon rules out user fees, vows bed-closing freeze," April 13, 1988 p.1.

CHANGES IN CAPACITY, COSTS, AND CONTROL

While the Pawley administration's tenure mirrored that of the Lyon administration in that it did not implement any substantive changes in the organization of Manitoba's delivery system, its approach to management of the province's health care policy community saw a return to the policy planning assumptions that guided the Schreyer administration in the 1970s. The most important of these assumptions was that the provincial government should be the dominant actor in the province's health care policy community since it was responsible for providing most of the funding for the delivery of services. Further, that policy goals and plans should strive to improve access to community-based services rather than further enhancing the capacity of the established medical care delivery system. However, there were also notable differences in the Pawley administration's approach. On the one hand, while the Schreyer administration developed its plan for delivery system rationalization privately, and then moved to debate its plan with members of the province's health care policy community, the Pawley administration opted for a more public planning process involving consultation with pressure group actors prior to the establishment of formal goals. On the other hand, the Schreyer administration had grounded its plans for organizational rationalization on enhanced citizen control of delivery system administration at the district level based on the assumption that this would make the system more effective which, in turn, would enhance efficiency. However, the Pawley administration grounded its planning

on the need for greater provincial administrative control over the behaviour of the delivery system based on the assumption that, if delivery system efficiency could be enhanced through organizational realignments, the budgetary resources saved through those realignments could then be utilized to enhance delivery system effectiveness.

Despite these differences, the discussion in this chapter indicates that Pawley administration was influenced by the same three sets of factors that influenced the administrations that preceded it. With regard to the role of the federal government, the debate preceding the passage of *The Canada Health Act* in 1984, and the subsequent implementation of this Act, were important events. While the implementation of this Act did not alter the federal-provincial framework for health care funding established in 1977, Taylor notes that the federal government's position in the debate leading to the passage of this Act was "...that what was needed was significant restructuring and reorganizing of health care priorities and delivery systems." [33] Given that the NDP in Manitoba had supported this position since the late 1960s, it is not surprising that the Pawley administration actively pursued organizational rationalization as its primary policy option. As noted above, it assumed that successful organizational realignments could not be implemented without first increasing the province's authority in the province's health care services delivery subsystem. As a result, the devolution of provincial authority to the province's

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[33] Taylor, *Health Insurance and Canadian Public Policy*, 444.

regions or hospital/health care districts was never central to policy community debates during the tenure of this administration. Rather, the Pawley administration translated the NDP's "democratic socialist" philosophy of governing into health care policy planning by focussing on challenging the independent authority of health care providers related to the utilization of provincial budgetary resources. Therefore, it is not surprising that conflict between executive council and provider pressure group actors dominated health care policy debates during this administration's tenure. Nor is it surprising that the Pawley administration was unable to implement the changes in the province's delivery system that it planned as, by the end of its tenure, it was confronted with a health care delivery subsystem that was openly antagonistic to its management of the policy process.

CAPACITY CHANGES

Table 8.1 below supports the assumption made in the above discussion that the tenure of the Pawley administration did not produce substantive changes in the functional scope of the province's health care delivery role beyond increases in the service delivery roles of community-based public health services provided by the Department of Health and the imposition of the province's ban on physician extra-billing.

Table 8.1: Changes in Functional Scope from 1981 to 1988

Functional Area	Status in 1981	Status in 1988
Public Health Services	The funding of services is divided between two provincial Departments.	Services funding remains divided, however, resource allocations for some services, in particular home care, are increased. The Winnipeg region is now divided into three regional units.
Acute Care Hospital Facilities	The insured services has expanded in the areas of ambulatory and out-patient care.	No substantive change in this area.
Institutions for the Aged and Infirm	No substantive changes in this area.	No substantive change in this area.
Services Provided by Physicians	No substantive changes in this area.	Extra-billing is banned following the passage of amendments to *The Health Services Insurance Act* in 1985.

While there was little change in the province's functional scope, there were a number of changes in the capacity of the health care services delivery system. Table 8.2 below indicates that the number of hospital beds per thousand persons in the province declined an average of 11.5 percent. This compares to an average increase in province-wide hospital capacity, measured in beds per thousand persons, of 7.9 percent during the tenure of the Lyon administration. The decline in the total number of beds per thousand indicated in this table, which is based on a summary of data drawn from Table D.12 in Appendix D, was the product of two related factors: a net reduction in bed capacity, which averaged 6.5 percent; and an increase in Manitoba's population,

which averaged slightly over 7 percent during the tenure of the Pawley administration, which influenced the bed per thousand ratio.

Table 8.2: Hospital Growth in Manitoba from 1981 to 1989

Region	1981/82	1988/89	% Increase
Central: # Communities with Facilities	13	13	0
: Rated Bed Capacity	480	452	-5.8
Eastman: # Communities with Facilities	7	7	0
: Rated Bed Capacity	213	202	-5.2
Interlake: # Communities with Facilities	7	7	0
: Rated Bed Capacity	211	197	-6.6
Norman: # Communities with Facilities	8	8	0
: Rated Bed Capacity	398	357	-10.3
Parkland: # Communities with Facilities	9	8	-11.1
: Rated Bed Capacity	388	363	-6.4
Westman: #Communities with Facilities	26	26	0
: Rated Bed Capacity	946	894	-5.5
Total Rural Capacity	2636	2465	-6.5
Total Rural Population (in thousands)	458.8	496.7	8.3
Rural Beds Per 1000 population	**5.7**	**5**	**-12.3**
Winnipeg: # of Facilities	10	10	0
Rated Bed Capacity	3946	3689	-6.5
Total Winnipeg Population (in thousands)	594.1	628.7	5.8
Winnipeg Beds Per 1000 population	**6.6**	**5.9**	**-10.6**

Table D.12 in Appendix D, which serves as the data base for Table 8.2, also indicates that the MHSC's 6/20 model for small rural communities was formally in place in two communities, MacGregor and Whitemouth, at the end of the Pawley administration's tenure and that a number of other communities

moved closer to the acute to long-term care bed ratio defined by this model. Further, Table D.12 indicates that the number of DHCs in the province doubled, from twenty-two in 1981 to forty-five in 1988, and that all of the DHCs established during this period were of the Type I model. Turning to changes in long-term care capacity, Table 8.3 below, which is also based on the data in Table D.12, indicates that province wide-capacity also changed in this area.

Table 8.3: Long-Term Care Facility Growth in Manitoba from 1981 to 1989

Region	1981/82	1988/89	% Increase
Central: # of Communities with Facilities	10	12	20
: Rated Bed Capacity	718	734	2.2
Eastman: # of Communities with Facilities	5	7	40
: Rated Bed Capacity	390	433	11
Interlake: # of Communities with Facilities	5	7	40
: Rated Bed Capacity	428	520	21.5
Norman: # of Communities with Facilities	2	2	0
: Rated Bed Capacity	132	130	-1.5
Parkland: # of Communities with Facilities	6	7	16.7
: Rated Bed Capacity	378	405	7.1
Westman: # of Communities with Facilities	16	22	37.5
: Rated Bed Capacity	1426	1520	6.6
Total Rural Capacity	3472	3742	7.8
Total Rural Population (in thousands)	458.8	496.7	8.3
Rural Beds Per 1000 population	**7.6**	**7.5**	**-1.3**
Winnipeg: # of Facilities	34	33	-2.9
Rated Bed Capacity	4074	4594	12.8
Total Winnipeg Population (in thousands)	594.1	628.7	5.8
Winnipeg Beds Per 1000 population	**6.9**	**7.3**	**5.8**

In short, Table 8.3 indicates that, while the number of rural communities with facilities increased, along with the total rural bed capacity, rural population increases during the 1980s resulted in a decrease in the number of beds per thousand persons by 1.3 percent. On the other hand, Winnipeg's capacity growth was positive in that the total number of beds increased by 12.8 percent and the beds per thousand population increased by 5.8 percent. This growth was the primary reason for a province-wide average growth in beds per thousand population of 2.3 percent during the Pawley administration's tenure. This compares with a total average growth in beds per thousand of 9.2 percent experienced during the tenure of the Lyon administration.

COST CHANGES

The Pawley administration's success in containing capacity growth in the province's delivery system relative to population growth, is also reflected in the changes related to the allocation of delivery system resources. These changes are noted Table 8.4 below which is based on Table D.13 in Appendix D. This table indicates that the Pawley administration was somewhat successful in shifting the relative allocation of resources from insured services and other hospital-based services to public health services. This resulted in increased home care spending as well as increases in budgets related to the Community Field Services section of the Department of Health.

Table 8.4: Provincial Budgetary Changes from 1982 to 1989

Budget Line	1981-82	1988-89
Total Provincial Budgetary Expenditures	2431.8 million	4484.3 million
Provincial Health Care Expenditures	525.4 million	934.9 million
Health Care Expenditures as % of Total	21.61%	20.84%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	.11%	.29%
Psychiatric Services Division	5.48%	4.29%
Public Health Services Division	3.4%	9.4%
MHSC/Other Hospital Services	90.99%	86.01%
Totals	100%	100%

With regard to the decrease in the MHSC/Other Hospital Services area of the budget, Table D.14 in Appendix D indicates that while the relative allocation of expenditures for facilities increased by 1.3 percent and the allocation to other services increased by 1.5 percent, the allocation to medical services fell by the total of these increases; 2.8 percent. This suggests that the Pawley administration's approach to fee schedule negotiations with the MMA had a positive net effect on containing the budget allocation to the MHSC.

CONTROL CHANGES

The application of the nine category list of administrative roles defined by Mills et al. to changes in the province's functional roles during the tenure of the Pawley administration is offered in Table 8.5 below. It indicates that the most important changes related to the passage of The Canada Health Act and the

subsequent banning of provider extra-billing for insured services.

Table 8.5: The Pawley Administration's Impact on Functional Roles

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	Increased with regard to physicians through the province's ban on physician extra-billing motivated by the passage of *The Canada Health Act* in 1984.
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased with the federal government prior to and after the passage of The Canada Health Act.
Revenue-Raising Functions related to the funding of services.	No substantive change.
Planning and Resource Allocation Functions related to services delivery.	Increased in the context of the Pawley administration's efforts to undertake a consultative planning process.
Policy-Making Functions related to the licencing of and standards for services providers.	No substantive change.
Inter-Agency coordinative Functions related to services delivery.	No substantive change. However, efforts were made to broaden participation in health care delivery subsystem debates, in particular with regard to nursing professionals.
Regulatory Functions related to the resource utilization practices of professional providers.	Increased in the area of provider extra-billing through amendments to *The Health Services Insurance Act* that banned extra-billing. Also increased through the MHSC's deficit reduction program for facilities.
Training Functions Related to the education and placement of Professional Providers.	No substantive change.
Management Functions related to the day-to-day administration of services delivery.	Increased due to the provincial ban on extra-billing which informally included user fees for insured services.

In summary, the Pawley administration's most significant contribution to the evolution of Manitoba's health care delivery system involved the containment of provincial delivery system growth in terms of its capacity and costs. While the extensive planning and consultation process it undertook during much of its tenure confirmed the need for further organizational realignment of the province's delivery system to increase its efficiency and effectiveness, this administration's conflicts with key provider pressure groups, coupled with the unexpected 1988 election, precluded the implementation of the recommendations for policy change produced by this process.

CHAPTER 9.

THE ERA OF PROVINCIAL COST CONTROL

This chapter summarizes and evaluates the policy behaviour of the provincial administrations that governed Manitoba between 1969 and 1988. In addition, it offers a summary of policy behaviour in Manitoba across the forty year time frame of this study. Like Chapter 5, this chapter's description and evaluation of policy behaviour utilizes the questions and hypotheses described in Chapter 2. To set the stage for the discussion of these questions, three general observations are noteworthy. The first is that Manitoba's policy experience supports the division of the post-World War II evolution of health care policy in that province into two broad eras; The Era of Provincial Capacity Growth and The Era of Provincial Cost Control. The findings indicate that governments in Manitoba were somewhat successful in achieving their policy goals during both of these eras. These findings also indicate that while all of the governing administrations reviewed preferred organizational rationalization as a policy option, provider pressure group resistance to alterations in the organizational arrangements for services delivery, which Marmor et al. suggest were the result of policy compromises during the establishment of the "expansionary paradigm", limited the implementation of substantive changes related to capacity, costs, and delivery system control.[1]

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[1] Marmor et al., "The Determinants of a Population's Health," 221.

The second observation is that policy initiatives at the federal level of government in Canada played an important role in the timing and direction of provincial policy change. As the discussion in Chapter 3 indicates, the 1946 federal taxation agreement and the 1948 introduction of the National Health Grants Program were instrumental in allowing Manitoba to begin pursuing the goal of capacity growth. While capacity growth declined following the 1953 provincial election, it began to increase in the late 1950s with the implementation of HIDSA and continued to increase during the 1960s. The implementation of *The Medical Care Act* in the late 1960s, coupled with new provincial insured services programs in the 1970s, continued to increase the province's capacity and costs. These increases did not begin to slow until the late 1970s when ongoing federal threats to contain its share of health care delivery costs were realized with the implementation of the EPF Act in 1977.

A third general observation involves the impact of provincial policy actors on the content and implementation of health care policy. Here the findings indicate that the interests of, and intermediation between, key actors in the province's health care services delivery subsystem played an important role in the way each government approached the formation and implementation of provincial cost control policies, in particular, organizational rationalization. In short, this study supports neo-pluralist assumptions that the interplay between executive council actors and key provider pressure groups play an important role in capacity and cost behaviours in a province. It also indicates that debates

related to capacity and costs may mask a more important set of policy issues; the distribution of organizational authority among key actors in a delivery system related to legitimate control over the allocation and utilization of public resources.

GOAL FORMATION

Question 1: What forms of policy initiatives did executive council actors in each administration attempt to pursue in their interactions with other actors in the province's health care policy community, in particular, the subsystem actors responsible for services delivery ?

As the discussion in Chapter 6 indicates, The Era of Provincial Cost Control formally began with the election of the Schreyer administration in 1969. This government's primary health care policy goal was outwardly similar to that of the PC party administrations it replaced; improved delivery system capacity to enhance access to services. However, its strategy for achieving this goal differed from the Roblin and Weir administrations in two important ways. On the one hand, the NDP was primarily concerned with equality of citizen access to services and assumed that the elimination of health care insurance premiums, combined with new approaches to the organization of the delivery system was necessary for improvements in this area. On the other hand, it assumed that increased provincial and local control over the planning and administration of the services delivery system was necessary for improved equity of access by enhancing the ability of both parties to allocate public resources to the areas of

greatest need. These differences were significant in shaping the Schreyer administration's approach to all three types of cost control defined in Chapter 2. While cost-shifting was not seen as a policy option and price and supply constraints were only practised towards the end of Schreyer's tenure,[2] organizational rationalization to contain the capacity of and budgetary growth related to medical care was central to this administration's policy agenda. This focus is evident in Saul Miller's November 1972 speech to a MHA annual meeting in Brandon which was based on the findings of the Hastings Commission and the province's White Paper. In this speech Mr. Miller reviews the growth in provincial health care costs and then states:

> Let me emphasize that when we talk of unacceptable cost escalation, we do not expect any system of care to actually reduce present costs. However, as a government we must insist that the present use of resources be as effective as possible so that future cost increases will not prevent the development of other services needed by Manitobans.[3]

To control "unacceptable cost escalation" and foster improved access to "other services" in the health care sector the Schreyer administration embarked on four initiatives. First, it centralized insured health services planning and administration in the MHSC to reduce organizational fragmentation, increase administrative efficiency, and improve the province's ability to implement

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[2] On September 10, 1976 the MHSC announced its first formal Fiscal Restraint Program which was based on a 1% reduction in semi-monthly payments to hospitals for the period October 1, 1976 to March 31, 1977.

[3] Manitoba, Speech by the Honourable Saul Miller to the Annual Meeting of the Manitoba Hospital Association (unpublished: Brandon Manitoba, November 2, 1972), 6.

resource allocation shifts from hospitals to long-term care institutions and community-based services. Second, it took full funding and administrative responsibility for public health services to allow the "temporary" regional integration of the continuum of primary and preventive health and social services now under the province's administrative control. Third, it initiated the creation of DHSDCs based on the transfer of three types of delivery system responsibilities to the boards of these centres: provincial authority for public health and social services; municipal authority for the administration of hospitals; and private provider authority for publically insured services currently offered on a fee-for-service basis. Fourth, it attempted to rationalize the scope and capacity of hospitals and long-term care facilities in Winnipeg as well as attempting to increase access to services in City neighbourhoods through the development of urban CHCs. The Schreyer administration's initiative to develop a regional governance model also played a role in health care policy planning during its first term as this model was intended to link planned realignments in the province's health care delivery system with a broader set of changes related to the regionalization of local governance. However, because this initiative did not reach the implementation stage, the assumption that population health benefits would flow from inclusion of the "stay option" concept in regional policy planning were never tested in policy practice.

While the Schreyer administration did not practice cost shifting, focussed its resources on organizational rationalization, and instituted formal price and

supply constraints in the latter part of its tenure, the Lyon administration employed the latter two approaches but reversed the order of their implementation. As the discussion in Chapter 7 indicates, Lyon instituted formal price and supply constraints first, in the form of a government-wide freeze on departmental budgets, and then spent the last half of his term implementing some of the less controversial features of the Schreyer administration's initiatives to rationalize services delivery at the district level. In short, this administration's policy behaviour did not differ substantively from that of the Schreyer administration. However, while Schreyer's approach assumed that policy change could be rationally planned and quickly implemented by the province's bureaucracy, Lyon's approach emphasized a more incremental process in which change was jointly planned by executive council actors and key provider pressure groups in the province's health care policy subsystem.

As Chapter 8 indicates, the Pawley administration drew on the experience of the Schreyer and Lyon administration's in its approach to cost control policy. On the one hand, it agreed with Schreyer's position that cost -shifting was not a viable policy option and that organizational rationalization was preferred over the imposition of price and supply constraints. One the other, it assumed that the Lyon administration's more incremental approach to policy change was necessary for policy success. It is notable that, when the NDP entered office in 1981, cost-shifting to individuals was being actively promoted by the CMA as a solution to delivery system "underfunding" by the federal and provincial

governments. Taylor's review of the debates leading to the passage of *The Canada Health Act* in 1984 indicates that key actors in Canada's health care policy community divided into two coalitions in the early 1980s: one was led by the Canadian Medical Association and its provincial affiliates who supported cost-shifting, in the form of extra-billing, as a policy response to underfunding; the other was led by the federal Liberal cabinet and provincial NDP governments who viewed extra-billing as inconsistent with the principles of national health care policy.[4] The Pawley administration's involvement in the latter coalition focussed provincial government policy attention on this national issue until *The Canada Health Act* was brought into force in 1984. As a result, a concerted effort to realign the organization of Manitoba's delivery system did not get underway until 1984.

The Pawley administration's behaviour related to delivery system rationalization is notable because, while it established twenty-three Type I District Health Centres during its tenure, there was no obvious attempt to implement the Type II or III model until 1988 when the implementation of the Primary Health Centre (PHC) concept was given serious consideration. As Chapter 8 notes, Manitoba's interest in the implementation of this concept, which was similar to the CHC concept defined in Manitoba's 1972 White Paper on health policy, was evident in early 1985.[5] It is also suggested in Mr. Desjardins'

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[4] Taylor, *Health Insurance and Canadian Public Policy*, p. 435-462.

[5] Manitoba, *Submission To the Health Services Commission Board* (unpublished; MHSC Facilities Division, January 21, 1985).

1987 statement the Pawley administration's primary health care policy goal was to refocus the capital program of the MHSC to:

> ...provide expanded community care, to expand ambulatory care services for medical and surgical same-day procedures, and to provide a one-time non-recurring fund for demonstration projects that would show the way in which pressure on institutional beds could be lessened by a substitution of services."[6]

One year prior to the publication of this statement, the government began the implementation of its, as yet, unreleased plan to realign the delivery system based on the PHC concept by introducing price and supply constraints. These constraints were intended to facilitate the release budgetary resources to finance the implementation of a PHC program. However, the public controversy that the implementation of these constraints produced in late 1986 and in 1987, coupled with the government's defeat during a budget vote in 1988, precluded the formal implementation of a PHC program and likely contributed to the NDP's defeat on April 26, 1988.

In summary, the study findings related to this question are similar to those discussed in Chapter 5. They do not support the study hypothesis as they indicate that, during the time frame of this study, executive council actors in Manitoba preferred organizational rationalization to price and supply constraints and/or cost-shifting. If the Lyon and Weir administrations, which governed for six of this study's forty year time frame, are excluded it is also evident that during

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[6] L.L Desjardins, "Public Expectations, Public Funds," *Health Management Forum* (Summer 1987), 35-40. See p. 38.

most of this time frame the governments surveyed here followed a similar pattern in their approach of cost control. This approach involved the initial utilization of organizational rationalization. If/when the recommendations of these rationalization exercises were resisted by key provider pressure groups, governments in Manitoba then tended to pursue formal price and supply constraints.

Question 2: How did actors in the policy subsystem respond to the agenda of executive council actors in each administration and were advocacy coalitions evident in these responses?

Throughout the Schreyer administration's tenure a coalition of actors represented by the PC party led legislative opposition to this government. While this coalition did not directly attack the Schreyer administration's goal of equitable citizen access to services, due to public support for actions such as the removal of health insurance premiums, it was critical of growth in the province's health care budget during the 1973 and 1977 election campaigns. This is supported by Dyck who indicates that the PC opposition, led by Sidney Spivak between 1971 and 1975 and Sterling Lyon from 1975 onward, consistently attacked the NDP by suggesting that its programs were too costly and risked hindering provincial economic growth by forcing increased taxation.[7] This opposition coalition also undertook a more ideological attack under the

[7] Dyck, "Manitoba," 410-11.

leadership of Sterling Lyon who suggested that the Schreyer administration's efforts to increase the province's authority in the health sector were part of a "socialist agenda" to diminish the authority of citizens and local governments.[8] While PC party criticism of the government had little impact on the results of the 1973 election, they were more significant in the 1977 provincial election which saw Sterling Lyon base his election campaign on an appeal to voters to support the PC party, rather than the Liberals, to ensure that government candidates would not be elected due vote splitting by those opposed to the NDP.

With regard to provider pressure groups, the Schreyer administration's first term saw a continuation of the trend started in the late 1960s related to increasingly public disagreements among key policy subsystem actors. The MMA was the most willing to force public debates on issues that it perceived as negatively affecting its membership. This is evident in the MMA's January 20, 1973 response to *The White Paper on Health Policy* which gave tentative support to: the administrative regionalization of hospital and community-based services on an "area" basis that was sensitive to established patterns of medical practice and patient utilization; the inclusion of long-term care facilities as part of the provincial health services insurance plan as long as the government did not remove funds from the hospital and medical insurance programs; the development of hospital-based and physician-managed home care programs to

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[8] Ibid., on p.410 Dyck notes the role of the Group for Good Government in supporting the PC and Liberal opposition parties through its public identification and support of opposition candidates that they perceived had the best chance of defeating the NDP candidate in a constituency.

relieve the demand on acute care beds; and the effort to broaden the range of health and social services available to northern and remote areas of the province. This response also opposed: the integration of the service delivery roles of physicians with other professional providers; changes to the fee-for-service method of remuneration; and the development of DHSDCs if their implementation interfered with the rights of patients to choose their physician and the setting in which they received services. The MMA's willingness to participate in public debates with the government is also evident in its September 1973 response to Mr. Toupin's successful effort to initiate a national study related to alternative payment schemes for physicians and in the government's attempts to negotiate new fee schedules with the Association.

The MHA/MHO's interactions with the Schreyer administration were less public in nature but were no less self-interested. In one of its few public documents, released on January 25, 1973, it responded to the White Paper by indicating that its member institutions were willing to support: the province's assumption that the demand on hospitals could be decreased by increasing the number of personal care home beds if member institutions were given administrative responsibility for these beds; the creation of a province-wide home care program if District Hospital/Health Centre boards were also allowed to administer this program; the "cautious development" of DHSDCs; and the province's removal of a legislative requirement that local ratepayers provide twenty percent of the capital financing for the construction/renovation of health

care facilities to ensure that planning for new facilities was based on the health care needs of a community, not on its ability to raise capital. While the Association sided with the MMA on the issue of fee-for-service as the principal means of physician remuneration, it also displayed its independence by recommending that the province's fee schedule be reviewed to provide more incentives for physicians to offer preventive services. Following the release of this paper, the MHA/MHO supported the development of Type I and II DHSDCs throughout the tenure of the Schreyer administration. As the discussion related to Question 7 below indicates, this support contributed to the establishment of ten DHSDCs by the end of 1977 with at least one in each rural region of the province.

Turning to government-opposition party interactions during the tenure of the Lyon administration, the discussion in Chapter 7 suggests that the NDP opposition was unable to mount much of a challenge to the government's formal health care policy agenda.[9] As a result, it based its criticisms of the Lyon administration on suggestions that the PC party had a hidden health care policy agenda and that, if it was allowed to serve a second term, it would realize this agenda by introducing user fees and allowing extra-billing for insured services delivery. While no evidence of such an agenda could be found in the research related to this study, the NDP was successful in promoting public suspicion that

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[9] Following Edward Schreyer's December 1978 resignation to become Canada's Governor General, the NDP was led by Howard Pawley.

the Lyon administration was composed of closet "neo-conservatives" intent on privatizing some features of health care delivery in the province. This success was likely due to the growth of debates in other nations, notably the United States and Britain, related to the reprivatization of health care services.[10]

With regard to provider pressure groups, the MMA was not combative in its relations with the Lyon administration due to this government's more traditional view of the scope and allocation of organizational authority in the province's delivery system. This more cooperative relationship is most evident in the ability of both parties to reach an agreement on fee schedules without a public disagreement. The Lyon administration's relationship with the MHO is more difficult to assess. During the first two years of its tenure this administration appears to have been suspicious of the MHO's motives. However, a more cooperative relationship also appears to have developed during its last two years in office.

Turning to government-provider pressure group relations during the Pawley administration, three distinct periods are evident. The first, which covered the period from 1981 to 1984, was dominated by the debate which led to the passage of *The Canada Health Act.* During this period the MMA was the most vocal critic of the Pawley administration's management of health care policy while the MHO limited its public position to suggestions that the

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[10] For a discussion of the growth of this debate and its content see Geoffrey R. Weller and Pranlal Manga, "The Push for Reprivatization of Health Care Services in Canada, Britain, and the United States," *Journal of Health Politics, Policy, and Law*, Vol. 8, No. 3 (1983): 495-518.

government should expand its District Health Centre program from the Type I to the Type II model. The second period followed the passage of *The Canada Health Act*. It was dominated by negotiations between the government and the MMA related to the implementation of a ban on extra-billing in exchange for a provincial guarantee of binding arbitration for the settlement of fee schedule disputes. While this period saw the successful implementation of a binding arbitration agreement by mid-1985, the relative calm in government-MMA relations that followed was replaced by renewed conflict in early 1987. The events of February and March 1987 signalled the beginning of a third period which continued to the end of the Pawley administration's tenure. As the discussion in Chapter 8 indicates, government-MMA relations during this period deteriorated to the point where the MMA viewed a public advertising campaign as the most effective way of communicating its policy position to the government.

While government-provider pressure group relations deteriorated under the Pawley administration, its relations with the PC opposition in the legislature improved somewhat. During the first two years of Pawley's tenure, Sterling Lyon remained as the PC party leader. During this period relations between the government and the opposition were acrimonious at best. However, when Gary Filmon replaced Lyon in early 1984, the PC party's approach became less ideological and more focussed on policy management. In particular it focussed on the government's lack of a formal plan to accommodate the concerns of physicians and hospitals related to the problem of services underfunding. When

the Pawley administration introduced its price and supply constraints program in 1986, PC opposition criticism expanded to include demands that the government respond to the negative impacts that the PCs argued this program was having on the health care needs of citizens.

In the context of Sabatier and Jenkins-Smith's advocacy coalition model, the discussion in Chapters 6, 7 and 8 indicates that, in addition to executive council actors, two coalitions of subsystem actors were active in Manitoba throughout The Era of Provincial Cost Control; the coalition represented by the PC party and the coalition of provider pressure groups led, for the most part, by the MMA. This finding lends support for the hypothesis pertaining to this question. Given the finding related to this question in Chapter 5, it can also be argued that this hypothesis is more generally supported by this study. Table 9.1 below summarizes the policy positions of the key actors in these coalitions during the time frame of the study in the context of the three dimensions of organizational rationalization defined by Carrothers et al.

Table 9.1: The Policy Positions of Key Advocacy Coalition Actors

Actor	Geographic Dimension	Decentralization Dimension	Rationalization Dimension
LP	Supported the District concept for institutional services and the regional concept, in the form of LHUs, for public health services.	Supported the delegation of provincial authority to municipal, voluntary and private providers.	Supported the joint venture approach to organizational arrangements in the delivery system.

PC	Supported the District concept for institutional services and the regional concept, in the form of LHUs, for public health services.	Supported the delegation of provincial authority to municipal, voluntary, and private providers.	Supported the joint venture approach to organizational arrangements in the delivery system.
NDP	Under Schreyer supported the District concept for the delivery of all services. Under Pawley supported regional public health services delivery and the delivery of institutional services at the district level.	Under Schreyer supported the devolution of provincial responsibilities to DHCs. Under Pawley supported the centralization of all non-institutional services under provincial authority.	Under Schreyer supported the integration of all professional providers in SUDS-based teams employed by a DHC. Under Pawley supported the integration of some providers based on the PCH concept.
MMA	Supported the District Hospital concept and while it accepted the Type I DHC concept, it did not support other types of geographic realignment.	Supported the devolution of provincial responsibility for medical care to Districts and private providers.	Support the traditional separation of provider roles established by the joint venture.
MHA/ MHO	Supported the District Hospital and DHC concept.	Supported the devolution of provincial responsibility for public health services to District Hospital Boards.	Supported the integration of institutional and community-based services delivery if these services were administered by its membership.

Question 3: What type of communications network did Manitoba's health care services delivery subsystem display and what kinds of normative assumptions were expressed by subsystem actors?

As the discussion in Chapter 6 suggests, a notable shift related to interest intermediation in Manitoba's health care services delivery subsystem occurred during the Schreyer administration's tenure. This shift is evident in the more

public nature of differences between provider pressure group and executive council actors during the 1970s which revolved around issues related to the province's legitimate planning and administrative roles. While provider pressure groups favoured the joint venture approach to the organizational arrangements for policy planning and services delivery, which involved a pressure pluralist type of policy network, cabinet members and the planners surrounding them assumed that a more corporatist type of network based would be preferable. The Schreyer administration's more corporatist approach flowed from two sources. First, the NDP's "social democratic" philosophy which Beaulieu summarizes as "...an activist approach to government, in which the 'instrumentality of government in the public interest' is used to create a more equitable distribution of the goods of the world and a greater equality in the human condition."[11] Second, the findings of the 1969 Task Force on the Costs of Health Care and the findings of the Hastings Report which gave provincial planners greater legitimacy in their promotion of organizational rationalization as an approach to delivery system cost control. The combination of these sources produced a consensus among government and bureaucratic actors that rational, as opposed to incremental, changes in Manitoba's health care policy framework were necessary and that the implementation of these changes could best be accomplished through the centralization of administrative authority for health

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[11] Paul Beaulieu, *Ed Schreyer, A Social Democrat in Power* (Winnipeg: Queenston House, 1977) 1. For a similar discussion of the Schreyer administration's philosophy see McAllister, *The Government of Edward Schreyer*, 4-6.

services delivery in the province's bureaucracy.

The key provider pressure groups in the province's policy subsystem responded differently to this shift. As the discussion in Question 2 indicates, the MHA/MHO took the more pragmatic path by opting to seek a consensus with the government that accommodated the interests of its membership. On the other hand, the MMA took a more ideological position. Esuke's discussion of pressure group interactions during the Schreyer administration argues that the MMA shifted from a non-partisan pressure group to a more partisan position based on its assumption that the NDP was "...a radical party which offered proposals that appeared to aim at the destruction of professional autonomy."[12] His findings also suggest that the MMA's willingness to cooperate with the Lyon administration was based on the association's perception that the PC party was more favourable to the organizational status quo.

Esuke's findings indicate that the normative assumptions displayed by executive council actors during the tenure of the Lyon administration were no different to those displayed by the Roblin/Weir administrations. In short, they appear to have been based on two general assumptions: that the scope and functions of health care policy should be limited to the delivery of public health services and institutional medical care; and that responsibility for the formation and implementation of policy change should be shared between the province and key provider pressure groups on a more or less equal basis. However, the

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[12] Esuke, *The Issues That Led to the Development of Medicare in Manitoba*, 75.

translation of these assumptions into policy practice was not attempted by the Lyon administration for two reasons. The first relates to changes in the province's administrative roles under the Schreyer administration. While responsibility for the funding and administration of services was shared between the province, local governments, and private providers during the 1960s, by the late 1970s, responsibility for all community-based services had been centralized at the provincial level. A return to the status quo of the1960s would have required the decentralization of a portion of this responsibility to local governments and their ratepayers who, having divested themselves of this responsibility in the early 1970s, were not prepared to take it back along with its attendant costs. The second relates to the changing national definition of "health care" as a policy area. As the discussion in Chapter 1 indicates, the 1970s saw growing support for resource allocation shifts from sickness care to what was assumed to be less expensive wellness care. This support indicated to planners in the Lyon administration that a return to the 1960s focus on the former would be neither efficient nor effective in the long run for the province's health care budget.

As the discussion in Question 1 above indicates, the return of the NDP to power in 1981 also brought a return of the normative assumptions displayed by the Schreyer administration. As a result, the Pawley administration pursued a corporatist type of intermediation with other subsystem actors while the MMA, returned to its more ideological pursuit of public support for resistance to policy

changes proposed by the government. During the 1980s the Association argued that health care policy should continue to focus on the delivery of medical care and that the formation and implementation of policy change should continue to be shared between the province and key provider pressure groups on a more or less equal basis.

In summary, this discussion lends support to the hypothesis related to this question. As a result, it is suggested here that the assumptions made by key subsystem actors related to their role in the policy subsystem and the nature of policy intermediation appear to have affected the scope and content of the public policy initiatives that were produced during the era of provincial capacity growth. Given a similar finding in Chapter 5 pertaining to this question, support for this hypothesis can also be seen during the entire time frame of this study. Table 9.2 below summarizes the findings pertaining to both of the eras surveyed in this study and notes the impact of each actor's belief system on their ability to participate in the development of consensus positions regarding policy change.

Table 9.2: Policy Core Beliefs Displayed by Key Subsystem Actors

Actor	Policy Core Belief	Impact on Participation
LP	The province's role was to facilitate public health through the maintenance and enforcement of reasonable standards for services delivery, the provision of support for the medically indigent, and the provision of grants to local government, voluntary, and private providers to assist them in providing services.	This position allowed the province to participate in effective compromises as long as it was able to accommodate growing provider resource demands.

PC	This party's position was similar to the position taken by the LP party except that it assumed that the province should be the principle planner of the delivery system's evolution within the joint venture arrangement for services delivery.	This position also allowed the province to participate in effective compromises as long as it was able to accommodate provider resource demands in its planning exercises.
NDP	The province's role was to ensure equal and equitable citizen access to health care services regardless of geographic location or economic status. In order to do this in the most efficient and effective fashion the province should be the principle planner and administrator of services delivery.	This position made compromises with local government, voluntary and private providers difficult as it required these actors to relinquish so or all of their established authority for services delivery.
MMA	The province's role was to maintain the professional independence of physicians while, at the same time, ensuring that their ability to provide clinical and institutional services was maintained or enhanced.	This position made compromises with the province difficult whenever a provincial initiative was perceived as negatively affecting professional independence.
MHA/ MHO	The province's role was to provide district boards with the funding support necessary to allow the district to provide as broad a range of institutional health care services that it could to citizens residing in the district.	This position made compromises with the province difficult if a provincial initiative was perceived as negatively affecting a district's established service delivery role.

POLICY IMPLEMENTATION

Question 4: What types of initiatives were actively pursued by executive council actors in Manitoba's health care delivery subsystem into the implementation stage?

As the discussion in Chapter 6 indicates, the Schreyer administration implemented four major initiatives during its tenure. The first was the administrative integration of insured health services programs. While this

initiative was started by the Roblin/Weir administration in response to federal policy changes related to insured health care services, its goals were extended following the1969 election to facilitate the NDP's response to:

> - Schreyer's 1969 election promise to reduce and, ultimately, eliminate the premium-based system of payment for insured services;
>
> - the MHA's demand that planning authority for hospitals be shifted from the Department of Health and Social Development to an agency that would be more responsive to the needs of its membership;
>
> - and the Hunt Commission's call for the centralized regulation of medical staff policies and the development of planned alternatives to hospital-based care.

In early 1973, plans for further enlargements in the Commission's planning and administrative authority were finalized for three additional reasons. First, preparations for the government's election platform included the extension of insured services funding to personal care homes and prescription drugs. Second, problems related to the coordination of policy implementation between the Department of Health, the White Paper Working Group, and the MHSC suggested the need for the centralization of implementation planning in a single agency. Third, by May 1973 it was apparent that the government needed to move forward with its plans in order to control rising health care costs. The latter reason is evident in a May memorandum from Ted Tulchinsky to Saul Miller regarding the province's preparations for an upcoming First Minister's Meeting on federal-provincial cost shared programs. It indicated that over the remainder of the decade hospital funding costs were expected to rise 13 percent per annum, medical care costs were expected to rise 7.2 percent per annum, and

combined provincial health care costs were expected to rise by 11 percent per annum.[13]

The second area where the Schreyer administration succeeded in its policy implementation plans related to the expansion of provincial authority for community-based health and social services through the regionalization of services delivery. In this area, the Roblin/Weir administration's intent to regionalize social services delivery was enlarged by the Schreyer administration to include all public health services. It is notable that while the Schreyer administration legitimized the 1973 transfer of authority for LHUs from the municipal sector to the province based on administrative effectiveness and efficiency rationales, the ultimate intent of this transfer was to facilitate the implementation of its DHSDC initiative by giving the province the authority to delegate responsibility for the delivery of public health and social services to these Centres which, in turn, would utilize the SUDS concept. The viability of the SUDS concept for the integrated delivery of public health and social services was tested in two pilot projects established in September 1972 in the Westman Region and September 1973 in the Eastman Region. These pilots involved the formation of four "Personal Services Teams" made up of social services and public/mental health professionals in Brandon and three districts in the Eastman region. While the evaluation of these pilots suggested that the SUDS concept

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[13] Manitoba, Memorandum from Dr. Ted Tulchinsky to The Hon. Saul Miller Re: First Minister's Meeting on Federal-Provincial Cost Shared Programs, May 21, 1973.

was effective[14], it was never broadly implemented in the province's health regions based on the assumption that their delivery system role, as opposed to their regional administrative role, was "temporary" and would be devolved to DHSDCs as they were established.

The implementation of the DHSDC concept was one of two unique contributions that the Schreyer administration made to provincial health care policy. While Chapters 3 and 4 indicate that the regional integration of rural services was studied by provincial planners during the 1950s implemented by the Roblin/Weir administrations in the 1960s in the area of social services and primary/secondary education, the Schreyer administration was the first to translate this concept into the delivery of health care services. In its effort to do so, it was confronted with a range of policy issues defined in Table 9.3 below which also summarizes the response to each of these issues following the 1975 passage of *The District Health and Social Services Act.* A notable feature of the NDP's post 1975 approach to these issues was its recognition that successful implementation would require an "evolutionary" approach to delivery system realignment rather than the more revolutionary approach suggested by the 1972 *White Paper on Health Policy.* The reasons for the adoption of this approach are elaborated below in the discussion related to Question 5 which suggests that

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[14] See Manitoba, *Brandon Evaluation Project* (unpublished report by the Division of Research, Planning and Program Development, Department of Health and Social Development, September 1973) and Manitoba, *Eastman Evaluation Project* by the same Division dated March 1974. For a published discussion of the Brandon Project see Donald E. Vernon, "Integrating Social Services in Manitoba," Public Welfare, Vol. 31, No. 3 (Summer 1973), 2-6.

provider pressure group responses to the government's first term policy goals forced the adoption of this more incremental approach during the government's second term.

Table 9.3: Issues and Responses Pertaining to DHSDC Development

Policy Issue	Implementation Response
Whether rural regionalization should be based on large geographic regions or be limited to established District Hospital service areas.	The use of Districts for services delivery combined with regional units responsible for the planning, funding, and administrative coordination of the services provided by the DHSDCs in a region.
Whether regional or district administrative units should be governed by elected boards or a mix of elected and appointed municipal and provincial representatives.	While elected or mixed boards were favoured, appointed boards at the District level were ultimately allowed to facilitate the conversion District Hospital Boards to Type I DHSDCs.
Whether public health and social services should be combined with institutional and/or clinical medical services under the administrative authority of a single board.	The combined approach was favoured so that DHSDCs could lessen the demand on institutional services by increasing local access to community-based services.
Whether regional or district boards should be funded by a global, block or line budgetary system by the province.	Global budgeting was favoured but due to concerns related to the maintenance of established lines of funding for institutional services block budgeting was ultimately allowed.
Whether residents in a region or district should directly contribute to the operational funding and/or capital costs related to DHSDCs.	While local funding was allowed in the 1975 Act, and capital funding was required, municipal concerns related to a return to operational funding responsibility and/or demands for capital contributions for the conversion to DHSDC status stalled the implementation process on matters related to this issue.

The fourth major initiative implemented by the Schreyer administration involved the realignment of Winnipeg's institutional capacity. The discussion in Chapters 3 and 4 indicates that the Roblin/Weir administration began this

process due to the Campbell administration's focus on rural capacity development which had failed to anticipate growth in the number of elderly persons in the City and the development of suburban areas. In the 1960s, provincial planners responded by: relocating new facilities for the Concordia, Grace, and Victoria General Hospitals in suburban Winnipeg; constructing the D.A. Stewart Rehabilitation Hospital on the Manitoba Medical Centre site to improve the City's extended care capacity; and expanding the number of long-term care facilities from twenty-nine in 1964 (with a combined rated bed capacity of 1883), to thirty-five in 1969 (with a combined rated bed capacity of 2520). Through this process the province effectively realigned the balance between rural Manitoba's total capacity and that of Winnipeg to better reflect the province's post-War demographic shift to urban areas.[15] As a result, when the Schreyer administration entered office the balance between rural and urban capacity was not a major policy issue. However, demand on the City's hospitals coupled with the problems related to the administrative arrangements for access to specialized services in the City's teaching hospitals, became a major policy issue in the early 1970s.

As the discussion in Chapter 6 indicates, the Schreyer administration's

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[15] Table 4.5 indicates that the number of acute care beds dropped by 8.1percent between 1959 and 1969 leaving Winnipeg with 6.8 beds per thousand population relative to 5.8 in rural areas. Given the province's long-standing assumption that approximately ten per cent of Winnipeg's beds would be utilized by rural patients, this brought the City close to parity with rural areas. The goal of parity can also be seen in Table 4.6 which indicates that LTC capacity between 1959 and 1969 increased to 4.8 beds per thousand population in Winnipeg equalling the rate in rural areas of the province.

establishment of the Hunt Commission and its response to the Commission's findings accelerated the realignments initiated in the 1960s which, in turn, shaped the NDP's health care policy agenda in a number of important ways. The government's initial response to this Commission came in April 1971 through its decision to include long-term care services in the province's insured services program. This decision was premised on the assumption that improvements in the access to, and quality of, long-term care institutions would contain demands for growth in Winnipeg's acute care capacity and facilitate the realignment of services delivery in rural Manitoba by allowing the conversion of existing acute care beds to long-term care beds to take place under the administrative umbrella of the MHSC. This was followed by the 1971 decision to move forward on the redevelopment of the Manitoba Medical Centre site which had been initiated in the mid-1960s by the Roblin administration. While the Hunt Commission's findings related to the need to improve Winnipeg's extended and specialized care capacity contributed to this decision, a federal promise of additional funding support through its Health Resources Fund in November 1970 also appears to have been an important motivator.[16] The third decision resulting from the Hunt Commission's findings related to the November 1973 establishment of the MHSC's Medical Appointments Review Committee. This decision opened the granting of staff privileges in Winnipeg's teaching hospitals

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[16] It is noteworthy that in late 1968 the federal government reduced its commitment to this project in what appears to have been an effort to force Manitoba to co-operate with it on the implementation of *The Medical Care Act*. See Manitoba, "Federal Health Intentions Disappointing, Says Johnson," Public Information Branch, November 8, 1968.

to the City's physicians and, like the 1971 decision related to long-term care facilities, was premised on the need to improve access to services. The final decision has its base in a long-standing commitment by Saul Miller to the residents of north Winnipeg. When Mr. Miller was the Mayor of West Kildonan in the 1960s he initiated discussions with the MHC related to the construction of a hospital in the north eastern part of the City. His 1974 decision to begin planning the construction of Seven Oaks General Hospital fulfilled his commitment to an area of the City that had consistently elected CCF/NDP MLAs since 1949.[17] While the discussion in Question 7 below indicates that the decision to build Seven Oaks and redevelop the HSC did not have a substantial impact on Winnipeg's acute care capacity during the tenure of the Schreyer administration, due in large part to the time frame needed for construction, it also indicates that the decision to insure long-term care services had a more significant impact on the province's capacity than was originally anticipated.

The Lyon administration's contribution to policy implementation in Manitoba relates to the extension of three initiatives developed by the Schreyer administration. The first involved the ongoing establishment of Type I DHC's in rural Manitoba. As the discussion related to Question 7 indicates, the Lyon administration's contribution was, on the one hand, to add a further twelve Type I

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[17] Manitoba, *Statement of Votes*, (Winnipeg: Chief Electoral Officer of Manitoba, various years). A review of provincial election results indicates that in the 1949 and 1953 elections the constituency of Kildonan-Transcona elected CCF MLAs. In the 1958, 1959, 1962, 1966, 1969, and 1973 elections the constituencies of Kildonan and Seven Oaks elected CCF/NDP MLAs with the exception of the 1962 election when Kildonan elected a PC MLA by a margin of four votes over the NDP candidate.

DHCs to the five established during the Schreyer administration and, on the other, to halt the development of Type II and III Centres. The second initiative involved extending the province's insured services program to ambulatory and out-patient care. The Lyon administration's contribution in this area was to allow hospitals and private providers greater flexibility in the planning and utilization of resources for their out-patient services capacity. The third initiative relates to the continued realignment of Winnipeg's institutional capacity. In this area the Lyon administration continued the redevelopment of the HSC and was responsible for the completion of the construction of Seven Oaks General Hospital.

The discussion in Chapter 8 indicates that two major cost control initiatives reached the implementation stage under the Pawley administration. The first was the government's implementation of a ban on extra-billing by physicians through the 1985 passage of amendments to the *Health Services Insurance Act*. As noted in Chapter 8, this ban was motivated by provisions in *The Canada Health Act* which allowed the federal government to deduct a portion of its EPF transfers equal to the amount extra-billed by physicians in a province. The second was the price and supply constraint program which began in April 1986. This program placed a two percent limit on increases in facilities budgets. It was extended in April of the following year with the announcement that unapproved facilities deficits would no longer be covered by the MHSC.

In summary, the findings related to this question are similar to those contained in Chapter 5. As a result, the study hypothesis pertaining to this

question does not appear to be supported. Further, while governments in Manitoba employed formal and informal price and supply constraints programs throughout this study's time frame, they do not appear to have preferred programs of this nature due to the political conflicts they generated among provider pressure groups in the province's health care delivery subsystem. Table 9.4 below summarizes each administration's approach to cost containment, along with the general response of pressure group actors to major policy initiatives. It supports this study's assumption that formal price and supply constraints were utilized only when efforts to rationalize the organizational arrangements for services delivery were resisted by provider pressure groups.

Table 9.4: The Cost Control Policies of Governments in Manitoba

Government	Formal Cost Control Strategies	Policy Subsystem Responses
Campbell (LP) 1948 to 1958.	The primary strategy was cost-shifting to local governments, voluntary, and private providers for public health and institutional services. Rationalization was considered in 1952 but was not implemented. Formal price and supply constraints were employed following the 1953 election in the form of a freeze on facilities construction, which was lifted in 1956.	These strategies did not produce high levels of conflict. The promise of future increases in federal funding after 1955 appears to have played a role in minimizing conflict.
Roblin (PC) 1958 to 1968	While cost-shifting remained the primary cost control strategy, this administration considered organizational rationalization but opted to introduce formal price and supply constraints on hospital budgets in 1962. This program remained in place throughout the tenure of this administration.	These strategies did not produce high levels of conflict,. due, in part, to the influx of federal funds for insured hospital services

Weir (PC) 1968 to 1969	This administration continued the Roblin administration's program of cost shifting combined with formal price and supply constraints.	While conflict increased during this administration's tenure, this was largely due to MMA resistance to the federal medical care insurance program.
Schreyer (NDP) 1969 to 1977	The primary strategy was organizational rationalization through the creation of DHSDCs combined with price and supply constraints on physician's fee schedules. When the implementation of DHSDCs was slowed, this administration turned to formal price and supply constraints on hospital budgets in 1976.	The primary strategy produced conflict. However, this conflict was based on deeper issues related to the provincial assumptions pertaining to its authority in the subsystem. Further, while the MHO was resistive to budget constraints, it did not publically engage the government on this issue.
Lyon (PC) 1977 to 1981	The initial strategy was price and supply constraints through a freeze on all budgetary increases. This freeze was lifted during the administration's second year and was replaced by a focus on organizational rationalization.	These strategies did not produce high levels of conflict in the province's policy subsystem.
Pawley (NDP) 1981 to 1988	This administration combined price and supply constraints with planning for organizational rationalization. In 1986 formal price and supply constraints on institutional providers were introduced. The 1988 election precluded the announcement of an implementation strategy for planned organizational realignments.	While the price and supply constraints program contributed to policy community conflict, the underlying reasons for this conflict were similar to those that affected subsystem intermediation during the Schreyer administration.

Question 5: Were pressure group and/or opposition party barriers to the implementation of these initiatives encountered by executive council actors?

While three of the four initiatives that the Schreyer administration implemented were not openly resisted by pressure group actors in the health care delivery subsystem, the implementation of DHSDCs was targeted by these actors. As noted in Question 3 above, the MHA/MHO forced the government to adopt an "evolutionary approach" to the conversion of District Hospital boards to Type I DHSDC boards. This, in turn, forced the government into a longer than anticipated time frame for the establishment of these Centres and required it to provide incentives for conversion in the form of commitments to increase long-term care capacity in a district and eliminate local funding requirements. While these changes impacted negatively on government policy and budgetary planning, the discussion in Chapter 6 indicates that the MHO's ongoing goal was to find a compromise that allowed the government to implement its DHSDC program while, at the same time, enhancing the delivery system roles of its member institutions.

While the MHO acknowledged the government's authority to realign organizational arrangements in the province's delivery system, the MMA refused to allow that the government was anything more than an equal partner in the delivery of services. With regard to DHSDCs this was due to the MMA's concern that the Schreyer administration was intent on diminishing the autonomy of its members through the pursuit of a salaried remuneration system for physicians in

the context of DHSDC development. However, the Association's concerns are also evident its late 1973 and early 1974 responses to the breakdown in fee schedule negotiations noted in Chapter 6. When the Association openly challenged the government in its December 5, 1973 letter, the Schreyer administration's response was to suggest that the Association's ultimate goal was to force the province to give it "...a role in policy matters which is not available to any other group of citizens in society." To some degree the Association was successful as, in early 1974, the government agreed to establish a joint MHSC - MMA Consultative Committee which the 1974 MHSC *Annual Report* indicates was intended to "...develop an ongoing dialogue and process of consultation between the Association and the Commission in order to promote mutual co-operation and understanding."[18] Following the March formation of this Committee, the co-operation and understanding it was intended to promote lasted until early 1976 when Mr. Desjardins unilaterally imposed a limit on fee schedule increases. While the MMA did not react publically at the time, this event signalled the return of open conflict in the province's health care delivery policy subsystem.

During the tenure of the Lyon administration, no observable barriers were erected to its limited policy agenda. While the discussion in Chapter 8 indicates that the election of the Pawley administration saw a return to heightened conflict among key policy actors, no evidence could be found pertaining to the erection

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[18] Manitoba Health Services Commission, *1974 Annual Report* (Winnipeg, MHSC, 1975), 11.

of specific barriers to its policy agenda. This Chapter does, however, indicate that the MMA was intent on eroding the legitimacy of the government. While it is not possible to assess the specific contribution the MMA's campaign made in this area, Dyck notes that by 1988 the Pawley administration's popularity had "plummeted" to a new low.[19] This was reflected in the decision of a NDP backbench MLA to vote against the government's budget bill which precipitated the 1988 election campaign.

While opposition party barriers to the cost control programs implemented by the administrations surveyed in Chapters 6, 7, and 8 were largely limited to an ongoing effort to erode the legitimacy of the governing party's policies, these chapters also indicate that both of the key provider pressure groups in Manitoba's policy subsystem played a role in the process of policy implementation during The Era of Provincial Cost Control. As result, the hypothesis related to this question appears to be supported. In short, the MMA and the MHO were able to challenge the organizational realignments planned by NDP administrations during this Era by converting "top-down" provincial plans into "bottom-up" political debates. The MMA's approach suggested that any increase in the province's authority which negatively affected the professional autonomy of physician's would damage their ability to provide adequate patient care which, in turn, would result in physicians leaving the province. Given that the less affluent eastern, interlake and northern regions of the province, which

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[19] Dyck, "Manitoba,", 416.

generally voted NDP, had always experienced physician retention problems, the Schreyer administration was forced to limit its plans related to DHSDCs to the Type I model. During the Pawley administration's tenure government-MMA relations deteriorated to the point where the MMA found it necessary to undertake a public media campaign opposing the government. This administration's failure to anticipate the willingness of the MMA to openly challenge its legitimacy appears to have contributed to its reluctance to announce planned delivery system realignments after its 1986 re-election.

The MHO's approach, while less confrontational than that of the MMA, was nevertheless successful for similar reasons. It argued that the Schreyer administration's plan to convert Hospital Districts to DHSDC's would, in addition to reducing access to institutional care, have negative economic impacts on communities due to the loss of provider incomes from a local economy. As a result, the MHO argued that rather than a "top down" replacement of District Hospital Boards, the province should take a "bottom up" approach to implementation. This approach, which evolved during Schreyer's second term, contained two steps; the initial conversion of existing Hospital Districts to Type I DHCs followed by the later conversion of Type I centres to Type II with the transfer of community-based health services administration to the Centre's board. While it lessened the negative economic impacts of conversion on rural communities, this approach required the province to construct long-term care beds prior to the realignment of DHC capacity to conform with the MHSC's 6/20

model. This had the effect of turning a program intended to reduce the province's hospital bed capacity into a program that actually increased the province's overall institutional bed capacity.

At a more general level, the MMA and MHO were also successful in forcing NDP governments to take a generally cautious approach to delivery system realignments. As the discussion in Chapter 1 suggests, the expansionary paradigm that evolved during The Era of Provincial Capacity Growth was premised on the assumption that delivery system capacity growth was the moral and political equivalent of "doing the right thing". The Schreyer administration employed this premise to its political benefit in its 1969 and 1973 electoral platforms. The Pawley administration also drew on this assumption in its 1981 and 1986 election campaigns by suggesting that a PC government would contain provincial health care costs by privatizing services. When both of these administrations then attempted to implement their own cost controls, public support for them declined.

As the hypothesis related to this question is also supported in Chapter 5, it can be argued that, during the time frame of this study, executive council actors in Manitoba were unable to fully implement their cost control initiatives when they failed to anticipate and develop strategies to overcome opposition party and/or pressure group barriers.

Question 6: Were bureaucratic barriers to these initiatives encountered by executive council actors?

While no bureaucratic barriers to the implementation of the Schreyer administration's initiatives were observed, it is evident that this administration's inability to implement its DHSDC initiative was, in part, due to the fragmented nature of its implementation strategy. This created uncertainty among bureaucratic actors as to the government's intent and policy direction which can be seen in Mr. Schneider's February 1973 discussions with Dr. Tulchinsky noted in Chapter 6. This uncertainty is also evident in the January 7, 1974 letter to Premier Schreyer from the MHO Board expressing concerns that the division of implementation responsibility between the Department, the White Paper Working Group, and the MHSC was "...both confusing and frustrating to us and our members...". While the Schreyer administration did centralize responsibility for DHSDC implementation within the MHSC during its second term, uncertainty among key bureaucratic actors remained. For example, the recommendations contained in the MHSC's March 1977 study on Primary Care Facilities contain a call for cabinet clarification of the planning and implementation authority of the Commission relative to that of the Department of Health and Social Development in the area of primary health care.

While no explicit barriers to implementation were observed related to the tenure of the Lyon and Pawley administrations, the discussion in Chapter 7 indicates that the MHSC was not supportive of allowing the MHO's membership to gain greater administrative authority in the province's health care delivery

system. The Commission appears to have been successful in this regard because, while the Lyon administration proceeded with the establishment of new Type I centres, it did not allow the creation of Type II centres during its tenure. As the discussion in Chapter 8 indicates, the same behaviour was displayed by the Pawley administration throughout its tenure.

These findings appear to support the hypothesis related to this question. However, the lack of evidence offered here suggests that further study is necessary before a definitive response can be offered. Further, it is notable that during the period surveyed in Chapter's 6,7, and 8, "guidance instruments" that Sabatier and Jenkins-Smith identify as important influences on bureaucratic behaviour appear to have been utilized.[20] The utilization of direct instruments, such as Departmental reorganizations, to facilitate the implementation of policy initiatives, can be seen in the behaviour of all three of the administrations covered by these chapters. The use of indirect instruments, such as changes in the appointees on the MHSC's Board and the Commission's legislative authority, is also noted in these chapters. However, the linkage between the use of these instruments and their impact on minimizing the development of bureaucratic barriers to policy change requires additional research attention.

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[20] Sabatier and Jenkins-Smith, *Policy Change and Learning*, 226-27.

POLICY IMPACTS

As noted in the introduction to this chapter, the assessment contained in this section summarizes the findings related to Chapters 6, 7, and 8 in the context of Question 7 through 9 defined in Chapter 2. In addition, it summarizes the cumulative impacts of provincial policy behaviour across the entire time frame of this study.

Question 7: How did implemented cost control initiatives alter the functional and geographic scope of Manitoba's health care delivery system?

With regard to changes in the functional scope of Manitoba's health care delivery system, Table 9.5 below indicates that a number of substantive changes occurred during The Era of Provincial Capacity Growth. The most notable were: the centralization of administrative authority for public health services delivery at the provincial level of government; the addition of insured medical care, home care, and pharmacare programs; and the expansion of the province's insured services programs in the 1970s to include personal care homes and in the 1980s to include a range of out-patient and ambulatory services. In short, the findings related to the first set of indicators pertaining to this question suggest that the null hypothesis used to test this question is not supported based on the study findings.

Table 9.5: Changes in Functional Scope from 1969 to 1988

Functional Area	Status in 1969	Status in 1988
Public Health Services	Provincial roles included the funding and delivery of preventive and northern services, the shared-cost funding of LHU services, the delivery of public health nursing to areas not included in a LHU, and the delivery of care services to the elderly and infirmed.	All services are now centralized under provincial administrative authority and are delivered through the province's health and social services regions. In addition insured home care and pharmacare programs are added in the 1970s
Acute Care Hospital Facilities	The centralized regulation, and funding of hospital services through the province's hospital insurance program.	Insured services programs related to these facilities are expanded in 1980 in the areas of ambulatory and out-patient care.
Institutions for the Aged and Infirmed	The regulation of private and voluntary facilities coupled with increased planning control through the provision of construction grants to voluntary elderly persons housing projects.	An insured services program related to these facilities is added in 1973.
Services Provided by Physicians	The centralized funding of physician's services through the province's medical care insurance program.	Extra-billing is banned following the passage of amendments to *The Health Services Insurance Act* in 1985.

The second set of indicators utilized in this question focus on changes in the geographic scope of public health services, hospitals, and long-term care facilities. The findings in Chapters 6, 7, and 8 indicate that the geographic scope of public health services and the number of rural communities with hospitals remained largely unchanged. However, there were some changes in

the capacity of hospitals. These are described in Table 9.6 below.

Table 9.6: Hospital Growth in Manitoba from 1969 to 1989

Region	1968/69	1988/89	% Increase
Central: # Communities with Facilities	13	13	0
: Rated Bed Capacity	474	452	-4.6
Eastman: # Communities with Facilities	7	7	0
: Rated Bed Capacity	226	202	-10.6
Interlake: # Communities with Facilities	7	7	0
: Rated Bed Capacity	199	197	-1
Norman: # Communities with Facilities	7	8	14.3
: Rated Bed Capacity	344	357	3.8
Parkland: # Communities with Facilities	9	8	-11.1
: Rated Bed Capacity	423	363	-14.2
Westman: #Communities with Facilities	27	26	-3.7
: Rated Bed Capacity	941	894	-5
Total Rural Capacity	2607	2465	-5.5
Total Rural Population (in thousands)	452	496.7	9.9
Rural Beds Per 1000 population	**5.8**	**5**	**-13.8**
Winnipeg: # of Facilities	11	10	-9.1
Rated Bed Capacity	3514	3689	-5
Total Winnipeg Population (in thousands)	526.7	628.7	19.4
Winnipeg Beds Per 1000 population	**6.7**	**5.9**	**-11.9**

This table indicates that the average overall decline in the province's hospital capacity, measured in beds per thousand population, was 12.9 percent during this period with rural regions of the province experiencing a slightly higher rate of decline than Winnipeg. Table D.17 in Appendix D indicates that, in addition to this capacity decline, there were also changes in designation of rural

facilities. This table shows that 45 DHCs were established during The Era of Provincial Cost Control largely through the conversion of existing hospital districts. In total, forty of these DHCs were based on the Type I model and five were based on the Type III model. Turning to long-term care facilities, Table 9.7 below indicates that overall growth in this area, measured in beds per thousand population, averaged 55.8 percent.

Table 9.7: Long-Term Care Facility Growth in Manitoba from 1969 to 1989

Region	**1968/69**	**1988/89**	**% Increase**
Central: # of Communities with Facilities	7	12	71.4
: Rated Bed Capacity	400	734	83.5
Eastman: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	196	433	120.9
Interlake: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	338	520	53.8
Norman: # of Communities with Facilities	1	2	100
: Rated Bed Capacity	203	130	-36
Parkland: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	137	405	195.6
Westman: # of Communities with Facilities	12	22	83.3
: Rated Bed Capacity	893	1520	70.2
Total Rural Capacity	2167	3742	72.7
Total Rural Population (in thousands)	452	496.7	9.9
Rural Beds Per 1000 population	**4.8**	**7.5**	**56.3**
Winnipeg: # of Facilities	35	33	-5.7
Rated Bed Capacity	2520	4594	82.3
Total Winnipeg Population (in thousands)	526.7	628.7	19.4
Winnipeg Beds Per 1000 population	**4.7**	**7.3**	**55.3**

In summary, the null hypothesis pertaining to this question was not supported during The Era of Provincial Cost Control.

Table 9.8: Changes in Functional Scope between 1948 and 1988

Functional Area	Status in 1948	Status in 1988
Public Health Services	The shared-cost funding of LHU services with local governments and the direct delivery of public health nursing to municipalities and unorganized territories not included in a LHU.	Full administrative and funding responsibility for the delivery of all public health services outside of the core area of Winnipeg through the province's Health and Social Services Regions.
Acute Care Hospital Facilities	Delivery system planning and the provision of hospital construction grants as well as grants for up to three months for the care for indigents.	The planning and administration of the insured hospital services program which included planning, regulatory, and budgetary control over the services delivered by Hospital Districts and DHCs.
Institutions for the Aged and Infirm	Regulation of the construction of private and voluntary facilities.	The planning and administration of the insured long-term care program which included planning, regulatory, and budgetary control over the services delivered by DHCs and voluntary/private providers.
Services Provided by Physicians	The shared -cost funding, with local governments, of the services provided by a Medical Care Districts.	Administration of the medical care insurance program coupled with regulatory authority for the setting of fee schedules and the standards for hospital admitting privileges.

Turning to this study's cumulative findings, the summary offered in Table 9.8 above also indicates that the study hypothesis was not supported when changes during both of the eras surveyed for this study are taken into account. This Table shows that the province's roles related to delivery system planning, funding, and administration expanded in all four of the functional areas of interest to this study. With regard to the geographic scope of public health services, the findings also do not support the study hypothesis as the scope of services delivery in this area expanded from ten LHUs in 1948, serving approximately fifty percent of the province's population, to a province-wide delivery system serving all Manitobans outside of the boundaries of the City of Winnipeg's Health Department. Turning to changes in the geographic scope and capacity of hospitals during the entire time frame of the study, Table 9.9 below, which is based on Table D.15 in Appendix D, indicates that the number of rural communities containing a hospital increased by an average of 121.2 percent. It also indicates that the overall average capacity increase in rural Manitoba, measured in beds per thousand population, was 94.1 percent. However, Winnipeg experienced a 3.1 percent drop in beds per thousand population during this period due, in part, to a 93.4 percent increase in the City's population. In short, this table suggests that the study hypothesis was supported in the case of Winnipeg but was not supported in the case of rural regions due to the significant increases in the total bed capacity and the number of communities with facilities.

Table 9.9: Hospital Growth in Manitoba from 1949 to 1989

Region	1948/49	1988/89	% Increase
Central: # of Communities with Facilities	7	13	85.7
: Rated Bed Capacity	182	452	148.4
Eastman: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	76	202	165.8
Interlake: # of Communities with Facilities	4	7	75
: Rated Bed Capacity	118	197	66.9
Norman: # of Communities with Facilities	2	8	300
: Rated Bed Capacity	131	357	172.5
Parkland: # of Communities with Facilities	6	8	33.3
: Rated Bed Capacity	178	363	103.9
Westman:# of Communities with Facilities	13	26	100
: Rated Bed Capacity	407	894	119.7
Total Rural Capacity	1092	2636	129.5
Total Rural Population (in thousands)	427	496.7	16.3
Rural Beds Per 1000 population	**2.6**	**5**	**94.1**
Winnipeg: # of Facilities	9	10	11.1
Rated Bed Capacity	1967	3689	87.5
Total Winnipeg Population (in thousands)	325	628.7	93.4
Winnipeg Beds Per 1000 population	**6.1**	**5.9**	**-3.1**

With regard to the cumulative findings pertaining to long-term care facilities, Table 9.10 below, which is based on Table D.16 in Appendix D, indicates that the Winnipeg region and rural regions both experienced capacity increases during the three decade period for which data is available. Once again, the most significant increases occurred in rural regions of the province.

Table 9.10: Long-Term Care Facility Growth in Manitoba from 1959 to 1989

Region	1958/59	1988/89	% Increase
Central: # of Communities with Facilities	5	12	140
: Rated Bed Capacity	218	734	236.7
Eastman: # of Communities with Facilities	3	7	133.3
: Rated Bed Capacity	94	433	360.6
Interlake: # of Communities with Facilities	2	7	250
: Rated Bed Capacity	240	520	116.7
Norman: # of Communities with Facilities	1	2	100
: Rated Bed Capacity	96	130	35.4
Parkland: # of Communities with Facilities	2	7	250
: Rated Bed Capacity	54	405	650
Westman:# of Communities with Facilities	9	22	144.4
: Rated Bed Capacity	563	1520	170
Total Rural Capacity	1265	3742	261.6
Total Rural Population (in thousands)	427	496.7	16.3
Rural Beds Per 1000 population	**3**	**7.5**	**154.3**
Winnipeg: # of Facilities		33	
Rated Bed Capacity	1883	4594	144
Total Winnipeg Population (in thousands)	325	628.7	93.4
Winnipeg Beds Per 1000 population	**5.8**	**7.3**	**26.1**

In short, this Table indicates that the study hypothesis pertaining to this question was not supported given a total average capacity increase, measured in beds per thousand population, of 76.9 percent.[21]

[21] It is notable that hospital capacity growth in Winnipeg and rural regions varied with changes in the province's governing party. While LP and PC governments oversaw consistent capacity growth in rural regions relative to the City, NDP governments oversaw capacity declines in these regions while maintaining growth in Winnipeg's capacity.

Question 8: How did implemented cost control initiatives alter administrative authority in Manitoba's health care delivery system?

Like question 7, this question also utilizes two sets of indicators. The first set pertain to realignments in the planning and administrative authority of key actors in Manitoba's delivery system while the second set pertain to shifts in provincial budget expenditures. With regard to realignments in the authority of key actors during The Era of Provincial Cost Control, two are particularly important. On the one hand, the centralization of administrative responsibility for public health services at the provincial level in the early 1970s, combined with the deconcentration of this responsibility to the province's health and social services regions, was a logical realignment as it allowed the province to reduce administrative and service delivery fragmentation by linking public health and social services delivery. It is notable that this realignment was not opposed by municipal governments who welcomed the relief from services funding afforded by the province's takeover of their share of the responsibility for services delivery. On the other hand, the implementation of medical care insurance in 1969 and the expansion of insured programs in the 1970s expanded the province's administrative authority related to the funding and administration of medical care. However, the distribution of authority for the delivery of medical care services remained consistent with the joint venture organizational arrangements established during The Era of Provincial Capacity Growth. The discussion in the previous section of this chapter indicates that while the Schreyer and Pawley administrations attempted to realign these arrangements,

to diminish the resource utilization autonomy of key health care provider groups in the delivery system, they were not particularly successful. With regard to the tenure of the Schreyer, as well as the Lyon administration, this point appears to be supported by the detailed economic analysis of insured health services expenditures prepared for the province in 1985.[22] This study's findings indicate that between 1971 and 1983, MHSC budgetary increases averaged 13 percent. With regard to the growth in expenditures for public general hospitals it observed that: [23]

> - while Manitoba's per capita spending on institutional care was 5 percent below the national average in 1971, it was 10 per cent higher than the national average by 1982;
>
> - in non-teaching hospitals the total per capita cost after adjusting for inflation rose 62.3 percent between 1971 and 1983 compared to a national average increase of 35.7 percent for the same period;
>
> - in teaching hospitals the total per capita cost after adjusting for inflation rose 114 percent between 1971 and 1983 compared to a national average increase of 53.4 percent for the same period;
>
> - in the 1982-83 fiscal year Manitoba's hospital system alone cost as much on a per capita basis as the combined hospital and PCH programs provided by the other provinces.

This study also offers a number of observations related to the province's physician community. It indicates that, while there were no significant differences in the gross revenues generated by full-time practising physicians in Manitoba between 1971 and 1983, MHSC expenditures pertaining to the

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[22] Manitoba, *Manitoba and Medicare 1971 To the Present*, i.

[23] Ibid., iv - v.

services they provided increased as a result of a 25 percent increase in the practising physician-to-population ratio. Further, while the rural physician-to-population ratio remained largely unchanged over the twelve years of this study, this ratio increased in the Winnipeg region by 56 percent among general practitioners and 22 per cent among specialists.[24]

The ability of medical care providers to maintain their share of the province's health care budget during The Era of Provincial Cost Control is evident in Table 9.11 below which indicates that the null hypothesis pertaining to this question was not supported.

Table 9.11: Provincial Budgetary Changes from 1969 to 1989

Budget Line	1968-69	1988-89
Total Provincial Budgetary Expenditures	357.3 million	4,484.3 million
Provincial Health Care Expenditures	43.9 million	934.9 million
Health Care Expenditures as % of Total	12.3%	20.84%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	2.08%	.29%
Psychiatric Services Division	29.46%	4.29%
Public Health Services Division	19.57%	9.4%
MHSC/Other Hospital Services	48.89%	86.01%
Totals	100%	100%

Turning to the cumulative trend related to the first set of indicators, the findings do not differ from those pertaining to The Era of Provincial Cost Control. In short, while the province's authority for public health services delivery and the

[24] Ibid., i.

administration of insured services expanded, the allocation of authority for the delivery of medical care services remained fragmented. As a result, the null hypothesis was not supported. This hypothesis was also not supported in the context of the second set of indicators. Table 9.12 below, which is based on Table D.18 in Appendix D, indicates that provincial budgetary shifted during the study's time frame. This shift reflects the growth in hospital capacity and the implementation and subsequent expansion of insured medical care programs in Manitoba. While this growth greatly improved the ability of citizens to access health care services in the province, it also improved the ability of health care providers to access public funds for the delivery of these services.

Table 9.12: Provincial Budgetary Changes from 1949 to 1989 [25]

Budget Line	1948-49	1988-89
Total Provincial Budgetary Expenditures	37.5 million	4484.3 million
Provincial Health Care Expenditures	3.7 million	934.9 million
Health Care Expenditures as % of Total	10%	20.84%
Health Dept. Divisional Expenditures as a % of the Total Health Care Expenditures		
Executive Division	4.72%	.29%
Psychiatric Services Division	48.03%	4.29%
Public Health Services Division	32.44%	9.4%
MHSC/Other Hospital Services	14.81%	86.01%
Totals	100%	100%

[25] The budget amounts detailed in this Table only include budget line expenditures directly related to the health care services components of the Department of Health's operations. Service functions pertaining to social services, community development and corrections are not included in this calculation.

Question 9: How did implemented cost control initiatives alter functional roles in Manitoba's health care delivery system?

The assessment of this question employs the nine category list of functional roles that Mills et al. suggest are frequently targeted by health care policy changes. As Table 9.13 below indicates, the hypothesis related to this question was also not supported given that the province's administrative roles expanded during The Era of Provincial Cost Control.

Table 9.13: Changes in the Province's Functional Roles from 1969 to 1988

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	Increased with the centralization of delegated legislative authority for public health services and the implementation and expansion of insured services programs. Also increased with regard to physicians through the province's ban on physician extra-billing motivated by the passage of *The Canada Health Act* in 1984.
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased with the federal government with the implementation of medical care insurance, the negotiations leading to the April 1, 1977 implementation of the EPF Act, and the events surrounding the 1984 implementation *The Canada Health Act.*
Revenue-Raising Functions related to the funding of services.	Increased in areas related to general revenues due to the elimination of health insurance premiums.
Planning and Resource Allocation Functions related to services delivery.	Increased in the context of the NDP's efforts to plan and implement organizational realignments.
Policy-Making Functions related to the licencing of and standards for services providers.	Increased in the area of long-term care, through expansion of funding and regulatory authority, as well as with local facility boards due to the passage of *The District Health and Social Services Act*

Inter-Agency coordinative Functions related to services delivery.	No substantive change. However, efforts were made to broaden participation in health care delivery subsystem debates during the Pawley administration's tenure, in particular, with regard to nursing professionals.
Regulatory Functions related to the resource utilization practices of professional providers.	Increased with institutional providers though expansion of the MHSC's planning and administrative roles and with physicians due to the need to negotiate fee schedules and the imposition of the ban on provider extra-billing through amendments to *The Health Services Insurance Act*.
Training Functions Related to the education and placement of Professional Providers.	No substantive change.
Management Functions related to the day-to-day administration of services delivery.	Increased in the area of public health services due to the creation of the province's regional delivery system. Also increased due to provincial price and supply constraint programs and the ban on physician extra-billing.

The assessment of cumulative changes in this area also does not support this question's null hypothesis. This assessment is summarized in Table 9.14 below.

Table 9.14: The Province's Impact on Functional Roles from 1948 to 1988

Provincial Function	Type/Nature of Change
Legislative functions pertaining to governance of the delivery system.	Increased throughout the study's time frame as the province utilized its legislative powers to expand its regulatory and administrative roles
Inter-Sectoral Collaborative Functions with other jurisdictions to facilitate services funding and delivery.	Increased with the introduction of national programs for insured hospital and medical care which forced the province into an ongoing debate with the federal government related to insured services funding.

Revenue-Rasing Functions related to the funding of services.	Increased due to the introduction of insured services, which made the province responsible for the funding and administration of these services.
Planning and Resource Allocation Functions related to services delivery.	Increased due to the introduction of the National Health Grants program and further increased with the introduction of insured services programs.
Policy-Making Functions related to the licencing of and standards for services providers.	Increased throughout the time frame of the study as the province's authority for hospitals and long-term care institutions increased. However, the standards for professional providers remained within the authority of various professional associations responsible for the licensing of their members.
Inter-Agency coordinative Functions related to services delivery.	Increased with hospitals and agencies involved in the delivery of specialized institutional care following the introduction of National Health Grants Program. Further increased with the MMA following the introduction of the province's "medi-care" program and the later federal medicare program.
Regulatory Functions related to the resource utilization practices of professional providers.	Increased with institutional providers through the implementation of regulatory legislation and price and supply constraint programs. Increased with physicians in a more limited fashion in the context of fee schedule agreements.
Training Functions Related to the education and placement of Professional Providers.	Increased with the introduction of professional training grants through the National Health Grants Program. Further increased in the creation of the Health Sciences Co-ordinating Council and the Universities Grants Commission.
Management Functions related to the day-to-day administration of services delivery.	Increased in the area of public health services due to the province's takeover of LHUs in the 1970s.

In summary, the findings related to the above research questions indicate that the evolution of health care policy in Manitoba was the product of a complex interplay among key actors in the province's health care delivery subsystem. While provider pressure groups played an important role in policy intermediation in this subsystem, it is evident that executive council actors drawn from the political parties that dominated provincial politics during the time frame of this study also made important contributions to the changes in capacity, costs, and control described in this study. In addition to the roles these actors played in the events described in this study, which are summarized in the first two sections of this chapter, their broader motivations also deserve attention. Based on the findings here, two factors appear to have played an important role in the motives of these actors; their assumptions about the proper scope and direction of health care policy and their apparent tendency to utilize this policy sector to further partisan political ends.

With regard to the first factor, the study findings indicate that two approaches to health care policy dominated the evolution of policy change in Manitoba during the study's time frame. The first approach was favoured by the LP and PC parties and was based on the assumption that policy goals should be developed through pluralist intermediation and should strive to maintain the joint venture organizational arrangements established in the 1950s. As the introduction to Chapter 1 indicates, Horne elaborates the nature of this joint

venture in which the public sector assumes major responsibility for the funding of services while voluntary and private providers assume major responsibility for the production and delivery of services. As a result, the policy initiatives developed by the executive council actors drawn from these political parties were based on intermediation among key actors in the joint venture to ensure that the interests of all parties were represented. In the context of the intermediation process, providers were interested in increased delivery system capacity to enhance their access to facilities in which to provide services to citizens. On the other hand, executive council actors were interested in increased delivery system capacity to satisfy the demands for improved access made by providers as well as members of the general public. However, these demands were not cost free and, in order to meet them, executive council actors in the 1950s and 1960s assumed that the province's budgetary commitment could be minimized by shifting costs to individuals in the form of premiums and the use of a portion of their municipal tax bills. As a result, while these actors preferred consensus-based rational planning, they consistently utilized the concept of cost-shifting to minimize the province's exposure to rising health care costs.

NDP governments, on the other hand, displayed a different set of assumptions. They based their approach to policy change on a broad definition of health care in which the primary role of the province was to ensure that all citizens enjoyed equitable access to the available range of services. This

definition rejected the pluralism assumed by the joint venture arrangement, and assumed that services funded by the public sector should be within the direct administrative and political authority of that sector. In short, the NDP favoured a more corporatist set of assumptions which saw the provincial government as the dominant authority among actors involved in the delivery of health care services. While this definition accommodated the sharing of authority with actors at the local level, the NDP did not view appointed boards as the ideal place to delegate provincial authority. Rather, the NDP's approach assumed that local authority for health care delivery should be administered by elected boards to ensure that local administrative decisions were responsive to a broad range of community interests. While the Schreyer administration attempted to establish this approach in policy practice, through its DHSDC model, it was rejected by health care provider pressure groups who viewed the participation of lay citizens in decisions related to health care as unworkable.

Given the differences in both approaches, it is also not surprising that the direction of health care policy change in Manitoba evolved in an inconsistent fashion. Further, it appears that changes in the policy goals of the governing party, which occurred on average every 6.75 years, contributed to the capacity and budgetary growth found in this study for two reasons. On the one hand, new administrations generally spent their first term in office planning policy, implementation was deferred until their second term. As no administration governed longer than two terms, with the exception of the Roblin/Weir

administration, their implementation exercises were either terminated or modified by the incoming administration. On the other hand, the approaches to policy change displayed by all of the governing administrations contained important flaws. The LP/PC approach was flawed because it assumed that voluntary and private sector providers would respond to provincial policy goals as partners interested in the long-term viability of the province's delivery system. In short, this approach failed to account for the inability of provider pressure groups to balance their self-interests with the interests of the province. The NDP's approach was also flawed as it assumed that, because the province should be the dominant decision-maker in the province's health care policy community, due to its constitutional and political legitimacy, it did not need to accommodate the interests of provider pressure groups when they conflicted with the province's policy goals. As a result, NDP governments became embroiled in conflicts that might have been avoided had a more pragmatic and incremental approach to policy change been adopted.

While this study ends with the election of the Filmon PC administration in 1988, further changes in the organization of Manitoba's health care delivery system occurred while this study was being written. The most important was the 1996 passage of Bill 49, *The Regional Health Authorities and Consequential Amendments Act*, which gave the province the authority to establish regional health authorities (RHAs). Since the passage of this Act, thirteen RHAs have be created; two in Winnipeg with the remainder in rural regions of the province.

The RHAs in Winnipeg health are responsible, on the one hand, for the City's hospitals, and, on the other, for long term care and community-based services. In rural Manitoba the RHAs will ultimately be responsible for all types of health care services within their geographic boundaries. The establishment of these regional authorities highlights the need for the continuation of research related to Manitoba's health care delivery policy subsystem to determine how the interplay between executive council and provider pressure groups led to their implementation. In addition, the findings of this study raise a number of questions related to the potential impacts of these authorities on the structure and performance of the province's health care delivery system. The first is whether these authorities will be successful in arriving at a new balance between the need for community-based primary and preventive health services and the demands of medical care providers. By the early 1980s the consensus among key provincial bureaucratic actors was that the devolution of provincial authority for community-based services to institutional providers at the District level would be "the kiss of death" for these services. While the Filmon administration appears to be confident that the enforcement of strict budgetary controls will ensure that resources allocated to community-based services will not be diverted for institutional care, past experience suggests that the province's confidence that it can require key provider pressure groups to conform to its policy goals in a consistent and objectively rational fashion may be misplaced.

The second question relates to the role that physicians will ultimately play

in the province's new regional system. Given that no announcements pertaining to changes in their authority for the utilization of resources have been made by the government, it appears that the Filmon administration is employing the same "evolutionary" strategy that the Schreyer administration employed during its second term; that is, alter the administrative arrangements for services delivery first and assume that physicians will accept the products of these changes later. While the 1977 provincial election did not allow this strategy to be fully implemented, the MMA's consistent resistance to any change in its membership's service delivery roles throughout the time frame of this study suggests that it will be difficult, if not impossible, to accommodate the interests of this group of providers. In turn, it is likely that the threat of physician out-migration from the province will become a dominant feature in the MMA's attempts to turn the "top down" regionalization process undertaken by the Filmon administration into a "bottom up" political debate.

The third question relates to the impact that Regional Health Authorities will have on the interplay of actors within the province's health care delivery subsystem. Here the Filmon administration appears to be operating under the assumption that because *The Regional Health Authorities and Consequential Amendments Act* gives the Minister of Health considerable authority over the formation and budgets of these authorities, they will not form a coalition to resist the implementation of future provincial policy initiatives, in particular, price and supply constraints. The findings of this study indicate that health care providers

are quite willing to resist provincial policies that negatively affect their interests and are able to generate legitimacy for this resistance among a public that continues to accept the assumptions of the expansionary paradigm. Given this, it is possible that the regional integration of the province's institutions into thirteen large and more powerful administrative units may make the future implementation of provincial policy goals more, rather than less, challenging.

While these questions are important in the context of research in Manitoba, the findings of this study also suggest the need to extend the research framework to a comparative assessment of the evolution of health care policy in other provincial jurisdictions. The findings of this study suggest that while federal policy changes influenced the timing and direction of policy change in Manitoba, interactions within the province's policy community across the study's time frame contributed to the observed impacts. As a result, it would be useful to apply the research framework to provinces that display similarities to Manitoba's social and economic evolution, such as Saskatchewan and Alberta. A comparative study of this nature would allow further testing of the impacts of factors such as political parties, changes in governing administrations, and provider pressure group on the formation and implementation of provincial health care policy. That testing of this nature is necessary, is evident in the lack of consensus in the existing literature related to the role of these factors.

APPENDIX A:
A CHRONOLOGY OF MAJOR POLICY EVENTS

This Appendix summarizes the major legislative and policy community events that shaped Manitoba's health care delivery system between 1948 and 1988. It is divided into six sections based on the terms of the administrations that governed Manitoba over the forty year time frame of this study.

The Campbell Administration: 1948 - 1958

1948

A long-term plan for expansion of the province's hospital facilities is adopted late in the year which establishes targets of 8.5 beds per thousand population for the Winnipeg- St. Boniface region and 4.6 beds per thousand for rural Manitoba. To meet these targets the Campbell administration announces that 340 new general hospital beds will be opened in Winnipeg and 321 new beds will be opened in rural Manitoba during the 1949-50 fiscal year.

1949

In October Premier Campbell calls a general election for November 10. His coalition government is returned with fifty of the Manitoba legislature's fifty-seven seats. LP candidates hold twenty-seven of the fifty government seats with the remainder held by Independent and Progressive Conservative Party (PC) candidates. Eight of the LP party's candidates run unopposed and are elected by acclamation.

1950

In February the twenty-four person Manitoba Advisory Health Survey Committee is formed to make recommendations related to health care delivery system planning.

In June Dr. Carl Buck presents the findings of his "restudy" of public health services delivery to the province. The province responds to Dr. Buck's findings in the fall with alterations to The Manitoba Health Plan.

1952

In May the Manitoba Advisory Health Survey Committee submits its findings to the Campbell administration. The Committee's report contains sixty-three recommendations for changes in the province's health care delivery system.

1953

On June 8 the Campbell administration is elected to a second term in office with a thirty-one seat majority. The PC's form the official opposition with nine seats.

1954

The Campbell administration amends *The Public Health Act*, *The Municipal Act*, and *The Health Services Act* to expand the province's funding responsibilities and administrative authority related to the delivery of public health services.

1955

The Campbell administration amends *The Health Services Act* to allow Hospital Districts to enroll those residing in their boundaries as subscribers to the Manitoba Medical Service (MMS). It also introduces *The Electoral Redistribution Act* which establishes and independent commission to oversee the boundaries of provincial electoral divisions.

A federal-provincial conference is held in October at which an agreement is reached to pursue the development of a national hospital and diagnostic services insurance program.

1956

In January a federal-provincial committee of health and finance ministers releases a policy proposal for a national health insurance scheme. This proposal commits the federal government to pay one half of provincial costs related to diagnostic services and in-patient hospital care.

In March *The Elderly Persons' Housing Act* is passed by the legislature. This Act enables the province to provide construction grants to municipalities and voluntary organizations for hostels for the elderly and infirmed.

1957

In April the Hospital Insurance and Diagnostic Services Act (HIDSA) is passed by the federal parliament.

1958

In the April *The Hospitals Act* and *The Hospital Services Insurance Act* is passed by the legislature. These Acts establish the legislative framework for Manitoba's entry into the national hospital insurance program scheduled to take place on July 1.

A provincial election is held on June 16 and the Campbell administration is defeated by the PC party lead by Duff Roblin. The election gives the PCs a minority government with 26 seats. The LPs retain 19 seats, the CCF increases its standing to 11 seats, with the Social Credit (SC) party holding 1 seat.

The Roblin Administration: 1958- 1967

1958

On June 22 Dr. George Johnson is appointed the Minister of Health and Public Welfare in the Roblin administration. At the time of his appointment the Department is divided into the following divisions: General Administration; Hospitals; Public Health; Psychiatry; and Welfare. In addition, two advisory agencies a responsible for assisting Dr. Johnson in the process of policy formation: The Provincial Board of Health which is responsible for matters pertaining to public health and disease prevention; and The Ministerial Advisory Commission which is responsible for matters pertaining to hospitals and LHUs. The Advisory Commission is composed of twelve members including three representatives from the MMA, three representatives from the Union of Manitoba Municipalities, three citizens appointed by the Minister, one representative of The Associated Hospitals of Manitoba, the Deputy Minister of Health, and the Department's Director of Health.

On June 24 the Roblin administration approves a regulation authorizing implementation of The Manitoba Hospital Services Plan. This is followed on June 27 by the signing of an agreement with the Government of Canada to provide funding for insured hospital services.

On July 1 The Manitoba Hospital Services Plan is implemented. Under this plan insured hospital and diagnostic services are made available to all persons residing in Manitoba. Residents are required to register with the Plan and pay premiums which can be paid in three different ways; through employer groups, through pension groups, and through municipalities and local government districts. The Plan is administered by the office of The Commissioner of Hospitalization who reports to the Minster of Health and Public Welfare.

1958 (continued)

On October 21 The Manitoba Hospitals Council is established to advise the Commissioner of Hospitalization on policies related to the Manitoba Hospital Services Plan. This twelve member Council is composed of citizens appointed by the Minister. Two additional committees to advise the Commissioner are also established at this time: Medical Review Committee appointed by the MMA to advise the Commissioner on medical standards and practices in hospitals; a Dental Review Committee appointed by the Manitoba Dental Association to advise the Commissioner on the utilization of hospitals for services offered by its members.

The Commissioner of Hospitalization's *Annual Report* indicates that: the monthly Manitoba Hospital Services Plan premium rate was $2.05 for a single person and $4.10 for a family; negotiations had been initiated with the federal government to expand coverage to out-patient surgery; and an operating deficit of $5,893,383 was accumulated for the six months the Plan was in operation due to start-up costs.

1959

The Roblin minority government is defeated during a vote in the legislature and a provincial election is held on May 14. It results in a majority PC government with 36 seats. The LP party is reduced to 11 seats and the CCF retains 10 seats.

A study of the living conditions of Manitoba's northern population, initiated in 1956, is released in July. It finds that conditions are below acceptable standards. The government responds in September with the establishment of a Northern Health Services Branch in the Department of Health and Public Welfare to provide services to persons in unorganized territories north of the 53rd Parallel. At the same time expansion of the Dauphin and Portage LHUs is also announced.

On September 23 Dr. Johnson establishes The Manitoba Hospital Survey Board. It is mandated to survey the distribution of hospital and long term care facilities in the province and to establish a plan for the future supply of facilities as well as the personnel needs of those facilities. On October 7 The Manitoba Hospitals Council agrees to serve as an advisory committee to the Survey Board.

In October the Commissioner of Hospitalization is given responsibility for the hospital construction grant provided through the National Health Grants Program.

In November the Office of Alternative Care is established in the Department of Public Health and Welfare. It is responsible for regulating long-term care institutions and is also charged with the promotion of improved treatment and living conditions for the residents of these institutions

The Commissioner of Hospitalization's *Annual Report* indicates that: an agreement was reached with the Federal government to expand the Hospital Plan's insured coverage to out-patient surgery and therapy and to make coverage under the Plan available to patients served by Federal nursing stations; an agreement was reached with the Sanatorium Board of Manitoba and the St. Vital Ward of the St. Boniface Hospital to house insured provincial patients; and a study of nursing homes and related institutions has been initiated.

1960

In April the Department of Health and Public Welfare establishes an Elderly Persons' Housing Branch within its General Administration Division based on the repeal and re-enactment of *The Elderly Persons Housing Act.* It also undertakes to further improve the living conditions of persons in northern regions by creating a Community Development Branch charged with enhancing the social and economic security of northern citizens.

1960 (continued)

In April the provincial government finalizes and agreement with the MMS and representatives of rural and urban municipalities to establish a province-wide Medi-care Program for persons receiving assistance under the *Social Allowances Act.*

In June Premier Roblin announces an increase in Manitoba Hospital Plan premiums effective January 1, 1961 due to an average 20% increase in hospital budgets.

The Commissioner of Hospitalization's *Annual Report* indicates: that out-patient benefits had been expanded in October; and hospitals had been allowed to retain 10% of their net income from differential charges for semi-private and private room accommodation.

1961

On January 1 increases in Manitoba Hospital Services Plan premiums take effect. Media reports of the day are critical of the government.

In March the Manitoba Hospital Survey Board releases its first report which calls for a stronger provincial policy focus on community-based services, the administrative integration of health and social services delivered jointly by the province and participating municipalities, and the administrative regionalization of existing Hospital Districts into regional units containing an average of six facilities.

On October 26 Dr. Johnson announces that effective January 1, 1962 the Hospital Services plan premiums that were increased at the start of the year will be reduced to a monthly payment of $2.00 for a single person and $4.00 for a family. This reduction is due to new fiscal arrangements negotiated with the federal government which have altered the method used to arrive at the number of insured persons in the province.

On October 28 The Department of Health and Welfare is reorganized and two separate Departments are created; the Department of Health and the Department of Welfare. Dr. Johnson retains the Health portfolio.

The Commissioner of Hospitalization's *Annual Report* indicates that the Commissioner: is studying the Hospital Survey Board report and will present a plan for hospital construction and renovation for the next seven years in early 1962; wrote to all hospital boards in September requesting their co-operation in limiting budget increases for 1962 to 3% over the hospital's 1961 budget.

1962

In January amendments to *The Hospital Services Insurance Act* are introduced in the legislature. These amendments are designed to consolidate provincial administrative responsibility for the hospital sector under the authority of the Manitoba Hospital Commission (MHC) which replaces the Commissioner of Hospitals. The Medical and Dental Review Committees are retained in the Commission's organizational structure. The MHC formally begins operations on July 1 and is responsible for: the administration of the hospital insurance plan; the licensing and inspection of all hospitals; and province-wide planning of hospital services. Also in January Dr. Johnson makes a submission to the federal Royal Commission on Health Services outlining key problems and goals related to the province's health care delivery system.

The MHC's first *Annual Report* indicates that: the mandate and legislative powers of the Commission are under review to clarify the Commission's future policy roles; a summary of the impacts of the Manitoba Hospital Services Plan since its inception has been initiated; hospital budget increases for 1963 will be limited to 4% over 1962 levels.

1962 (continued)

A provincial election is held on December 14. The PC party retains their 36 seats, the LP party holds 13 seats, the New Democratic Party (NDP), formally the CCF, drops to 7 seats, with the SC party retaining 1 seat. Following the election the new Minister of Health is Mr. C.H. Witney.

1963

In February The Royal Commission on Local Government Organization and Finance is established to study the distribution, administration, and financing of municipal services jointly funded by the provincial government.

In June The Hospital Survey Board releases its report on hospital personnel. It recommends funding increases to provincial post-secondary institutions to increase the number of health care professional staffs. Also in June the Department of Health adds a Care Services Branch to its Health Division. The creation of this Branch is based on the Hospital Survey Board's recommendations related to improved services co-ordination between institutional and community-based providers. It is charged with responsibility for the co-ordination of community-based services to the aged and infirm.

The MHC's 1963 *Annual Report* indicates that: increases in hospital budgets remained within the 4% maximum imposed by the Commission; Commission staff were studying the province's ambulance system; a regional laundry services program was initiated as the first step in the development of a shared services program among hospitals; and Commission staff were studying the feasibility of establishing larger hospital districts to increase the efficiency of hospital services and attract physicians to rural areas.

1964

In April The Royal Commission on Local Government Organization releases its report. It supports the transfer of all municipal authority for Local Health and Diagnostic Services Units as well as social services delivery to the provincial government. Further, it recommends that the province create eleven rural administrative regions for the integrated delivery of community-based provincial health and social services.

In April two pieces of Legislation are passed related to services for the elderly. The first is a revision to *The Elderly and Infirm Persons Act* to allow the province to increase its support for elderly persons housing in the form of construction grants. In addition, this revision enhances provincial authority related to the regulation of existing Personal Care Homes (PCHs) and Hostels. The second revision is to *The Public Health Act* to provide the province with enhanced regulatory control related to the construction of new facilities of this type.

The MHC's 1964 *Annual Report* indicates that the Commission: completed a study of extended treatment facilities for the chronically-ill that would form the basis of a five to seven year construction plan to meet the needs of this population; had begun assisting communities in the funding of PCH construction to ease the demands on local hospitals produced by the rising number of chronically-ill elderly persons.

1965

The MHC's 1965 *Annual Report* indicates that the Commission was continuing to promote the development of shared services agreements between hospitals to contain administrative cost increases due to an operational deficit of $1,138,043 for the year which had raised the Commission's net cumulative deficit to $5,440,187.

1966

A provincial election is held on June 23. The standing of the PC government drops to 31 seats, the LP party gains one seat to hold 14 seats, the NDP gains four seats to increase its standing to 11, and the SC party retains a single seat. C.H Witney retains the Health portfolio in the new Roblin cabinet.

The Medical Care Act is given first reading by the federal parliament in July.

Operation Productivity is initiated by the Roblin administration in September in an effort to increase the overall efficiency and effectiveness of government services. This study is based on an administrative planning process developed in the United States known as Planning, Programming, Budgeting (PPB).

In an October 13 speech to the MMA Premier Roblin announces that Manitoba is prepared to introduce a voluntary medical insurance scheme on July 1, 1967 if *The Medical Care Act* is passed by the federal parliament . However, he notes that Manitoba's decision to enter the federal scheme will be dependent on permission from Ottawa that MMS subscribers will be included in the determination of the 90% coverage of the province's population required by the funding provisions of the proposed federal Act. He also notes that the costs of the Manitoba Hospital Services Plan have doubled since 1959 and that while premiums collected by the Plan paid forty per cent of the plan's total costs in 1958, they now cover only twenty-five per cent of the total cost.

The MHC's 1966 *Annual Report* indicates that the Commission: had been holding meetings with representatives of the City of Winnipeg to discuss the development of a new hospital in the north-west region of the City and was participating in a cabinet committee established to consider the revision and consolidation of all legislation related to the province's institutional care sector.

1967

In February Health Minister Witney introduces his Department's estimates to the legislature. In the introduction of these estimates he notes that while the number of patient days in Manitoba's hospitals has remained at approximately 1.8 million since 1965, hospital boards are requesting budget increases averaging 20%. He goes on to indicate that the government is attempting to reduce these increases through budgetary controls.

In March Health Minister Witney introduces Bill 68, *An Act Respecting Insurance of Residents of the Province in Respect to the Cost of Medical Services,* to the legislature. In his introduction of this Bill he notes that Manitoba has been forced to establish a compulsory medical insurance plan to meet federal demands that 90% of the population must be enrolled in the plan before federal payments begin and that after three years 95% of the population must be enrolled. Witney goes on to note that the 60% of the province's population currently insured by the MMS, and the further 10% covered by other private insurers, cannot be included in these calculations. As a result, the province must enter the compulsory provisions of the plan or face the loss of federal contributions totalling $17 million annually. The MMA responds to this announcement by calling on the Roblin administration to withdraw its support for the federal scheme.

In April the MMS announces a premium increase of between 12.5 and 18 per cent effective July 1. These increases are said to be necessary due to increases in physician's fee schedules. The announcement is viewed by the media as an attempt to increase physician's incomes prior to the introduction of a provincial medical insurance plan.

1967 (continued)

An Act Respecting Insurance of Residents of the Province in Respect to the Cost of Medical Services is given Royal Assent on May 17. Under this Act, which is referred to as *The Medical Services Act*, the Manitoba Medical Services Insurance Corporation (MMSIC) is established to administer the province's proposed medical insurance program. In his announcement of the formation of the MMSIC, Premier Roblin indicates that the province has entered into negotiations to purchase the MMS and utilize its administrative infrastructure to administer the proposed provincial medical insurance program.

In November Duff Roblin resigns as the province's Premier. He is replaced by Walter Weir as party leader and Premier on November 27.

The MHC's 1967 *Annual Report* indicates that: budget requests from hospitals totalled $58.6 million for the 1967-68 fiscal year which represented a 19% increase from the previous fiscal year; the Commission provided $55.7 million to hospitals during the 1966-67 fiscal year which represented 95% of their budgetary requests; a total of thirty-six hospital construction projects were in progress including the development of a complex of health sciences facilities in Winnipeg initiated following the establishment of the Health Resources Fund by the Federal government; the Commission realized a net surplus for the year of $555,553 reducing its net cumulative deficit to $7,747,413.

The Weir Administration: 1968-1969

1968

In a February 1 telegram to Prime Minister Pearson, Premier Weir announces that Manitoba will delay its participation in the national medicare scheme for at least one year due to his administration's concern that the funding arrangements will be too expensive for the province. Further, Weir indicates that he wants the federal government to revise the compulsory arrangements for medicare so that patients would pay the first $50 of their costs and 20 percent of the costs after that up to a maximum of $100, directly to the physician. The province would fund any costs over these amounts through the medicare program. The announcement of this telegram generates considerable public criticism of the Weir administration's resistance to entry into the federal medicare scheme.

On May 1 the Weir administration introduces amendments to the *Manitoba Medical Services Insurance Act* for first reading. At the same time the Minister of Health tables a study on hospital costs in the legislature prepared by the MHC titled *Forecast of Costs and Financial Requirements*. It indicates that in the 1967 calendar year per capita shareable in-patient costs were $56.97 in Manitoba which was the seventh lowest among the ten provinces. In addition, while in-patient days in Manitoba rose from 1,758 per thousand in 1960 to 1,948 per thousand in 1964, they had stabilized since 1964 and were 1,908 per thousand in 1967. Despite the lack of change in in-patient days since 1964, the total cost of operating the Hospital Plan has risen to $62 in 1967 requiring the province to make direct contributions of $21 million as premiums made up only 20 per cent of the total cost of the program in 1967. The report cites two main factors in the cost increases related to the Plan:

- the increase in hospital staff size and salaries from 7,348 and $21.2 million in 1960 to 10,000 and $42 million in 1967;
- 61 hospital construction and renovation projects undertaken by the province since 1960 totalling a further $42 million.

With regard to the future the report notes that the total cost of the Plan's operations was expected to rise to $71.2 million in 1968, to $79 million in 1969, to $87.3 million in 1970, and to $97.7 million in 1971. As a result, the Minister announces that Manitoba Hospital Services Plan

1968 (continued)
premiums will undergo their first increase since 1961 and will rise to $3.60 per month for a single person and $7.20 per month for a family effective January 1, 1969. This increase in premiums is expected to yield an additional $23.5 million annually between 1969 and 1972.

On May 6 the MMS announces a further 23 per cent increase in its premiums and a reduction in coverage to 75% of the costs for persons earning over $1000 per year. These changes are to take effect in July and result in further media criticism of the Weir administration's position related to the introduction of a medical insurance program.

On May 26 the amendments to the *Manitoba Medical Services Insurance Act* are passed amid growing public criticism of the Weir administration's health care policy agenda. These amendments allow the introduction of a voluntary medical insurance scheme based on agreements with the MMS and other private insurers.

In early September the Manitoba Hospital Association (MHA) presents a brief to Health Minister Witney expressing its concern that since the introduction of the Hospital Services Plan there as been "...a disturbing trend..." in the province's health care the delivery system in the form of "...the gradual erosion of the responsibility and authority of governing boards and their Association." The brief calls on the Minister to shift the province's administrative authority for hospitals to an independent health services planning board that would be responsible for policy and planning related to the hospital and long term care sector.

On September 27 Premier Weir announces that Manitoba will begin operating a public medical insurance program on April 1, 1969 administered by the MMSIC. He also announces a cabinet shuffle and reorganization of government departments based on the findings of Operation Productivity. The cabinet shuffle results in Dr. Johnson assuming the Health and Social Services portfolio.

On November 1 Dr. Johnson announces the new organizational structure of Department of Health and Social Services is fully operational. It integrates health, welfare, and corrections services within five administrative divisions. In addition, The Clean Environment Commission, which is responsible for the administration of pollution control policies, is also contained within the Minister's portfolio.

On November 4 and 5 the Conference of Ministers of Health meets in Ottawa. At this meeting the federal government announces that it plans to eliminate cost-sharing with the provinces for existing hospital and proposed medical insurance programs by the end of 1973. To replace cost-sharing the federal government indicates that a new funding formula will be offered that will be the *fiscal equivalent* of the existing arrangements. The response by the Conference of Health Ministers is establishment of The Committee on the Cost of Health Services to study how the provinces can improve their cost-control policies prior to 1973.

On November 8 Dr. Johnson returns from the Conference of Ministers of Health meeting and announces that he is concerned about the policy direction Ottawa is taking related to health services. In his announcement he indicates that he is *uneasy* with Ottawa's plan to replace cost-sharing with a new funding mechanism after 1973 and *surprised* at the federal government's resistance to clearly defining its jurisdictional and funding responsibilities for the health of aboriginal persons within the proposed funding formula for medical insurance.

1968 (continued)

The MHC's 1968 *Annual Report* indicates that: the Commission had initiated a study to determine the effect of home care programs on the length of post-operative stays in hospitals; had completed planning for regional laundry services located in Dauphin, Brandon, Portage, and Selkirk as part of the Commission's promotion of shared hospital services; and the Commission realized an operational deficit of $2,607,082 for the year bringing the net cumulative deficit to $10,354,495.

The 1968 *Annual Report* of the Department of Health and Social Services indicates that while the number, service areas, and functions of the fifteen LHUs remained unchanged from the previous year, the Department is intends to change the way social services are delivered. It notes that the new Social Services Division in the Department is being organized so that its services will be administered through eleven regional offices utilizing a single unit delivery system (SUDS) concept.

1969

On January 10 the Chair of the MHC assumes the Chair of the MMSIC board and begins of process of integrating the administrative responsibilities of both organizations.

On January 27 Premier Weir and Dr. Johnson announce the details of Manitoba's medical insurance program. During the first year of operations the MMS will serve as an agent for the processing of claims made by physicians and will be absorbed by the MMSIC on April 1, 1970 based on a tentative purchase agreement. Premiums for medical services will be $4.90 per month for a single person and $9.80 per month for a family. Combining these premiums with Hospital Insurance Plan premiums of $3.60 per month for a single person and $7.20 for a family results in a total premium of $8.50 per month for a single person and $17 per month for a family. Premier Weir indicates that the total cost of the medical insurance program for the next two years is expected to be $55 million annually and that premiums are expected to raise $26 million annually. This announcement also indicates that the schedule of payments to physicians will be 85% of the MMA's 1967 schedule of fees due to the administrative cost reductions for physicians resulting from implementation of the plan. In addition, physician extra-billing will not be allowed under the new program.

On February 27 the Weir administration opens the legislative session with a Speech from the Throne. In the area of health services the government makes a number of commitments including: the extension of medical insurance to optometric and chiropractic services; increases in construction grant supports for personal care homes; and the expansion of hospital-based home care services to rural communities.

On April 1 the name of the MMSIC is changed to the Manitoba Health Services Insurance Corporation (MHSIC). On this date the MHSIC begins administering the province's medical insurance program through a contract with the MMS to provide infrastructure services for the program.

On July 1 the medical insurance plan is expanded to include optometric and chiropractic services.

The Schreyer Administration: 1969-1977

1969

A provincial election takes place on June 25 and gives the NDP, under the leadership of Edward Schreyer, 28 seats. The PC party retains 22 seats, the LP drops to 5 seats, the SC party and an independent candidate each hold one seat. Mr. Sidney Green is appointed the Minister of Health and Social Services. After a fall sitting of the legislature he is replaced by Mr. Rene E. Toupin in December.

On August 14 the Schreyer administration's first Speech from the Throne announces that a "substantial reduction" in the medical insurance portion of health insurance premiums will be implemented. During the fall sitting of the legislature *The Medical Services Insurance Act* is amended to allow all health insurance premiums to be combined in a single payment. Based on the November passage of this amendment the government announces a reduction in combined premiums to $4.15 for a single person and $8.30 for a family effective January 1, 1970.

In November the Conference of Health Ministers Committee on the Costs of Health Services releases its report. The report supports the regionalization of provincial hospital services, calls for changes in the day-to-day management of hospitals, and suggests that alternatives to hospital care should be actively explored by the provinces.

The MHC's 1969 *Annual Report* indicates that: net revenues exceeded expenses in 1969 by $5,485,232 and were applied to the Commissions accumulated operating deficit of $10,353,495 bringing the net cumulative deficit to $4,869,263; much of the $7.7 million increase in expenditures to hospitals over the previous year were attributable to increased salary ($3.6 million) and staffing costs ($1.5 million); the average annual in-patient cost per hospital bed rose 11.4% from $10,597 in 1968 to $11,809 in 1969; Commission staff who had served on the federal-provincial Committee on the Costs of Health Services had been engaged since December in discussions of the Committee's findings with the Manitoba Hospital Association and other professional and community groups.

1970

In February an orthopaedic specialist, Dr. David McQueen, complains publicly that the teaching hospitals in Winnipeg (The Winnipeg General Hospital and the St. Boniface General Hospital) are restricting patient access to persons admitted by physicians who hold active staff privileges with these hospitals. As a result, courtesy (non-teaching) staff do not have the same opportunity to provide their patients with the services provided by these facilities. The Schreyer administration's response it to establish the Commission of Inquiry Into Hospital Admissions in March. The mandate of this Commission, which is Chaired by Mr. Justice J.M. Hunt, is to study the admissions practices of hospitals in Winnipeg to determine if they ensure equitable access to all citizens.

On April 1 the MMS ceases to be the agent for processing medical claims on behalf of the MHSIC. MMS staff are absorbed by the MHSIC.

In May the name of the Department of Health and Social Services is changed to the Department of Health and Social Development. In addition, the Department is further reorganized based on a six division structure by moving corrections services from the Social Services Division to create a separate Corrections Division.

On July 21 *The Health Services Insurance Act* receives Royal Assent. On October 21 it comes into force with the establishment of the Manitoba Health Services Commission (MHSC) which assumes the combined administrative responsibilities of the MHC and the MHSIC.

1970 (continued)

On August 26 the Department of Health and Social Development presents a submission to cabinet. It proposes the implementation of conterminous regional boundaries for the delivery of all provincially funded public health and social services based on the SUDS concept that the Social Services Division began implementing in its regional offices in 1969. Following cabinet approval of the proposal, a working group is established in September to explore the feasibility of applying the SUDS concept to health services.

On September 24 the Minister of Municipal Affairs, Howard Pawley, makes a speech to the annual meeting of the Manitoba Urban Association in Winnipeg. In this speech the Minister indicates that the government is studying the development of a regional government system based on the transfer of a variety of municipal and provincial responsibilities, including public health and social services, to regional administrative units. To facilitate the potential development of these regional units, the Minister announces that *The Municipal Act* will be amended to enable the province to release municipalities from shared administrative and financial responsibilities. The amendment is passed in November and following its passage officials in the Municipal Affairs and the Industry and Commerce Departments begin a joint study on the feasibility of transferring existing municipal and provincial responsibilities to a regional government level.

In December Mr. Toupin and senior members of his Department leave on a fact-finding visit to the Scandinavian countries to determine whether new models for community-based health and social services delivery developed by these countries could be applied to Manitoba's delivery system. Upon his return his Department releases a discussion paper on its goals.

The MHSC's 1970 *Annual Report* indicates: combined premium rates were $4.15 for a single person and $8.30 for a family; six hospital construction and renovation projects were completed during the year.

1971

In March the Hunt Commission releases its report which finds that:

- Hospital Boards in Winnipeg should retain their autonomy in the area of medical staff appointments but should cooperate more effectively to ensure reasonable access to their facilities by all physicians;
- that staff appointment policies and practices should be standardized in all Winnipeg hospitals and that there should be a fair division of beds between teaching and non-teaching staff;
- that the demand for hospital beds in Winnipeg could be decreased through the construction of additional extended care and nursing home beds coupled with improved admissions, treatment and discharge practices in the city's hospitals.

In the conclusion of its report, the Commission also suggests that an important factor in the demand for hospital beds is the medical community's resistance to placing elderly patients in extended care and nursing home facilities. The Commission argues that this resistance is due to physician recognition of the financial demands that an admission to these types of facility would place on patients and their families. As a result, it recommends that the province explore expanding its hospital insurance plan to cover care services offered in more cost effective institutional settings such as nursing homes. In addition, it suggests that the province explore the amalgamation of some facilities in Winnipeg, in particular those adjacent to the Winnipeg General Hospital, to enhance administrative efficiencies related to the utilization of acute and long-term care beds.

1971 (continued)

In March *The Health Services Insurance Act* is amended to allow the Chair of the MHSC to be a part-time appointment, rather than a full-time administrative position, and to expand the size of the Commission's board from seven to nine members. In August the amendment comes into force with the appointment of an Executive Director to serve as the chief executive officer of the Commission responsible for its day-to-day administrative activities. As a result, the primary focus of the Commission's Board shifts to an emphasis of what the 1971 *Annual Report* describes as "...in-depth examinations of proposals relating to long-range health care planning."

In its April 8 Speech from the Throne the Schreyer administration indicates that it intends to bring into force a range of health and social services policy changes during the spring session of the legislature including:

- the integration of a new provincial income security system with public health services delivery;
- the development of new policies to reduce the cost of prescription drugs;
- the development of CHCs;
- the expansion of extended and personal care facilities;
- the inclusion of nursing home care in the provincial health services insurance program if care is required for medical reasons.

The Speech cites the recommendations of the Hunt Commission as the basis for the last two policy initiatives.

On May 21 Dr. Ted Tulchinsky is appointed as a special advisor on public health to the Minister of Health and Social Development with the rank of Associate Deputy Minister. Since mid-March Dr. Tulchinsky had been employed as a consultant to Mr. Toupin.

In June Dr. Tulchinsky retains Dr. Cecil Sheps, Vice Chancellor, Health Sciences, University of North Carolina, as a consultant to the government on the development of CHCs in the province.

On July 2 the Minister of Health and Social Development announces a further reorganization of the Department effective October 1. This announcement indicates that the goal of these organizational changes is to "...control escalating health and social care costs while at the same time improving the overall quality and effectiveness of these services, particularly preventive services." It also lists a number of new departmental initiatives including:

- the development of health and social services centres designed to shift the demand for institutional care to non-institutional preventive and care services;
- the enhancement of citizen participation in the planning and administration of local health and social services;
- the initiation of a study of Manitoba's aging population by the Research Division to determine the long-term policy needs of this population;
- the development of new programs in the area of corrections, prescription drugs and insured personal care services.

On August 3 Dr. Tulchinsky makes a submission to the cabinet requesting additional funding support for his study the reorganization of the province's health care delivery system. It is approved by the cabinet.

On September 24 the government announces that it is planning to create CHCs in the northern communities of Churchill and Leaf Rapids. Following this announcement the MMA presents the government with a discussion paper titled *A Paper on Community Health Centres* which is critical of the establishment of CHCs in Manitoba.

1971 (continued)

On October 12 Mr. Toupin responds to the MMA paper. His response begins with a review of successful examples of CHCs in Canada and goes on to offer six points on p.8-9 related to why he is exploring the implementation of this concept.

"1. We feel that the consumer and the local community should be able to take responsibility for their community health and social services just as they do in education.
2. We feel that professional practice in community facilities will be attractive to many health and social service professionals if facilities and programs are designed for service to the community.
3. We are concerned about the fragmentation, over specialization, and discontinuity of both health and social services.
4. We are concerned about the over dependence on acute hospital care, the most costly part of the service spectrum, to the detriment of putting our limited public resources into preventive and public health care, and preventive social development services.
5. We are concerned about the rapid escalation of health costs.
6. Most important of all, we want to improve the quality and availability of health care to the people of the province. We want to extend the range of services to include low cost prescription drugs, hearing aids, eye glasses and other services to the people. We think that re-allocation of our health care resources will help us achieve these goals."

On October 22 Premier Schreyer announces initiation of the second phase of his administration's efforts to introduce a regional government model. It will involve the creation of a Regional Analysis Caravan that will visit 75 rural communities to communicate the findings of the first phase and assess the response to these findings.

In November Dr. Tulchinsky retains Dr. C.W. Ekstrand, a faculty member at the University of Calgary, to begin quantitative research related to the reorganization of the province's health and social services delivery system.

On December 29 a Task Force made up of senior Department of Health and Social Development staff is given responsibility for defining regional boundaries to facilitate the implementation of an integrated SUDS-based delivery system for community-based health and social services. Its mandate is based on the findings of the SUDS Working Group appointed in September of the previous year. While this Task Force does not report until May 1972, the intent of its mandate is reflected in the 1971 *Annual Report* of the Department. The introduction of this Report indicates that the Department's central policy goal to reduce administration fragmentation through the integration of services delivery on a regional basis. It goes on to indicate that this will be accomplished through the merger of public health and social services administration at the regional level.

The MHSC's *Annual Report* for 1971 indicates that limb prosthetic devices were added to the list of insured services and nine hospital construction/ renovation projects were completed during the year.

1972

In January the province's Executive Council Department is reorganized. With this reorganization the structure of the Planning and Priorities Committee of the Cabinet (PPCC) is changed so that the Planning Secretariat of Cabinet becomes the central policy planning agency of the Schreyer administration. In addition, subcommittees reporting to The Planning Secretariat are created and given responsibility for key policy sectors. Dr. Tulchinsky is appointed the secretary of The Health, Education, and Social Policy (HESP) subcommittee which is chaired by Saul Miller, the Minister responsible for The Planning Secretariat.

1972 (continued)

On January 31 the members of the HESP subcommittee, the Premier, and Saul Miller meet with Dr. Cecil Sheps to plan the province's policy agenda for the year.

In a March 3 letter to Saul Miller, Dr. Sheps indicates that he is receiving working papers related the province's White Paper on Health Policy which is being co-ordinated by the HESP subcommittee. In this letter Dr. Sheps offers two observations. First, that greater attention needs to be given to what he terms "items of leverage" related to the reform process. Regarding this area he notes that the structure of the existing institutional care system demands that the White Paper deal with the issues of services funding and utilization controls. Second, with regard to the CHC concept he argues that "...optimism that a large percentage of the population will be covered in a short period of time..." by CHCs may be unfounded and urges "...a cautious approach..." to statements related to their development.

On March 17 the Minister responsible for the Industry and Commerce Department, Len Evans, announces that the Regional Analysis Caravan created the previous fall has visited 75 communities and has spoken to over 10,000 persons at community meetings. He goes on to indicate that responses to the regional government model have been positive and that the next phase in the development of this model will an assessment of the findings of the Caravan and further discussions with representatives of the municipal government sector.

On April 1 the province relieves municipal governments participating in DSUs of their administrative obligations for these Units and takes responsibility for the services they provide. This responsibility is given to the newly created Diagnostic Services Division of the MHSC. In addition, administrative responsibility for the planning and construction of personal care homes, as well as determination of the per diem rates for the residents receiving income support from the province, is transferred from the Community Operations Division of the Department of Health to the MHSC.

In May the regional boundaries Task Force appointed the previous December reports to cabinet. It recommends the division of rural Manitoba into seven health and social services regions based on what it describes as "interim boundaries" that, for the most part, follow the existing boundaries of established LHUs. The seven regions are:

- the Central Manitoba Region (Central);
- the Eastern Manitoba Region (Eastman);
- the Interlake Region (Interlake);
- the Northern Manitoba Region (Norman);
- the Parkland Region (Parkland);
- the Western Manitoba Region (Westman);
- the Winnipeg Region (Winnipeg).

The Winnipeg Region defined in the report includes only those areas served by the existing LHUs. At page 3 the Task Force notes that this is because inclusion of the City of Winnipeg Health Department in the new regional structure would "...dredge up the thorny issues of financing the inner-city health department."

In July The Community Health Centre Project, established in 1971 by the Conference of Health Ministers, releases its findings. The report calls for the creation of Community Health Centres as an alternative to the construction and/or expansion of hospitals.

On July 12 *The Manitoba White Paper on Health* is tabled in the legislature by Saul Miller.

1972 (continued)

In September a Health White Paper Working Group is formed to develop general policies and specific implementation plans arising from the recommendations of the White Paper on Health. The Working Group is made up of persons hired by Dr. Tulchinsky and staff employed by the MHSC Financial support is, for the most part, provided by a special National Health Grant that has been awarded to the province to assist in the development and implementation of CHCs.

In an October 10 progress report to Dr. Sheps, Dr. Tulchinsky describes the mandate of the White Paper Working Group as "...to work closely and co-operatively with the Department and the Commission to bring about the Community Health Centre concept." He also indicates that Dr. Eugene Vayda has been retained as a consultant to the Working Group to assist in the definition of its operational goals.

On November 2 Saul Miller presents a speech to the Manitoba Hospital Association annual meeting in Brandon. This speech focuses on the need to contain the costs of health services and uses the findings of the Hastings Commission and the White Paper to support the need for a new approach to delivery system organization in Manitoba.

On December 2 Dr. Tulchinsky and the Working Group meet in Winnipeg with Dr. Bill Bicknell, Health Commissioner for the State of Massachusetts. The minutes of this meeting indicate that its purpose is to assess Dr. Bicknell's experience related to the establishment of community health centres in Massachusetts. Dr. Bicknell indicates that successful implementation requires that the centre serve a relatively small geographic area, that it be controlled by representatives of the population it serves, and that global funding mechanisms be put in place to ensure cooperation among professional providers.

The MHSC's 1972 *Annual Report* indicates that: global budgeting was introduced to hospitals located in Winnipeg and Brandon during the year; initial steps had been taken to create the Health Sciences Centre (HSC) which would integrate the administration of facilities located on the Manitoba Medical Centre site; seven hospital construction/renovation projects and seven personal/care home construction/renovation projects were completed during the year.

1973

On January 19 two Appendices to the White Paper are released by the province which contain data supporting the Paper's findings.

On January 20 a special meeting of the MMA membership approves the Association's response to the White Paper on Health Policy in the form of a Position Paper containing a total of nineteen recommendations.

On January 25 the MHA releases a Position Statement on the White Paper on Health Policy. It contains a total of twelve recommendations.

On February 21 Dr. Tulchinsky meets with Mr. H. Schneider, Deputy Minister of Health and Social Development. At this meeting Mr. Schneider indicates that the Department's lack of involvement in the initial stages of policy implementation has left it unable to anticipate the staffing and funding demands that might be placed on it throughout the year.

On February 22 the Schreyer administration opens a new legislative session with a Speech from the Throne. In this speech the government makes a variety of commitments including:

1973 (continued)

- the extension of health insurance coverage to all levels of institutional care, in particular, services offered in nursing homes and special facilities for the aged and infirm;
- the extension of an exemptions program related to the payment of health insurance premiums for persons over the age of 65 years;
- the expansion of home care services in all regions of the province and the extension of health insurance coverage for medical services performed within this program;
- the introduction of a program to pay 80 per cent of the drug costs of persons over the age of 65 years as well as a commitment to study the introduction of a broader program to lessen the long-term costs of drugs for the chronically-ill of all ages;
- the introduction of a new grants for municipalities coupled with a special loan fund to help finance job-creating municipal capital works projects;
- study of a program to provide families with assistance in meeting the dental care costs of school-age children.

On March 6 Mr. Toupin, announces that effective April 1, 70,000 Manitobans over the age of 65 will be exempted from paying health insurance premiums. This is in addition to the 26,000 persons over age 65 already exempted due to their limited income level. In total, this exemption program is expected to decrease the MHSC's premium revenues by $4.8 million.

In March the government releases *Guidelines For the Seventies*. This statement of the government's policy intent for rural Manitoba indicates that its regional government model is based on the integration of government services at the District level to support what it defines as the "stay option".

On March 30 Premier Schreyer introduces the budget for the next fiscal year. In the area of health and social services the budget indicates that the government intends to:

- eliminate the collection of health insurance premiums for all Manitobans effective June 1 which will cost the province an additional $25 million;
- introduce the promised pharmacare program for persons aged 65 and over on July 1 at a cost of $1.5 million;
- introduce the promised home care program on July 1;
- introduce the promised unconditional per capita grants program to the municipal sector effective April 1 based on agreements with the municipal sector that the province will assume full funding and administrative responsibility for community-based health and social services.

In addition, the budget contains a $2 million line to cover the province's offer to the City of Winnipeg to assume funding and administrative responsibility for the City's Health Department as well as its court and detention facilities.

On April 1 the new health and social services regions begin their first full year of operation. The management of these regions is the responsibility of the Community Operations Division of the Department of Health and Social Development. The delivery of services is integrated at the regional level under the administrative supervision of the Region's Director.

On April 5 the provincial cabinet approves a submission by Saul Miller which recommends that the province begin the integration of public health and social services, as well as institutional care, through the creation of DHSDC boards responsible for the delivery of a progressive care system of services. Further he recommends that the MHSC be given full responsibility for the implementation of all health services delivery system reforms including the establishment of DHSDCs.

1973 (continued)

In May Premier Schreyer makes final preparations for an upcoming First Minister's Meeting on Federal-Provincial Cost Shared Programs. In a May 21 memorandum from Ted Tulchinsky to Saul Miller, the province's position at this meeting related to health services funding is discussed. This memorandum indicates that with regard to expenditures:

- the province's responsibility for Hospital funding is expected to rise 13% per annum over the rest of the decade from $91,620,500 in 1970 to $312,200,00 in 1980;
- the province's responsibility for medical services funding is expected to rise 7.2% per annum over the decade from $54,444,000 in 1970 to $107,179,000 in 1980;
- total costs are expected to rise by 11% per annum over the rest of the decade from $146, 064, 500 in 1970 to $419, 379,000 in 1980.

Based on these projections the memorandum goes on to discuss options for the province's position at the meeting. It indicates that a transfer of tax points to the province is considered the most attractive relative to a Risk-Sharing option proposed by the federal government based on GNP growth.

On May 8 the White Paper Working Group presents a Discussion Paper titled *Framework- District Health System* to the HESP subcommittee. It provides a concise statement of what provincial planners view as the central health services policy problems faced by the province, the policy goals that should be pursued to respond to these problems, and the "major mechanisms" that should be utilized to facilitate implementation.

A provincial election takes place on June 28. The results give the NDP 31 seats, the PC party drops to 21 seats, and the LP retains 5 seats.

On July 1 the Schreyer administration initiates four new programs promised during the provincial election. The first two are the responsibility of the MHSC at take the form of an insured personal care home program and a pharmacare program for elderly persons designed to rebate 80% of the prescription drug costs exceeding $50 on an annual basis. Under the former program the Commission pays the full cost of standard accommodation except for a residential charge of $4.50 per day which is the patient's responsibility. The new program covers 86 personal care homes in the province containing a total of 6,789 beds. The Commission is also given responsibility for the licensing of these facilities.

The other two programs are the responsibility of the Community Operations Division of the Department of Health and Social Development. The first is a provincial home care program to be delivered by the Health and Social Services Regions. It is designed to contain rising hospital costs by facilitating the early discharge of patients. The second is a Child Day Care Program to improve the quality of care provided to pre-school children. In addition, the Directors of the Health and Social Services Regions are given responsibility for the assessment, placement, and follow-up of elderly persons who qualify for insured personal care services.

On September 28 Mr. Toupin returns from a federal-provincial health minister's meeting in Charlottetown and issues a statement indicating that several provinces shared concerns expressed by Manitoba related to the over-supply of physicians in urban centres relative to rural centres. It also indicates that the question of alternative to the fee-for-service remuneration of physicians was discussed at length and that "....Mr. Toupin agreed with all other ministers that different payment schemes for physicians would have to be carefully promoted and evaluated by all the provinces."

On October 4 the Manitoba Association of Social Workers presents its response to the White Paper on Health Policy. While the Association is supportive of the government's goal of services integration, it is critical of the White Paper's sole focus on health services.

1973 (continued)

In November the MHA changes its name to Manitoba Health Organizations Inc. (MHO) and broadens its constitution to include institutions other than hospitals, principally personal care homes and community health centres.

On December 5 the MMA issues a public letter addressed to Mr. Toupin demanding that the Minister reach agreement with the Association on a number of areas of dispute related to fee schedule negotiations by January 15, 1974.

On December 12 Mr. Toupin responds to the MMA through a press release which indicates that the MMA's concerns have been answered by the government and that the primary goal of the Association in this dispute is to force the government to give it "...a role in policy matters which is not available to any other group of citizens in society."

The MHSC's 1973 *Annual Report* indicates that: on November 1 responsibility for the functions of the Cadham Provincial Laboratory were transferred from the Department of Health and Social Development to the Commission; on November 8 a Medical Appointments Review Committee of the Commission was established based on the recommendations of the 1971 Commission of Inquiry into Hospital Admissions; Commission staff had held a total of 162 meetings with community groups and health care facility boards to discuss the findings of the White Paper on Health; global budgeting had been extended to all hospitals containing more than 50 beds; four hospital construction/renovation projects and three personal care home construction projects had been completed during the year.

The 1973 *Annual Report* of the Department of Health and Social Development indicates that during the year the White Paper Working Group was active in the establishment on DHSDCs in the northern communities of Churchill, Leaf Rapids, Gilliam and Grand Rapids and the southern communities of
Gladstone, Hamiota, and Lac Du Bonnet. In addition, is was involved in the redevelopment the Mount Carmel Clinic and the development of the Norwest Co-op and Klinic in Winnipeg.

1974

In a January 7 letter to Premier Schreyer, the MHO Board indicates that it has concerns related to the way health services policy initiatives flowing from the recommendations of the White Paper on Health Policy are being implemented by his government. These concerns centre on the fact that three separate agencies have varied responsibility for policy implementation which the MHO Board views as "...both confusing and frustrating to us and our members...".

On January 28 Premier Schreyer announces that Mr. Toupin has been replaced as the Minister of Health and Social Development by the Minister of Colleges and University Affairs and the Chairman of the HESP subcommittee of the Planning Secretariate, Mr. Saul Miller. In addition, this announcement indicates that Mr. H.J. Schneider has resigned as the Chair of the MHSC and has been replaced by Mr. L.L. Desjardins, the current Minister of Tourism, Recreation and Cultural Affairs.

On February 7 the MMA and the MHSC sign an agreement related to a new fee schedule. In addition, this agreement contains provisions for the establishment of a joint MHSC - MMA Consultative Committee which the 1974 MHSC *Annual Report*, at page 11, indicates is intended to "...develop an ongoing dialogue and process of consultation between the Association and the Commission in order to promote mutual co-operation and understanding. This Committee holds its first meeting in March.

1974 (continued)

On February 15 Mr. Miller announces that Dr. Graham Clarkson and Dr. Eugene Vayda have been retained by the government as consultants to study the development of the Health Sciences Centre in the context of the health facility and program needs of the province.

On March 18 a document titled *Implementation of the White Paper on Health Policy In Manitoba* is completed. Jointly authored by the Health White Paper Working Group, MHSC, and the Department of Health and Social Development, it defines the province's intent to implement a Progressive Care Services system through the establishment of DHSDCs funded by global budgets. This document also outlines an *evolutionary approach* to implementation containing three stages in the development of a DHSDC.

On May 3 Premier Schreyer announces that Dr. Tulchinsky has been promoted from Associate Deputy Minister to the Deputy Minister of Health and Social Development.

On May 4 Mr. Miller is the guest speaker at the annual meeting of the MMA in Winnipeg. His speech commends the Association on recent improvements in its relations with the government. It also emphasizes that the need for "...constructive and reasonable discussion of medical care problems..." will be increased in the future as the province attempts to solve the problem of "...burgeoning health care costs..." through delivery system rationalization.

In a May 6 letter to Mr. Miller, the MHO thanks the Minister for the information supplied by his government related to District Health Centres and notes that based on this information "There are a large number of our members who are now ready to abandon their present organizational framework, name, and role, in favour of the district health board concept." The letter goes on to enquire whether the government is considering legislation to enable the creation of these boards.

On June 1 the MHSC adds a Planning Division as part of a major organizational restructuring. The White Paper Working Group is transferred to this Division from the Department of Health and is given responsibility for the long range development of District Health Centres.

In a June 5 letter responding to the MHO's May 6 letter, Mr. Miller indicates that while no legislation is planned for the present session, "...we intend, at the next session of the legislature, to introduce new legislation now being developed which will more adequately allow for district health systems development." The letter notes that existing legislation can be employed to establish new boards and cites the creation of the Seven Regions and Hamiota Health Boards as examples.

On July 2 the delivery of corrections services is consolidated in the newly created Corrective and Rehabilitative Services Division of the Department of Health and Social Development. Mr. J.R. Boyce is appointed as the Minister Responsible for this Division of the Department.

On September 9 Dr. Tulchinsky meets with the President of the MMA, Dr. Peter Lommerse, to discuss the province's implementation plans for DHSDCS. At this meeting Dr. Lommerse expresses four concerns His Association related to the implementation process. Dr. Tulchinsky responds to these concerns in an October 4 letter.

On October 14 Mr. Miller announces that development will proceed on the construction of the Seven Oaks General Hospital to service citizens in the Seven Oaks and West Kildonan areas of the City of Winnipeg.

1974 (continued)

On November 8 MHSC Chair Mr. L.L. Desjardins announces that the reorganization of the Commission over the previous six months should result in "...a more co-ordinated approach to the development of policy and the implementation of programs in the health care field." He goes on to note that the primary goal of the reorganization was to separate the day-to-day functions of the Commission from a new set of longer range functions related to health services policy planning, implementation and evaluation.

In late November Mr. Desjardins resigns as the Chair of MHSC. to run in the St. Boniface by-election.

On December 23 Saul Miller is replaced as the Minister of Health and Social Development by Mr. Desjardins who resigned as the MHSC Chair in November to run in a provincial by-election in St. Boniface after the courts had voided the election results in the constituency from June 1973. Mr. Miller is re-appointed the Minister of Urban Affairs.

The MHSC's 1974 *Annual Report* indicates that eight hospital construction/renovation projects and nine personal care home construction projects were completed during the year along with the construction of the Westman Regional Laboratory in Brandon.

The Department of Health and Social Development's 1974 *Annual Report* indicates that the coordination of services to the elderly was improved during the year through the September creation of an Office of Continuing Care to administer home care services and a new focus on the needs of children was introduced through improved funding support for new day services and the development of a Children's Dental Care Program.

1975

On January 1 the province's pharmacare program, which is the responsibility of the MHSC, is expanded to include all citizens of the province.

On January 17 Mr. Desjardins presents Manitoba's position on the re-negotiation of cost-sharing at a federal-provincial health ministers meeting in Ottawa. He prefaces this position by noting that provincial projections indicate a 15 to 20 per cent annual increase in Manitoba's health budgets over the next three fiscal years and that at least one-half of these increases will be for programs for which no cost-sharing is available. Further, he calls for modifications in the HIDSA to permit cost-sharing for alternatives to hospital care such as home care, community-based health and social services, and ambulatory care. Following the conference a number of committees are established to study the funding of insured home care and prescription drugs.

Upon his return from Ottawa, Mr. Desjardins introduces Bill 48 to the provincial legislature to establish *The District Health and Social Services Act.*

In a March 17 memorandum to Mr. A Getz, Director, Planning Division, MHSC a program consultant in this Division, Peter Dueck, discusses the status of DHSDC development. He indicates that four District Hospital boards he has met with since the start of the year have expressed an interest in conversion but that consideration needs to be given to "...the way of promoting conversion to a Type I." The memo goes on to suggest that one option would be to offer the construction of new PCH beds in these communities as an incentive to convert to a Type I District Board.

1975 (continued)

In April the MHSC completes a study of the province's health care delivery system. The highlights of this study are presented to the Commission's Board on May 13 and indicate that:

- the total number of acute and extended care beds in the province was 5,970 with 3431 beds in Winnipeg and 2539 in rural areas;
- the ratio of acute and extended care beds per thousand population was 4.4 in Winnipeg and 6.7 in areas outside of Winnipeg;
- the average LOS for short term admissions to these beds was 6.70 days while for long term admissions it was 59.31 days;
- out of the total of 3,431 acute and extended care hospital beds in Winnipeg 27.2% were occupied by rural Manitobans and non-residents (779 and 154 respectively);
- the total number of personal care home beds in the province was 5,552 with 3,374 in Winnipeg and 2,178 in rural Manitoba;
- the total number of hostel beds in the province on April 1 was 1,580 with 580 in Winnipeg and 1,000 in rural Manitoba;
- a total of 1071 Winnipeg residents were awaiting admission to a PCH while 1,155 rural residents were awaiting admission;
- four Type III DHSDCs were operational in Churchill, Hamiota, Gladstone (Seven Regions), and Leaf Rapids along with one Type IIIA centre in Lac Du Bonnett;
- four Community Clinics were operational in Winnipeg; the Community Health Action Centre, Klinic, Nor West Co-op, and Mount Carmel Clinic.

Based on the findings of this report, the Board implements of a new system for major construction projects which required the boards of all facilities planning capital projects exceeding $500,000 to report to a quantity surveyor for approval of each stage of the project. In addition, it approves a new model related to the conversion of Hospital Districts to Health Districts. This model allows for the construction of a 20 bed PCH as a part of the conversion process if it is agreed that the Health District will reduce the number of acute care beds to six for every 20 operational PCH beds. Hence, this model is termed the 6/20 model.

On May 1 Mr. T.R. Edwards is appointed the new Chair of the MHSC He continues to hold the position of CEO of the Commission, a position he has held since November 1974.

On May 9 Dr. Tulchinsky speaks to the Annual Meeting of the MMA in Winnipeg. He focuses on the rising costs of health services and the resultant need to establish the DHSDC concept as quickly as possible.

The District Health and Social Services Act is given Royal Assent on June 19, 1975 and is brought into force the same day. This Act contains four key sections which:

- define the list of health and social services that a Health District may have jurisdiction over (Sec.1);
- set out the procedures for the formation of a Health District and the definition of its boundaries (Sec.2-7);
- define the governance, administration, and funding of a Health District by an appointed and/or elected board including the Board's financial obligations to the province for the costs of services delivery (Sec. 8- 35)
- define the authority of the Province through the Minister over the activities of the Board (Sec.36- 42).

On July 4 Mr. Desjardins and senior MHSC staff meet with members of the MHO board. This meeting indicates that a number of concerns regarding the contents of *The District Health and Social Services Act* had been voiced at a series of meetings in May and June between the MHO Board and its member institutions. To assist the government in responding to these problems the MHO proposes a joint Departmental, MHSC, MHO Task Force to formulate regulations for the establishment of District boards. Further, it suggests that the MHO be

1975 (continued)
provided a permanent consultative role within the MHSC's Planning Division to facilitate the province's development of District Health Centres. Mr. Desjardins responds to these proposals by placing a moratorium on the establishment of new DHSDCs and ordering the MHSC's Planning Division to prepare a policy paper related to the implementation of *The District Health and Social Services Act.*

On October 17 the findings of the study commissioned in February 1974 conducted by Dr. Clarkson and Dr. Vayda is released. It calls for realignments in Winnipeg's institutional delivery system focussing on a two phase redevelopment of the HSC over a ten year time frame. The first phase, which is budgeted at $32.3 million, calls for a reduction of 270 acute beds with the redistribution of these beds to the Seven Oaks and Concordia Hospitals. The second phase, which is budgeted at $32.5 million, involves a construction and renovation program to increase the Centre's specialized and extended care capacity. In total, these realignments are expected to cost $64.8 million.

On December 29 Mr. Desjardins makes public the province's proposal to the MMA for the 1976 fee schedule. It allows the MMA's membership to increase their total fee schedule income by no more than 9.15 per cent over 1975 levels. This proposal is rejected by the MMA in early January.

The MHSC's 1975 *Annual Report* indicates that the Commission: established a new Ambulance Grants Program to encourage municipalities to develop and operate local ambulance systems; implemented a 5% increase in the Schedule of Benefits for insured medical services in accordance with the conditions of a two year agreement signed with the MMA on February 7, 1974; funded the completion of two hospital and four PCH building/renovation projects

The 1975 *Annual Report* for the Department of Health and Social Development indicates that the Department experienced a number of organizational realignments during the year including a reduction of the boundaries of the Norman Region to the areas serviced by the communities of The Pas, Flin Flon, and Sheridan. At the same time an eighth rural Health and Social Services region, the Thompson Region, was created. It is made up of the remainder of the area formally contained in the Norman Region and includes the communities of Thompson, Lynn Lake, Leaf Rapids and Churchill.

1976

On January 14 Mr. Desjardins unilaterally imposes the government's proposed 9.15 per cent total fee schedule increase on the MMA indicating that he will no longer negotiate the issue of fee schedules for the 1976 calender year.

In February the Schreyer administration approves a 1976-77 capital budget totalling $26.5 million for the HSC redevelopment.

In June Prime Minister Trudeau once again proposes the termination of open-ended cost-sharing arrangements for health at a federal-provincial conference. Negotiations for a new funding arrangement begin in July.

Also in June the government releases a Policy Paper related to the implementation of District Health Centres completed by the MHSC's Planning Division in March. This paper, which was the product of Mr. Desjardins' order for a study the previous July, contains a number of significant changes in the government's policy position.

1976 (continued)

On September 10 the MHSC announces a new Fiscal Restraint Program based on a 1% reduction in semi-monthly payments to hospitals for the period October 1, 1976 to March 31, 1977.

On September 15 the MHSC's Board approves a five year $135 million capital program for the construction and renovation of health facilities throughout the province. This program has been developed in conjunction with a five year policy planning exercise by the Department of Health and Social Development. Following this meeting Dr. Tulchinsky outlines the primary objectives of the Department of Health and Social Development for the next five years. These objectives focus on the development of a rural district health system and the expansion of provincial authority for public health and socials services in the City of Winnipeg. Following this presentation Dr. Tulchinsky announces he is resigning his position as Deputy Minister to take a position in Israel.

In October the MHSC assumes liability for the ten percent equity share in District Health Centres held by participating municipalities. This decision is based on the elimination of the owner's equity contribution to new construction and is retroactive to April 1, 1975.

On October 18 a meeting between Mr. Desjardins, MHSC Planning Division staff, and the MHO Board results in an agreement between the government and the MHO that "...A joint MHSC/MHO approach would be taken to get local municipal councils to support District Health Systems."

In early November the MHO Annual Meeting passes a resolution supporting the establishment of regulations related to the formal implementation District Health Centres. This resolution reads as follows: Whereas Bill 48 was given Royal Assent in July 1975, and Whereas there are a number of DHCs functioning without being truly legal, and Whereas there are many areas waiting to form District Health Boards once the regulations to Bill 48 are approved, Therefore be it resolved that MHO on behalf of its members put a concentrated effort and pressure on the appropriate authorities to ensure that the Regulations under Bill 48 receive prompt approval.

The MHSC's 1976 *Annual Report* indicates that the Commission approved funding for Phase 1 of the HSC redevelopment and implemented a 6% increase in the Schedule of Benefits for insured medical services in accordance with the conditions of the two year agreement signed with the MMA on February 7, 1974.

1977

On February 4 the province formally announces that it will relieve municipalities and hospital boards of $14 million in debt, interest charges and owners contributions to health care facilities. This relief is retroactive to April 1, 1975. It is based on the negotiations with the MHO the previous October designed to allow the implementation of a district health system.

In March the MHSC completes a study of primary care facilities in rural Manitoba which details changes in delivery capacity between 1970 and 1975. The findings indicate that: the number of hospital beds increased by 2% during this period; the number of personal care beds increased by 49%; the total number of hospital days in care decreased by 3%; and the total number of personal care days in care increased by 49%. Further, it indicates that the total cost of services delivery increased by 122% during the period; acute care facilities accounted for 64% of the total cost increase with personal care homes accounting for much of the remainder; and salary and per diem costs were the main contributors to the overall cost increases rising by 134% and 126% respectively.

1977 (continued)

Based on these findings the study offers eight recommendations including:
- that District Health Centres be established in every region of the province to demonstrate their viability as an alternative to District Hospitals;
- that consideration be given to the development of regional referral centres for primary care;
- that the role and responsibilities of the province related to the delivery of primary care be better defined in legislation that delegates authority for this area to the MHSC;
- that new evaluation mechanisms be established designed to link regional health status with the availability of health services.

On April 1 the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF) comes into force. It is scheduled to remain in force from April 1, 1977 to March 31, 1982.

In April the MHSC enters into discussions with the MHO executive related to the recommendations contained in its March study. While the MHO is supportive of the recommendations, it expresses a concern that Sections 28 and 35 of Bill 48 represent an attempt by the province to "unload" the annual operating costs of District Health Centres not included in MHSC and Department of Health and Social Development funding mechanisms onto participating municipalities. While the MHSC is sympathetic to this position, it indicates that it cannot respond to these concerns until a provincial Finance Department study of the budgetary implications of the April 1 implementation of the EPF Act is completed.

In September Premier Schreyer calls a provincial election for October 11. During the campaign the NDP does not promote the implementation of District Health Centres. Rather, it emphasizes the redevelopment of Winnipeg's acute care system and promises to extend the pharmacare program and introduce an insurance program for dentures and eye-glasses. The election results leave the NDP in opposition with 23 seats, the PC party becomes the government with 33 seats, and the Liberal Party retains a single seat.

The Lyon Administration: 1977-1981

1977

Following the October 11 election Premier Lyon appoints Louis R. Sherman as the Minister of Health and Social Development. He is also appointed the Minister Responsible for Corrective and Rehabilitative Services.

On October 14 the MHO executive meets with the MHSC Board. At this meeting the MHO once again expresses its concern with the lack of progress over the issue of local responsibility for any non-insured costs related to the establishment and operation of District Health Centres.

On October 24 one of the Lyon administration's first announcements is the establishment of a Task Force on Government Organization and Economy to review the structure and operations of existing government departments. This Task Force is headed by the Minister Without Portfolio, Sidney Spivak.

On November 22 Mr. Sherman presents a speech to the annual meeting of the MHO. In this speech he focuses on the increasing costs of health services delivery and announces that a freeze on new construction has been instituted by his Department to allow his officials time to study new approaches to the cost control issue.

1977 (continued)

The 1977 *Annual Report* of the Department of Health and Social Development indicates that no significant changes in the structure and operations of the Department were undertaken during the year.

1978

On February 6 the MHSC's Medical Manpower Committee reports to Mr. Edwards on the findings of a study initiated following the completion of the Planning and Construction Division study of primary care facilities in rural Manitoba the previous March.

On March 8 the MHO Board forwards a letter to Mr. Sherman. Included with this letter is a document titled *Discussion Paper on Methods of Cost Reductions in the Delivery of Health and Related Social Services to Manitobans*. This document contains a total of eight recommendations.

On March 29 Finance Minister Don Craik announces the Lyon administration's 1978-79 budget. In this budget Department of Health and Social Development expenditures increase by $21.7 million from $632.1 to $658.8 million. Much of this increase is due to the MHSC budget line which increases from $426 million to $444.7 million.

On March 31 the Task Force on Government Organization and Economy releases its report. The Task Force calls for a government-wide reorganization which includes dividing the Department of Health and Social Development into two departments.

The MHSC's *Annual Report* for 1977-78 (which covers a 15 month period from January 1, 1977 to March 31, 1978 due to changes in federal reporting requirements) indicates that on April 1, 1977 responsibility for the Patient Air Transportation Program was transferred from the Department of Renewable Resources and Transportation Services to the Commission and ownership of the former Shriner's Hospital for Crippled Children was transferred to the province.

On April 3 Reg Edwards, MHSC Chair/Executive Director, forwards a letter to Mr. Sherman containing his response to the March 8 MHO Discussion Paper.

On May 1 the name of the Department of Health and Social Development is changed to the Department of Health and Community Services.

On May 17 Mr. F. Bell, Co-ordinator of Special Projects for the MHSC, forwards a memorandum to Reg Edwards. In it he discusses the MHO's efforts to gain support for the conversion of District Hospital Boards to Type II District Health Centres. He suggest that if the Boards of these Centres are given global budgets it would be "the kiss of death" for community-based programs.

On July 26 Mr. A. Getz, the MHSC's Director of Planning & Construction, forwards a memorandum to Mr. D.B. Nelson, the Commission's Secretary commenting on a letter dated July 6 sent by the MHO's Executive Director, Mr. H. Crewson, to Mr. Edwards. In this memorandum Mr. Getz observes that Manitoba's inability to implement effective alternatives to the present delivery system is, in part, due to a lack of agreement on whether the system should evolve based on the District System model or on a "...fully developed public utility model...".

On December 15 a new MHSC board is appointed. At this time the responsibilities of the Chair and the CEO are separated. Mr. Gordon Pollock is appointed the new Chair of the Commission while Reg Edwards retains his position as CEO. In January 1979 Mr. Pollock initiates a review of the Commission's organizational structure.

1978 (continued)

The 1978 *Annual Report* of the Department of Health and Community Services indicates that no substantive changes in the structure and operations of the Department were undertaken during the year.

1979

On February 9 the Lyon administration announces that the Department of Health and Community Services has been reorganized into two operational groups. In addition, this announcement indicates that a five member management team to advise Mr. Sherman has been formed.

Also on February 9 the Lyon administration approves a review of all health related legislation to be conducted by a committee headed by the Executive Council. The intent of this review is to determine the need for legislative changes related to the government's planned reorganization of the Department of Health and Community Services.

In its February 15 Throne Speech the Lyon administration announces that the freeze on health facilities construction has been lifted. The speech indicates that thirteen construction/renovation projects will be initiated in the new fiscal year.

The MHSC *Annual Report* for 1978-79 indicates that there was little change in the Commission's policy mandate and/or agenda for the year.

On April 1 the province expands its insured services program to include adult day care and respite services offered by hospitals and personal care homes. On this date a series of changes in the Commission's organizational structure is also initiated.

On June 19 Mr. Sherman announces the approval of funds for construction projects at the HSC. He indicates that $138 million has been made available for these projects which are expected to be completed over an eleven year time frame.

On September 20 Mr. Sherman returns from a Federal-Provincial Health Ministers meeting in Ottawa held September 17-18. In a September 21 announcement he indicates that this meeting supported the federal government's intent to establish a Commission, chaired by Mr. Justice Emmett Hall, to review the national health insurance program.

In October the MHSC and the MMA enter into negotiations for a new fee schedule to begin on April 1, 1980.

On November 1 the Department of Health and Community Services is formally separated into two Departments. Mr. Sherman retains the Health portfolio while Mr George Minaker is appointed the Minister of Community Services and Corrections. Dr. George Johnson becomes the Acting Deputy Minister of Health.

On November 7 Mr. Sherman speaks to a meeting of the Winnipeg Medical Society. In this speech he notes the growing national concern over the financing of health services as well as physician dissatisfaction related to the climate for medical practice in Canada. He indicates that he will try to deal with these concerns by supporting improved planning and policy co-ordination between his government and the physician community.

On December 14 Mr. Sherman speaks to a MHO seminar on facilities management.

1980

In January 1980 the MHSC and the MMA reach a two year agreement on fee schedules beginning in April 1980. This agreement provides a general increase of 8.9 per cent for each year as well as a 10 per cent differential for physicians delivering services north of the 53rd parallel.

In March 1980 the Manitoba Council on Aging is established by the Lyon Administration. This 10 member Council, appointed by the Cabinet, is mandated to study the future impacts of Manitoba's aging population on the demand for health and community services.

The MHSC *Annual Report* for 1979-80 indicates that the province expanded the insured services program on April 1, 1979 to include breast prostheses for women who have had mastectomies and hearing aids for children under the age of 18 years.

On April 1 the Department of Health expands its Maternal and Child Health program through the implementation of high-risk obstetrical and perinatal programs at the Health Sciences Centre and St. Boniface General Hospital.

In June the Standing Committee on Medical Manpower reports to Mr. Sherman. This nine member committee, appointed in December, indicates that the distribution of physicians in the province compares favourably with other provinces. However, it also notes that there are shortages in the areas of anaesthesia, psychiatry, public health, and ophthalmology.

In September the Chairs of Winnipeg Hospital Boards meet with Mr. Sherman to discuss the shortage of acute care beds in the City. The Minister asks the MHSC to respond to these concerns. The Commission determines that the bed shortage is largely due to the backlog of elective procedures that has resulted from summer staff vacations and a shortage of nurses and long-term care beds and responds by instituting a new PCH admissions policy to ensure that persons discharged from hospitals are given priority.

On October 1 a Physician Placement Bureau is established by the Commission. It is responsible for an incentive program recommended by the Standing Committee on Medical Manpower in June.

On October 2 the new Cadham Provincial Laboratory is officially opened by Mr. Sherman. It is located on the HSC site.

The Department of Health's 1980 *Annual Report* indicates that there were no major changes in the organizational structure of the Department.

1981

On January 7 the Manitoba Health Research Council is established. It is composed of 14 members appointed by the Cabinet and is responsible for the promotion of health services research in the province.

On March 2 The Rehabilitation Centre for Children Inc. is established. This corporation, which includes MHSC representation on the Board of Directors, takes ownership of the old Shriner's Hospital building.

On March 13 Mr. Sherman announces his Department's policy agenda for the upcoming year during the presentation of his Department's budget estimates.
In his estimates presentation Mr. Sherman notes that the primary policy goal of his Department is "...to shift the health care system over to a much greater emphasis on day hospitals, adult day care, respite care, home care and the training of specialists in gerontology."

1981 (continued)

The MHSC *Annual Report* for 1980-81 indicates that the most significant highlight of the year was the authorization of $51.2 million for the construction of hospital and personal care facilities and the expansion of respite care programs in ten rural long-term care facilities.

On July 1 a new incentive program to encourage physicians to practice in rural areas of the province is implemented by the MHSC. It includes support for first and second year medical students for employment in rural areas of the province, forgivable loans for third and fourth year medical students if the opt to practice in rural areas after graduation, and incentive grants for physicians to practice in medically under serviced areas.

Also in July a new Maternal and Child Health Program is implemented by the Commission at the HSC and St. Boniface General Hospital. This program includes a Newborn Transport Program to ensure the safe transport of high-risk neonatal cases to these facilities.

On October 11 Premier Lyon calls a provincial election for November 17. During the election campaign the government campaigns on its record of fiscal restraint and the dangers to the province's financial stability related to the re-election of an NDP government. The election takes place on November 17. It leaves the PC party with 23 seats. The NDP forms a majority government with 34 seats.

The Pawley Administration: 1981-1988

1981

On November 28 Mr. Laurent Desjardins is appointed the Minister of Health in the Pawley administration. In December he names Mr. Reg Edwards as the Deputy Minister of Health. Mr. Edwards retains his position as the Executive Director of the MHSC.

The 1981 *Annual Report* of the Department of Health indicates that the only major change in the organization of the Department was the September creation of an Environmental Health Services unit in the Community Health Services Division. The primary role of this unit is to co-ordinate the Department's environmental health services with the services provided by the Clean Environment Commission and the federal Department of the Environment.

1982

In January the Pawley administration and the MMA begin negotiations related to a new fee schedule for the upcoming fiscal year. At these negotiations the government indicates that it is not prepared to offer any major fee schedule increase. The MMA rejects this position and talks break off.

The MHSC *Annual Report* for 1981-82 indicates that eleven new long-term care facilities were opened with a net gain of 464 beds. The Commission's financial statement also shows a $44 million operating deficit for the year.

On April 1 the province initiates an insured services program for orthopaedic shoes for children under 18 years of age.

On April 23 Mr. Desjardins presents his Department's budget estimates to the legislature. They contain a 26 per cent increase in spending over the previous year with 93 per cent of this increase allocated to the MHSC. The remainder of the increase is designated for:

1982 (continued)

On May 26 Mr. Desjardins presents Manitoba's position at a Federal-Provincial Conference of Health Ministers in Ottawa. In this speech he is critical of the federal government's funding policies

On July 1 the province initiates an insured services program for medically-required frames and/or lenses for persons over the age of 65.

On October 1 Mr. Desjardins announces the realignment of senior staff positions at the MHSC in order to relieve Mr. Edwards of some of his administrative responsibilities. It sees two assistant executive directors at the Commission assume associate executive directorships. In addition, Mr. Desjardins announces that the position of Provincial Gerontologist has been created in the Department to provide consulting services to professional and institutional service providers.

On October 15 Mr. Desjardins announces the formation of a Working Group on Mental Health to examine the structure and content of existing mental health programs and recommend options for policy change.

On October 22 Mr. Desjardins writes the executive of the MMA indicating that the government is willing to agree to binding arbitration for a two year period commencing April 1, 1983. The MMA rejects this offer and makes a counter offer on November 19 related to a fee schedule increase retroactive to the start of the fiscal year.

On November 29 Mr. Desjardins once again writes the MMA offering to enter into binding arbitration. The MMA rejects this offer and negotiations are undertaken in December which result in a January agreement effective April 1, 1983 that gives the MMA an average fee increase of less than three percent in the 1982-83 and 1983-84 fiscal years.

Also on November 29 Mr. Desjardins and the federal Minister of Veterans Affairs, Bennett Campbell, sign an agreement allowing the province to take over ownership of the Deer Lodge Hospital on April 1, 1983.

On December 22 Mr. Desjardins replaces the MHSC board. Evelyn Shapiro is appointed the Commission's Chair.

1983

In January Mr. Desjardins announces a further restructuring of his Department. This restructuring is scheduled to be completed by April 1. He also announces the formation of an Interdepartmental Task Force on the Young Disabled in Personal Care Homes.

The MHSC. *Annual Report* for 1982-83 indicates that: a new building was opened on September 24 to house the Mount Carmel Clinic; an Obstetric Outreach Program was established at the HSC and St. Boniface General Hospital to provide diagnostic support to physicians in rural and remote communities; a pediatric cardiology unit had be reestablished at the HSC.

On April 1 the new organizational structure for the Department of Health is announced.

On April 8 Mr. Desjardins presents his Department's spending estimates to the legislature. They total over one billion dollars and represent an 11.6 per cent increase over the previous year. The MHSC's budget increases 9.9 per cent, from $819.6 to $909.2 million.

1983 (continued)

On April 15 Mr. Desjardins presents the MHSC's five year capital construction program. Totalling $188.8 million this program includes $102.1 million in current construction, $82.7 million in projects to be started during the year, and $4 million to upgrade existing facilities through the year.

On September 7 Mr. Desjardins makes a presentation at a provincial Health Ministers meeting in Halifax. In this presentation he calls for a return to federal-provincial cost-sharing as the solution to the current problems facing the national medicare program. In addition he calls on the federal government to convene a federal-provincial meeting to discuss the development of a more equitable cost-sharing program.

On September 16 the Working Group on Mental Health present recommendations to Mr. Desjardins that call for the expansion of community-based services in all regions of the province. Mr. Desjardins responds by establishing a Mental Health Advisory Committee to receive feedback on the study from interested agencies and individuals.

On October 14 Mr. Desjardins forwards a letter to federal Health Minister Monique Begin. In this letter Mr. Desjardins reiterates the need for a federal-provincial health ministers meeting to discuss the development of more equitable cost-sharing program for the delivery of health services.

In December Mr. Desjardins establishes a Health Services Review Committee to report on major health services issues in the provinces policy community. The committee contains senior Health Department officials as well as representatives from the MMA, the College of Physicians and Surgeons, the Manitoba Association of Registered Nurses, and urban/rural hospital administrators.

1984

In January a Nursing Review Committee is established by Mr. Desjardins to examine the supply and utilization of nursing professionals.

On February 24 Mr. Desjardins makes a submission to the House of Commons Standing Committee on Health, Welfare and Social Affairs which is holding hearings on Bill C-3, *The Canada Health Act*, introduced the previous fall. In his submission Mr. Desjardins supports the provisions of the Act. However, he is critical that the Act does not deal with the issue of health services funding and once again calls for a return to a 50-50 cost sharing arrangement.

The MHSC *Annual Report* for 1983-84 indicates that: ultrasound and renal disease programs were expanded during the year; funding for adult day care programs in hospitals had been increased; and a pilot program for maternity early discharge had been established at the St. Boniface General Hospital.

In April the province establishes a Standing Committee on Diagnostic Services to review applications from health care facilities for new or expanded diagnostic capacity.

Also In April the MHSC approves a $16 million interim financing agreement with the City of Winnipeg for the redevelopment of the Winnipeg Municipal Hospital system. The first phase of the redevelopment, which is expected to cost a total of $28 million, involves the construction of a new 205 bed facility.

In August the Manitoba Home Care Orderly Service is implemented to provide an expanded range of services to home care clients in the province's health regions.

1984 (continued)

On October 2 the Manitoba Adolescent Treatment Centre containing 25 beds in two separate living units is opened.

On December 28 Mr. Desjardins and the MMA make a joint announcement related to fee schedule negotiations. This announcement indicates that the MMA has accepted an average 2 per cent fee increase for the 1984-85 fiscal year and that both parties have agreed to enter into a binding arbitration process for a three year period beginning April 1, 1986

The 1984 *Annual Report* of the Department of Health indicates that during the year the new Health Promotion Directorate implemented a province-wide Diabetes Education Program in cooperation with the Canadian Diabetes Association. In addition, a new Support Services for Seniors program was implemented to provide funding for senior resource centres.

1985

On January 21 the MHSC's Facilities Division and the Research and Planning Directorate of the Department of Health present a paper to the Commission's Board on Community Health Centres. This paper offers a variety of recommendations based on its finding that CHCs should continue to be expanded to provide specialty community-based primary health care services in the province.

In February the Interdepartmental Task Force on the Young Disabled in Personal Care Homes, established in January 1983, releases its report. It supports the provision of a wider range of lifestyle options for the young disabled, in particular, greater opportunity for assisted independent living accommodation.

In early March a study commissioned by the Research and Planning Directorate of the Department of Health in 1984, authored by Dr. Robert Evans and Mr. Denis Roch, is presented to cabinet. It indicates that Manitoba's health services expenditures over the previous decade have, as a percentage of GNP, been consistent with the national average but that when adjusted for inflation they exceeded the inflation rate by three percent during the 1970s.

On March 7 the Pawley administration outlines its health policy goals for the year in The Speech From the Throne. This speech indicates that the government plans to introduce legislation banning physician extra-billing, expand chemotherapy services to rural areas of the province, and continue to develop Community Health Centres for the delivery of specialized primary care.

On March 20 Mr. Reg Edwards begins forwarding letters to all hospitals in the province informing them of the province's new cost containment program. This letter indicates that in the upcoming fiscal year no budgetary increases will be provided by the MHSC for salaries and that a maximum of a two per cent increases over the previous fiscal year will be allowed for supplies.

The MHSC's *Annual Report* for 1984-85 indicates that: the Commission expanded intensive care services in the St. Boniface General Hospital and the HSC; Village Community Health Centre was opened to provide services to persons with AIDS and AIDS related complex; and the Commission had completed arrangements for upgrading the air ambulance program through the lease of a new aircraft expected to start service in the next fiscal year.

In April the Nursing Review Committee established in January 1984 presents its report to Mr. Desjardins. It offers a range of recommendations related to the future preparation of nursing professionals and the role of these professionals in the province's delivery system.

1985 (continued)

On May 16-17 Mr. Desjardins attends a Federal-Provincial Health Ministers meeting held in Winnipeg. At this meeting he points out that Manitoba currently contains the same proportion of persons over the age of 65 as provinces in much of the rest of the country will not have to face until 1995. Based on this problem, he urges the federal government to develop new funding mechanisms to facilitate current and pending provincial needs related to the provision of services to Canada's aging population.

On June 13 Mr. Desjardins travels to Ottawa to protest the enactment of Bill C96. This Bill, which contains amendments to the EPF Act which allow the federal government to link increases in federal transfers to increases in the Gross National Product (GNP), is at the second reading stage. It is passed in the fall and takes effect in the 1986-87 fiscal year.

On August 1 amendments to the *Health Services Insurance Act*, passed in May, come into force. These amendments ban extra-billing by health services providers. The MMA is critical of the implementation of this ban and predicts that physicians will leave the province due to its impact on the professional freedoms of its membership.

In November a reorganization of the Department of Health increases the number of divisions in the Department to four by creating a separate Mental Health Services Division.

On December 16 the Health Services Review Committee established in December 1983 releases its final report. Mr. Desjardins responds to this report by indicating that the Health Services Review Committee will be designated as a permanent advisory body on health issues. He also indicates that the Committee's next task will be to solicit responses to the report from health services providers.

1986

On February 11 Premier Pawley calls a provincial election for March 18. During the election campaign the NDP's health policy platform focuses on creating public concern that the re-election of a PC party government will result in a massive privitization of health services. The PC party, under the leadership of Garry Filmon, responds with a campaign critical of the Pawley administration's management of the province's budget. In the area of health services it denies the NDP's claim that it is interested in the privitization of services and is critical of Mr. Desjardins over his handling of health policy issues.

On March 18 the provincial election gives the NDP 30 seats, the PC party 26 seats, and the Liberal Party 1 seat. Mr. Desjardins retains the health portfolio when the new cabinet is announced a week later.

The MHSC *Annual Report* for 1985-86 indicates that during the year three new CT scanners were purchased, two in Winnipeg and one in Brandon, and planning was initiated for the addition of extended treatment beds at the Grace General Hospital and the Concordia General Hospital.

In April the MHSC initiates a new deficit elimination policy for facilities. This policy limits total budget increases to 2 per cent for the year and requires officials from facilities in Manitoba to meet with MHSC staff to develop plans for budgetary reductions in future years. At p.18 the Commission's Annual Report notes that while total patient days, emergency, and out-patient visits have been declining somewhat since 1983-84, the number of staff positions in hospitals has increased by 700 persons.

1986 (continued)

On May 16 Mr. Desjardins and Community Services Minister Muriel Smith announce that the Winnipeg health region will be divided into three regions so that services can be provided in a manner that is sensitive to the unique character of neighbourhoods in the City.

On July 4 Mr. Desjardins announces that Dr. Nick Poushinsky has been appointed to develop an implementation plan to reform Manitoba's health services delivery system.

In September the Department of Health and the emergency departments at St. Boniface General Hospital and Grace General Hospital initiate a pilot project designed to prevent hospital admissions by providing emergency patients with appropriate home care alternatives where possible.

In October plans for budget reductions at the provinces larger hospitals, which were submitted in July, are approved by MHSC staff. They include bed closures in Brandon (29 beds), with the space converted to day surgery, and the closure of a total of 98 beds in Winnipeg at the HSC, St. Boniface Hospital, and the Victoria General Hospital.

On November 13 a symposium on rural health care is held in Killarney. It is attended by health services personnel and physicians from rural Manitoba. The symposium's primary topic is the regionalization of health services administration and delivery.

In December Mr. Desjardins retains the services of Michael Decter to review the operational mandate of the MHSC relative to the mandate of the Department of Health. At the same time Mr. Desjardins issues a request for proposals for health care demonstration projects intended to reduce the province's dependency on institutional services.

On December 23 Mr. Desjardins is presented with an arbitration ruling which proposes a 6.5 per cent fee schedule increase for members of the MMA retroactive to the beginning of the 1986-87 fiscal year. Mr. Desjardins rejects this proposal based on his position that a new contract with the MMA must include a commitment on the part of the Association to impose controls on the volume of medical services utilized by its members.

1987

In early January Mr. Decter presents his report to the cabinet. His findings suggest that the separation of public health institutional policy roles between the Department of Health and MHSC has contributed to the Pawley administration's inability to shift resource allocations from curative services to primary and preventive care. As a result, he recommends amalgamation of the functions of MHSC with the Department of Health.

On January 23 Mr. Desjardins suggests that he will terminate the government's agreement with the MMA to utilize binding-arbitration as a method to resolve fee disputes when the province's present contract expires on March 31. However, following a cabinet meeting on February 3, he indicates that he has instructed the MHSC to provide a 5.6 per cent increase in fee schedule payments retroactive to April 1, 1986 based on the arbitrator's recommendations.

On February 1 the MHSC creates an Emergency Health and Ambulance Services Division through the amalgamation of the Rural Ambulance Services Division and the Medical Transport Division.

On February 4 Mr. Desjardins announces that beginning April 1 the MHSC will no longer fund any form of hospital deficit.

1987 (continued)

On March 6 Mr. Desjardins indicates that the Pawley administration is considering legislation to limit the number of physicians licenced to practice in the province.

The MHSC Annual Report for 1986-87 indicates that a 200 bed construction project has been approved for the Deer Lodge Hospital and the Hope Community Health Centre was opened in Winnipeg to provide services to First Nations persons resident in Winnipeg's core area.

On April 10 Mr. Desjardins presents his Department's budget estimates to the legislature. The Department's total expenditure is $1.3 billion with 9.5 percent of the ten percent total increase over the previous year going to the MHSC budget line. The remainder of the increase is directed to the further expansion of the province's Home Care program.

On August 26 Mr. Desjardins announces that he is resigning as the Minister of Health effective September 11. He is replaced by Wilson Parasiuk.

At a September 9-10 provincial Ministers of Health meeting in Saint John New Brunswick Mr. Parasiuk calls on the federal government to alter funding arrangements with the provinces to allow the development of alternative service delivery systems at the community level.

On October 3 the MMA issues a letter to its members critical of the Department of Health's failure to properly co-ordinate recent service cuts that the Association feels has negatively affected the ability of physicians to deliver services. Based on member feedback to the letter the Association begins a public campaign critical of the Pawley administration's management of the province's health services delivery system.

On November 5 Mr. Parasiuk attends a federal-provincial health ministers meeting in Toronto. At this meeting he once again calls on the federal government to implement a new funding arrangement supportive of the development of alternatives to institutional curative care services.

On December 1 members of the Manitoba Society of Professional Pharmacists begin service cutbacks to long-term care facilities in the province due to a dispute with the MHSC over a new agreement on dispensing fees.

On December 11 Mr. Parasiuk announces that his government has approved $1.1 million in grants to fund demonstration projects designed to reduce the costs of health services delivery.

On December 22 Mr. Parasiuk indicates that he is planning a series of reforms to the province's health services delivery system. However, he does not indicate what form these reforms will take.

1988

On February 8 the MMA writes to federal health minister, Mr. Jake Epp, calling on him to withhold federal health transfers to Manitoba if the province does not agree to enter into binding arbitration on fee schedules. Mr. Epp does not respond publically to this request.

On February 12 the Pawley administration presents The Speech From the Throne. In this speech the government indicates that it will begin a major new program during the year to shift resources from institutional services delivery to community-based programs. To facilitate this shift the province will undertake a program to establish a province-wide system of DHCs.

1988 (continued)

On February 19 Finance Minister Eugene Kostyra presents Manitoba's budget for the next fiscal year. This budget indicates that $1.44 billion will be spent by the Department of Health, an $111 million increase over the previous fiscal year.

On February 23 Mr. Parasiuk makes a statement to the legislature introducing Bill 2, *An Act to Establish The Health Services Development Trust Fund.* This fund is intended to provide transitional funding to communities that agree to undertake improvements in the balance between institutional and community-based care services. The budgetary allocation for this fund is $50 million.

On March 4 Mr. Parasiuk announces that the MMA has countered the province's offer of a three per cent fee schedule increase over the next two years with a demand for a seven percent increase. He indicates that the demand is not reasonable and the province will not consider it.

On March 5 the MMA indicates that its membership will withdraw their services on April 5 if the province does sent the issue of fee schedule increases to binding arbitration.

On March 9 the legislature dissolves after the Pawley administration is unable to gain a majority in a vote on its budget bill. The provincial election is called for April 26 1988.

On April 25 the Province and the MMA sign a three year agreement retroactive to April 1, 1987. The agreement provides a general fee schedule increase of 3 per cent with a cost of living clause in the third year of the agreement. In addition, a maximum limit of $5.99 million in total fee schedule expenditures over the term of the contract is included in this agreement.

On April 26 the election results in a PC Party minority government under the leadership of Garry Filmon. The election gives the PCs 25 seats, the Liberal Party forms the official opposition with 20 seats and the NDP is reduced to 12 seats. Following the election Donald Orchard is appointed the Minister of Health in the new Filmon cabinet.

APPENDIX B:
MANITOBA'S RURAL INSTITUTIONAL SECTOR

This Appendix profiles the evolution of rural institutional capacity over the time frame of this study. It is based on a review of Annual Reports by the province's Health Departments and Hospital/Health Services Commissions as well as data from the 1949 and 1959 hospital surveys. The profile of each community follows a standardized format which contains five features:

1. The name of each community followed by three regional geographic designations utilized by the province between 1949 and 1988-89: the **Divisional** designation used between 1949 and 1958; the **Zone** designation used between 1959 and 1973; and the **Regional** designation used between 1974 and 1988-89.

2. Definition of the Primary Service Area (PSA) of the facilities in the community based on the findings of the 1959 Hospital Survey Board.

3. A review of changes in the rated bed capacity of facilities in the community between 1949 and 1989 which employs these abbreviations:

AT	Acute Treatment
DH	District Hospital
DHC	District Health Centre
DPCH	District Personal Care Home
ET	Extended Treatment
ETH	Extended Treatment Hospital
GH	General Hospital
Lay	Lay facility board
MNU	Medical Nursing Unit
Mun	Municipal facility board
PCH	Personal Care Home
RBC	Rated Bed Capacity
Rel	Religious facility board

4. The year of conversion, if any, to a DHC and the arrangements for governance of the Centre.

5. The integration of local boards based on a review of the 1989 Manitoba Health Organizations Membership Directory.

ALTONA/ Eastern Division/South-West Zone /Central Region

PSA: Town of Altona, Villages of Plum Coulee and Gretna, RM of Rhineland.

1949: Altona DH RBC 30.
Construction of an 8 bed DH expansion and Ebenezer Home PCH begins in 1962. In 1964 the DH RBC is 38 and the Ebenezer Home RBC is 46.
Construction of a PCH attached to the DH begins in 1973. In 1974 the Altona & District PCH opens with an RBC of 25.

1980: In January the Altona Community Memorial Health Centre is established by O in C #25/80 to serve the Town of Altona, the Village of Gretna, and the RM of Rhineland. Board: 11 (All appointed). District: Type I. Services: DHC, DPCH.

1989: Altona DHC RBC 32. Altona & District DPCH RBC 25. Ebenezer Home PCH RBC 46. DHC Classification: Mun. The PCH CEO and Board Chair differ from those of the DHC/DPCH.

ARBORG/Eastern Division/ Interlake Zone/Interlake Region

PSA: Villages of Arborg and Riverton, RM of Bifrost, part of the LGDs of Armstrong and Fisher, Village of Fisher Branch.

1949: No Listing.
In 1950 construction of a 10 bed MNU in Fisher Branch is completed and construction begins on an 8 bed MNU in Arborg. In 1953 the Arborg MNU RBC is 8 and the Fisher Branch MNU RBC is10.
In 1961 construction of the 15 bed Arborg DH is completed. The following year construction begins on St. Benedict's Manor PCH. By 1963 the Arborg DH RBC is 15, the Fisher Branch MNU RBC is 11, and the St. Benedict's PCH RBC is 45.
In 1973 the Fisher Branch MNU is closed.
In 1977 the 40 bed Pioneer Health Services PCH, attached to the Arborg DH, replaces St. Benedict's Manor.

1981: In January The Arborg & District Health Centre is established by O in C #10/81 to serve the Town of Arborg, the Villages of Riverton and Fisher Branch, the RM of Bifrost, and the LGDs of Armstrong and Fisher. Board: 11(All appointed). District: Type I. Services: DHC; DPCH; Clinic (Fisher Branch); Ambulance Service

1989: Arborg DHC RBC 16. Pioneer Health Services DPCH RBC 40. DHC Classification: Mun. All facilities under one board.

ASHERN/ Eastern Division/Interlake Zone/Interlake Region

PSA: RM of Siglunes, LGD of Grahamdale.

1949: No Listing.
In 1954 the newly constructed Siglunes MNU opens with an RBC of 9.
In 1963 renovations are undertaken to the MNU and in 1964 the Lakeshore DH is opened with an RBC of 10.
In 1970 a new 16 bed DH building is completed.

1977: The Lakeshore District Health System is created by O in C 810/77 to provide services to the RMs of Siglunes (containing Ashern), Eriksdale, Coldwell (containing Lundar), and the LGD of Grahamdale. Board: 13 (All appointed). District: Type I. Services: DHC; DPCH
In 1981 a 20 bed DPCH is completed.

1989: Lakeshore DHC RBC 16. Lakeshore DPCH RBC 20. DHC Classification: Mun. All facilities under one board.

BALDUR/Western/South-West/Westman

PSA: part of the RM of Argyle surrounding Baldur.

1949: No Listing.
In 1950 the Baldur MNU opens with an RBC of 8.
In 1961 the MNU building is upgraded to DH status with an RBC of 16..
In 1982 the 20 bed Baldur Manor is completed.

1984: In April the Baldur Health District established by O in C #429/84 to serve part of the RM of Argyle containing Baldur. Board: 7 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service

1989: Baldur DHC RBC 16. Baldur Manor DPCH RBC 20. DHC Classification: Mun. All facilities under one board.

BEAUSEJOUR/ Eastern/South-East/Eastman Region

PSA: Town of Beausejour, RM of Brokenhead

1949: No Listing.
In 1950 Beausejour DH opens with an RBC of 22.
In 1973 the DH expands and construction begins on a PCH. In 1974 the Beausejour DH RBC is 30 and the Eastgate Lodge PCH RBC is 60.

1989: Beausejour DH RBC 30. Eastgate Lodge PCH RBC 60. DH Classification: Mun. DH/PCH CEO is the same but the board chairs differ.

BENITO/Northern/Park/Parkland

PSA: Village of Benito, Part of the RM of Swan River, LGD of Park.

1949: No Listing.
In 1950 the Benito MNU opens with an RBC of 10.

1989: Benito MNU RBC 9. MNU Classification: Mun

BIRTLE/ Western/ South-West/Westman

PSA: Town of Birtle; RM of Birtle, Part of the RM of Ellice including the Village of St. Lazare.

1949: Birtle MNU RBC 8.
In 1955 the MNU is expanded to a 14 bed DH.
In 1959 the DH is further expanded to a an RBC of 28 .

1978: In October Birtle Health Services District established by O in C #988/78 to serve the RM and Town of Birtle and the Village of St. Lazare. Board: 9 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service. A 20 bed PCH is completed that year.

1989: Birtle DHC RBC 19. Birtle DPCH RBC 20. DHC Classification: Mun. All facilities under one board.

BOISSEVAIN/Western/ South West/Westman

PSA: Town of Boissevain; RM of Morton; Part of the RM of Whitewater.

1949: Boissevain, Morton and Minto Memorial Hospital RBC10 (opened 1948).
In 1957 the DH is expanded to 17 beds.
In 1962 the 44 bed Westview Lodge PCH is opened with an RBC of 44.
In 1977 a new 12 bed hospital and attached 20 PCH is opened.

1984: In October the Boissevain Health Centre District is established by O in C #1141/84 to serve the Town of Boissevain, the RM of Morton, and part of the RM of Whitewater. Board: 8 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service.

1989: Boissevain DHC RBC 12. BMW DPCH RBC 20. Westview Lodge PCH RBC 44. DHC Classification: Mun. The CEO/Board Chair of the DHC differs from the PCH.

BRANDON/Western/South West/Westman

PSA: City of Brandon; RMs of Cornwallis and Elton; part of the RM of Whitehead.

1949: Brandon General Hospital RBC 202.
In 1962 a new 220 bed General Hospital is opened along with the Assiniboine ET Hospital with an RBC of 186. The community also contains 8 PCHs with a total RBC of 392.

1989: Brandon GH RBC 279. Assiniboine ETH RBC 122. 6 PCHs with a total RBC of 642. GH Classification: Lay. GH and ETH have the same Board.

CARBERRY/Western/ South-West/Westman

PSA: Town of Carberry, RM of North Cypress.

1949: No Listing.
In 1950 the Fox Memorial District Hospital opens with an RBC of 10.
In 1956 the DH expands by 6 beds and a 14 bed PCH opens.
In 1963 the hospital expands by a further 13 beds.
In 1974 the original PCH closes. It is replaced by the new 30 bed Carberry Plains PCH.

1989: Fox Memorial DH RBC 29. Carberry Plains PCH RBC 30. DH Classification: Mun. DH and PCH have different Boards.

CARMAN/Eastern/South-West/Central Region

PSA: Town of Carman, RMs of Dufferin and Grey

1949: Carman Memorial District Hospital RBC 19.
In 1950 the DH is expanded by 24 beds.
In 1967 the 70 bed Boyne Lodge PCH is opened.
In 1982 a new 30 bed DH is opened.

1989: Carman Memorial DH RBC 30. Boyne Lodge PCH RBC 70. DH Classification: Mun. DH and PCH have different boards.

CARTWRIGHT/Western/South-West/Westman

PSA: Village of Cartwright, RM of Roblin.

1949: No Listing.
In 1950 the Cartwright MNU opens with an RBC of 8.

1980: In April the Tri-Lake Health District established by O in C #327/80 to serve the Village of Cartwright, the RMs of Turtle Mountain and Roblin, part of the RM of Riverside, and the Town of Killarney. Board: 9 (All appointed). District: Type I. Services: DH; PCH; Clinic (Dunrea); Ambulance Service.

1989: Cartwright DHC RBC 10. DHC Classification: Mun

CHURCHILL/Northern/Northern/Norman

PSA: LGD of Churchill.

1949: Served by Fort Churchill Military Hospital RBC 75.
In 1962 the Churchill GH is established with an RBC of 41.
In 1971 planning for a DHC begins with the September 10 announcement by Rene Toupin that an agreement had been reached with the federal government to establish a DHSDC in the community A multi-year construction plan is initiated in the summer of 1972. The Centre's nine member Board, which is made up of provincial and federal appointees as well as elected local representatives, is formed in 1974 and takes formal administrative control of the Type III DHSDC in 1975 under the provisions of *The District Health and Social Services Act*. The range of services provided by the Churchill Health Centre includes: Institutional Acute and Extended Care; Clinical Medical Services, Public Health Nursing; Community Mental Health Nursing; Physiotherapy; Dental Care; Home Care; Social Services; Child Day Care.

1989: Churchill Health Centre RBC 31. HC Classification: Mun.

CRYSTAL CITY/Eastern/ South-West/Westman

PSA: Village of Crystal City, part of the RM of Louise.

1949: Crystal City MNU RBC 10.
In 1954 the MNU expands to 16 beds.
In 1967 the MNU is converted to a 16 bed DH.

1977: In November The Rock Lake Health District is established by O in C #1248/77 to serve the Villages of Crystal City and Pilot Mound, the RM of Louise, and part of the RM of Argyle. Board: 13 (All appointed). District: Type I. Services: DHC(Crystal City);DPCH (Pilot Mound); Ambulance Service.

1989: Crystal City DHC RBC 16. DHC Classification: Mun.

DAUPHIN/Northern/Park/Parkland

PSA: Town of Dauphin, RM of Dauphin, part of the RM of Ochre River.

1949: Dauphin GH RBC 89.
In the 1950s two PCHs open; the Moroz Home with and RBC of 17 beds and the St. Paul's Home with an RBC of 25.
In 1962 a new 100 bed Hospital is opened and the old hospital building is converted to a 35 bed ETH in 1962.
In 1969 St. Paul's Home expands to 70 beds and Moroz Home is closed.
In 1978 the Dauphin PCH with an RBC of 65 is opened.
In 1982 construction of a new hospital building is completed.

1989: Dauphin GH RBC 105 AT/20 ET. St. Paul's Home PCH RBC 70. Dauphin PCH RBC 65. GH Classification: Lay.

DELORAINE/Western/ South-West/Westman Region

PSA: Town of Deloraine, RM of Winchester, part of the RM of Brenda.

1949: Deloraine MNU RBC 14.
In 1952 the MNU is converted to a 16 bed DH.
In 1959 the 16 bed Deloraine Senior's Home is opened.
In 1969 the Senior's Home is expanded to 30 beds and renamed the Bren-Del-Win Lodge.
In 1977 the 16 bed Deloraine & District PCH is opened.

1984: In May The South West Health District is established by O in C #638/84 to serve the Towns of Deloraine and Melita, the Villages of Waskada and Napinka, and the RMs of Winchester, Brenda, Arthur, Edward and Albert. Board: 15 (All appointed). District: Type I. Services: DHC; DPCH (note name change to Delwynda Court); Ambulance Service.

1989: Deloraine DHC RBC 18. Delwynda Court DPCH RBC: 16. Bren-Del-Win Lodge PCH RBC 30. DHC Classification: Mun. The DHC and PCH have different Boards.

ELKHORN/Western/South-West/Westman

PSA: Village of Elkhorn, parts of the RMs of Wallace and Archie.

1949: No Listing.
In 1951 the Elkhorn MNU opens with an RBC of 9.

1987: In March Health District No. 10 is established by O in C #255/87 to serve the Town of Virden, the Villages of Elkhorn and Reston, the RMs of Wallace, Woodsworth, and Pipestone, and part of the RM of Archie. Board: 12 (All Appointed). Type: I. Services: DHC; DPCH, Ambulance Service.

1989: Elkhorn DHC RBC 8. DHC Classification: Mun.

EMERSON/Eastern/South-East/Central Region (part of Morris DH)

PSA: Town of Emerson, RM of Franklin, part of the RM of Montcalm.

1949: No Listing.
In 1951 the Emerson MNU opens with an RBC of 10.
In 1965 a 10 bed expansion is completed bringing the RBC to 18.
In 1978 the 20 bed Red River Valley Lodge PCH is opened.

1983: In March Red River Valley Health District is established by O in C #244/83 to serve the Towns of Emerson and Morris and parts of the RMs of Morris, DeSalaberry, Franklin and Montcalm. Board: 12 (All appointed). Type: I. Services: DHC; DPCH.

1989: Emerson DHC RBC 12. Red River Valley Lodge DPCH RBC 20. DHC Classification: Mun.

ERICKSON (& Sandy Lake)/Western/South West/Westman Region

PSA: Village of Erickson, RMs of Clanwilliam and Harrison, part of the LGD of Park.

1949: No Listing.
In 1951 the Erickson MNU opens with an RBC of 6.
In 1951 the Sandy Lake MNU opens with an RBC of 4.
In 1959 the Erickson MNU is expanded to 15 beds and the Sandy Lake MNU is converted to a 20 bed PCH.
In 1970 the Erickson MNU is renovated and converted to a 14 bed DH.
In 1973 the Sandy Lake PCH is expanded to 36 beds.

1987: In September the Erickson Health District is established by O in C #1057/87 to serve the Village Erickson, The RMs of Clanwilliam and Harrison, and part of the LGD of Park. Board: 9 (All appointed). District: Type I. Services: DHC; DPCH

1989: Erickson DHC RBC12. Erickson & District DPCH (opened Dec. 1989) RBC 14. Sandy Lake PCH RBC 36. DHC Classification: Mun. The DHC and PCH have different Boards.

ERIKSDALE (& Lundar)/Eastern/Interlake/Interlake

PSA: RMs of Eriksdale and Coldwell.

1949: E.M.Crowe Memorial District Hospital RBC 10.
In 1963 a new 17 bed hospital building is opened.

1977: In July the Lakeshore District Health System is created by O in C 810/77 to provide services to the RMs of Siglunes (containing Ashern), Eriksdale, Coldwell (containing Lundar), and the LGD of Grahamdale. Board: 13 (All appointed). District: Type I. Services: DHC; DPCH.
In 1982 20 bed DPCHs are opened in Eriksdale and Lundar.

1989: E.M. Crowe DHC RBC 17. Eriksdale DPCH RBC:20. Lundar DPCH RBC 20. DHC Classification: Mun.

FLIN FLON/Northern/Northern/Norman

PSA: Town of Flin Flon and surrounding area.

1949: Flin Flon General Hospital RBC 27. Hudson Bay Mining Employees' Health Association Hospital RBC 21.
In 1952 the GH building is expanded to 67 beds.
In 1972 the GH is expanded to 125 beds and the HBMEHA Hospital closes.
In 1973 the 30 bed Northern Lights Manor PCH is opened.
In 1981 the 30 bed Flin Flon PCH is opened.

1989: Flin Flon GH RBC:100. Northern Lights Manor PCH RBC 30. Flin Flon PCH RBC 30. GH Classification: Lay. The GH and both PCHs have the same CEO and Board Chair.

GILBERT PLAINS/Northern/Park/Parkland

PSA: Villages of Gilbert Plains and Ethelbert, RMs of Gilbert Plains and Ethelbert.

1949: Gilbert Plains MNU RBC 10.
In 1963 the MNU is converted to a DH and expanded to 21 beds.

1985: In January the Gilbert Plains Health District is established by O in C #107/85 to serve the Village and RM of Gilbert Plains. Board: 6 (All appointed). District: Type I. Services: DHC, DPCH
In 1986 a 30 bed PCH is opened.
In 1989 the hospital closes.

1989: Gilbert Plains DPCH RBC 30. DPCH Classification: Mun.

GILLAM/Northern/Northern/Norman

PSA: LGD of Gillam

1949: No Listing.
In 1967 the 15 bed Gillam Hospital opens.

1989: Gillam Hospital RBC 10. Hospital Classification: Lay.

GIMLI/Eastern/Interlake/Interlake

PSA: Town of Gimli, Village of Winnipeg Beach, RM of Gimli, part of the LGD of Armstrong.

1949: Johnson Memorial DH RBC 36.
In 1957 the 91 bed Betel Home PCH opens.
In 1971 the DH is expanded to 45 beds.

1989: Johnson Memorial DH RBC 35. Betel Home PCH RBC 95. DH Classification: Mun.
The DH and PCH have different Boards.

GLADSTONE/Eastern/South-West/Central

PSA: Town of Gladstone, RMs of Westbourne and Lakeview, parts of the Rm of Lansdowne and the LGD of Alonsa.

1949: Gladstone MNU RBC 8.
In 1951 the MNU is converted to a DH and expanded to 22 beds.
In 1971 planning for the Seven Regions Health Centre begins. During 1972 members of the White Paper Working Group hold meetings with representatives of the existing hospital board, the local health unit board, the Sandy Bay Band Council, and six municipal corporations. In September 1973 the first meeting of the centre's board takes place based on incorporation as a Type III centre under the province's *Company's Act*. At this time construction of the 50 bed Third Crossing Manor PCH is approved. It is completed in 1974.

1983: In October the Centre's board is re-established under *The District Health and Social Services Act* through O in C #1080/83. The Centre's service area includes: the Town of Gladstone; the RMs of Westborne and Lakeview, parts of the RMs of Glenella and Lansdowne, part of the LGD of Alonsa, and the Sandy Bay Indian Band. The range of services includes: Institutional Acute and Personal Care; Clinical Medical Services; Public Health Nursing; Community Mental Health Nursing; Home Care; Dental Services; Optometric Services; Social Services. Board: 16 (7 appointed 9 elected).

1989: Seven Regions DHC RBC 25. Third Crossing Manor DPCH RBC 50. DHC Classification: Mun.

GLENBORO/ Western/South-West/Westman

PSA: Village of Glenboro, RM of South Cypress, part of the RMs of Strathcona and Argyle.

1949: No Listing
In 1953 the 10 bed Glenboro Memorial DH is opened.
In 1958 the16 bed Glenboro Senior's Home PCH is opened.
In 1960 the DH is expanded to 16 beds.

GLENBORO (continued)

1981: In August the Glenboro Health District established by O in C #745/81 to serve the Village of Glenboro, the RM of South Cypress and part of the RMs of Strathcona and Argyle. Board: 7 (All appointed). District: Type I. Services: DHC; DPCH.
In 1984 the new 20 bed Glenboro PCH opens and the16 bed unit closes.

1989: Glenboro DHC RBC 14. Glenboro DPCH RBC 20. DHC Classification: Mun.

GRANDVIEW/Northern/Park/Parkland

PSA: Town of Grandview, RM of Grandview.

1949: Grandview MNU RBC 8.
In 1954 the MNU is upgraded to a DH and expands to 17 beds.
In 1957 the 12 bed Grandview Senior's Home PCH is opened.
In 1975 the new 40 bed Grandview PCH is opened.
In 1988 a new 18 bed DH building is opened.

1989: Grandview DH RBC 18. Grandview PCH RBC 40. DH Classification: Mun. The DH and PCH have different Boards.

HAMIOTA/Western/South-West/Westman

PSA: Town of Hamiota, RMs of Hamiota, Blanshard and Miniota, and part of the RM of Woodworth.

1949: Hamiota DH RBC 8.
In 1950 a new 26 bed DH is opened.
In January 1973 planning for the Hamiota District Health Centre begins when a physician in the community, Dr. E. Hudson, writes Mr. Toupin requesting the establishment of a DHC. Meetings between the White Paper Working Group and community representatives result in an agreement that in January 1974 the Hamiota DH Board will expand its administrative role to that of a DHC based on a global budget developed by the MHSC for this Centre. The range of services of the Hamiota DHC provides include: acute care; clinical medical care; Public Health Nursing; Community Mental Health Nursing; Occupational Therapy; Physiotherapy; Home Care; Social Services.
In 1983 the 30 bed Birch Lodge PCH is opened.

1986: In September the Hamiota District Health Centre is re-established under *The District Health and Social Development Act* by O in C #1046/86 to serve the Village of Hamiota, the RMs of Blanshard, Hamiota, and Miniota, and parts of the RM of Woodworth. Board: 10 (All appointed).

1989: Hamiota DHC RBC 21. Birch Lodge DPCH RBC 30. DHC Classification: Mun.

HARTNEY/Western/South-West/Westman

PSA: Town of Hartney, RM of Cameron.

1949: No Listing
In 1952 the 4 bed Hartney MNU is opened.
In 1968 the MNU is expanded by 5 beds.

1986: In September The Souris Health District is established by O in C #1044/86 to serve the Towns of Souris and Hartney, the RMs of Cameron and Glenwood; and parts of the RM of Oakland, Sifton, Whitehead, and Whitewater. Board: 15 (All appointed). District: Type I. Services: DHC; PCH, Ambulance Service.

1989: Hartney DHC RBC 9. DHC Classification: Mun.

KILLARNEY/Western/South-West/Westman

PSA: Town of Killarney, Village of Dunrea, RM of Turtle Mountain, part of the RM of Riverside.

1949: Killarney DH RBC 30 (opened 1948).
In 1949 the Shamrock Haven PCH opens with an RBC of 20.
In 1958 the 21 bed Lakeview PCH is opened.
In 1973 Lakeview PCH is expands to 42 beds.
In 1976 a new 26 bed hospital and attached 30 bed Bayside PCH is opened. Shamrock Haven PCH closes that year.

1980: In April the Tri-Lake Health District is established by O in C #327/80 to serve the Town of Killarney, the Villages of Cartwright and Dunrea, the RMs of Turtle Mountain and Roblin, and part of the RM of Riverside. Board: 9 (All appointed). District: Type I. Services: DHC; DPCH; Clinic (Dunrea); Ambulance Service.

1989: Tri-Lake DHC RBC 26. Bayside DPCH RBC 30. Lakeview PCH RBC 39. DHC Classification: Mun. The DHC/DPCH Board is different from that of PCH which is governed by a municipal board.

LAC du BONNET/Eastern/South-East/Eastman

PSA: Town of Lac du Bonnet, part of the RM of Lac du Bonnet, Community of Great Falls.

1949: No Listing ((Served by Selkirk, Beausejour, and later Pinawa)
In September 1971 planning for a DHC is initiated when a committee of residents writes Mr. Toupin requesting an acute care facility in the community. In 1972 meetings with the White Paper Working Group result in agreement that the community's greatest need is expanded primary care capacity as the hospital at Pinawa is located near the community. As a result, The Lac du Bonnet DHC Board is formed in May 1973 as a non-profit Type IIIA corporation under the province's *Company's Act*. It begins providing services in January 1974 to residents of the Village of Lac du Bonnet, the RM of Lac du Bonnet, part of the LGDs of Alexander and
Reynolds, and the settlements of Great Falls and Pointe du Bois. The range of services includes: clinical medical care; Public Health Nursing; Community Mental Health Nursing; Home Care; Social Services; Environmental Health Services; Visiting optometric Services. Board: 8 elected and 4 appointed.
In 1985 the 30 bed Lac du Bonnet DPCH is opened.

1989: Lac du Bonnet DHC/DPCH RBC 30. DPCH Classification: Lay.

LEAF RAPIDS/Northern/Northern/Norman

PSA: Town of Leaf Rapids

1949: No Listing
In 1972 planning for the Leaf Rapids Health Centre begins as part of the development of a new mining community in northern Manitoba. This Type III centre began operations in 1973 providing the following services: Clinical Medical Services; Public Health Nursing; Mental Health Nursing; Social Services; Occupational Therapy; Physiotherapy; Home Care.
In 1974 eight in-patient beds were added to the Centre.

1986: In March the Leaf Rapids DHC is established by O in C #241/86 to serve the Town of Leaf Rapids. Board: 8 (All appointed). Type III.

1989: Leaf Rapids DHC RBC 8. Classification: Mun.

LYNN LAKE/Northern/Northern/Norman

PSA: LGD of Lynn Lake.

1949: No Listing
In 1952 the Sherritt Gordon Mines Hospital opens with an RBC of 11.
In 1971 the new 25 bed Lynn Lake DH is opened.

1989: Lynn Lake DH RBC 25. Classification: Mun.

MacGREGOR /Eastern/South West/Central

PSA: Town of MacGregor, RM of North Norfolk.

1949: No Listing
In 1953 the 6 bed North Norfolk-MacGregor MNU is opened.
In 1968 the MNU expands to 12 beds.
In 1982 the 20 bed MacGregor PCH attached to the MNU is opened.

1985: In March the MacGregor and District Health Centre is established by O in C #265/85 to serve MacGregor and the RM of North Norfolk. Board: 7 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service.

1989: MacGregor DHC RBC 6. MacGregor DPCH RBC 20. DHC Classification: Mun.

MANITOU/Eastern/South-West/Central

PSA: Village of Manitou, RM of Pembina.

1949: No Listing
In 1952 the 8 bed Pembina-Manitou MNU is opened.
In 1969 the MNU is expanded to 14 beds.

1982: In August The Pembina-Manitou Health District is established by O in C #1014/82 to serve the Village of Manitou and the RM of Pembina. Board: 7 (All appointed). District: Type I. Services: DHC; Ambulance Service

1989: Manitou DHC RBC 14. DHC Classification: Mun.

McCREARY/Northern//South-West/Parkland

PSA: Village of McCreary, RM of McCreary, part of the LGD of Alonsa.

1949: No Listing
In 1954 the McCreary MNU opens with an RBC of 8.
In 1964 the MNU is expanded to 16 beds.

1977: In April The McCreary Alonsa Health Centre is established by O in C #443/77 to serve the Village of McCreary, the RM of McCreary, and part of the LGD of Alonsa. Board: 8 (All appointed). District: Type I. Services: DHC; DPCH.
In 1978 the 20 bed McCreary-Alonsa DPCH is opened.

1989: McCreary-Alonsa DHC RBC 13. McCreary-Alonsa DPCH RBC 20. DHC Classification: Mun.

MELITA/Western/South-West/Westman

PSA: Town of Melita, Villages of Waskada and Napinka, RMs of Arthur, Edward, Albert, and part of the RM of Brenda.

1949: No Listing
In 1955 the Wilson Memorial DH opens with an RBC of 22.
In 1977 the 20 bed Melita PCH is attached to the DH.

1984: In May The South West Health District is established by O in C #638/84 to serve the Towns of Deloraine and Melita, the Villages of Waskada and Napinka, and the RMs of Winchester, Brenda, Arthur, Edward and Albert. Board: 15 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service

1989: Melita DHC RBC 11. Melita DPCH RBC 20. DHC Classification: Mun.

MINNEDOSA /Western/South-West/Westman

PSA: Town of Minnedosa, Village of Rapid City, RMs of Minto, Odanah, and Saskatchewan.

1949: Minnedosa DH RBC 9.
In 1950 the Minnedosa DH expands to 26 beds.
In 1951 the Lady Minto PCH opens with an RBC of 22.
In 1975 the 50 bed Minnedosa PCH opens attached to the DH and the Lady Minto PCH closes.

MINNEDOSA (continued)

1987: In March The Minnedosa Health District is established by O in C #256/87 to serve the Town of Minnedosa, the Village of Rapid City and teh RMs of Minto, Odanah, and Saskatchewan. Board:15 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service.

1989: Minnedosa DHC RBC 35. Minnedosa DPCH RBC 50. DHC Classification: Mun.

MORDEN/Eastern/South-West/Central

PSA: Town of Morden, RM of Stanley, parts of the RMs of Pembina, Thompson, and Roland.

1949: Morden DH RBC 22.
In 1952 the Morden DH expands to 56 beds
In 1957 the 30 bed Tabor Home PCH is opened.
In 1969 the Morden DH adds 20 beds bringing its RBC to 48 AT/27 ET.
In 1969 the Tabor Home expands to 60 beds.

1982: In August the Morden Health District is established by O in C #1014/82 to serve the Town of Morden, the RM of Stanley, and parts of the RMs of Pembina, Thompson, and Roland. Board: 10 (All appointed). District: Type I. Services: DHC; Ambulance Service.

1989: Morden DH RBC 48 AT/23 ET. Tabor Home PCH RBC 60. DH Classification: Mun. DH Board different from that of the PCH.

MORRIS/ Eastern/South-West/Central

PSA: Town of Morris, RM of Morris, part of the RM of Montcalm.

1949: Morris DH RBC 11.
In 1950 the Morris DH expands to 21 beds.
In 1959 the Morris Eventide Home PCH opens with an RBC of 26.
In 1960 the Morris DH is expanded to 52 beds.
In 1974 the 40 bed Red River Valley PCH is attached to the DH.

1983: In March the Red River Valley Health District is established by O in C #244/83 to serve the Towns of Emerson and Morris, the RMs of Morris, Montcalm, and Franklin, and parts of the RM of DeSalaberry. Board: 12 (All appointed). District: Type: I. Services: DHC; DPCH.

1989: Morris DHC RBC 39. Red River Valley DPCH RBC 40. Morris Eventide Home PCH RBC 26. DHC Classification: Mun. The DHC/DPCH Board is different from that of the PCH.

NEEPAWA/Western/South-West/Westman

PSA: Town of Neepawa, RM of Langford, and part of the RMs of Rosedale Glenella and Lansdowne.

1949: Neepawa DH RBC 23.
In 1950 the Neepawa DH expands to 35 beds.
In 1958 the Osborne PCH opens with an RBC of 26.
In 1967 the 75 bed East View Lodge PCH is opened.
In 1974 East View Lodge expands to 125 beds.
In 1986 Osborne PCH closes.

1989: Neepawa DH RBC 38. East View PCH RBC 125. DH Classification: Mun. The DH and PCH Boards are different.

NOTRE DAME de LOURDES/Eastern/South-West/Central

PSA: Village of Notre Dame, parts of the RMs of South Norfolk and Lorne.

1949: No Listing
In 1952 the Notre Dame MNU opens with an RBC of 8.
In 1959 the Foyer Notre Dame PCH opens with an RBC of 15.
In 1962 the Foyer Notre Dame PCH expands to 42 beds.
In 1972 the Foyer Notre Dame PCH expands to 68 beds.

NOTRE DAME de LOURDES (continued)

1989: Centre de Sante Notre Dame RBC 10. Centre de Sante Notre Dame Foyer PCH RBC 61. Classification: Mun. DH and PCH have the same board.

PILOT MOUND/Eastern/South-West/Westman

PSA: Village of Pilot Mound, parts of the RMs of Louise and Argyle.

1949: No Listing
In 1954 the Pilot Mound MNU opens with an RBC of 8.
In 1966 the Prairie View PCH opens with an RBC of 30.

1977: In November the Rock Lake Health District is established by O in C #1248/77 to serve the Villages of Crystal City and Pilot Mound, the RM of Louise, and part of the RM of Argyle. Board: 13 (All appointed). District: Type I. Services: DHC (Crystal City); DPCH (Pilot Mound).
In 1979 the MNU is replaced by the 24 bed Rock Lake PCH.

1989: Rock Lake DPCH RBC 24. Prairie View PCH RBC 30. DPCH Classification: Mun. DHC/DPCH Board differs from that of the PCH.

PINE FALLS /Eastern/South-East/Eastman

PSA: Town of Pine Falls, Village of Powerview, Village of Great Falls, LGD of Alexander, RM of Victoria Beach.

1949: Manitoba Paper Company Hospital RBC 15.
In 1952 the Paper Company Hospital is expanded to an RBC of 30.
In 1964 the Pine Falls DH is established and the hospital building is expanded to 48 bed to replace beds lost with the closure of the Fort Alexander Federal Hospital the same year.
In 1987 a new 35 bed DH is opened.

1989: Pine Falls DH RBC 35. DH Classification: Lay.

PORTAGE LA PRAIRIE/Eastern/South-West/Central

PSA: City of Portage la Prairie, RM of Portage la Prairie.

1949: Portage DH RBC 60.
In 1953 the Portage DH is expanded to an RBC of 80.
In 1956 the 20 bed Holiday Retreat PCH is opened.
In 1957 the 30 bed Municipal Farm Home PCH is opened.
In 1963 the Holiday Retreat PCH expands to 48 beds.
In 1970 the 100 bed Lions Manor PCH opens. The Municipal Farm Home closes that year.
In 1974 a 45 bed DH expansion is completed bringing the RBC to 104 AT and 35 ET.
In 1978 the Lions Manor PCH expands to an RBC of 150.
In 1987 Holiday Retreat PCH closes.

1989: Portage DH RBC 104 AT/27 ET. Lions Prairie Manor PCH RBC 151. DH Classification: Mun. DH and PCH boards are different.

RESTON/Western/ South-West/ Westman

PSA: Part of the RM of Pipestone (facility part of the Virden HD).

1949: No Listing
In 1952 the Reston MNU opens with an RBC of 8.
In 1961 the MNU expands to 17 beds.
In 1984 the 20 bed Willowview PCH opens.

1987: In March Health District No. 10 is established by O in C #255/87 to serve the Town of Virden, the Villages of Elkhorn and Reston, the RMs of Wallace, Pipestone, and part of the RM of Woodworth. Board: 15 (All Appointed). District: Type I. Services: DHC; DPCH, Ambulance Service.

1989: Reston DHC RBC 17. Willowview Home DPCH RBC 20. DHC/DPCH Classification:Mun.

RIVERS/Western/South-West/Westman

PSA: Town of Rivers, RM of Daly.

1949: No Listing
In 1959 Riverdale DH opens with an RBC of 20.

1980: In December Riverdale Health Services District is established by O in C #1194/80 to serve the Town of Rivers and the RM of Daly. Board: 8 (All appointed). District: Type I. Services: DCH; DPCH.
In 1981 the 20 bed Riverdale DPCH is opened.

1989: Riverdale DHC RBC 16. Riverdale DPCH RBC 20. DHC Classification: Mun.

ROBLIN/Northern/Park/Parkland

PSA: Town of Roblin, RMs of Shell River and Hillsburg, parts of the RMs of Shellmouth and Boulton, and the LGD of Park.

1949: No Listing
In 1950 the Roblin DH opens with an RBC of 28.
In 1976 a new 25 bed DH and the attached 30 bed Roblin PCH opens.

1985: In May the Roblin Health District is established by O in C #573/85 to serve the Town of Roblin, The RMs of Shell River and Hillsburg, and parts of the RMs of Shellmouth, Boulton and the LGD of Park. Board: 15 (All appointed). District: Type I. Services: DHC; DPCH.

1989: Roblin DHC RBC 25. Roblin DPCH RBC 20. DHC Classification: Mun.

ROSSBURN/Western/South-West/Westman

PSA: Village of Rossburn, RM of Rossburn and part of the LGD of Park.

1949: No Listing
In 1952 the Rossburn MNU opens with an RBC of 10.
In 1959 the MNU expands to 16 beds.

1981: In February The Rossburn District Health Centre is established by O in C #153/81 to serve the Village and RM of Rossburn. Board: 7 (All appointed). District: Type I. Services: DCH; DPCH; Ambulance Service.
In 1982 the 20 bed Rossburn PCH is opened.

1989: Rossburn DHC RBC 10. Rossburn DPCH RBC 20. DHC Classification: Mun.

RUSSELL/Western/South-West/Westman

PSA: Town of Russell, Village of Binscarth, RMs of Russel and Silver Creek, and part of the RMs of Shellmouth and Boulton.

1949: Sacred Heart Hospital RBC 35.
In 1970 a DH Board is formed and the hospital is expanded to an RBC of 38.
In 1972 the 40 Russell PCH is opened.

1989: Russell DH RBC 30. Russell PCH RBC 40. DH Classification: Mun. The DH and PCH boards are different.

STE. ANNE /Eastern/South-East/Eastman

PSA: Village of Ste. Anne, RMs of Ste. Anne and Tache.

1949: No Listing
In 1954 the Ste. Anne MNU opens with an RBC of 8.
In 1954 the Greenland PCH with an RBC of 10.
In 1959 the Greenland PCH expands to 22 beds.
In 1966 the 25 bed Villa Youville PCH is opened.
In 1972 the Villa Youville PCH expands to 75 beds.
In 1980 Greenland PCH closes.
In 1982 a new 18 bed DH is opened.

1989: Ste. Anne DH RBC 21. Villa Youville PCH RBC 75. DH Classification: Mun. The DH and PCH boards are different.

STE. ROSE du LAC/Northern/Park/Parkland

PSA: Village of Ste. Rose du Lac, RMs of Ste. Rose and Lawrence, part of the RM of Ockre River, part of the LGD of Alonsa.

1949: Ste. Rose Hospital RBC 27.
In 1959 the Ste. Rose Hospital expands to an RBC of 71.
In 1975 the 40 bed Dr. Gendreau Memorial PCH is opened.

1989: Ste. Rose Hospital RBC 68. Dr. Gendreau Memorial PCH RBC 40. Hospital Classification: Rel. The Hospital and PCH boards are different.

ST. CLAUDE/Eastern/South-West/Central

PSA: RM of Grey.

1949: No Listing
In 1957 St. Claude MNU opens with an RBC of 13.
In 1982 the 20 bed Manior de St. Claude PCH is opened.
In 1984 a new 12 bed DH building is opened.

1989: St. Claude DH RBC 12. Manoir de St. Claude PCH RBC 18. DH Classification: Mun. The DH and PCH have the same board.

ST. PIERRE-JOLYS/Eastern/South-East/Eastman

PSA: Village of St. Pierre-Jolys, RM of De Salaberry.

1949: No Listing
In 1950 the De Salaberry MNU opens with an RBC of 12.
In 1956 the MNU expands to 21 beds.
In 1957 the Providence St. Theresa PCH in Otterburne opens with an RBC of 42.
In 1974 the St. Pierre PCH opens with an RBC of 16.
In 1979 the Providence St. Theresa PCH closes.

1984: In November the Centre Medico-Social De Salaberry District Health Centre is established by O in C #1252/84 to serve the Village of St. Pierre-Jolys and the RM of De Salaberry. Board: 7 (All appointed). District: Type I. Services: DHC; DPCH, Ambulance Service.

1989: De Salaberry DHC RBC 16. Manoir St. Pierre DPCH RBC 16. DHC Classification: Mun.

SELKIRK/Eastern/Interlake/Interlake

PSA: Town of Selkirk, RMs of St. Andrews and St. Clements.

1949: Selkirk DH RBC 42.
In 1952 the Bethania PCH (St. Andrews) opens with an RBC of 82.
In 1955 the Selkirk DH expands to 74 beds.
In 1956 the Selkirk PCH opens with an RBC of 67.
In 1969 the Betal PCH opens with an RBC of 62.
In 1970 the Bethenia PCH closes when the new 76 bed Tudor House PCH opens.
In 1981 Selkirk PCH closes when the a new 104 bed Red River Place PCH opens.
In 1984 a new 75 bed DH is opened.

1989: Selkirk DH RBC 75. Betel PCH RBC 94. Tudor House PCH RBC 76. Red River Place PCH RBC 104. DH Classification: Mun. The DH and all PCH boards are different.

SHOAL LAKE/Western/South-West/Westman

PSA: Villages of Shoal Lake and Strathclair, the RMs of Shoal Lake and Strathclair, and part of the LGD of Park.

1949: Shoal Lake DH RBC 15.
In 1953 the DH expands to an RBC of 23.
In 1974 the Morely House PCH opens with an RBC of 40.

SHOAL LAKE (continued)

1981: In February the Shoal Lake-Strathclair Health Centre is established by O in C #152/81 to serve the Village of Shoal Lake, the RMs of Shoal Lake and Strathclair, and part of the LGD of Park. Board: 11 (All appointed). District: Type I. Services: DHC;DPCH; Ambulance Service.

1989: Shoal Lake-Strathclair DHC RBC: 23. Morley House DPCH RBC 40. DHC Classification: Mun.

SNOW LAKE/Northern/Northern/Norman

PSA: Town of Snow Lake

1949: Hudson Bay Mining Employees' Health Ass. Hospital RBC 7.
In 1980 the Snow Lake HC opens with an RBC of 7.

1989: Snow Lake HC RBC 4. HC Classification: Mun.

SOURIS/Western/South-West/Westman

PSA: Town of Souris, RM of Glenwood, parts of the RMs of Whitehead, Oakland, Whitewater, and Sifton.

1949: Souris DH RBC 25.
In 1954 the DH expands to 34 beds.
In 1956 Riverbend PCH opens with an RBC of 16.
In 1965 Victoria Park Lodge PCH opens with an RBC of 24.
In 1971 a new 36 bed DH is opened. Riverbend PCH closes.
In 1976 the 34 bed Souris PCH opens. It is attached to the DH.

1986: In September The Souris Health District is established by O in C #1044/86 to serve the Towns of Souris and Hartney, the RMs of Cameron and Glenwood; and parts of the RM of Oakland, Sifton, Whitehead, and Whitewater. Board: 15 (All appointed). District: Type I. Services: DHC; DPCH, Ambulance Service.

1989: Souris DHC RBC 30. Souris DPCH RBC 34. Victoria Park Lodge PCH RBC 20. DHC Classification: Mun. DHC/DPCH board differs from that of the PCH board..

STEINBACH/Eastern/South-East/Eastman

PSA: Town of Steinbach, RMs of Hanover and La Broquerie containing the communities of St. Adolph and Grunthal.

1949: Bethesda DH RBC 43.
In 1959 the Mennonite Invalid Home PCH opens with an RBC of 30.
In 1963 the Mennonite Invalid Home is renamed the Rest Haven Home.
In 1963 the Menno Home for the Aged opens in Grunthal with an RBC of 31.
In 1964 a new 65 bed DH is opened.
In 1972 the Bethesda PCH opens with an RBC of 60.
In 1973 the 40 bed St. Adolph PCH opens in St. Adolph.

1988: In October The Bethesda Health and Social Services District is created by O in C #617/88 to serve the Town of Steinbach and RMs of Hanover and La Broquerie. Board: 12 (All appointed). District: Type I. Services: DHC; DPCH.

1989: Bethesda DHC RBC 60 AT/ 20 ET. Bethesda DPCH RBC 60. Rest Haven PCH RBC 60. Menno Home for the Aged PCH RBC 40. St. Adolph PCH RBC 42. DHC Classification: Mun. The DHC/DPCH board differs from those of the PCHs.

STONEWALL/Eastern/Interlake/Interlake

PSA: Town of Stonewall; parts of the RMs of Rockwood and Woodlands.

1949: No Listing
In 1952 the Rockwood-Stonewall MNU opens with an RBC of 8.
In 1961 the MNU is expanded to a DH with an RBC of 18.
In 1976 the 30 bed Rosewood Lodge PCH is attached to the DH.

STONEWALL (continued)

1981: In February the Stonewall & District Health Centre is established by O in C #124/81 to serve the Town of Stonewall, the RM of Rosser, and parts of the RMs of Woodlands and Rockwood. Board: 9 (All appointed). District: Type I. Services: DHC; PCH, Ambulance Service.

1989: Dr. Evelyn Memorial DHC RBC 18. Rosewood Lodge DPCH RBC 30. DHC Classification: Mun.

SWAN LAKE/Western/South-West/Westman

PSA: The RM of Lorne.

1949: No Listing
In 1955 the Lorne Memorial MNU opens with an RBC of 11.
In 1969 the MNU expands to 22 beds.
In 1980 the MNU converts to a DH with an RBC of 22.

1989: Lorne Memorial DH RBC 22. DH Classification: Mun.

SWAN RIVER/Northern/Park/Parkland

PSA: Town of Swan River; Part of the RM of Swan River, RM of Minitonas; LGD of Mountain (including Birch River).

1949: Swan River DH RBC 30.
In 1949 the Birch River MNU opens with an RBC of 10.
In 1958 the Swan River DH expands to 42 beds.
In 1962 the Swan River Valley Lodge PCH opens with an RBC of 53.
In 1966 the DH expands to an RBC of 68AT/ 20 ET.
In 1973 the Swan River Valley PCH opens with an RBC of 60.
In 1975 the Birch River MNU is closed.

1989: Swan River DH RBC 68AT/ 19 ET. Swan River Valley Lodge PCH RBC 50. Swan River Valley PCH RBC 60. DH Classification: Mun. All facilities are under the same board.

TEULON/Eastern/Interlake/Interlake

PSA: Village of Teulon, parts of the RMs of Rockwood, Woodlands and St. Laurent.

1949: Hunter Memorial DH RBC 30.
In 1955 a new 20 bed DH is opened.
In 1977 a new 20 bed DH is opened along with the attached Goodwin Lodge PCH with an RBC of 20.

1986: In January the Teulon-Hunter Memorial Health Centre is established by O in C #93/86 to serve the Village of Teulon and parts of the RMs of Rockwood, Woodlands, and St. Laurent. Board: 11 (All appointed). District: Type I. Services: DHC; DPCH; Ambulance Service.

1989: Teulon-Hunter Memorial DHC RBC 20. Goodwin Lodge DPCH RBC 20. DHC/DPCH Classification: Mun.

THE PAS/Northern/Northern/Norman

PSA: Town of The Pas, LGD of Consol.

1949: St. Anthony's Hospital RBC 76.
In 1951 St. Anthony's Hospital expands to a RBC of 96.
In 1958 the 96 bed Eventide PCH is opened.
In 1969 the Eventide PCH is renovated and renamed St. Paul's PCH with an RBC of 72.

1989: St. Anthony's Hospital RBC 84. St. Paul's PCH RBC 70. Hospital Classification: Lay. Both facilities are owned by The Pas Health Complex Inc.

THOMPSON/Northern/Northern/Thompson

PSA: City of Thompson, LGD of Mystery Lake

1949: No Listing
In 1960 the International Nickel Company Hospital opens in 1960 with a RBC of 32.
In 1967 the hospital is converted to a Provincial facility and expands to 75 beds.

1989: Thompson General Hospital RBC 100. Classification: Prov.

TREHERNE/Eastern/South-West/Central

PSA: Village of Treherne, RM of Victoria, part of the RM of South Norfolk.

1949: No Listing
In 1955 the Victoria, South-Norfolk Treherne DH opens with an RBC of 22.
In 1976 the 22 bed Tiger Hills PCH opens.

1984: In February the Tiger Hills Health District is established by O in C #114/84 to serve the Village of Treherne, the RM of Victoria and part of the RM of South Norfolk. Board: 8 (All appointed). District Type I. Services: DHC; DPCH; Ambulance Service.

1989: Tiger Hills DHC RBC 18. Tiger Hills DPCH RBC 22. DHC Classification: Mun.

VIRDEN/Western/South-West/Westman

PSA: Town of Virden, parts of the RMs of Wallace, Pipestone, Woodworth and Sifton.

1949: Virden DH RBC 18.
In 1952 the Virden DH RBC expands to 32.
In 1965 the 50 bed Sherwood PCH is opened.
In 1972 the 50 bed Westman PCH is opened.

1987: In March Health District No. 10 is established by O in C #255/87 to serve the Town of Virden, the Villages of Elkhorn and Reston, the RMs of Wallace and Pipestone and parts of the RMs of Woodworth and Sifton. Board: 15 (All Appointed). District: Type I. Services: DHC; DPCH, Ambulance Service.

1989: Virden DHC 32. The Sherwood PCH RBC 50. Westman PCH RBC 50. DHC Classification: Mun. The DHC and PCHs boards are different.

VITA/Eastern/South-East/Eastman

PSA: Village of Vita, LGDs of Stuartburn and Piney.

1949: Vita DH RBC 18.

1954: Vita DH RBC 18.
In 1976 the 30 bed Shevchenko PCH is attached to the DH. The DH RBC drops to 13.

1980: In January the Vita and District Health Centre is established by O in C #26/80 to serve parts of the LGDs of Piney and Stuartburn. Board: 9 (4 appointed,5 elected). District Type I. Services: DHC; DPCH; Ambulance Service.

1989: Vita DHC RBC 11. Shevchenko PCH RBC 30. DHC Classification: Mun.

WAWANESA/Western/South-West/Westman

PSA: Village of Wawanesa, parts of the RMs of Riverside Oakland and South Cypress.

1949: No Listing
In 1953 the Wawanesa MNU opens with an RBC of 10.

1979: In November the Wawanesa & District Memorial Health Centre is established by O in C #1127/79 to serve the village of Wawanesa and parts of the RMs of Oakland, Riverside, and South Cypress. Board: 9 (All appointed). District Type I. Services: DHC; DPCH; Ambulance Service.
In 1981 the 20 bed Wawanesa PCH is opened.

1989: Wawanesa DHC RBC 9. Wawanesa DPCH RBC 20. DHC Classification: Mun.

WHITEMOUTH/Eastern/South-East/Eastman

PSA: Village of Whitemouth, RM of Whitemouth, LGD of Reynolds.

1949: No Listing
In 1950 the Whitemouth MNU opens with an RBC of 10.

1985: In June the Whitemouth District Health Centre is established by O in C #706/85 to serve the RM of Whitemouth and part of the LGD of Reynolds. Board: 5 (All appointed). District Type I. Services: DHC; DPCH.
In 1987 the 20 bed Whitemouth PCH is opened.

1989: Whitemouth DHC RBC 6. Whitemouth DPCH RBC 20. DHC Classification: Mun.

WINKLER/Eastern/South-West/Central Region

PSA: Town of Winkler, parts of the RMs of Stanley, Rhineland, and Roland.

1949: Bethel DH RBC 32.
In 1958 the 90 bed Salem PCH opens.
In 1965 the DH is expanded to an RBC of 57 beds.
In 1973 the Salem PCH is expanded to an RBC of 118.

1989: Bethel DH RBC 57. Salem PCH RBC 125. DH Classification: Mun. The DH and PCH boards are different.

WINNIPEGOSIS/Northern/Park/Parkland

PSA: Village of Winnipegosis, RM of Mossey River, part of the LGD of Mountain.

1949: Crerar Hospital RBC 14.
In 1966 a new DH building opens with an RBC of 22.
In 1981 the 20 bed Winnipegosis-Mossey River PCH opens.

1989: Winnipegosis General Hospital RBC 18. Winnipegosis-Mossey River PCH RBC 20. GH Classification: Rel. Both facilities have the same board.

APPENDIX C:
WINNIPEG'S INSTITUTIONAL SECTOR

This Appendix reviews capacity changes in hospitals and long-term care facilities funded by the Province during the time frame of this study as well as the service delivery roles of Community Health Centres established, in all but one case, following the election of the Schreyer administration in 1969.

The geographic area utilized for the facilities described in this Appendix was first defined by the Roblin administration when it implemented a metropolitan system of government for the City of Winnipeg and its surrounding municipalities in 1960. While the implementation of this system integrated a range of administrative functions, such as planning, zoning, tax assessment and garbage disposal, public health services remained a local undertaking within the jurisdiction of the municipal governments participating in the metropolitan system.

In 1972 the Schreyer administration implemented the Unicity system which amalgamated the City of Winnipeg with twelve adjacent municipalities to form a single municipal government. The twelve municipalities included in unicity were; the Cities of St. Boniface and St. James, the Towns of Tuxedo and Transcona, and the RMs of Assiniboia, Charleswood, East Kildonan, Fort Gary, North Kildonan, Old Kildonan, St. Vital, and West Kildonan.

While the geographic boundaries of the Unicity define the Winnipeg Region for the purposes of these profiles, it is noteworthy that within the boundaries of the old City of Winnipeg, responsibility for the delivery of public health services was retained by the City of Winnipeg. LHUs funded by the other municipalities included in Unicity were integrated within the province's regional system in 1973.

PUBLIC GENERAL HOSPITALS

The Children's Hospital

This Hospital was established in 1909 and operated from at site in Winnipeg's Redwood and Main street area until a new facility was constructed in 1956 at the Manitoba Medical Centre site.

1949: RBC 77

In 1956 a new facility opens on the Manitoba Medical Centre site.

1959: RBC 232

1969: RBC 232

In 1973 the facility becomes part of the Health Sciences Centre.

Concordia Hospital

This Hospital was established in 1934 by the Mennonite Hospital Society through the purchase of the Winnipeg Sanatorium building located in the Elmwood area of Winnipeg.

1949: RBC 50

1959 RBC 81

1969: RBC 69

In 1973 a new 132 bed facility is opened in the east Elmwood area.

1977: RBC 124

1981: RBC 132

1989: RBC 136

D.A. Stewart Rehabilitation Hospital

This Hospital began operations in 1962 on the Manitoba Medical Centre site. It was operated by the Sanatorium Board of Manitoba prior to its integration with the HSC.

1964: RBC 160
1969: RBC 224

In 1973 the facility becomes part of the Health Sciences Centre.

Grace Hospital

This Hospital was established in 1906 in the Arlington Street area by the Salvation Army. It primary service area was the west Winnipeg area.

1949: RBC 260

In 1955 renovations reduce the number of beds.

1959: RBC 208

In 1966 a new 260 bed facility opens in the St. James.

1969: RBC 258

In 1971 a 40 bed psychiatric unit is opened.

1977: RBC 302
1981: RBC 302
1989: RBC 301

Health Sciences Centre

The HSC was established in 1973 through the amalgamation of the Winnipeg General and Children's Hospitals, the D.A. Stuart Centre, the Winnipeg Psychiatric Institute, and the Women's Pavilion. It is located in central Winnipeg on the former Manitoba Medical Centre site.

1974: RBC 1404

In 1976 Phase I planning for the redevelopment of the HSC site is approved with a capital budget of $26.5 million. This planning focuses on the reduction of in-patient beds and increases in the Centre's ambulatory and emergency capacity. Major construction starts in the fall of 1979.

1977: RBC 1339
1981: RBC 1277
1989: RBC 1113

Misericordia General Hospital

The Misericordia General Hospital was established in 1907 by the Les Soeurs de Misericorde, a group attached to the Catholic Church. It is located in the south central area of Winnipeg and serves residents from that area and adjacent municipalities to the south and west.

1949: RBC 247

In 1950 27 new beds are added.

In 1957 a 150 bed expansion is completed.

1959: RBC 427
1969: RBC 418
1977: RBC 409
1981: RBC 409
1989: RBC 409

Shriner's Hospital/Rehabilitation Centre for Children

This Hospital was established in 1950 by the Shriner Khartum Temple to provide orthopaedic services to children in Manitoba. It opened with an RBC of 40.

1959: RBC 40
1969: RBC 40

In 1975 an agreement between the province and the Khartum Temple converts this facility to an out-patient rehabilitation centre.

Shriner's Hospital/Rehabilitation Centre for Children (continued)
1977: RBC 40
On March 2, 1981 this centre is incorporated as an extended treatment facility and is renamed the Rehabilitation Centre for Children.
1989: RBC 20

St. Boniface Hospital
This Hospital was established in 1871 by the Sisters of Charity Grey Nuns. It is located in the St. Boniface area of Winnipeg and serves residents from that area and municipalities to the south and east of Winnipeg.
1949: RBC 427
In 1955 a new wing is opened expanding the total bed capacity.
1959: RBC 723
1969: RBC 658
1977: RBC 605
In 1981 a 48 bed psychiatric residence is opened.
1981: RBC 624
1989: RBC 617

Seven Oaks Hospital
The construction of this facility, in the northern part of Winnipeg, was announced by the Schreyer administration in 1974 ,however construction did not begin until 1977. It was largely completed in late 1980 and the first patient was admitted on January 14, 1981. The facility combines 216 active treatment beds with 120 extended treatment beds.
1984: RBC 332
1989: RBC 326

Victoria General Hospital
This Hospital began operations in 1912 at a site in central Winnipeg. In 1970 it moved to the Fort Garry area on the south-west side of the City.
1949: RBC 78
In 1950 a new 80 bed wing opens.
1959: RBC 145
1969: RBC 139
In 1970 a new 254 hospital located in south Fort Garry opens.
1977: RBC 254
1981: RBC 252
1989: RBC 246

Winnipeg General Hospital
This Hospital was established in 1872. Located at the former Manitoba Medical Centre site in central Winnipeg, it became part of the Health Sciences Centre complex in 1973.
1949: RBC 613
In 1950 a new 150 bed wing is completed .
In 1958 further expansion increases total bed capacity.
1959: RBC 864
In 1966 a 175 bed expansion opens.
1969: RBC 967
In 1973 the facility becomes part of the Health Sciences Centre.

EXTENDED TREATMENT HOSPITALS

Deer Lodge Hospital

This Hospital began operations in 1916 as a federal convalescent facility for WW I veterans. Located in the old City of St. James it served veterans from Manitoba and northern Ontario as well as Armed Forces and RCMP staff from those areas. In 1949 its RBC was 440 which decreased to 300 beds by1981. In 1982 the Province and the Federal government signs an agreement giving the province to take ownership of the facility effective April 1, 1983. That year province moved patients from the facility and began renovations.

1984: RBC 94

In 1987 the construction of a 200 bed expansion is announced.

1989: RBC 106.

St. Vital Hospital

This Hospital was constructed in the 1920s in the RM of St. Vital by the Sisters of Charity Grey Nuns to serve as an extended treatment facility and was originally called the St. Boniface Convalescent Hospital.

1949: RBC 40
1959: RBC 40
1964: RBC 40

In 1966 the facility is renovated and expanded.

1969: RBC 188
1977: RBC 188
1981: RBC 188
1988: RBC 184

Winnipeg Municipal Hospitals

This complex of facilities began operations in 1912 with the construction of the King Edward Memorial Hospital as a tuberculosis treatment facility. In 1914 the King George Hospital was added for the treatment of infectious diseases. In 1950 the Princess Elizabeth Hospital was build as a chronic treatment facility.

1949: RBC 299 (King Edward:124/King George:175)

In 1950 the King George's RBC falls to 80 with the addition of the Princess Elizabeth Hospital with an RBC of 208.

1959: RBC 503
1969: RBC 401
1977: RBC 401
1981: RBC 401

In 1985 a major redevelopment of the Hospital is announced.

1989: RBC 337

LONG-TERM CARE FACILITIES

Provincial reporting of the capacity of these facilities did not begin until 1963. As a result, this section begins with the 1964 capacity of proprietary and non proprietary nursing homes and hostels in metropolitan Winnipeg.

1964: 29 institutions: Total RBC 1883
1969: 35 institutions: Total RBC 2520
1977: 36 institutions: Total RBC 4275
1981: 34 institutions: Total RBC 4048
1989: 33 institutions: Total RBC 4594

COMMUNITY HEALTH CENTRES

Health Action Centre

Planning for this Centre began in 1971 when a community group was awarded a Local Improvement Project (LIP) grant to hire nine persons to undertake health promotion and out-reach programs in Winnipeg's core area. In 1974 the Citizen's Health Action Centre was incorporated as a non-profit corporation under the province's Company's Act to provide services to inner city residents. The Centre is governed by the board of the Health Sciences Centre. The range of services include: clinical medical services; public health nursing; community mental health nursing; child day care, preventive out-reach programs.

Hope Community Health Centre

This Centre began operations in April 1986 in the core area of Winnipeg. Its mandate is to provide services to First Nations persons living in the core area. The range of services include: pubic health nursing, social services, and preventive out-reach programs.

Klinic

Klinic began as a crisis intervention "street clinic" in the late 1960s with funding from federal grants related to the non-medical use of drugs. Psychological and social services counselling along with public health nursing was added to Klinic's service base in June 1972 through funding by the provincial Department of Health and Social Development. Klinic's service base was further expanded in 1974 when the MHSC agreed to fund the services of a physician. The centre is governed by a board elected by the sitting board and serves residents from all areas of Winnipeg. The range of services includes: clinical medical care; nursing outreach, community mental health services; occupational health services; social services; crisis intervention.

Mount Carmel Clinic

Mount Carmel Clinic was founded in 1926 as a Jewish charity providing medical services to immigrants. It is located in north central Winnipeg and is governed by a board made up of persons appointed by local organizations and elected from the community served by the Clinic. Mount Carmel pioneered many of the services common to C.H.C.s in Manitoba and maintains a number of unique programs in the area of pharmaceutical services and out-reach preventive services. Between 1958 and 1974 the Clinic was largely financed by three sources: fee-for-service billings to provincial health insurance programs; grants from the province for specialized services; and grants from the United Way. In 1974 the Clinic was placed on a block payment system with costs shared by the MHSC and the Department of Health and Social Development. On September 24, 1982 a new clinic building was opened. The range of services includes: clinical medical services; public health nursing and out-reach services; occupational health services social services; pharmacy services; home care; dental services.

Nor'-west Co-operative Health and Social Services Centre

Planning for this centre began in 1972 based on a survey of health and social services needs by the Co-operative Housing Association of Manitoba who intended to develop new services to its members. While the original intent of the centre was not realized, it began operations in 1974 as a CHC for residents in the northwestern part of Winnipeg. It is governed by a fifteen member board elected by the membership of the co-operative. The range of services includes: clinical medical services; public health nursing and out-reach services with a focus on the needs of first nations persons.

Youville Clinic

This centre was established by the Grey Nuns in 1984 to provide services to persons in the St. Boniface area of Winnipeg. The primary focus of this centre is the provision of nursing services and health education to persons in their homes.

Village Clinic

This centre was opened in early 1984 and concentrates on medical, nursing and social services supports to persons with HIV/AIDS. It serves all residents of Winnipeg and offers out-reach support to residents of rural Manitoba. The range of services includes: clinical medical services, nursing and out-reach services, counselling program, community education programs.

Women's Health Centre

The focus of this Centre is to provide primary medical services and counselling services in the area of reproductive health. The Centre serves residents of Winnipeg and rural Manitoba. The range of services includes: reproductive counselling; self-help groups.

APPENDIX D:
SUPPLEMENTARY DATA

This Appendix contains Figures and Tables that serve as the data base for the Tables contained in Chapters 3 through 8. The data in the Tables has been collected from a variety of sources including the 1952 Advisory Health Survey Committee Report, the 1959 Hospital Survey Board Report, Department of Health Annual Reports, and MHC/MHSC Annual Reports and Statistical Supplements. The contents of this Appendix include:

Figures

Figure D.1: 1959 LHU Boundaries
Figure D.2: 1950 Hospital District Boundaries
Figure D.3: 1974 MHSC Regional Boundaries

Tables

Table D.1: Provincial Facilities Growth 1949 to 1959
Table D.2: Provincial Health Expenditures 1949 to 1959
Table D.3: Provincial Facilities Growth 1959 to 1969
Table D.4: Provincial Health Expenditures 1959 to 1969
Table D.5: Commissioner of Hospitalization/MHC Budgets 1959 to 1969
Table D.6: Provincial Facilities Growth 1969 to 1977
Table D.7: Provincial Health Expenditures 1969 to 1978
Table D.8: MHC/MHSC Budgets 1969 to 1979
Table D.9: Provincial Facilities Growth 1977 to 1981
Table D.10: Provincial Health Expenditures 1978 to 1981
Table D.11: MHSC Budgets 1979 to 1981
Table D.12: Provincial Facilities Growth 1981 to 1989
Table D.13: Provincial Health Expenditures 1981 to 1989
Table D.14: MHSC Budgets 1981 to 1989
Table D.15: Provincial Hospital Growth 1949 to 1989
Table D.16: Provincial LTC Growth 1959 to 1989
Table D.17: Rural DHC Growth
Table D.18: Provincial Health Care Expenditures 1949 to 1989

Figure D.1: 1959 LHU Boundaries

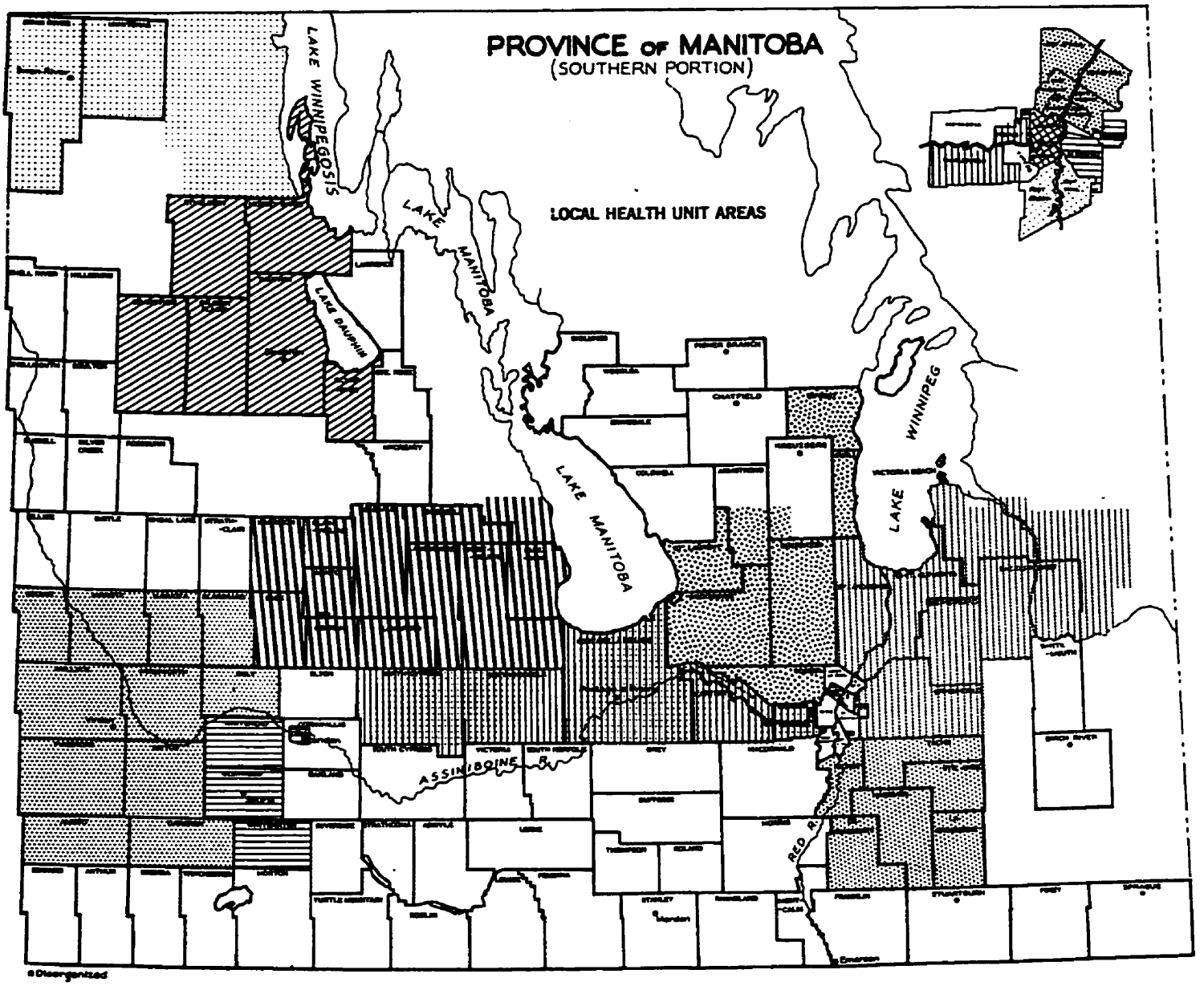

Figure D.2: 1950 Hospital District Boundaries

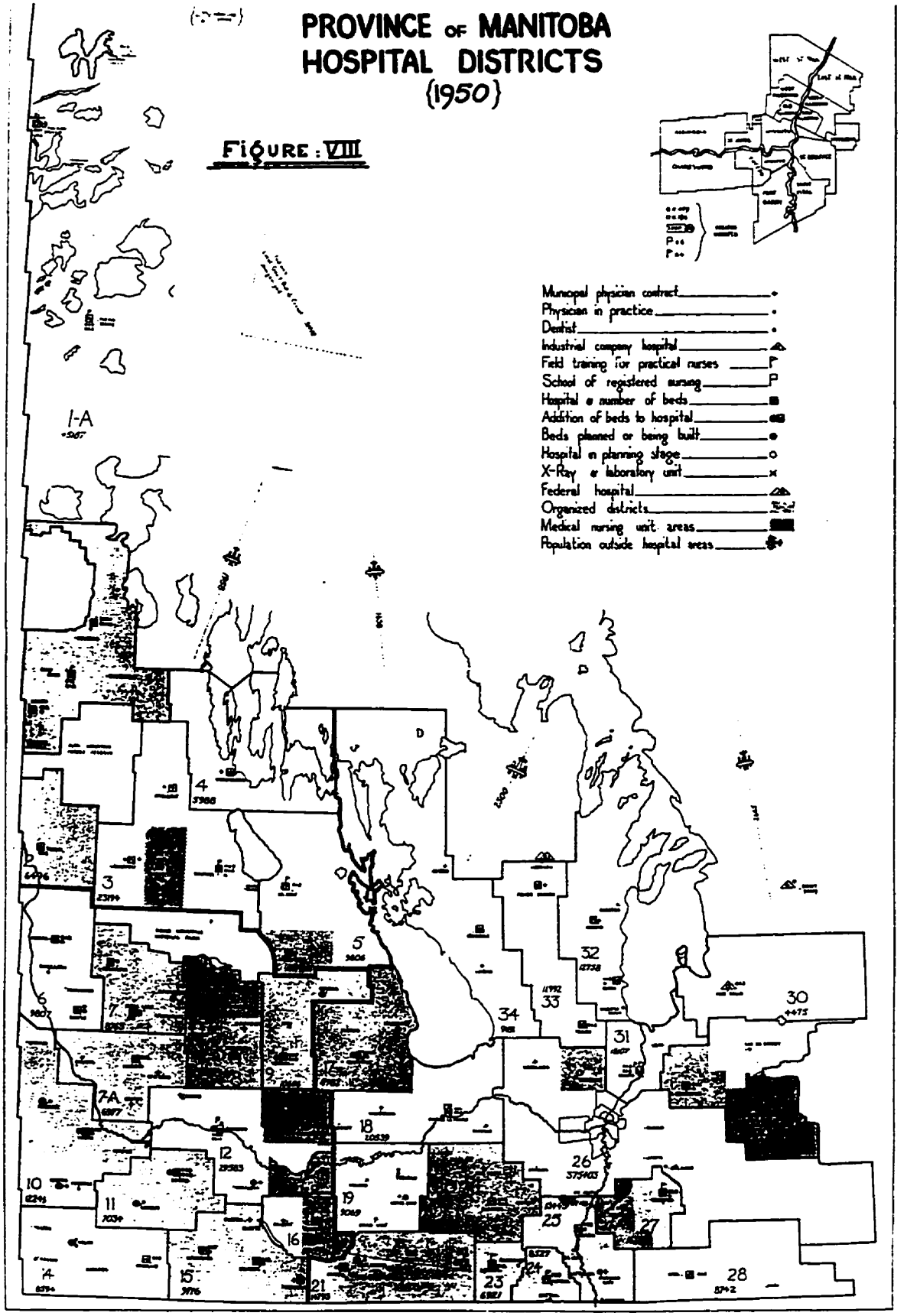

Figure D.3: 1974 MHSC Regional Boundaries

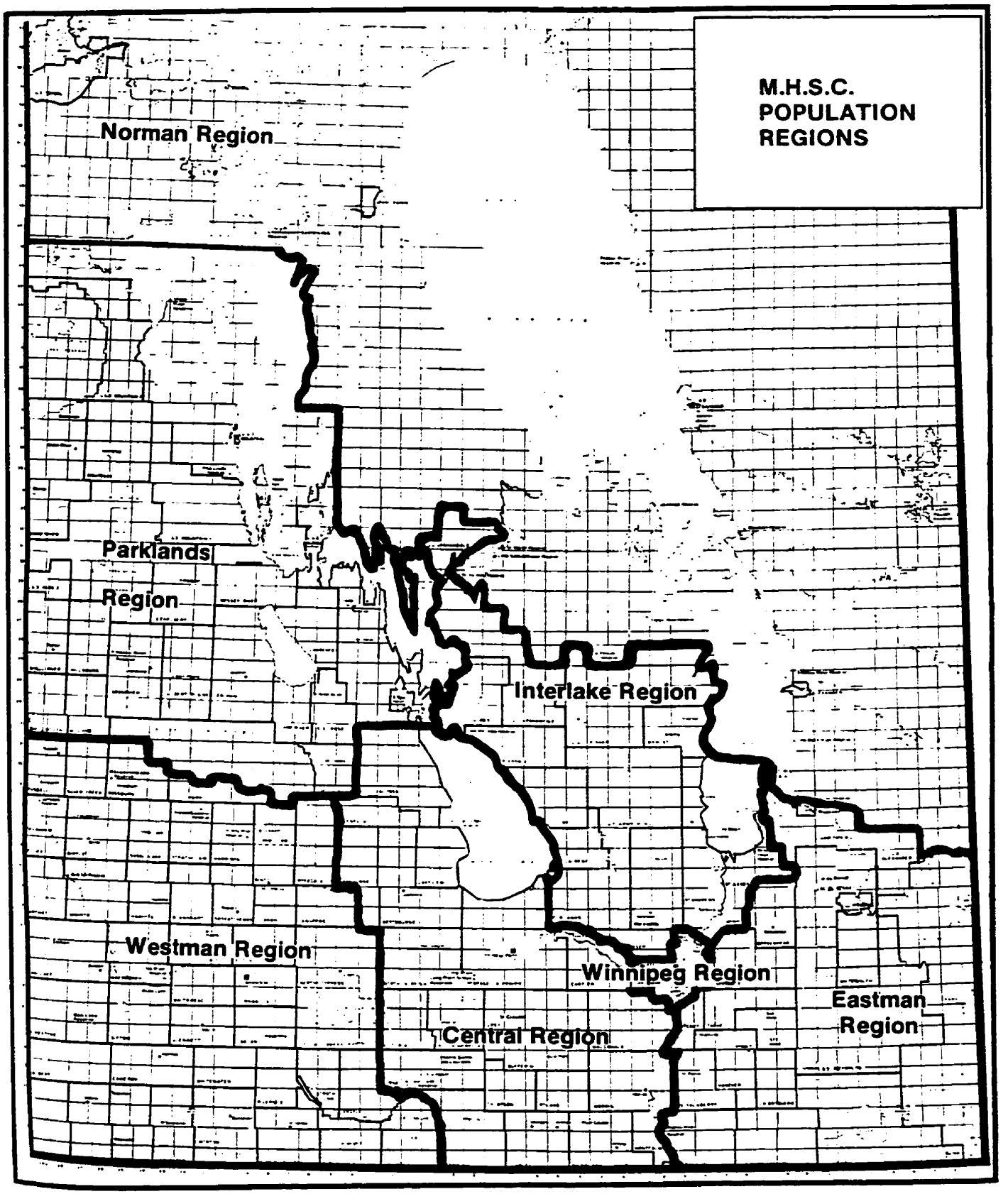

Table D.1:				
Provincial Facilities Growth				
1949 to 1959				
Rural Region and Key	**Rated Beds**	**Rated Beds**	**Rated Beds**	**LTC Beds**
Communities	**1949**	**1954**	**1959**	**1959**
Central n = 13				
Altona	30	29	30	0
Carman	19	43	42	0
Emerson	0	0	10	0
Gladstone	8	22	22	0
MacGregor	0	6	6	0
Manitou	0	8	10	0
Morden	22	28	57	33
Morris	11	21	21	28
Notre Dame	0	8	8	14
Portage La Prairie	60	80	83	50
St. Claude	0	0	13	0
Treherne	0	0	22	0
Winkler	32	32	25	93
Total Rated Capacity	**182**	**277**	**349**	**218**
Communities with Facilities	**7**	**10**	**13**	**5**
Eastman n = 8				
Beausejour	0	22	22	0
Lac du Bonnet	0	0	0	0
Pine Falls	15	30	30	0
Ste. Anne	0	8	13	22
St. Pierre-Jolys	0	12	21	42
Steinbach	43	42	42	30
Vita	18	18	13	0
Whitemouth	0	10	10	0
Total Rated Capacity	**76**	**142**	**151**	**94**
Communities with Facilities	**3**	**7**	**7**	**3**
Interlake n = 7				
Arborg & FB	0	18	19	0
Ashem	0	9	10	0
Eriksdale	10	10	9	0
Gimli	36	36	24	91
Selkirk	42	42	71	149
Stonewall	0	8	9	0
Teulon	30	30	20	0
Total Rated Capacity	**118**	**153**	**162**	**240**
Communities with Facilities	**4**	**7**	**7**	**2**

Table D.1 (continued):				
Provincial Facilities Growth				
1949 to 1959	**Rated Beds**	**Rated Beds**	**Rated Beds**	**LTC Beds**
	1949	**1954**	**1959**	**1959**
Norman n = 8				
Churchill	0	0	0	0
Flin Flon	48	88	117	0
Gillam	0	0	0	0
Leaf Rapids	0	0	0	0
Lynn Lake	0	11	11	0
Snow Lake	7	7	10	0
The Pas	76	96	100	96
Thompson	0	0	0	0
Total Rated Capacity	**131**	**202**	**238**	**96**
Communities with Facilities	**2**	**4**	**4**	**1**
Parkland n = 9				
Benito	0	10	10	0
Dauphin	89	89	63	42
Gilbert Plains	10	10	10	0
Grandview	8	8	20	12
McCreary	0	8	8	0
Roblin	0	28	32	0
Ste. Rose	27	27	71	0
Swan River	30	42	52	0
Winnipegosis	14	14	17	0
Total Rated Capacity	**178**	**236**	**283**	**54**
Communities with Facilities	**6**	**9**	**9**	**2**
Westman n = 27				
Baldur	0	8	8	0
Birtle	8	8	28	0
Bossevain	10	10	17	0
Brandon	202	202	367	392
Carberry	0	10	16	14
Cartwright	0	8	8	0
Crystal City	10	10	16	0
Deloraine	14	16	20	16
Elkhorn	0	9	9	0
Erikson	0	6	15	20
Glenboro	0	0	10	16
Hamiota	8	26	28	0
Hartney	0	4	4	0
Killarney	30	30	31	41
Melita	0	0	22	0
Minnedosa	9	26	25	22
Neepawa	23	34	35	26
Pilot Mound	0	8	8	0
Reston	0	8	8	0
Rivers	0	0	20	0
Rossburn	0	10	16	0
Russell	35	35	28	0
Shoal Lake	15	23	24	0

Table D.1 (continued):				
Provincial Facilities Growth				
1949 to 1959				
Westman (continued)				
Souris	25	34	34	16
Swan Lake	0	0	11	0
Virden	18	32	33	0
Wawanesa	0	5	10	0
Total Rated Capacity	**407**	**562**	**851**	**563**
Communities with Facilities	**13**	**23**	**27**	**9**
Winnipeg Public Hosptials	**Rated Beds**	**Rated Beds**	**Rated Beds**	**LTC Beds**
	1949	**1954**	**1959**	**1959**
Children's	77		232	
Concordia	50		81	
Grace	260		208	
Misericordia	247		427	
Winnipeg Municipal Hospitals	175		543	
St. Boniface	427		723	
St. Vital Convalescent	40		40	
Shriners Hospital	0		40	
Victoria	78		145	
Winnipeg	613		864	
Total	**1967**		**3303**	
LTC Facilities	**700**			**1883**
Sources: 1953 Manitoba Advisory Health Survey Committee Report				
: 1961 Manitoba Hospital Survey Board Report				

Table D.2:				
Provincial Health Care Expenditures				
1949 to 1959	**1949**		**1959**	
Total Provincial Expenditures	37522214		85356800	
Total Provincial Revenues	37522214		85356800	
Surplus (Deficit)	0		0	
Health Budget (Dept. Divsions)		**% Total**		**% Total**
Executive Division	177731	4.720675	436251	4.024552
Psychiatric Services Division	1808415	48.03292	3975474	36.67499
Public Health Services Division	1221191	32.43579	2559456	23.61178
Institutional Services	557612	14.81061	3868561	35.68868
Total Health Expenditures	**3764949**	**100**	**10839742**	**100**
Health Expenditures as % of Total Expenditures		10.03392		12.69933
Detail				
Public Health Services Division		% Total		% Total
Division Administration	6567	0.537754	21809	0.852095
Environmental Sanitation	38914	3.186561	75215	2.93871
Food Control	7060		12435	
Industrial Hygiene	11071		20578	
Preventive Medical Services	7750	0.634626	14322	0.559572
Disease Control	261197	21.38871	637921	24.92409
TB Control	390791	32.00081	1008983	39.42178
Maternal & Child Hygiene	10753		13649	
Public Health Nursing	58311	4.774929	91920	3.591388
Local Health Services	19699	1.613097	7683	0.300181
Local Health Units	255801	20.94685	317920	12.42139
Diagnostic Units	28838	2.361465	128630	5.025677
Medical Care	1563		3772	
Graduate Training	14900		44142	
MOHs in Unorganized Territories	5855	0.47945	12646	0.494089
Emergency Air Services	1464		6363	
Dental Care	18548	1.518845	27902	1.090154
Provincial Lab Services	47919	3.923956	94017	3.67332
Research Grants	18419		19549	
Physical Fitness	15771			
Total	**1221191**		**2559456**	
Institutional Services				
Hospital Services and Grants	374995	67.25017	3196987	82.64021
Hosptial Construction Grants	182617	32.74983	541612	14.00035
LTC Construction Grants			129962	3.35944
Total	**557612**	**100**	**3868561**	**100**
Sources: Public Accounts of Manitoba Fiscal 1948-49 and 1958-59.				

Table D.3:					
Provincial Facilities Growth					
1959 to 1969					
Rural Region and Key	Rated Beds	LTC Beds	Rated Beds	Rated Beds	LTC Beds
Communities	1959	1959	1964	1969	1969
Central n = 13					
Altona	30	0	38	38	48
Carman	42	0	42	42	70
Emerson	10	0	8	18	0
Gladstone	22	0	22	25	0
MacGregor	6	0	6	12	0
Manitou	10	0	10	14	0
Morden	57	33	57	75	60
Morris	21	28	52	52	26
Notre Dame	8	14	8	10	44
Portage La Prairie	83	50	94	94	82
St. Claude	13	0	13	15	0
Treherne	22	0	24	22	0
Winkler	25	93	26	57	70
Total Rated Capacity	349	218	400	474	400
Communities with Facilities	13	5	13	13	7
Eastman n = 8					
Beausejour	22	0	21	21	0
Lac du Bonnet	0	0	0	0	0
Pine Falls	30	0	48	48	0
Ste. Anne	13	22	13	18	47
St. Pierre-Jolys	21	42	21	21	42
Steinbach	42	30	65	95	107
Vita	13	0	13	13	0
Whitemouth	10	0	10	10	0
Total Rated Capacity	151	94	191	226	196
Communities with Facilities	7	3	7	7	3
Interlake n = 7					
Arborg & FB	19	0	26	30	50
Ashern	10	0	10	10	0
Eriksdale	9	0	17	17	0
Gimli	24	91	24	24	85
Selkirk	71	149	74	77	203
Stonewall	9	0	18	18	0
Teulon	20	0	20	23	0
Total Rated Capacity	162	240	189	199	338
Communities with Facilities	7	2	7	7	3

Table D.3 (continued):					
Provincial Facilities Growth					
1959 to 1969	**Rated Beds**	**LTC Beds**	**Rated Beds**	**Rated Beds**	**LTC Beds**
	1959	**1959**	**1964**	**1969**	**1969**
Norman n = 8					
Churchill	0	0	41	41	0
Flin Flon	117	0	119	119	0
Gillam	0	0	0	15	0
Leaf Rapids	0	0	0	0	0
Lynn Lake	11	0	5	10	0
Snow Lake	10	0	7	7	0
The Pas	100	96	74	77	203
Thompson	0	0	32	75	0
Total Rated Capacity	**238**	**96**	**278**	**344**	**203**
Communities with Facilities	**4**	**1**	**6**	**7**	**1**
Parkland n = 9					
Benito	10	0	10	10	0
Dauphin	63	42	139	139	70
Gilbert Plains	10	0	21	21	0
Grandview	20	12	17	17	12
McCreary	8	0	16	16	0
Roblin	32	0	32	32	0
Ste. Rose	71	0	71	68	0
Swan River	52	0	52	98	55
Winnipegosis	17	0	17	22	0
Total Rated Capacity	**283**	**54**	**375**	**423**	**137**
Communities with Facilities	**9**	**2**	**9**	**9**	**3**
Westman n = 27					
Baldur	8	0	16	16	0
Birtle	28	0	28	28	0
Bossevain	17	0	17	14	46
Brandon	367	392	406	413	474
Carberry	16	14	29	29	16
Cartwright	8	0	8	7	0
Crystal City	16	0	16	16	0
Deloraine	20	16	20	21	30
Elkhorn	9	0	9	8	0
Erikson	15	20	14	14	22
Glenboro	10	16	16	16	16
Hamiota	28	0	25	25	0
Hartney	4	0	5	9	0
Killarney	31	41	31	29	46
Melita	22	0	17	17	0
Minnedosa	25	22	25	35	22
Neepawa	35	26	35	34	101
Pilot Mound	8	0	8	8	30
Reston	8	0	15	17	0
Rivers	20	0	20	20	0
Rossburn	16	0	16	16	0
Russell	28	0	28	28	0
Shoal Lake	24	0	23	23	0

Table D.3 (continued):					
Provincial Facilities Growth					
1959 to 1969					
Westman (continued)					
Souris	34	16	33	34	40
Swan Lake	11	0	11	22	0
Virden	33	0	32	32	50
Wawanesa	10	0	10	10	0
Total Rated Capacity	**851**	**563**	**913**	**941**	**893**
Communities with Facilities	**27**	**9**	**27**	**27**	**12**
Winnipeg Public Hosptials	**Rated Beds**	**LTC Beds**	**Rated Beds**	**Rated Beds**	**LTC Beds**
	1959	**1959**	**1964**	**1969**	**1969**
Children's	232		232	232	
Concordia	81		79	69	
Grace	208		208	258	
Misericordia	427		418	418	
Rehabilitation Hospital			160	224	
St. Boniface	723		655	648	
St. Vital Convalescent	40		40	188	
Shriners Hospital	40		40	40	
Victoria	145		145	139	
Winnipeg General	864		943	967	
Winnipeg Municipal Hospitals	543		446	401	
Total	**3303**	**1883**	**3366**	**3584**	**2520**
Sources : 1961 Manitoba Hospital Survey Board Report					
: 1969 Statistical Supplement of the MHC					

Table D.4:				
Provincial Health Care Expenditures				
1959 to 1969	**1959**		**1969**	
Total Provincial Expenditures	85356800		357331901	
Total Provincial Revenues	85356800		357331901	
Surplus (Deficit)	0		0	
Health Budget (Dept. Divsions)		**% Total**		**%Total**
Executive Division	430251	4.024552	915930	2.084338
Mental Health Division	3975474	36.67499	12945948	29.46048
Public Health Services Division	2559456	23.61178	8597711	19.5654
Institutional Services*	3868561	35.68868	21483854	48.88978
Total Health Expenditures	**10839742**	**100**	**43943443**	**100**
Health Expenditures as % of Total Expenditures		12.69933		12.29765
Detail				
Public Health Services Division		**% Total**		**%Total**
Division Administration	21809	0.852095	1341197	15.59947
Environmental Sanitation	75215	2.93871	373480	4.343947
Food Control	12435			
Industrial Hygiene	20578			
Preventive Medical Services	14322	0.559572	436219	5.073664
Disease Control	637921	24.92409	141518	1.645996
TB Control	1008983	39.42178		
Maternal & Child Hygiene	13649			
Public Health Nursing	91920	3.591388	198725	2.311371
Local Health Services	7683	0.300181	127079	1.478056
Local Health Units	317920	12.42139	3447067	40.09285
Diagnostic Units	128630			
Medical Care	3772			
Graduate Training	44142			
MOHs in Unorganized Territories	12646			
Emergency Air Services	6363	0.248608	36312	0.422345
Dental Care	27902	1.090154	202144	2.351137
Provincial Lab Services	94017	3.67332	459246	5.341491
Research Grants	19549			
Physical Fitness				
Rehabilitation Services			1834724	
Total	**2559456**		**8597711**	
Institutional Services		% Total		%Total
MHC/Other Hospital Services	3196987	82.64021	21015000	97.81764
Hosptial/LTC Construction Grants	671574	17.35979	468854	2.182355
Total	**3868561**	**100**	**21483854**	**100**
Sources: Public Accounts of Manitoba Fiscal 1958-59 and 1968-69.				
* This amount represents the province's expenditure only. It does not include				
federal transfers or premium revenues paid to the MHC.				

Table D.5						
Commissioner of Hospitalization/MHC Budgets 1959 to 1969						
Revenues:	**1959**	**%Total**	**1964**	**%Total**	**1969**	**%Total**
Insurance Premiums	12.8	47.05882	12.8	28.31858	24.4	28.31858
Provincial Funding	3.1	11.39706	10.8	23.89381	21	24.27746
Federal Funding	11.2	41.17647	21.4	47.34513	39.9	46.12717
Other	0.1	0.367647	0.2	0.442478	1.2	1.387283
Total Revenues	**27.2**	**100**	**45.2**	**100**	**86.5**	**100.1105**
Expenditures	27.1		45.5		81	
Op Surplus/Deficit	**0.1**		**-0.3**		**5.5**	
Expenditure Detail						
Administration	1.5	5.535055	1.5	3.296703	1.5	1.851852
General Hospitals	23.8	87.82288	41.1	90.32967	75	92.59259
Federal Hosptials	1.2	4.428044	1.7	3.736264	2.5	3.08642
Other Hospitals	0.2	0.738007	0.6	1.318681	0.8	0.987654
Out-of-Province Bills	0.4	1.476015	0.6	1.318681	1.2	1.481481
Total	**27.1**	**100**	**45.5**	**100**	**81**	**100**
Sources: Commissioner of Hospitilization Annual Report 1959						
: MHC Annual Report 1969						
All dollar amounts are listed in millions of dollars						

Table D.6:					
Provincial Facilities Growth					
1969 to 1977					
Rural Region and Key Communities	Rated Beds 1969	LTC Beds 1969	Rated Beds 1977	LTC Beds 1977	District Formation
Central n = 13					
Altona	38	48	32	25	
Carman	42	70	35	70	
Emerson	18	0	18	0	
Gladstone	25	0	25	50	1973
MacGregor	12	0	12	0	
Manitou	14	0	14	0	
Morden	75	60	75	60	
Morris	52	26	52	40	
Notre Dame	10	44	10	68	
Portage La Prairie	94	82	139	150	
St. Claude	15	0	15	0	
Treherne	22	0	18	20	
Winkler	57	70	57	118	
Total Rated Capacity	**474**	**400**	**502**	**601**	
Communities with Facilities	**13**	**7**	**13**	**9**	**1**
Eastman n = 8					
Beausejour	21	0	30	60	
Lac du Bonnet	0	0	0	0	1973
Pine Falls	48	0	48	0	
Ste. Anne	18	47	18	97	
St. Pierre-Jolys	21	42	19	16	
Steinbach	95	107	95	126	
Vita	13	0	11	30	
Whitemouth	10	0	10	0	
Total Rated Capacity	**226**	**196**	**231**	**329**	
Communities with Facilities	**7**	**3**	**7**	**5**	**1**
Interlake n = 7					
Arborg & FB	30	50	18	40	
Ashern	10	0	16	0	1977
Eriksdale	17	0	17	0	1977
Gimli	24	85	45	135	
Selkirk	77	203	77	243	
Stonewall	18	0	18	30	
Teulon	23	0	20	20	
Total Rated Capacity	**199**	**338**	**211**	**468**	
Communities with Facilities	**7**	**3**	**7**	**5**	**2**

Table D.6 (continued):					
Provincial Facilities Growth					
1969 to 1977	**Rated Beds**	**LTC Beds**	**Rated Beds**	**LTC Beds**	**District**
	1969	**1969**	**1977**	**1977**	**Formation**
Norman n = 8					
Churchill	41	0	31	0	1971
Flin Flon	119	0	125	30	
Gillam	15	0	15	0	
Leaf Rapids	0	0	8	0	1973
Lynn Lake	10	0	25	0	
Snow Lake	7	0	7	0	
The Pas	77	203	112	72	
Thompson	75	0	100	0	
Total Rated Capacity	**344**	**203**	**423**	**102**	
Communities with Facilities	**7**	**1**	**8**	**2**	**2**
Parkland n = 9					
Benito	10	0	10	0	
Dauphin	139	70	104	70	
Gilbert Plains	21	0	21	0	
Grandview	17	12	18	40	
McCreary	16	0	17	0	1977
Roblin	32	0	25	14	
Ste. Rose	68	0	68	40	
Swan River	98	55	88	113	
Winnipegosis	22	0	22	0	
Total Rated Capacity	**423**	**137**	**373**	**277**	
Communities with Facilities	**9**	**3**	**9**	**5**	**1**
Westman n = 27					
Baldur	16	0	16	0	
Birtle	28	0	28	0	
Bossevain	14	46	12	66	
Brandon	413	474	433	628	
Carberry	29	16	29	30	
Cartwright	7	0	7	0	
Crystal City	16	0	16	0	1977
Deloraine	21	30	21	30	
Elkhorn	8	0	8	0	
Erikson	14	22	14	36	
Glenboro	16	16	19	16	
Hamiota	25	0	25	0	1974
Hartney	9	0	9	0	
Killarney	29	46	26	73	
Melita	17	0	17	20	
Minnedosa	35	22	35	50	
Neepawa	34	101	38	149	
Pilot Mound	8	30	8	30	1977
Reston	17	0	17	0	
Rivers	20	0	20	0	
Rossburn	16	0	17	0	
Russell	28	0	38	0	
Shoal Lake	23	0	23	0	

Table D.6 (continued):					
Provincial Facilities Growth					
1969 to 1977					**District Formation**
Westman (continued)					
Souris	34	40	30	34	
Swan Lake	22	0	22	0	
Virden	32	50	32	50	
Wawanesa	10	0	10	0	
Total Rated Capacity	**941**	**893**	**970**	**1212**	
Communities with Facilities	**27**	**12**	**27**	**13**	**3**
Winnipeg Public Hosptials	**Rated Beds**	**LTC Beds**	**Rated Beds**	**LTC Beds**	
	1969	**1969**	**1977**	**1977**	
Children's	232		HSC		
Concordia	69		124		
Grace	258		302		
Health Sciences Centre			1339		
Misericordia	418		409		
Rehabilitation Hospital	224		HSC		
St. Boniface	648		605		
St. Vital Convalescent	188		188		
Shriners Hospital	40		25		
Victoria	139		254		
Winnipeg General	967		HSC		
Winnipeg Municipal Hospitals	401		401		
Total	**3584**	**2520**	**3647**	**4275**	
Sources : 1969 Statistical Supplement of the MHC					
: 1977-78 Statistical Supplement of the MHSC					

Table D.7:				
Provincial Health Care Expenditures				
1969 to 1978	**1969**		**1978**	
Total Provincial Expenditures	357331901		1077980917	
Total Provincial Revenues	357331901			
Surplus (Deficit)	0			
Health Budget (Dept. Divsions)		**%Total**		**%Total**
Executive Division	915930	2.084338	4349450	1.440321
Psychiatric Services Divison	12945948	29.46048	38190330	12.64673
Public Health Services Division	8597711	19.5654	34154047	11.31012
MHSC/Other Hospital Services*	21483854	48.88978	225284000	74.60283
Total Health Expenditures	**43943443**	**100**	**301977827**	**100**
Health Expenditures as % of Total Expenditures		12.29765		28.01328
Public Health Services Division		**%Total**		**%Total**
Division Administration	1341197	15.59947	352204	1.031222
Preventive Medical/Medical Public Health	436219	5.073664	1910429	5.593566
Environmental Sanitation	373480	4.343947	Community Field Servic	
Disease Control	141518	1.645996	Community Field Servic	
Public Health Nursing	198725	2.311371	179922	0.526796
Local Health Services	127079	1.478056	Community Field Servic	
Local Health Units	3447067	40.09285	Community Field Servic	
Emergency Air Services	36312	0.422345	Community Field Servic	
Community Field Services			16424465	48.08937
Continuing Care Services (Home Care)			8281718	24.24813
Dental Care	202144	2.351137	1522932	4.459009
Provincial Laboratory Services	459246	5.341491	Community Field Servic	
Health Education and Library Services	Medical Public Health		306380	0.897053
Rehabilitation Services	1834724	21.33968	5175997	15.15486
Total	**8597711**		**34154047**	
Sources: Public Accounts of Manitoba Fiscal 1968-69 and 1977-78.				
* This amount represents the province's expenditure only. It does not include				
federal transfers or premium revenues paid to the MHC/MHSC.				

Table D.8

MHC/MHSC Budgets 1969 to 1979

Revenues:	**1969**	**%Total**	**1974**	**%Total**	**1979**	**%Total**
Insurance Premiums	24.4	28.20809	Discontinued in 1973			
Provincial Funding	21	24.27746	138.8	54.49548	444.2	99.15179
Federal Funding	39.9	46.12717	115	45.15116	General Revenues*	
Other	1.2	1.387283	0.9	0.353357	3.8	0.353357
Total Revenues	**86.5**	**100**	**254.7**	**100**	**448**	**99.50514**
Expenditures	**81**		**257.8**		**444.8**	
Op Surplus/Deficit	**5.5**		**-2.9**		**3.2**	
Expenditures:		**% Sub**		**% Sub**		**% Sub**
Facilities & Admin		**Total**		**Total**		**Total**
Commission Admin	1.5	1.851852	5.4		8.1	2.423698
General Hospitals	75	92.59259	145.7	74.64139	248	74.20706
Federal Hosptials	2.5	3.08642	3.2		4.9	1.466188
Other Hospitals	0.8	0.987654	8.5		4.4	1.316577
Out-of-Province Bills	1.2	1.481481	2		4.9	1.466188
P.C.H.s			30.4	15.57377	63.9	19.12029
Sub-Total	**81**		**195.2**		**334.2**	
% Total Expenditure	**100**		**75.71761**		**75.13489**	
Medical Services						
Dr.'s Billings			54.6	93.33333	90.7	96.1824
Other Dr.'s Services			3.6	6.153846	3.1	3.287381
Dental/Oral Surgery			0.3	0.512821	0.5	0.530223
Sub-Total			**58.5**		**94.3**	
% Total Expenditure			**22.69201**		**21.20054**	
Other Services						
Chiropractic Services			1.5	37.5	3.2	19.5241
Optometric Services			1	25	1.9	11.59243
Prosthetics/Orthotics			0.2	5	0.09	0.549115
Pharmacare					8	
Ambulance Grants					1.2	
Other			1.3		2	
Sub-Total			**4**		**16.39**	
% Total Expenditure			**1.55159**		**3.684802**	

Sources: 1969 MHC/1974 and 1978-79 MHSC Annual Reports

Note: All Data reported in Millions of Dollars

: 1978-79 data used due to the conversion to fiscal year reporting in 1977-78 which resulted in a 15 month reporting period.

* In the 1978-79 fiscal year the Province stopped reporting federal transfer revenues in the Health Department Budget and MHSC budgets.

Table D.9:					
Provincial Facilities Growth					
1977 to 1981					
Rural Region and Key Communities	**Rated Beds 1977**	**LTC Beds 1977**	**Rated Beds 1981**	**LTC Beds 1981**	**District Formation**
Central n = 13					
Altona	32	25	32	71	1980
Carman	35	70	35	70	
Emerson	18	0	12	20	
Gladstone	25	50	25	50	1973
MacGregor	12	0	12	0	
Manitou	14	0	14	0	
Morden	75	60	67	60	
Morris	52	40	52	66	
Notre Dame	10	68	10	65	
Portage La Prairie	139	150	131	176	
St. Claude	15	0	15	0	
Treheme	18	20	18	22	
Winkler	57	118	57	118	
Total Rated Capacity	**502**	**601**	**480**	**718**	
Communities with Facilities	**13**	**9**	**13**	**10**	**2**
Eastman n = 8					
Beausejour	30	60	30	60	
Lac du Bonnet	0	0	0	0	1973
Pine Falls	48	0	48	0	
Ste. Anne	18	97	18	117	
St. Pierre-Jolys	19	16	19	16	
Steinbach	95	126	77	167	
Vita	11	30	11	30	1980
Whitemouth	10	0	10	0	
Total Rated Capacity	**231**	**329**	**213**	**390**	
Communities with Facilities	**7**	**5**	**7**	**5**	**2**
Interlake n = 7					
Arborg & FB	18	40	18	40	1981
Ashern	16	0	16	0	1977
Eriksdale	17	0	17	0	1977
Gimli	45	135	45	95	
Selkirk	77	243	77	243	
Stonewall	18	30	18	30	1981
Teulon	20	20	20	20	
Total Rated Capacity	**211**	**468**	**211**	**428**	
Communities with Facilities	**7**	**5**	**7**	**5**	**4**

Table D.9 (continued):					
Provincial Facilities Growth					
1977 to 1981	**Rated Beds**	**LTC Beds**	**Rated Beds**	**LTC Beds**	**District**
	1977	**1977**	**1981**	**1981**	**Formation**
Norman n = 8					
Churchill	31	0	31	0	1975
Flin Flon	125	30	100	60	
Gillam	15	0	15	0	
Leaf Rapids	8	0	8	0	1973
Lynn Lake	25	0	25	0	
Snow Lake	7	0	7	0	
The Pas	112	72	112	72	
Thompson	100	0	100	0	
Total Rated Capacity	**423**	**102**	**398**	**132**	
Communities with Facilities	**8**	**2**	**8**	**2**	**2**
Parkland n = 9					
Benito	10	0	10	0	
Dauphin	104	70	124	135	
Gilbert Plains	21	0	21	0	
Grandview	18	40	18	40	
McCreary	17	0	13	20	1977
Roblin	25	14	25	30	
Ste. Rose	68	40	68	40	
Swan River	88	113	87	113	
Winnipegosis	22	0	22	0	
Total Rated Capacity	**373**	**277**	**388**	**378**	
Communities with Facilities	**9**	**5**	**9**	**6**	**1**
Westman n = 27					
Baldur	16	0	16	0	
Birtle	28	0	19	20	1978
Bossevain	12	66	12	66	
Brandon	433	628	433	628	
Carberry	29	30	29	30	
Cartwright	7	0	8	0	1980
Crystal City	16	0	16	0	1977
Deloraine	21	30	18	46	
Elkhorn	8	0	8	0	
Erikson	14	36	14	36	
Glenboro	19	16	19	16	1981
Hamiota	25	0	25	0	1974
Hartney	9	0	9	0	
Killarney	26	73	26	73	1980
Melita	17	20	12	20	
Minnedosa	35	50	35	50	
Neepawa	38	149	38	149	
Pilot Mound	8	30	0	54	1977
Reston	17	0	17	0	
Rivers	20	0	20	0	1980
Rossburn	17	0	17	0	1981
Russell	38	0	38	40	
Shoal Lake	23	0	23	40	1981

Table D.9 (continued):					
Provincial Facilities Growth					
1977 to 1981					**District**
					Formation
Westman (continued)					
Souris	30	34	30	58	
Swan Lake	22	0	22	0	
Virden	32	50	32	100	
Wawanesa	10	0	10	0	1979
Total Rated Capacity	**970**	**1212**	**946**	**1426**	
Communities with Facilities	**27**	**13**	**26**	**16**	**11**
Winnipeg Public Hosptials	**Rated Beds**	**LTC Beds**	**Rated Beds**	**LTC Beds**	
	1977	**1977**	**1981**	**1981**	
Children's	HSC		HSC		
Concordia	124		132		
Grace	302		302		
Health Sciences Centre	1339		1277		
Misericordia	409		409		
Rehabilitation Hospital	HSC		HSC		
St. Boniface	605		624		
St. Vital Convalescent	188		188		
Seven Oaks General	0		336		
Shriners Hospital	25		25		
Victoria	254		252		
Winnipeg General	HSC		HSC		
Winnipeg Municipal Hospitals	401		401		
Total	**3647**	**4275**	**3946**	**4074**	
Sources : 1977-78 Statistical Supplement of the MHSC					
: 1981-82 Statistical Supplement of the MHSC					

Table D.10:				
Provincial Health Care Expenditures				
1978 to 1982	**1978**		**1982**	
Total Provincial Expenditures	1077980917		2431863998	
Total Provincial Revenues			2180821120	
Surplus (Deficit)			-251042878	
Health Budget (Dept. Divsions)		**%Total**		**%Total**
Executive Division	4349450	1.440321	600107	0.114199
Psychiatric Services Division	38190330	12.64673	28821686	5.484721
Public Health Services Division	34154047	11.31012	17959371	3.41764
MHSC/ Other Hospital Services*	225284000	74.60283	478109300	90.98344
Total Health Expenditures	**301977827**	**100**	**525490464**	**100**
Health Expenditures as % of Total Expenditures		**28.01328**		**21.60855**
Public Health Services Division		**%Total**		**%Total**
Division Administration	352204	1.031222	542709	3.021871
Preventive Medical/Medical Public Health	1910429	5.593566	2813884	15.66805
Public Health Nursing	179922	0.526796	226383	1.260529
Community Field Services	16424465	48.08937	1365166	7.601413
Continuing Care Services (Home Care)	8281718	24.24813	8750779	48.72542
Dental Care	1522932	4.459009	3699684	20.6003
Health Education and Library Services	306380	0.897053	560766	3.122414
Rehabilitation Services	5175997	15.15486	Preventive Medical Care	
Total	**34154047**	**100**	**17959371**	**100**
Sources: Public Accounts of Manitoba Fiscal 1977-78 and 1981-82.				
* This amount represents the province's expenditure only. It does not include				
estimated federal transfers or other revenues obtained by the MHSC.				

Table D.11:				
MHSC Budgets 1979 to 1981				
Revenues:	**1979**	**%Total**	**1981**	**%Total**
Provincial Funding	444.2	99.15179	566.1	99.61288
Other	3.8	0.848214	2.2	0.387119
Total Revenues	**448**	**100**	**568.3**	**100**
Expenditures	**444.8**		**572.3**	
Op Surplus/Deficit	**3.2**		**4**	
Expenditures:		**% Sub**		**% Sub**
Facilities & Admin		**Total**		**Total**
Commission Admin	8.1	2.423698	9	2.077083
General Hospitals	248	74.20706	323.4	74.63651
Federal Hosptials	4.9	1.466188	7	1.615509
Other Hospitals	4.4	1.316577	5.8	1.338565
Out-of-Province Bills	4.9	1.466188	6.3	1.453958
P.C.H.s	63.9	19.12029	81.8	18.87838
Sub-Total	**334.2**	**100**	**433.3**	**100**
% Total Expenditure	**75.13489**		**75.71204**	
Medical Services				
Dr.'s Billings	90.7	96.1824	112.8	96.24573
Other Dr.'s Services	3.1	3.287381	3.7	3.156997
Dental/Oral Surgery	0.5	0.530223	0.7	0.59727
Sub-Total	**94.3**	**100**	**117.2**	**100**
% Total Expenditure	**21.20054**		**20.47877**	
Estimated Revenue*	**171.4**		**220.2**	
Other Services				
Chiropractic Services	3.2	19.5241	4.7	21.46119
Optometric Services	1.9	11.59243	2.6	11.87215
Prosthetics/Orthotics	0.09	0.549115	1.2	5.479452
Pharmacare	8	48.81025	10.6	48.40183
Ambulance Grants	1.2	7.321538	1.3	5.936073
Other	2	12.20256	1.5	6.849315
Sub-Total	**16.39**	**100**	**21.9**	**100**
% Total Expenditure	**3.684802**		**3.826664**	
Source: 1978-79 and 1980-81 MHSC Annual Reports				
:All Data reported in Millions of Dollars				
* This represents the estimated federal tranfer for facilities and				
at 40% of the amounts billed for facilities and medical care.				

Table D.12:					
Provincial Facilities Growth					
1981 to 1989					
Rural Region and Key	Rated Beds	LTC Beds	Rated Beds	LTC Beds	District
Communities	1981	1981	1989	1989	Formation
Central n = 13					
Altona	32	71	32	71	1980
Carman	35	70	30	70	
Emerson	12	20	12	20	1983
Gladstone	25	50	20	50	1973
MacGregor	12	0	6	20	1985
Manitou	14	0	14	0	1982
Morden	67	60	71	60	1982
Morris	52	66	39	66	1983
Notre Dame	10	65	10	61	
Portage La Prairie	131	176	131	151	
St. Claude	15	0	12	18	
Treherne	18	22	18	22	1984
Winkler	57	118	57	125	
Total Rated Capacity	**480**	**718**	**452**	**734**	
Communities with Facilities	**13**	**10**	**13**	**12**	**8**
Eastman n = 8					
Beausejour	30	60	30	60	
Lac du Bonnet	0	0	0	30	1973
Pine Falls	48	0	35	0	
Ste. Anne	18	117	21	117	
St. Pierre-Jolys	19	16	19	16	1984
Steinbach	77	167	80	160	1988
Vita	11	30	11	30	1980
Whitemouth	10	0	6	20	1985
Total Rated Capacity	**213**	**390**	**202**	**433**	
Communities with Facilities	**7**	**5**	**7**	**7**	**5**
Interlake n = 7					
Arborg & FB	18	40	16	40	1981
Ashern	16	0	16	20	1977
Eriksdale	17	0	17	40	1977
Gimli	45	95	35	95	
Selkirk	77	243	75	275	
Stonewall	18	30	18	30	1981
Teulon	20	20	20	20	1986
Total Rated Capacity	**211**	**428**	**197**	**520**	
Communities with Facilities	**7**	**5**	**7**	**7**	**5**

Table D.12 (continued):					
Provincial Facilities Growth					
1981 to 1989	**Rated Beds**	**LTC Beds**	**Rated Beds**	**LTC Beds**	**District**
	1981	**1981**	**1989**	**1989**	**Formation**
Norman n = 8					
Churchill	31	0	31	0	1975
Flin Flon	100	60	100	60	
Gillam	15	0	5	0	
Leaf Rapids	8	0	8	0	1973
Lynn Lake	25	0	25	0	
Snow Lake	7	0	4	0	
The Pas	112	72	84	70	
Thompson	100	0	100	0	
Total Rated Capacity	**398**	**132**	**357**	**130**	
Communities with Facilities	**8**	**2**	**8**	**2**	**2**
Parkland n = 9					
Benito	10	0	9	0	
Dauphin	124	135	125	135	
Gilbert Plains	21	0	0	30	1985
Grandview	18	40	18	40	
McCreary	13	20	13	0	1977
Roblin	25	30	25	30	1985
Ste. Rose	68	40	68	40	
Swan River	87	113	87	110	
Winnipegosis	22	0	18	20	
Total Rated Capacity	**388**	**378**	**363**	**405**	
Communities with Facilities	**9**	**6**	**8**	**7**	**3**
Westman n = 27					
Baldur	16	0	16	20	1984
Birtle	19	20	19	20	1978
Bossevain	12	66	12	64	1984
Brandon	433	628	401	642	
Carberry	29	30	29	30	
Cartwright	8	0	10	0	1980
Crystal City	16	0	16	0	1977
Deloraine	18	46	18	46	1984
Elkhorn	8	0	8	0	1987
Erikson	14	36	14	36	1987
Glenboro	19	16	14	20	1981
Hamiota	25	0	21	30	1974
Hartney	9	0	9	0	1986
Killarney	26	73	26	69	1980
Melita	12	20	11	20	1984
Minnedosa	35	50	35	50	1987
Neepawa	38	149	38	125	
Pilot Mound	0	54	0	54	1977
Reston	17	0	17	20	1987
Rivers	20	0	16	20	1980
Rossburn	17	0	10	20	1981
Russell	38	40	38	40	
Shoal Lake	23	40	23	40	1981

Table D.12 (continued):					
Provincial Facilities Growth					
1981 to 1989					**District**
Westman (continued)					**Formation**
Souris	30	58	30	34	1986
Swan Lake	22	0	22	0	
Virden	32	100	32	100	1987
Wawanesa	10	0	9	20	1979
Total Rated Capacity	**946**	**1426**	**894**	**1520**	
Communities with Facilities	**26**	**16**	**26**	**22**	**22**

Winnipeg Public Hosptials	**Rated Beds**	**LTC Beds**	**Rated Beds**	**LTC Beds**
	1981	**1981**	**1989**	**1989**
Concordia	132		136	
Grace	302		301	
Health Sciences Centre	1277		1113	
Misericordia	409		409	
St. Boniface	624		617	
St. Vital Convalescent	188		184	
Seven Oaks General	336		326	
Shriners Hospital	25		20	
Victoria	252		246	
Winnipeg Municipal Hospitals	401		337	
Total	**3946**	**4074**	**3689**	**4594**

Sources : 1981-82 Statistical Supplement of the MHSC
: 1988-89 Statistical Supplement of the MHSC

Table D.13:				
Provincial Health Care Expenditures				
1981 to 1989	**1982**		**1989**	
Total Provincial Expenditures	2431.8		4484.3	
Total Provincial Revenues	2180.8		4342.9	
Surplus (Deficit)	-251		-141.4	
Health Budget (Dept. Divsions)		**%Total**		**%Total**
Executive & Resources Division	0.6	0.114199	2.8	0.299497
Psychiatric Services Division	28.8	5.481538	40.1	4.289229
Public Health Services Division	17.9	3.406928	87.9	9.402075
MHSC/ Other Hospital Services*	478.1	90.99734	804.1	86.0092
Total Health Expenditures	**525.4**	**100**	**934.9**	**100**
Health Expenditures as % of Total Expenditures		**21.6054**		**20.84829**
Public Health Services Division		**%Total**		**%Total**
Division Administration	0.5	2.793296	0.9	1.023891
Preventive Medical/Medical Public Health	2.8	15.64246	12.9	14.67577
Public Health Nursing	0.2	1.117318	Community Field S	
Community Field Services	1.4	7.821229	27.6	31.39932
Continuing Care Services	8.7	48.60335	0.9	1.023891
Dental Care	3.7	20.67039	4.5	5.119454
Health Education and Library Services	0.6	3.351955	2.1	2.389078
Home Care	Continuing Care		39	44.3686
Total	**17.9**	**100**	**87.9**	**100**
Sources: Public Accounts of Manitoba Fiscal 1981-82 and 1988-89.				
: All Data reported in Millions of Dollars				
* This amount represents the province's expenditure only. It does not include estimated federal transfers or other revenues obtained by the MHSC.				

Table D.14:
MHSC Budgets 1981 to 1989

Revenues:	**1981**	**%Total**	**1984**	**%Total**	**1989**	**%Total**
Provincial Funding	566.1	99.61288	887	97.55829	1247.6	96.36953
Other	2.2	0.387119	22.2	2.441707	47	3.630465
Total Revenues	**568.3**	**100**	**909.2**	**100**	**1294.6**	**100**
Expenditures	**572.3**		**909.2**		**1294.6**	
Op Surplus/Deficit	**4**		**0**		**0**	
Expenditures:		**% Sub**		**% Sub**		**% Sub**
Facilities & Admin		**Total**		**Total**		**Total**
Commission Admin	9	2.077083	13.1	1.895803	18.6	1.86541
General Hospitals	323.4	74.63651	519.7	75.20984	742	74.41581
Federal Hosptials	7	1.615509	0.9	0.130246	1.6	0.160465
Other Hospitals	5.8	1.338565	9.4	1.360347	27	2.707853
Out-of-Province Bills	6.3	1.453958	9.3	1.345876	18.2	1.825293
P.C.H.s	81.8	18.87838	138.6	20.05789	189.7	19.02517
Sub-Total	**433.3**	**100**	**691**	**100**	**997.1**	**100**
% Total Expenditure	**75.71204**		**76.00088**		**77.01993**	
Medical Services						
Dr.'s Billings	112.8	96.24573	168.9	94.14716	225.6	98.42932
Other Dr.'s Services	3.7	3.156997	9.3	5.183946	2.3	1.00349
Dental/Oral Surgery	0.7	0.59727	1.2	0.668896	1.3	0.56719
Sub-Total	**117.2**	**100**	**179.4**	**100**	**229.2**	**100**
% Total Expenditure	**20.47877**		**19.73163**		**17.70431**	
Estimated Revenues*	**220.2**		**348.2**		**490.5**	
Other Services						
Chiropractic Services	4.7	21.46119	6.5	16.75258	9	13.17716
Optometric Services	2.6	11.87215	3.9	10.05155	5.5	8.052709
Prosthetics/Orthotics	1.2	5.479452	2.5	6.443299	3.3	4.831625
Pharmacare	10.6	48.40183	21.5	55.41237	40.4	59.15081
Ambulance Grants	1.3	5.936073	1.8	4.639175	4.2	6.149341
Other	1.5	6.849315	2.6	6.701031	5.9	8.63836
Sub-Total	**21.9**	**100**	**38.8**	**100**	**68.3**	**100**
% Total Expenditure	**3.826664**		**4.267488**		**5.275761**	

Sources: 1980-81 and 1988-89 MHSC Annual Reports
: All Data reported in Millions of Dollars
* This represents the estimated federal tranfer for facilities and at 40% of the amounts billed for facilities and medical care.

Table D.15:			
Provincial Hospital Growth			
1949 to 1989			
Rural Region and Key Communities	**Rated Beds 1949**	**Rated Beds 1989**	**%Change**
Central n = 13			
Altona	30	32	
Carman	19	30	
Emerson	0	12	
Gladstone	8	20	
MacGregor	0	6	
Manitou	0	14	
Morden	22	71	
Morris	11	39	
Notre Dame	0	10	
Portage La Prairie	60	131	
St. Claude	0	12	
Treherne	0	18	
Winkler	32	57	
Total Rated Capacity	**182**	**452**	**148.35165**
Communities with Facilities	**7**	**13**	**85.714286**
Eastman n = 8			
Beausejour	0	30	
Lac du Bonnet	0	0	
Pine Falls	15	35	
Ste. Anne	0	21	
St. Pierre-Jolys	0	19	
Steinbach	43	80	
Vita	18	11	
Whitemouth	0	6	
Total Rated Capacity	**76**	**202**	**165.78947**
Communities with Facilities	**3**	**7**	**133.33333**
Interlake n = 7			
Arborg & FB	0	16	
Ashern	0	16	
Eriksdale	10	17	
Gimli	36	35	
Selkirk	42	75	
Stonewall	0	18	
Teulon	30	20	
Total Rated Capacity	**118**	**197**	**66.949153**
Communities with Facilities	**4**	**7**	**75**

Table D.15 (continued):			
Provincial Hospital Growth			
1949 to 1989	**Rated Beds 1949**	**Rated Beds 1989**	**%Change**
Norman n = 8			
Churchill	0	31	
Flin Flon	48	100	
Gillam	0	5	
Leaf Rapids	0	8	
Lynn Lake	0	25	
Snow Lake	7	4	
The Pas	76	84	
Thompson	0	100	
Total Rated Capacity	**131**	**357**	**172.51908**
Communities with Facilities	**2**	**8**	**300**
Parkland n = 9			
Benito	0	9	
Dauphin	89	125	
Gilbert Plains	10	0	
Grandview	8	18	
McCreary	0	13	
Roblin	0	25	
Ste. Rose	27	68	
Swan River	30	87	
Winnipegosis	14	18	
Total Rated Capacity	**178**	**363**	**103.93258**
Communities with Facilities	**6**	**8**	**33.333333**
Westman n = 27			
Baldur	0	16	
Birtle	8	19	
Bossevain	10	12	
Brandon	202	401	
Carberry	0	29	
Cartwright	0	10	
Crystal City	10	16	
Deloraine	14	18	
Elkhorn	0	8	
Erikson	0	14	
Glenboro	0	14	
Hamiota	8	21	
Hartney	0	9	
Killarney	30	26	
Melita	0	11	
Minnedosa	9	35	
Neepawa	23	38	
Pilot Mound	0	0	
Reston	0	17	
Rivers	0	16	
Rossburn	0	10	
Russell	35	38	
Shoal Lake	15	23	

Table D.15 (continued):			
Provincial Hospital Growth			
1949 to 1989			**%Change**
Westman (continued)			
Souris	25	30	
Swan Lake	0	22	
Virden	18	32	
Wawanesa	0	9	
Total Rated Capacity	**407**	**894**	**119.65602**
Communities with Facilities	**13**	**26**	**100**
Winnipeg Public Hosptials	**Rated Beds**	**Rated Beds**	
	1949	**1989**	
Children's	77	HSC	
Concordia	50	136	
Grace	260	301	
HSC		1113	
Misericordia	247	409	
St. Boniface	427	617	
St. Vital Convalescent	40	184	
Seven Oaks General		326	
Shriners Hospital		20	
Victoria	78	246	
Winnipeg General	613		
Winnipeg Municipal Hospitals	175	337	
Total	**1967**	**3689**	**87.544484**
Average Rural Capacity Increase			**129.53299**
Average Provincial Capacity Increase			**111.02828**
Total Rural Population	427	496.7	**16.323185**
Total Winnipeg Population	325	628.7	**93.446154**
Total Population	752	1125.4	**49.654255**
Rural RBC per Thousand	2.557377049	4.962754178	**94.056413**
Winnipeg RBC per Thousand	6.052307692	5.867663432	**-3.0508075**
Total RBC per Thousand	4.067819149	5.468277946	**34.427755**
Sources: 1953 Manitoba Advisory Health Survey Committee Report			
: 1988-89 MHSC Statistical Supplement			
All population data reported in thousands of persons.			

Table D.16:			
Provincial LTC Growth			
1959 to 1989			
Rural Region and Key Communities	**Rated Beds 1959**	**Rated Beds 1989**	**%Change**
Central n = 13			
Altona	0	71	
Carman	0	70	
Emerson	0	20	
Gladstone	0	50	
MacGregor	0	20	
Manitou	0	0	
Morden	33	60	
Morris	28	66	
Notre Dame	14	61	
Portage La Prairie	50	151	
St. Claude	0	18	
Treherne	0	22	
Winkler	93	125	
Total Rated Capacity	**218**	**734**	**236.69725**
Communities with Facilities	**5**	**12**	**140**
Eastman n = 8			
Beausejour	0	60	
Lac du Bonnet	0	30	
Pine Falls	0	0	
Ste. Anne	22	117	
St. Pierre-Jolys	42	16	
Steinbach	30	160	
Vita	0	30	
Whitemouth	0	20	
Total Rated Capacity	**94**	**433**	**360.6383**
Communities with Facilities	**3**	**7**	**133.33333**
Interlake n = 7			
Arborg & FB	0	40	
Ashern	0	20	
Eriksdale	0	40	
Gimli	91	95	
Selkirk	149	275	
Stonewall	0	30	
Teulon	0	20	
Total Rated Capacity	**240**	**520**	**116.66667**
Communities with Facilities	**2**	**7**	**250**

Table D.16 (continued):			
Provincial LTC Growth			
1959 to 1989	**Rated Beds 1959**	**Rated Beds 1989**	**%Change**
Norman n = 8			
Churchill	0	0	
Flin Flon	0	60	
Gillam	0	0	
Leaf Rapids	0	0	
Lynn Lake	0	0	
Snow Lake	0	0	
The Pas	96	70	
Thompson	0	0	
Total Rated Capacity	**96**	**130**	**35.416667**
Communities with Facilities	**1**	**2**	**100**
Parkland n = 9			
Benito	0	0	
Dauphin	42	135	
Gilbert Plains	0	30	
Grandview	12	40	
McCreary	0	0	
Roblin	0	30	
Ste. Rose	0	40	
Swan River	0	110	
Winnipegosis	0	20	
Total Rated Capacity	**54**	**405**	**650**
Communities with Facilities	**2**	**7**	**250**
Westman n = 27			
Baldur	0	20	
Birtle	0	20	
Bossevain	0	64	
Brandon	392	642	
Carberry	14	30	
Cartwright	0	0	
Crystal City	0	0	
Deloraine	16	46	
Elkhorn	0	0	
Erikson	20	36	
Glenboro	16	20	
Hamiota	0	30	
Hartney	0	0	
Killarney	41	69	
Melita	0	20	
Minnedosa	22	50	
Neepawa	26	125	
Pilot Mound	0	54	
Reston	0	20	
Rivers	0	20	
Rossburn	0	20	
Russell	0	40	
Shoal Lake	0	40	

Table D.16 (continued):			
Provincial LTC Growth			
1959 to 1989	**Rated Beds**	**Rated Beds**	**%Change**
Westman (continued)			
Souris	16	34	
Swan Lake	0	0	
Virden	0	100	
Wawanesa	0	20	
Total Rated Capacity	**563**	**1520**	**169.98224**
Communities with Facilities	**9**	**22**	**144.44444**
Winnipeg	**1883**	**4594**	**143.97238**
Average Rural Capacity Increase			**261.56685**
Average Provincial Capacity Increase			**244.76764**
Total Rural Population	427	496.7	**16.323185**
Total Winnipeg Population	325	628.7	**93.446154**
Total Population	752	1125.4	**49.654255**
Rural RBC per Thousand	2.962529274	7.533722569	**154.30036**
Winnipeg RBC per Thousand	5.793846154	7.307141721	**26.119015**
Total RBC per Thousand	4.186170213	7.407144127	**76.943214**
Sources : 1961 Manitoba Hospital Survey Board Report			
: 1988-89 MHSC Statistical Supplement			
All population data in thousands of persons.			

Table D.17:						
Rural DHC Growth	**Hosptial Rated Beds**	**LTC Rated Beds**	**CYear**	**DType**	**Board**	**ASI**
	1989	**1989**				
Central n = 13						
Altona	32	71	1980	Mun I	AA	No
Carman	30	70		Mun		No
Emerson	12	20	1983	Mun I	AA	Yes
Gladstone	20	50	1973	Mun III	A/E	Yes
MacGregor	6	20	1985	Mun I	AA	Yes
Manitou	14	0	1982	Mun I	AA	Yes
Morden	71	60	1982	Mun I	AA	No
Morris	39	66	1983	Mun I	AA	No
Notre Dame	10	61		Mun		Yes
Portage La Prairie	131	151		Mun		No
St. Claude	12	18		Mun		Yes
Treherne	18	22	1984	Mun I	AA	Yes
Winkler	57	125		Mun		No
Total Rated Capacity	**452**	**734**				
Communities with Facilities	**13**	**12**	8	1Type III	1 A/E	7 ASI
Eastman n = 8						
Beausejour	30	60		Mun		No
Lac du Bonnet	0	30	1973	Mun IIIA	A/E	Yes
Pine Falls	35	0		Lay		Yes
Ste. Anne	21	117		Mun		No
St. Pierre-Jolys	19	16	1984	Mun 1	AA	Yes
Steinbach	80	160	1988	Mun 1	AA	No
Vita	11	30	1980	Mun 1	A/E	Yes
Whitemouth	6	20	1985	Mun 1	AA	Yes
Total Rated Capacity	**202**	**433**				
Communities with Facilities	**7**	**7**	5	1 Type III	2 A/E	5 ASI
Interlake n = 7						
Arborg & FB	16	40	1981	Mun 1	AA	Yes
Ashern	16	20	1977	Mun 1	AA	Yes
Eriksdale	17	40	1977	Mun 1	AA	Yes
Gimli	35	95		Mun		No
Selkirk	75	275		Mun		No
Stonewall	18	30	1981	Mun 1	AA	Yes
Teulon	20	20	1986	Mun 1	AA	Yes
Total Rated Capacity	**197**	**520**				
Communities with Facilities	**7**	**7**	5	0 Type III	0 A/E	5 ASI
Norman n = 8						
Churchill	31	0	1975	Mun III	A/E	Yes
Flin Flon	100	60		Lay		Yes
Gillam	5	0		Lay		Yes
Leaf Rapids	8	0	1973	Mun III	AA	Yes
Lynn Lake	25	0		Mun		Yes
Snow Lake	4	0		Mun		Yes
The Pas	84	70		Lay		Yes
Thompson	100	0		Prov		Yes
Total Rated Capacity	**357**	**130**				
Communities with Facilities	**8**	**2**	2	2 Type III	1 A/E	7 ASI

Table D.17 (continued):	Hosptial	LTC	CYear	DType	Board	ASI
Rural DHC Growth	**Rated Beds**	**Rated Beds**				
	1989	**1989**				
Parkland n = 9						
Benito	9	0		Mun		Yes
Dauphin	125	135		Lay		No
Gilbert Plains	0	30	1985	Mun	AA	Yes
Grandview	18	40		Mun		No
McCreary	13	0	1977	Mun 1	AA	Yes
Roblin	25	30	1985	Mun 1	AA	Yes
Ste. Rose	68	40		Rel		No
Swan River	87	110		Mun		Yes
Winnipegosis	18	20		Rel		Yes
Total Rated Capacity	**363**	**405**				
Communities with Facilities	**8**	**7**	3	0 Type III	0 A/E	6 ASI
Westman n = 27						
Baldur	16	20	1984	Mun 1	AA	Yes
Birtle	19	20	1978	Mun 1	AA	Yes
Bossevain	12	64	1984	Mun 1	AA	No
Brandon	401	642		Lay		No
Carberry	29	30		Mun		No
Cartwright	10	0	1980	Mun 1	AA	Yes
Crystal City	16	0	1977	Mun 1	AA	No
Deloraine	18	46	1984	Mun 1	AA	No
Elkhorn	8	0	1987	Mun 1	AA	Yes
Erikson	14	36	1987	Mun 1	AA	No
Glenboro	14	20	1981	Mun 1	AA	Yes
Hamiota	21	30	1974	Mun III	AA	Yes
Hartney	9	0	1986	Mun 1	AA	Yes
Killarney	26	69	1980	Mun 1	AA	No
Melita	11	20	1984	Mun 1	AA	Yes
Minnedosa	35	50	1987	Mun 1	AA	Yes
Neepawa	38	125		Mun		No
Pilot Mound	0	54	1977	Mun 1	AA	No
Reston	17	20	1987	Mun 1	AA	Yes
Rivers	16	20	1980	Mun 1	AA	Yes
Rossburn	10	20	1981	Mun 1	AA	Yes
Russell	38	40		Mun		No
Shoal Lake	23	40	1981	Mun 1	AA	Yes
Souris	30	34	1986	Mun 1	AA	No
Swan Lake	22	0		Mun		Yes
Virden	32	100	1987	Mun 1	AA	No
Wawanesa	9	20	1979	Mun 1	AA	Yes
Total Rated Capacity	**894**	**1520**				
Communities with Facilities	**26**	**22**	22	1 Type III	0 A/E	15 ASI
Totals	**2465**	**3742**	**45**	**5**	**4**	**45**
			DHCs	Type IIIs	A/Es	ASI
				40		
				Type Is		

Table D.18:						
Provincial Health Care						
Expenditures 1949 to 1989						
	1949	**1959**	**1969**	**1978**	**1982**	**1989**
Total Expenditures						
% of Total Prov Budget	10	12.7	12.3	28	21.6	20.8
% Public Health Expenditure	32.4	23.6	19.6	11.3	3.4	9.4
% Medical Care Expenditure	14.8	35.7	48.9	74.6	90.9	86
Insured Medical Care						
Expenditures as % of						
MHC/MHSC Budget Lines						
Facilities		100	100	75.1	75.7	77
Medical Services				21.2	20.5	17.7
Other Services				3.7	3.8	5.3
Total		100	100	100	100	100

SOURCES CONSULTED

BOOKS AND ARTICLES

Adie, Robert F. and Paul G. Thomas. *Canadian Public Administration: Problematical Perspectives 2d ed.* Scarborough: Prentice Hall, 1987.

Alford, Robert. *Health Care Politics.* Chicago: University of Chicago Press, 1975.

Aucoin, Peter. "Federal Health Care Policy." In *Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends,* ed. Carl A. Meilicke and Janet L. Storch. Ann Arbor: Health Administration Press, 1980.

Aucoin, Peter and Herman Bakvis. *The Centralization-Decentralization Conundrum.* Halifax: The Institute for Research on Public Policy, 1988.

Babbie, Earl. *The Practice of Social Research 7d ed.* Toronto: Wadsworth Publishing Company, 1995.

Badgley, Robin F. "Regionalization of Health Services in Canada." *Israel Journal of Medical Sciences* 18 (1982).

Baxter-Moore, Nicolas. "Policy Implementation and the Role of the State: A Revised Approach to the Study of Policy Instruments." In *Contemporary Canadian Politics*, ed. Robert Jackson et al. Scarborough: Prentice-Hall, 1987.

Beaulieu, Paul. *Ed Schreyer, A Social Democrat in Power.* Winnipeg: Queenston House, 1977.

Boase, Joan Price. *Shifting Sands: Government-Group Relations in the Health Care Sector.* Montreal and Kingston: McGill-Queen's University Press, 1994.

Boase, Joan Price. "Institutions, Institutionalized Networks and Policy Choices: Health Policy in the US and Canada." Governance 9 (1996).

Brooks, Stephen. *Public Policy In Canada 2d ed.* Toronto: McClelland and Stewart, 1993.

Canadian Medical Association. *The Language of Health System Reform.* Ottawa: Canadian Medical Association, 1993.

Carrothers, L.C., S.M. Macdonald, J.M. Horne, D.G. Fish, and M.M. Silver. *Regionalization and Health Care Policy In Canada: A National Survey and Manitoba Case Study.* Winnipeg: University of Manitoba Department of Community Health Sciences, 1991.

Chandler, Marsha and Chandler, William. *Public Policy and Provincial Politics.* Toronto: McGraw-Hill Ryerson, 1979.

Crichton, Ann. *Health Policy Making.* Ann Arbour: Health Administration Press. 1980.

Crichton, Ann. "Restructuring Health Services in Canada: Challenges for Policy Makers, Planners and Managers in the Eighties." *International Journal of Health Planning and Management,* 1 (1985).

Coleman, William and G. Skogstad. *Policy Communities and Public Policy in Canada.* Mississauga: Copp Clark Pitman, 1990.

Decter, Michael B. *Healing Medicare.* Toronto: McGilligan Books, 1994.

Doern, G. Bruce and Richard Phidd. *Canadian Public Policy: Ideas, Structure, Process 2d ed.* Scarborough: Nelson, 1992.

Donabedian, A. *Explorations in Quality Assessment and Monitoring Vol. 1.* Ann Arbour: Health Administration Press. 1980.

Dyck, Rand. *Provincial Politics in Canada.* Scarborough: Prentice Hall, 1996.

Ellencweig, Avi Yacar. *Analysing Health Systems A Modular Approach.* Oxford: Oxford University Press, 1992.

Esuke, A. Arthur. *The Issues That Led to Development of Medicare in Manitoba.* M.A. Thesis, University of Manitoba, 1978.

Evans, Robert G.. "Canada: The Real Issues." *Journal of Health Politics, Policy and Law*, 17 (1992).

Evans, Robert G., Morris Barer, and Clyde Hertzman. "The 20-year Experiment: Accounting for, Explaining, and Evaluating Health Care Cost Containment in Canada and the United States." *Annual Review of Public Health*, 12 (1991).

Evans, Robert G. and G.L. Stoddart. "Producing Health, Consuming Health Care." In *Why Are Some People Healthy And Others Not?,* ed. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor. New York: Aldine De Gruyter, 1994.

Frankfort-Nachmias, Chava and David Nachmias. *Research Methods in the Social Sciences 5d ed.* New York: St. Martin's Press, 1996.

Gelber, Sylvia M.. "The Path To Health Insurance." In *Perspectives on Canadian Health and Social Services Policy*, ed. Carl A Meilicke and Janet L. Storch. Ann Arbor: Health Administration Press, 1980.

Hamilton, F.W. *Service At Cost.* Saskatoon: Modern Press, 1977.

Hancock, Trevor." Lalonde and Beyond: Looking back at 'A New Perspective on the Health of Canadians'." *Health Promotion* 1 (1986).

Harrop, Martin. *Power and Policy in Liberal Democracies.* Cambridge: Cambridge University Press, 1992.

Held, David. *Models of Democracy 2d ed.* Stanford: Stanford University Press, 1996.

Horne, John. "Health." In *The Canadian Economy: Problems and Options,* ed. R. Bellan. Toronto: McGraw-Hill Ryerson, 1981.

Howlett, Michael and M. Ramesh. *Studying Public Policy: Policy Cycles and Policy Subsystems.* Toronto: Oxford University Press, 1995.

Hurley, Jeremiah, Stephen Birch, John Eyles. *Information, Efficiency And Decentralization Within Health Care Systems.* Hamilton: The Centre For Health Economic and Policy Analysis Working Paper Series No.92-21, 1992.

Hurley, Jeremiah, Jonathan Lomas, Vandna Bhatia. "When tinkering is not enough: provincial reform to manage health care resources." *Canadian Public Administration* 37 (1994).

Jordan, Grant. "Policy Community Realism versus 'New' Institutionalism Ambiguity." *Political Studies 38* (1991).

Kernaghan, Kenneth and David Siegel. *Public Administration In Canada 3d ed.* Toronto: Nelson, 1995.

Lindquist, Evert. "Public Managers and Policy Communities: Learning To Meet New Challenges." *Canadian Public Administration 35* (1992).

Lindquist, Evert. "Recent Administrative Reform in Canada as Decentralization: Who is Spreading What Around to Whom and Why? *Canadian Public Administration* 37 (1994).

Lomas, J. and A.P. Contandriopoulos. " Regulating Limits to Medicine: Towards Harmony in Public and Self-Regulation." In *Why Are Some People Healthy and Others Not?*, ed. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor. New York: Aldine De Gruyter, 1994.

Manzer, Ronald. *Public Polices and Political Development in Canada.* Toronto: University of Toronto Press, 1985.

Marmor, T.R., M.L. Barer, and R.G. Evans. "The Determinants of a Population's Health: What Can Be Done to Improve a Democratic Nation's Health Status." In *Why Are Some People Healthy And Others Not?*, ed. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor. New York: Aldine De Gruyter, 1994.

Marshall, Catherine and Gretchen B. Rossman. *Designing Qualitative Research.* Newbury Park: Sage Publications, 1989.

McAllister, James. *The Government of Edward Schreyer.* Kingston and Montreal: McGill-Queen's University Press, 1984.

Mhatre, Sharmila and Raisa Deber. "From Equal Access to Health Care to Equitable Access to Health: A Review of Canadian Provincial Health Commissions and Reports." *International Journal of Health Services* 22 (1992).

Mills, Anne, J. Patrick Vaughan, Duane L. Smith, and Iraj Tabibzadeh ed. *Health System Decentralization Concepts, Issues and Country Experience.* Geneva: World Health Organization, 1990.

Morton, W.L. *Manitoba: A History 2d ed.* Toronto: University of Toronto Press, 1967.

Nachmias, David. *Public Policy Evaluation: Approaches and Methods.* New York: St. Martin's Press, 1979.

Pal, Leslie A.. *Public Policy Analysis 2d ed.* Scarborough: Nelson, 1992.

Peters, B. Guy. "The Policy Process: An Institutionalist Perspective." *Canadian Public Administration* 35 (1992).

Peters, B. Guy. "The Public Service, the Changing State, and Governance." In *Governance in a Changing Environment*, ed. B. Guy Peters and Donald J Savoie. Montreal and Kingston: McGill-Queen's University Press, 1995.

Peterson, Thomas. "Manitoba: Ethnic and Class Politics." In *Canadian Provincial Politics 2d ed.*, ed. Martin Robin. Scarborough: Prentice-Hall, 1978.

Pross, A. Paul. *Group Politics and Public Policy 2d ed.* Toronto: Oxford University Press, 1992.

Rachlis, Michael and Carol Kushner. *Strong Medicine*. Toronto: Harper Collins, 1994.

Rodwin, Victor G.. *The Health Planning Predicament*. Berkeley: University of California Press, 1984.

Roos, N.P. and L.L. Roos. "Small Area Variations, Practice Style, and Quality of Care." In *Why Are Some People Healthy and Others Not?*, ed. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor, New York: Aldine De Gruyter, 1994.

Sabatier, Paul and Daniel Mazmanian. "The Conditions of Effective Implementation: A Guide to Accomplishing Policy Objectives." *Policy Analysis 5* (1979).

Sabatier, Paul. "An Advocacy Coalition Model for Policy Change and the Role of Policy-Oriented Learning Therein." *Policy Sciences* 21 (1988).

Sabatier, Paul and Hank Jenkins-Smith. *Policy Change and Learning: An Advocacy Coalition Approach*. Boulder: Westview Press, 1993.

Savoie, Donald. "Globalization, Nation States, and the Civil Service." In *Governance in a Changing Environment*, ed. B. Guy Peters and Donald J Savoie. Montreal and Kingston: McGill-Queen's University Press, 1995.

Schulman, Paul R.. "Nonincremental Policy Making." In *Public Policy The Essential Readings*, ed. Stella Theodoulou and Matthew Cahn. Englewood Cliffs: Prentice Hall, 1995.

Serfaty, Meir. "Electoral Behaviour in Manitoba." In *The Geography of Manitoba*, ed. John Welsted, John Everitt, Christoph Stadel. Winnipeg: University of Manitoba Press, 1996.

Shah, C.P. *Public Health and Preventive Medicine in Canada 2d ed.* Toronto: Shah, 1990

Siler-Wells, Gail. "An Implementation Model for Health System Reform." *Social Science and Medicine* 24 (1987).

Taylor, Malcolm G.. *Health Insurance and Canadian Public Policy 2d ed.* Kingston and Montreal: McGill-Queen's University Press, 1987.

Taylor, Malcolm G.. "The Canadian Health Care System 1974-1984." In *Medicare At Maturity: Achievements, Lessons & Challenges*, ed. R.G. Evans and G.L. Stoddart. The Banff Centre for Continuing Education, 1986.

Tsalikis, George. *The Political Economy of Decentralization in Health and Social Services.* Ottawa: University of Ottawa Working Paper 85-23, 1985.

Tuohy, Carolyn. "Federalism and Canadian Health Policy." In *Challenges to Federalism: Policy-Making in Canada and the Federal Republic of Germany*, ed. William Chandler and Christian Zollner. Kingston: Queen's University Institute of Intergovernmental Relations, 1989.

Tuohy, Carolyn. *Policy and Politics in Canada.* Philadelphia: Temple University Press 1992.

Van Loon, Richard. "From Shared Cost to Block Funding and Beyond: The Politics of Health Insurance in Canada." In *Perspectives on Canadian Health and Social Services Policy*, ed. Carl A Meilicke and Janet L. Storch. Ann Arbor: Health Administration Press, 1980.

Van Loon, Richard and M. Whittington. *The Canadian Political System.* Toronto: McGraw-Hill Ryerson, 1981.

Vayda, Eugene, R.Evans and W. Mindell. "Universal Health Insurance in Canada: History, Problems, Trends." *Journal of Community Health* 4 (1979).

Vernon, Donald. "Integrated Social Services in Manitoba." *Public Welfare* 2 (1973).

Weller, Geoffrey R. "From Pressure Group Politics to Medical-Industrial Complex: The Development of Approaches to the Politics of Health Care." In *Perspectives on Canadian Health and Social Services Policy*, ed. Carl A Meilicke and Janet L. Storch. Ann Arbor: Health Administration Press, 1980.

Weller, Geoffrey R. and Pranlal Manga. "The Development of Health Policy in Canada." In *The Politics of Canadian Public Policy*, ed. Michael M. Atkinson and Marsha A. Chandler. Toronto: University of Toronto Press, 1983.

Weller, Geoffrey R. and Pranlal Manga. "The Push for Reprivatization of Health Care Services in Canada, Britain, and the United States." *Journal of Health Politics, Policy, and Law* 8 (1983).

Wiseman, Nelson. *Social Democracy in Manitoba.* Winnipeg: University of Manitoba Press, 1983.

Yin, Robert K.. *Case Study Research: Design and Methods.* Newbury Park: Sage Publications, 1989.

PUBLISHED GOVERNMENT DOCUMENTS

Canada. *Task Force Reports on the Cost of Health Services in Canada* Volumes I to III. Ottawa: Queen's Printer, 1969.

Canada. *The Community Health Centre in Canada, Report of the Community Health Centre Project To the Conference of Health Ministers.* Ottawa: Community Health Centre Project, July 1972.

Canada. *A New Perspective on the Health of Canadians: A Working Document* Ottawa: Ministry of National Health and Welfare, 1974.

Canada. *Review of Health Services in Canada*. Ottawa: Ministry of National Health and Welfare, 1976.

Manitoba. *Annual Reports of the Department of Health and Public Welfare*. Winnipeg: King's Printer, (various years).

Manitoba. *Annual Reports of the Department of Health and Public Welfare*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Annual Reports of the Department of Health and Social Services*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Annual Reports of the Department of Health and Social Development*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Annual Reports of the Manitoba Hospital Commission*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Annual Statistical Supplements of the Annual Reports of the Manitoba Hospital Commission*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Annual Reports of the Manitoba Health Services Commission*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Annual Statistical Supplements of the Annual Reports of the Manitoba Health Services Commission*. Winnipeg: Queen's Printer, (various years).

Manitoba. *Final Report of the Task Force on Regional Boundaries*. Winnipeg: Department of Health and Social Development, 1972.

Manitoba. *Forecast of Costs and Financial Requirements For the Years 1968 through 1971.* Winnipeg: Queen's Printer, 1968.

Manitoba. *Framework-District Health System*. Winnipeg: HESP Subcommittee of Cabinet, 1973.

Manitoba. *Guidelines For the Seventies*. Winnipeg: Queen's Printer, 1973.

Manitoba. *Information Guide to Manitoba Hospital Services Plan Premiums*. Winnipeg: Office of the Commissioner of Hospitalization, 1960.

Manitoba. *Manitoba and Medicare 1971 To the Present*. Winnipeg: Manitoba Health, 1985.

Manitoba. *Manitoba Health Survey Report*. Winnipeg. Queen's Printer, 1953.

Manitoba. *Manitoba Hospital Survey Board Report Vol. I*. Winnipeg: Department of Public Health and Welfare, 1961.

Manitoba. *Public Health In Manitoba 1941*. Winnipeg: King's Printer, 1941.

Manitoba. *Public Health in Manitoba 1950.* Winnipeg: Department of Public Health and Welfare, 1950.

Manitoba. *Public Health in Manitoba 1955.* Winnipeg: Department of Public Health and Welfare, 1950.

Manitoba. *Report of the Health Services Review Committee.* Winnipeg: Manitoba Health, 1985.

Manitoba. *Report of the Special Select Committee of Manitoba Legislature on Health.* Winnipeg: King's Printer. 1947.

Manitoba. *Report of the Manitoba Royal Commission on Local Government Organization and Finance.* Winnipeg: Queen's Printer, 1964.

Manitoba. *Statement of Votes.* Winnipeg: Office of the Chief Electoral Officer, (various years).

Manitoba. *Submission by Hon. George Johnson, M.D., Minister of Health on behalf of The Government of Manitoba to the Royal Commission on Health Services.* Winnipeg: Department of Public Health and Welfare, 1962.

Manitoba. *White Paper on Health Policy.* Winnipeg: Cabinet Committee on Health, Education, and Social Policy, 1972.

Ontario. *A Framework for Evaluating Devolution.* Toronto: Task Force on Devolution, Premier's Council on Health, Well-being and Social Justice, October 1994.

Ontario. *The Evolution of Devolution: A Brief Summary of Provincial Experiences.* Toronto: Ontario Premier's Council, June 1995.

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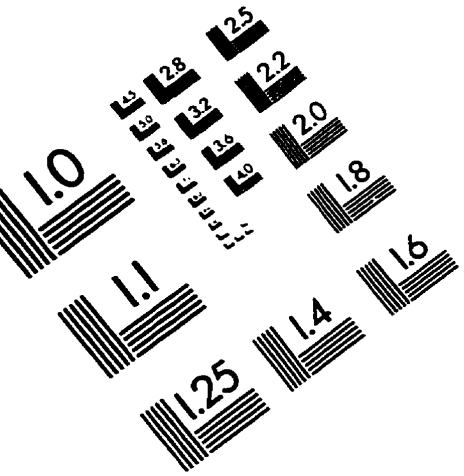

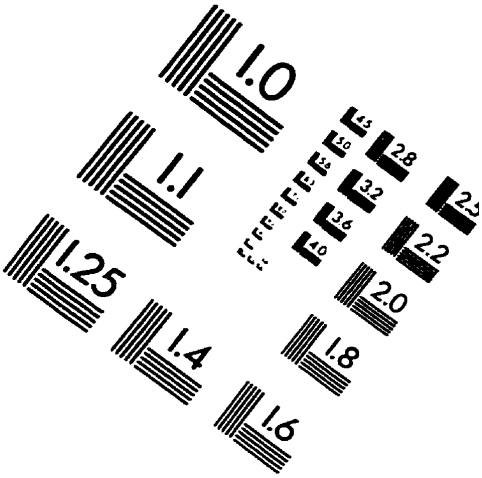

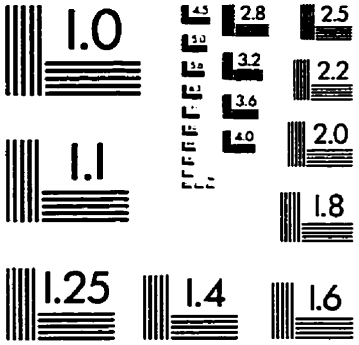

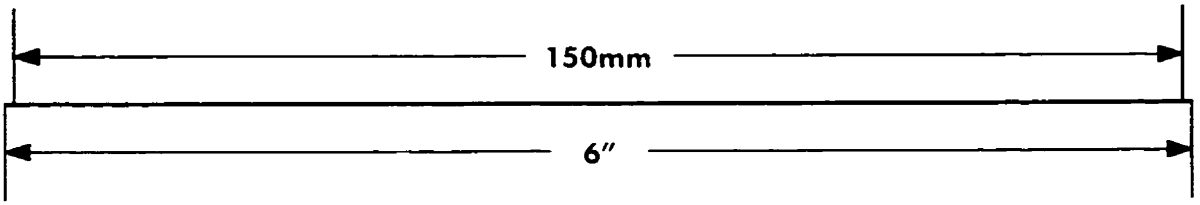

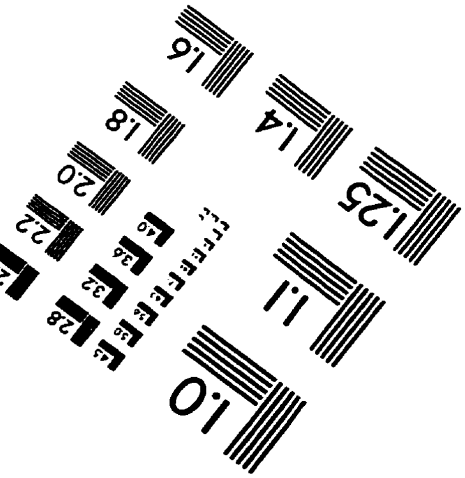

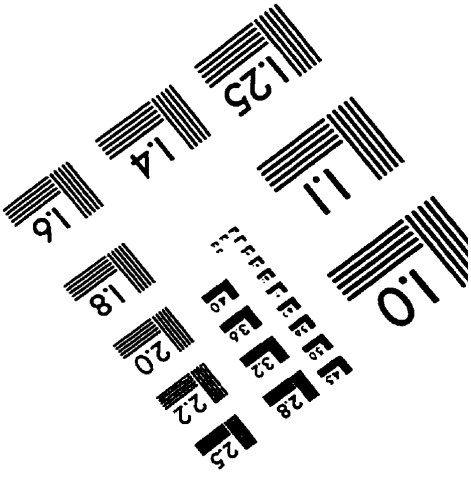

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