Regionalization and Health Services Restructuring in Saskatchewan

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*This paper is part of a larger project on the impact of regionalization in Alberta, Saskatchewan and Manitoba involving Mark Partridge, Professor and Canada Research Chair, and Rose Olfert, Associate Professor, of the Canadian Rural Economy Research Lab at the University of Saskatchewan, and Kevin O'Fee, a research fellow at the Saskatchewan Institute of Public Policy. I would like to acknowledge Saskatchewan Health for providing a start-up grant for this project.

> *"When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the whole delivery system – and of course, that's the big item. That's the thing we haven't done yet."*
>
> Tommy Douglas, from the 1982 film *Folks Call Me Tommy*, and quoted in Saskatchewan (1992) and Adams (2001).

In Saskatchewan, regionalization was undertaken by the provincial government in order to achieve two principal goals. The first was to save public health care costs by "rationalizing" over 400 separate health care organizations and the services they delivered into a system managed by a handful of public arm's-length institutions accountable to the provincial government. The second was to reallocate scarce resources from downstream illness care to upstream illness prevention and health promotion by transferring budgetary authority to geographically-based regional health authorities.

There were other goals and motives to be sure. These included, at least on the part of regionalization advocates if not governments, the desire to democratize health decision-making by delegating more responsibility and authority to local bodies and communities. And on the darker side, some governments may have seen regionalization as a means to push away the responsibility for difficult cost-cutting decisions from cabinet to regional boards.

Based upon statements and documentation at the time that regionalization was introduced, however, it is clear that the Saskatchewan government had two principal objectives: 1) a rationalization of health services in light of demographic shifts; and 2) an overall shift in the allocation of resources from illness care to wellness services.

Regional health authorities were established to carry these reforms forward, and in terms of both objectives, the hope was that reform would lead to more effective and long-term containment of health care costs.

A little over a decade has elapsed since regionalization was introduced in Saskatchewan. The purpose of this paper is to examine whether these two objectives have been met based upon a preliminary examination of administrative and financial data that has been collected by the provincial government.

The General Context of Regionalization

Numerous efforts have been made to define what is meant by regionalization but perhaps the simplest definition comes from a brief provided to the Castonguay Commission by the Fédération des médecins omnipraticiens du Québec (The Quebec General Practitioners' Union) in the late 1960s: "the integrated organization of a health care system possessing multiple coordinated functions and serving a delimited geographical territory" (Boudreau 1973). Beyond this very general "endpoint" definition, I would identify three common ingredients that have come to characterize regionalization in Canada.

The first involves the creation of units of organization whose mandate is to manage previously fragmented health service organizations – from acute care hospitals and long-term care institutions to home/community care and public health activities – in a single system of coordinated and integrated care. The main motive here was for government to move beyond being a passive insurer of public health services to create an

actual system of public health services and establish the public organizations that would actually manage that system.

The second aspect of regionalization is that it involves both decentralization and centralization by provincial governments. The authority to allocate budgets is decentralized from provincial health ministries to regional health authorities (RHAs). In terms of governance and health service decision-making, RHAs operate at arm's-length from provincial governments. At the same time, the delivery of services is centralized from numerous, independent individual health organizations to a single, managerial body. The motive here was to put resource allocation and managerial decisions in regionally-based bodies more cognizant of local needs than central health ministries and avoid putting too much decision-making authority and power in the hands of a single, central bureaucracy.

The third element of regionalization in the Canadian context is that it was accompanied by the political mandate to rationalize existing health care services. This rationalization took two forms: horizontal rationalization in terms of eliminating existing excess capacity (particularly hospital facilities) and focusing services where most needed; and vertical rationalization through better integrating or coordinating a broad continuum of institutional, community and home-based services while removing any potential overlap and duplication. The motive behind both types of rationalization was to cut health care costs, or at least reduce the growth in costs, while maintaining, to the greatest extent possible, existing service levels.

The two principal Canadian surveys of regionalization trace the origins of the reform to Great Britain and the Dawson Commission report of 1920 (Canada 1974:

Carrothers et al. 1991). The problem as perceived by the Dawson Commission was the multiplicity of independent health facilities which were incapable of ensuring any continuum of services for the patients they served. The solution was to create a new regionally-based organization capable of rationalizing and managing services for a defined population living within a geographic region. It would take more than a half-century, but regionalization was eventually introduced to the National Health Service in the structural reforms of 1974 (Webster 2002).

In Canada, a very mild form of regionalization was canvassed in the Commission on Health Services in the mid-1960s. The Hall Commission recommended the establishment of "local" health planning councils to serve in an advisory capacity to planners in provincial health ministries as well as delivering health services such as home care and rehabilitation not available at the community level (Canada 1965). As universal medical care insurance was being implemented on a national basis along the lines of the Hall Commission (Canada 1964), the federal-provincial Conference of Ministers of Health established an intergovernmental task force to make recommendations on how to manage the growing cost of public health care.

The most significant conclusions of the Conference of Ministers of Health (1969) focused on aspects of the system that could only be addressed through more direct public management of health services. Their report concluded that: (1) acute care hospitals were being individually managed in a way that exacerbated health cost inflations; 2) Medicare (including both universal hospital and universal medical care insurance) privileged diagnostic and treatment services by physicians at the expense of other health care modalities such as public health centres; and 3) coordination and integration were

required to address the inefficiencies inherent in a fragmented and uncoordinated set of institutions and delivery mechanisms (Aucoin 1980).

This report was a significant landmark. For the first time in Canada, regionalization was touted as a structural reform that could improve health services even while it saved public money. According to Carrothers et al. (1991, p. 1), the report "laid considerable emphasis on the fact that regional organization of all health services involving unification and coordination is essential to improve efficiency, arrest complexity and affect cost savings." In the words of then federal Minister of Health, John Munro, regionalization would achieve on behalf of all governments in Canada "the common goal of restraining the rate of increase in health service costs while maintaining and improving the quality of care" (Conference of Ministers of Health 1969, p. i).

Following the intergovernmental task force, five provinces – Quebec, Ontario, Manitoba, British Columbia, and Nova Scotia – called for their own public studies concerning the potential of regionalization. Although each of these governments considered implementing full-blown versions of regionalization, it would take another generation before regionalization was actually implemented. Although Saskatchewan was not among the five provinces which appeared ready to move on regionalization in the early 1970s, it would be among the first jurisdictions in the country to implement regionalization two decades later.

Regionalization in Saskatchewan

Beginning in 1944, Saskatchewan had been the first province to experiment with regionalization. In his report to the newly-elected CCF government led by Premier

Tommy Douglas, Professor Henry Sigerist of Johns Hopkins University recommended that the province be divided into health regions in order to plan and deliver a range of health services to a population of 840,000, two-thirds of whom then lived in the vast rural areas of the province (Saskatchewan 1947). However, the Douglas government soon found itself investing its scarce fiscal, administrative and political resources in the enormous task of establishing the country's first single-payer payment systems for hospital services and, subsequently, medical care insurance, both of which involved a relatively centralized administration based in Regina. After the implementation of the payment system, successive provincial administrations continued to avoid the issue of regionalization until accumulated government debt and ever-rising deficits created a crisis for the Progressive Conservative government of Grant Devine in the late 1980s and the New Democratic Party government of Roy Romanow in the early 1990s.

In response to the growing pressure to reduce government expenditures including health care, the Devine government established the Murray Commission on health care in 1988. Two years later, the Commission delivered its recommendations, the most important of which related to establishing a regionalized structure in Saskatchewan. These recommendations including replacing the over 400 individual hospitals, long-term care homes, home care service agencies, and ambulance organizations and their respective boards with 15 regional health authorities. The reasons given included the growing need for local community health services to be rationalized within a larger geographic area given the shift in population from rural to urban areas and the need to change the mix of services to meet the health needs of the older population remaining in the rural areas (Saskatchewan 1990).

To a considerable extent, the recommendations of the Murray Commission were aligned with initiatives aimed at reducing acute care costs that had already been undertaken by the provincial government. These included the "Integrated Facilities Program." Launched in 1984, this program encouraged rural communities to combine acute and long-term care beds into a single facility (Carrothers et al. 1991). Despite this, a deepening political and fiscal crisis prevented the Devine government from implementing the recommendations of the Murray Commission.

Regionalization was, however, introduced almost immediately after the electoral defeat of the Conservatives by the NDP in October 1991. The Romanow government moved quickly in large part because of the pressure it faced to address the province's desperate fiscal position. The new government's problem was simple: current spending plus the interest being paid on accumulated debt exceeded current revenues by an unsustainable margin. Since health care spending constituted at the time roughly one-third of total program spending, and generally grew faster than other public spending, it was part of the problem and, potentially, part of the solution to the fiscal crisis (Adams 2001).

To maintain existing service levels while instituting cuts to spending, the Romanow government pursued a major reorganization of the health system to find new savings through major service rationalization, integration and coordination. Structural reform through regionalization was the means to achieve this end. Indeed, the first Chief Executive Officer of the Saskatoon Health District said that, at its core, regionalization was really about integrating "services in an effort to deliver the best possible services with reduced resources" (Malcom 1996). As shown in figure 1, real health spending,

already in decline just before Romanow took office, dropped precipitously in response to the reforms.

Insert Figure 1 here (real Saskatchewan government health expenditures , 1975-2004)

As can be seen in Figure 2, Saskatchewan was hardly an outlier among provinces in cutting real health expenditures in the early 1990s. While the cuts went a little deeper than those experienced in Ontario, Manitoba and (after a lag) British Columbia, they were not as deep as those in Alberta over the same period. That said, health expenditures by all province provinces followed a very similar pattern over time. From 1980 until the early 1990s, provincial health expenditures were growing at a rate above inflation, a continuation of a long-term postwar trend. By the early 1990s (a little later in British Columbia), the prairie provinces and Ontario had reversed this trend and were able, on average, to hold health care costs below the rate of inflation. This period of cost containment lasted for about five years on average. By the mid to late 1990s, real health care growth rates spiked up well above the rate of inflation in response to years of disinvestment and stagnant remuneration for providers (Tuohy 2002).

Insert Figure 2 here (real per capita health expenditures, 5 provinces, 1980-2004

The four western provinces were selected for comparison because of the similarities among their approaches to regionalization as well as the timing of their reforms. Ontario has been added to these provinces for comparative purposes. As the

only province that did not adopt regionalization in this period, Ontario is the control case. As such, it is interesting that Ontario follows the same expenditure trend as the other provinces thereby illustrating the simple point that, whatever the intention of the western provincial governments, rationalization and cost-cutting could be achieved through means other than regionalization. Indeed the Ontario government, after an initial decline in real expenditures, established the Ontario Health Services Restructuring Commission and gave it the power to rationalize the existing hospital system in Ontario, a power that was unique among the many solely advisory commissions established to advise governments on the future of their public health systems (Sinclair et al. 2005).

In Saskatchewan, the new reforms involved two sequential stages (Adams 2001). The first was to streamline the existing "institutional delivery systems" and eliminate any unnecessary services. The second was to reallocate scarce resource from illness care "to a broad range of activities proven to contribute to health" (Saskatchewan 1992). The new regional health authorities were perceived as the essential vehicle for both steps.

Empirical Evaluation of Regionalization in Saskatchewan

The 1992 report issued by Saskatchewan Minister of Health Louise Simard emphasized the desire to have new regional bodies that would be large enough to achieve appropriate economies of scale in delivering services but small enough to be responsive to local health needs. While she allowed for a community-based process to determine the boundaries of the RHAs – to be called health districts – she expected the minimum size to enclose a minimum population of 12,000 and that between 20 to 30 health districts would

emerge out of the community process, including the urban districts of Regina, Saskatoon, and Prince Albert that had already been created by the government (Saskatchewan 1992).

The mandate given to the RHAs did not extend to administering, or allocating the budgets for, physician remuneration or prescription drug subsidies. In both cases, these would continue to be managed centrally by Saskatchewan Health rather than devolved to the RHAs. In this sense, the provincial government decided to continue the status quo, a decision persisted in by all provincial governments in Canada despite the arguments of various policy experts who have been advocating the decentralization of these significant budget items and, along with them, authority and responsibility, to regional bodies (Lomas 1997; Lewis and Kouri 2004).

Insert Figure 3 (transfers to RHA versus drug plan/physician expenditures)

While the RHAs would be expected to rationalize health services within their boundaries, the government decided to initiate as many hospital conversions and closures before the RHAs began operating in order to preserve the political viability of the new organizations. As a consequence, the acute care operations of 52 hospitals and integrated hospital facilities were shut down, with most of the facilities converted into long-term care facilities or wellness centres. While the health service and community impact of these "closures" continues to be debated (James 1999; Lepnurm and Lepnurm 2001; Liu et al. 2001), it seems indisputable that the regionalization reforms would have been poisoned from the start if the government had insisted on the RHAs carrying out the first and painful tranche of hospital rationalization.

Insert Figure 4 (per capita expenditures on hospitals, five provinces, 1980-2004)

As shown in five-province comparison in figures 4 and 5, most provincial governments cut hospital spending in the early to mid-1990s. By the end of the period, the Saskatchewan government, through the arm's-length budgetary decisions of the RHAs, was spending less per capita on hospitals, and devoting less of a percentage of its health budget to hospital expenditures, than the other four provinces. Compared to Saskatchewan, Alberta reflects an extreme version of "stop-go" financing. At the same time, even in the absence of regionalization, Ontario is in the mid-range of the five provinces in terms of what that provincial government, in the absence of regionalization, earmarked for hospital expenditures relative to other items in the overall public health care budget in recent years.

Insert Figure 5 (per cent of provincial health budgets allocated to hospitals, 1990-2004)

In 1992, the community-based consultation initiated by Saskatchewan Health Minister Louise Simard actually produced 32 health districts, over double the number recommended in the Murray Commission. This would soon create problems of critical mass in terms of the facility infrastructure and managerial capacity required to operate RHAs effectively. Established one decade after the Murray Commission delivered its report, the Fyke Commission on Medicare concluded that while regionalization had largely been a success in Saskatchewan, the sheer number of RHAs was impeding future

progress, and recommended that the 32 districts be reduced to between 9 and 11 regions. According to Ken Fyke, a shift to larger regions was essential in order to: sustain a broader range of services within each RHA; increase the organizational capacity of the rural RHAs to manage, plan and coordinate a broad range of health services; create more equality among regions; respond to the challenges of the continuing shift of population from rural to urban areas; and better encourage public participation and engagement (Saskatchewan 2001a).

In its response to the Fyke Report, the government of Saskatchewan decided to collapse the 32 health districts into 12 RHAs not including the Athabasca region in the far north which would continue as a partnership between the federal and provincial governments and the Dene First Nations of the region.

The administrative and financial data relied upon in this study were initially tabulated on the basis of the 32 health districts from the fiscal year 1993/94 until 2001/02. After this, the data were tabulated according to the 12 recently established health regions. Fortunately, the boundaries of the absorbed health districts fall neatly into the 12 health regions thereby allowing for the data to be tabulated as if the 12 health regions had existed from the beginning for the purposes of this study.

Insert Figures 6 and 7 (RHA old/new boundaries and health facilities within RHAs)

Table 1 sets out the demographic characteristics of the 12 provincial RHAs as well as the unique Athabasca RHA. They are classified in demographic peer groups

according to a methodology established by Statistics Canada and the Canadian Institute for Health Information (CIHI) for the study of RHAs throughout Canada.

Insert Table 1: Demographic characteristics of RHAs in Saskatchewan

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Unlike other Western provinces, Saskatchewan has no major urban concentrations of population on the scale of Vancouver, Calgary, Edmonton and Winnipeg. The Regina and Saskatoon health regions have both urban and rural populations within their borders and are characterized by low overall population growth, an Aboriginal population that constitutes almost 11 per cent of the population in Regina and almost 9 per cent in Saskatoon. Despite the fact that both regions encompass populations that are a fraction of the size of the large urban RHAs in neighbouring provinces, the Regina and Saskatoon health regions are enormous relative to all other RHAs in the province. Together, they receive almost 60 per cent of total RHA transfer funding from the provincial government.

The southern, predominantly rural, RHAs are characterized by negative population growth, older populations (22.4 per cent of the population in the Sunrise RHA is 65 and older) with a relatively small Aboriginal component. Long-term care services – particularly nursing homes – have absorbed between 34 per cent and 46 per cent of their total budgets during the past decade.

Insert Figure 8: Bar graph of resource allocation to long-term care, 12 RHAs, averages

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The northern, predominantly rural and remote, RHAs are characterized by a majority Aboriginal population, a very young average age, moderate population growth, and high rates of government transfers relative to the Canadian average. In terms of health services, these are exactly the regions where future benefits from current expenditures on illness prevention and health promotion would be greatest. In fact, over 30 per cent of the budgets of the Kewattin Yatthe and Manewatin-Churchill River health authorities are devoted to what are defined as "community services", a category that includes a number of illness prevention and health promotions services including: 1) population health initiatives managed by the RHAs; 2) community health/wellness services; 3) drug and alcohol treatment services; and 4) primary health care services directly run by RHAs.

From the inception of regionalization, one of the government's key goals was to shift resources from downstream illness care – in particular acute care – to upstream wellness care including public health, illness prevention and health promotion. Almost a decade after regionalization was introduced, the Saskatchewan government reiterated its commitment to this policy goal through its "Action Plan for Saskatchewan Health Care" (Saskatchewan 2001b). As indicated in a recent OECD report, however, this goal has proven elusive for most governments in the advanced industrial world. Despite major reform efforts, only 3 per cent of total health expenditures in OECD countries are earmarked for population-wide prevention and public health programs and the majority of funding continues to be allocated to illness care (OECD 2005).

Unfortunately, the manner in which financial and administrative data are defined and collected make it extremely difficult to determine how Saskatchewan has fared on

this major objective. First, public health and administration are tabulated together making it impossible to separate out the investment in public health alone. As a consequence, it is virtually impossible to determine the extent to which resources have been allocated to public health services by RHAs or Saskatchewan Health over the past decade.

Second, while data is collected in a category called community care services, this is an imperfect measure of population health programming. Although the core includes illness prevention and health promotion programs and initiatives, it also includes some activities that might be regarded as illness care services. As limited as it is, however, it is currently the only means by which any resource shift to wellness can be measured.

Figure 9 displays resource allocation among all the main health service categories from the mid-1990s to the present while Table 2 sets out actual spending by individual RHAs on community health services over the same period. In terms of both absolute expenditure levels and the share of the total health budget, the community health service segment has grown since regionalization. Although this growth could not be considered spectacular, it certainly well exceeds the 3 per cent share that is the OECD average.

Insert Figure 9: Health Resource Allocation in Saskatchewan, 1989/90 to 2004/05

It should also be kept in mind that this reallocation to wellness services increasingly has been in competition with increased spending on core Medicare services – in particular hospital and advanced diagnostic services as well as higher remuneration for health providers – since the late 1990s. By 2000, money was being earmarked for

items such as diagnostic equipment through intergovernmental agreement. By the time the provincial government released its “Action Plan” in 2001, Saskatchewan Health was focusing considerable resources on shortening surgical and diagnostic (including access to specialist physicians) wait times. This focus potentially requires a reallocation of resources to illness care services and, if so, conflicts with the wellness agenda of reallocating resources to the upstream side of the health equation.

Insert Table 2: Community Services Spending by Saskatchewan RHAs

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It remains to be seen, however, whether this growth in “wellness” expenditures is in line with other regionalized provinces such as British Columbia, Alberta and Manitoba, and whether the pattern in Ontario diverges or converges with the regionalized provinces. Unfortunately, differing accounting and financial reporting practices among the provinces (and, at times, even among RHAs within the same province) create enormous obstacles to such comparisons. Even in the Saskatchewan case, changes in financial reporting in which the expenditures for out-patient mental health programs were transferred from “mental health services” to “community health services” in fiscal year 2002/03, can create difficulties. To make these comparisons, and answer some basic questions concerning the impact of regionalization, a multi-faceted research agenda for the future is required.

Conclusion and Future Research Agenda

Although it can be said that regionalization was correlated with a substantial rationalization of the health system, in particular the elimination of acute care services in the sparsely populated regions of rural Saskatchewan, this rationalization could have been achieved without regionalization. The provincial government itself demonstrated this by taking direct responsibility for hospital closures and conversions. In addition, the case of Ontario demonstrates that hospital rationalization could (and did) take place in the absence of regionalization.

As to whether regionalization was an effective instrument in reallocating resources from illness care to wellness, the results indicate that a shift did occur with the onset of regionalization. Moreover, it is a shift which appears to have been sustained by the regional health authorities despite the recent emphasis on improving wait times for surgical and other services. This issue will require further research.

Case studies of selected RHAs within Saskatchewan group can be done to track wellness spending over time. These studies would permit due consideration of accounting and financial reporting changes over time and methods could be devised so that proper comparisons could be made. A similar case study approach is proposed for selected RHAs in Manitoba and Alberta so that similar calculations can be made that take into consideration the accounting and financial reporting conventions in those jurisdictions. Comparisons can then be made among RHAs in all three provinces using the peer group methodology. Finally, some assessment can be made of allocations on the provincial basis and these three western provinces can be compared to Ontario to see if regionalization has made a real difference in reallocating resources from illness care to wellness care.

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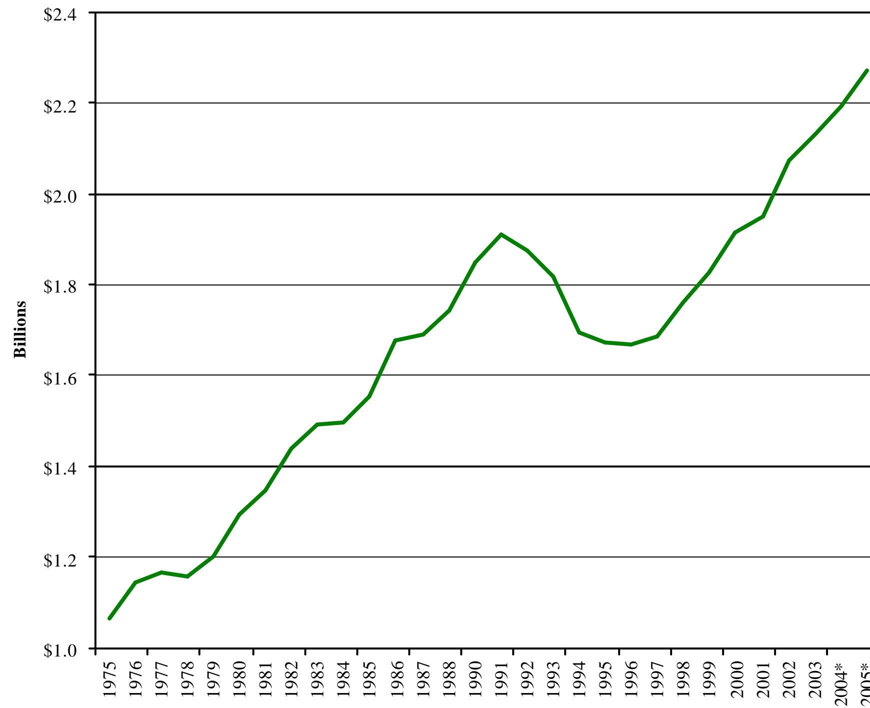
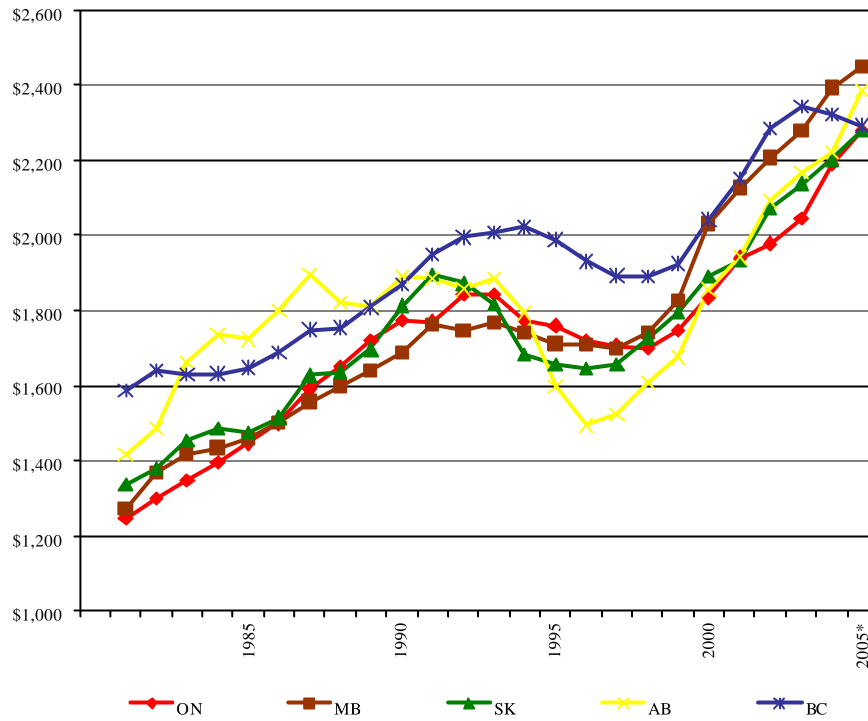
Figure 1: Real Provincial Government Health Expenditures, 1975-2005 (Constant 1997 $ in billions)



Note: * 2004 and 2005 are forecasts only. Data has been converted from "fiscal years" to "calendar years."

Source: CIHI. 2005, *Preliminary Provincial and Territorial Government Health Expenditure Estimates.* Ottawa: Canadian Institute for Health Information.

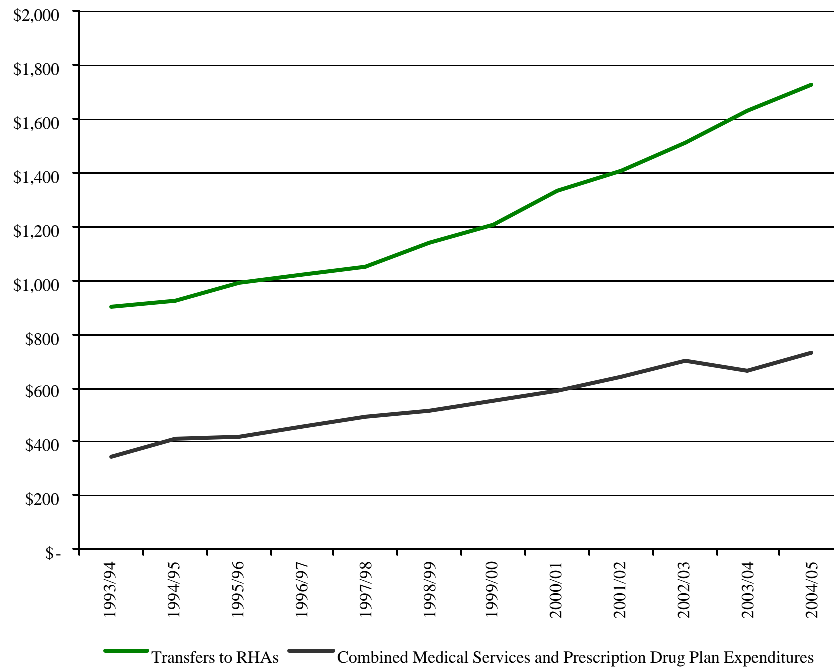
Figure 2: Real Provincial Government Per Capita Health Expenditures, 1975-2005, Selected Provinces (Constant 1997 $)



Note: * 2004 and 2005 are forecasts only. Data has been converted from “fiscal years” to “calendar years.”

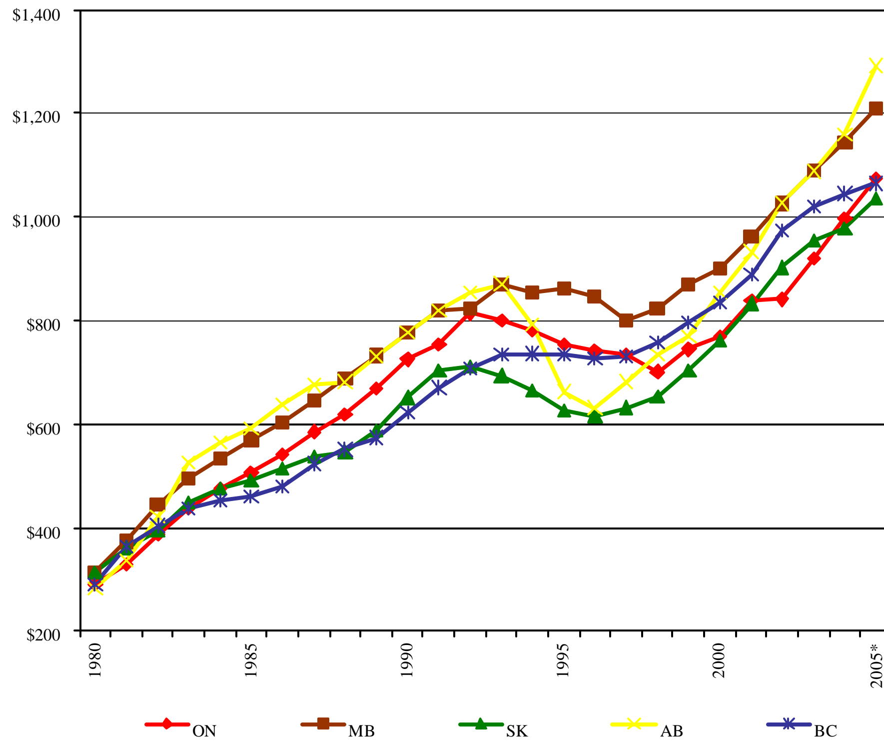
Source: CIHI. 2005, *Preliminary Provincial and Territorial Government Health Expenditure Estimates.* Ottawa: Canadian Institute for Health Information.

Figure 3: Transfers to RHAs versus selected centralized expenditures for Medical Services and Prescription Drug Plan, 1993/94 to 2004/05 (current $ in Millions)



Source: *Saskatchewan Health Annual Reports*, 1993/94 to 2004/05.

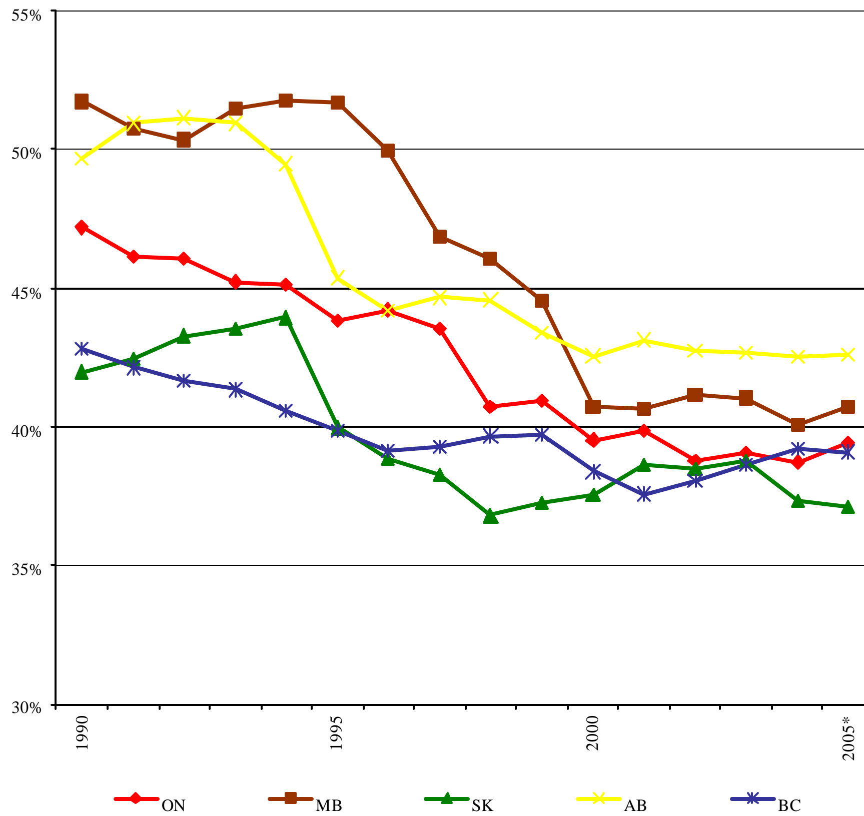
Figure 4: Per Capita Expenditures on Hospitals, 1980-2005, Selected Provinces ($ current dollars)



Note: * 2004 and 2005 are forecasts only. Data has been converted from "fiscal years" to "calendar years."

Source: CIHI. 2005, *Preliminary Provincial and Territorial Government Health Expenditure Estimates.* Ottawa: Canadian Institute for Health Information.

Figure 5: Per Cent of Provincial Health Budgets Allocated to Hospitals, 1990-2005, Selected Provinces



Note: * 2004 and 2005 are forecasts only. Data has been converted from "fiscal years" to "calendar years."

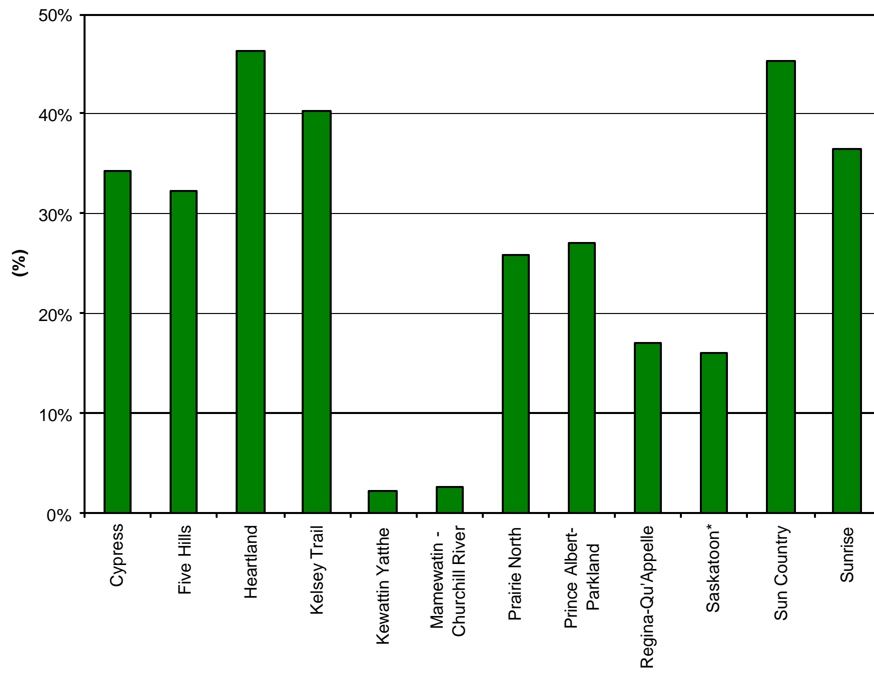
Source: CIHI. 2005, *Preliminary Provincial and Territorial Govern ment Health Expenditure Estimates.* Ottawa: Canadian Institute for Health Information.

Table 1: Demographic characteristics of RHAs in Saskatchewan

Peer Group	RHA	Rural (Percent of population)	Population Density (persons per sq. km.)	Aboriginal Popul ation (% of population)	Low Income (% of economic families)	Unemployment Rate	Percent of population Aged 1 - 14	Percent of population Aged 65+
Group A								
	Regina Qu'Appelle	18.5	9.2	10.7	11.4	3.2	19.7	13.7
	Saskatoon	20.3	8.6	8.7	12.8	3.3	20.5	13.0
Group C								
	Prince Albert–Parkland	51.0	2.5	31.4	15.1	4.5	22.8	15.1
Group D								
	Sun Country	55.5	1.7	3.8	7.6	1.4	19.7	18.3
	Five Hills	31.7	2.0	3.3	11.2	2.4	18.8	18.7
	Cypress	54.9	1.0	2.5	8.2	1.3	19.0	18.8
	Sunrise	48.9	2.4	7.8	10.8	2.7	17.8	22.4
	Heartland	57.3	1.1	1.5	9.1	1.5	21.0	15.9
	Kelsey Trail	61.1	1.0	13.2	10.7	3.7	20.8	18.7
Group F								
	Mamewatin	88.5	0.1	83.5	27.6	14.1	36.3	4.6
	Keewatin	100.0	0.1	94.5	40.1	18.1	36.3	4.6
	Athabasca	100.0	>0.1	93.4	22.5	21.2	36.2	4.5
Group H								
	Prairie North	54.8	2.3	28.3	11.9	3.5	25.0	12.4

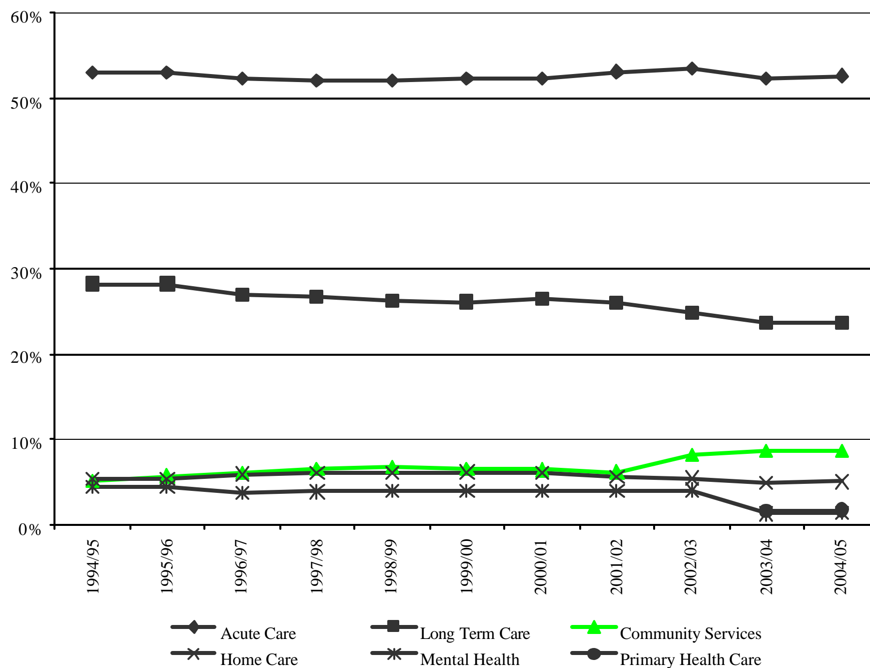
Source: Statistics Canada 2005, Health Indicators .Vol. 2005 (2), Catalogue no.: 82-221-XIE. Ottawa: Statistics Canada

Figure 8: Resource Allocation to Long-Term Care, Saskatchewan RHAs, 2003/04



Source: *Saskatchewan Health Annual Report*, 2003/04.

Figure 9: Health Resource Allocation in Saskatchewan RHAs, 1994/95 to 2004/05



Note: Data for primary care expenditures unavailable prior to 2003/04. Financial data for the individual expenditure categories expressed in the figure are unreliable prior to 1994/95 and therefore the first full year of RHA reporting has been omitted.

Source: *Saskatchewan Health Annual Report*, 2004/05.

Table 2: Community Service Spending by Saskatchewan RHAs, 1995/96 to 2004/05 (Current $ in Millions)

RHAs	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Cypress	3.8	4.8	5.4	5.3	4.9	4.9	4.9	5.1	7.4	7.9
Five Hills	3.3	3.9	4.4	4.3	4.9	5.2	5.6	6.3	8.2	8.5
Heartland	4.2	4.0	4.5	5.6	6.1	5.1	5.5	5.7	7.7	8.3
Kelsey Trail	2.8	3.7	4.2	4.3	4.2	4.9	5.8	6.8	6.2	7.9
Kewattin Yatthe	-	-	-	3.7	2.9	3.6	3.6	-	4.8	6.6
Mamewatin - Churchill River	-	-	-	3.8	4.2	4.8	4.7	5.0	5.9	6.3
Prairie North	5.3	5.5	6.3	6.8	6.4	6.9	7.5	8.8	13.9	17.5
Prince Albert - Parkland	4.4	5.8	7.6	9.2	10.9	11.2	7.5	8.0	11.1	10.9
Regina-Qu'Appelle	13.1	13.0	15.9	16.7	19.4	19.9	20.7	24.4	33.9	36.0
Saskatoon	11.4	14.0	15.6	16.0	16.0	17.6	19.0	50.1	38.9	42.3
Sun Country	12.4	10.0	10.1	5.0	5.6	5.2	7.1	8.1	9.9	12.8
Sunrise	4.7	5.3	5.9	6.0	5.9	6.0	6.3	5.1	9.2	10.8

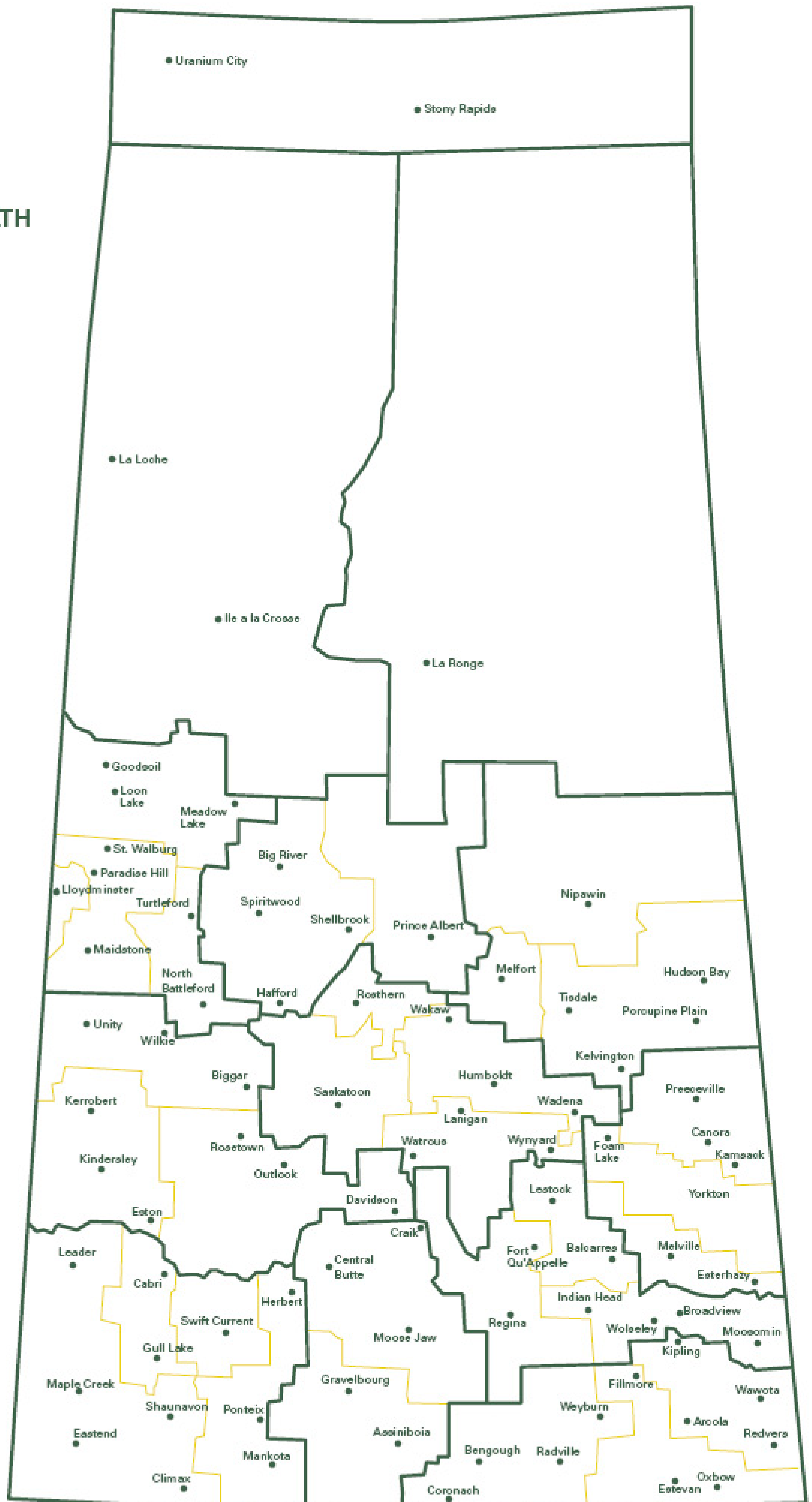
Note: In 2002/03, the figures for out-patient mental health programs, previously designated as “mental health” expenditures, were included in “community health services” for the first time.

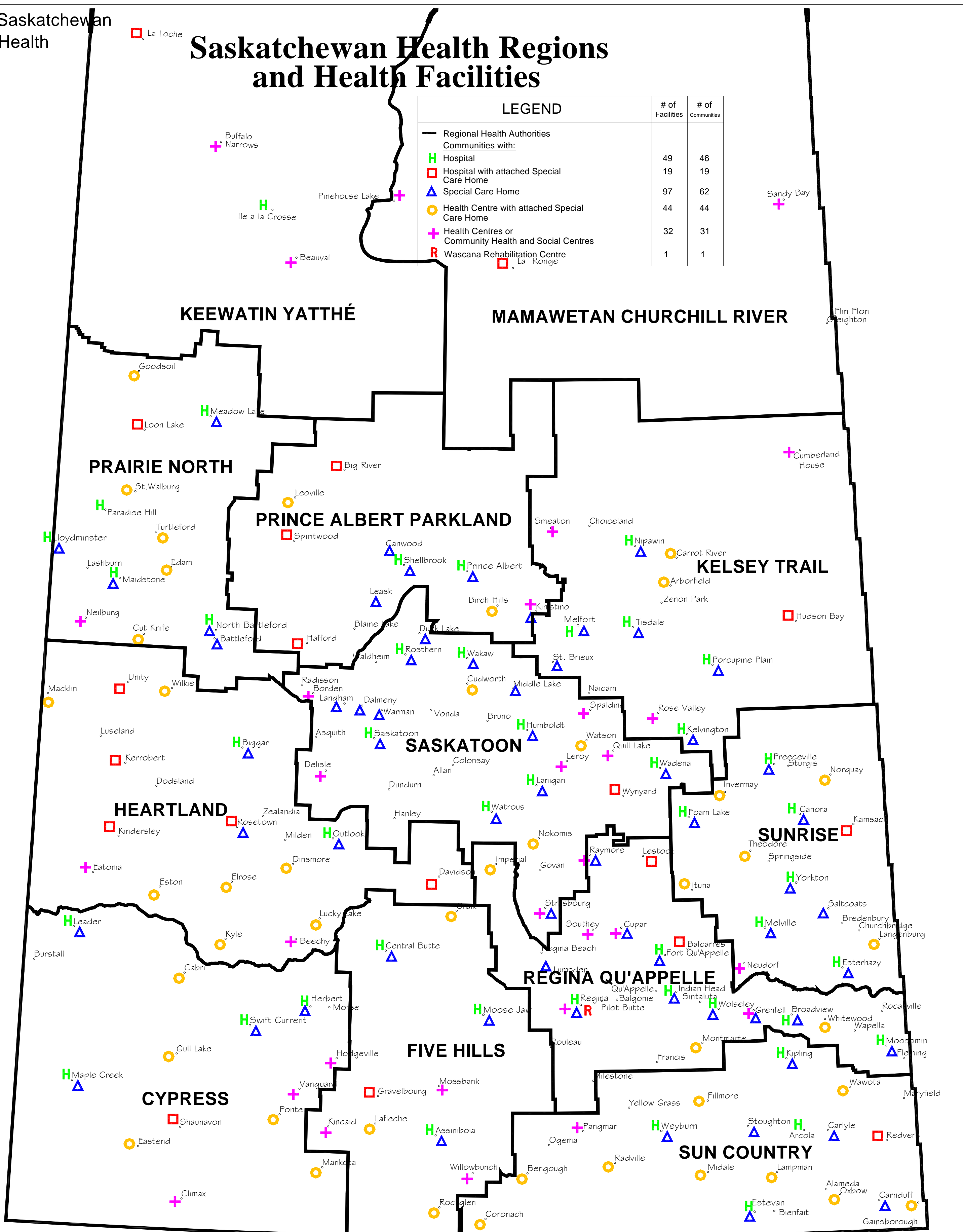
Source: *Saskatchewan Health Annual Reports*, 1995/96 to 2004/05.

REGIONAL HEALTH AUTHORITY BOUNDARIES

Health District Boundaries

New Regional Health Authority Boundaries





Note: Northern Communities Not Shown

Uranium City + Stony Rapids H

Facilities at Uranium City, Carrot River and Wawota have been operating as health centres since August 1999, December 1999 and August 2000 respectively.

CITB: GIS UNIT, RA, 03/15/04, Fac04-A.DWG

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