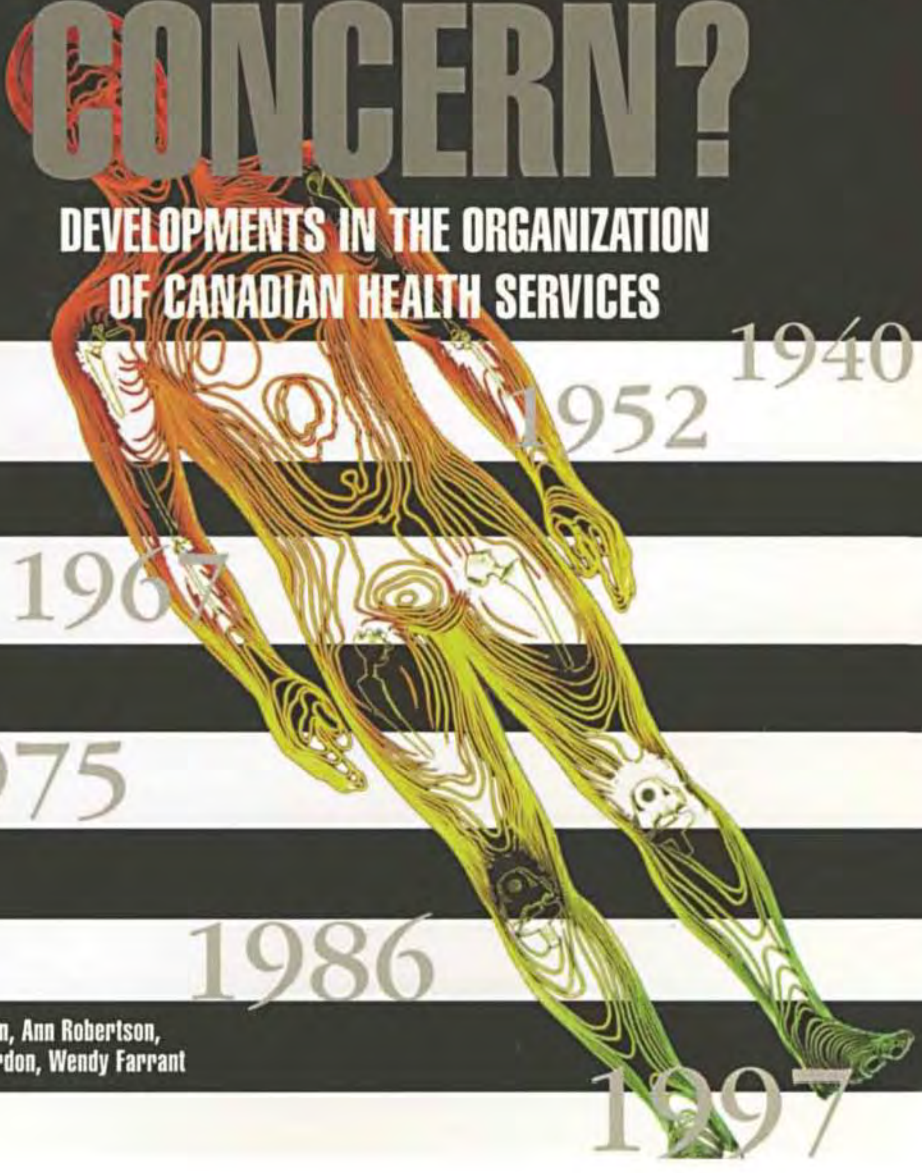
HEALTH CARE A COMMUNITY CONCERN?

DEVELOPMENTS IN THE ORGANIZATION OF CANADIAN HEALTH SERVICES



Anne Crichton, Ann Robertson,
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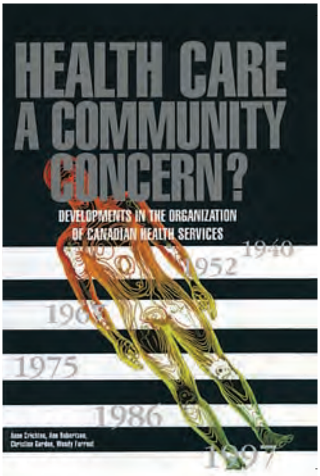

HEALTH CARE: A COMMUNITY CONCERN?

by Anne Crichton, Ann Robertson,
Christine Gordon, and Wendy Farrant

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Charts and Lists

Executive Summary[1]

There are three themes in this book:

1. Consumer involvement in decision making about social care
2. Canada's commitment to the welfare state or its replacement, the welfare society
3. The effectiveness of the present organization for delivering collectivist health care to Canadians and the prospects of improving it through regionalization

As a result of experiences arising out of the Great Depression of the 1930s and wartime experiences of the 1940s, Canada decided to follow other western developed countries and set up a welfare state organization to promote full employment and provide social supports for those who needed social care. But in 1945-46 efforts to introduce new programs of federal grant aid to enable the provincial governments to set up better service delivery schemes were thwarted, at first, by two provinces which raised constitutional objections to the federal government involvement in social affairs. These objections were ultimately overcome, but there were long delays in implementing federal plans and the Canadian welfare state was not in place until the end of the 1960s.

In the meantime the Province of Saskatchewan led the others in developing a plan for providing a provincial level of collectivist health care. Other English-speaking provincial governments were not so far ahead in their thinking as Saskatchewan, but they could see electoral advantages in supporting welfare state approaches. After Ontario's resistance to federal intervention was removed in 1957, the provinces were able to claim open-ended matching grants and to set up a wide range of social programs. Quebec made a separate deal with the federal government in 1963 which enabled that province to claim grant aid on its own terms.

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[1] See Appendix A for definitions of such terms as collectivist.

Quebec's planning activities influenced the new federal Deputy Minister of Health and Welfare Dr. Maurice Le Clair, appointed in the late 1960s. He raised a series of questions about the management of federal grant aid by the provinces and whether the current aims of the health care programs, that were to provide access to hospital and medical care, were really good enough for a collectivist system of care. By proposing that the emphasis on access should be shifted to concern for outcomes, he altered the model for health care from a biomedical to a social model.

There were many resistances to changing the model of care. First there were the constitutional resistances by the provinces to any federal intervention into social affairs. Then there were resistances of the medical profession to changes in practice organization. Compromises had to be made to the rational plans of Saskatchewan and Quebec. The doctors continue to maintain the organizational structures which were developed for providing individualistic health care before the war. Few changes to these have been accepted. While public health staff have been more ready to consider organizational change, this acceptance may still be rhetoric rather than reality. Care for the elderly is also threatened by medical resistance to change from the biomedical to the social model of care proposed by Le Clair.

The welfare state developments restricted community members from making inputs into decision making about social care. Politicians, bureaucrats and professional experts took over the responsibilities for planning and implementation of policies and programs.

The politicians and bureaucrats had to learn how to assume the formal responsibilities for organizing collectivist care. Since programs were introduced incrementally, they were poorly coordinated and often poorly managed. Efforts to improve coordination were only partially successful. This book goes on to explore whether research has contributed to our understanding of collectivist organizational development. After reviewing changes in approaches to research, this section explores some theoretical ideas about organizational transition and identifies problems in working them through. This is followed by a discussion of the emergence of ideas in the health promotion movement, and studies in the economics of community care. (These seemed to be the most relevant issues in research and development relating to the transitions which were being made in Canada's health service organization toward collectivism between 1940 and 1986.)

The next part of the discussion considers the moves toward reform and restructuring which have taken place since 1980. In that year an international conference considered the failures of the welfare state model of organization and proposed bringing into discussion corporate "partners" from the business and research communities. Some have called this shift toward partnerships "the welfare society." There were other challenges to the emphasis of welfare states on financial redistribution only. Canada appended a Charter of Rights and Freedoms to its new constitution patriated in 1982 and developed this into a revised Human Rights Act in 1983. This legislation shifts the emphasis from financial redistribution as the main aim of the welfare state to promoting attitude change to members of disadvantaged groups. The new emphasis on human rights and full citizenship for all has made it clear that good social organization and a healthy society cannot be attained without involving individuals and communities in taking responsibility for themselves and their fellow citizens. Thus there have been many discussions about community development, community networking and other forms of partnership in recent years.

Investigations of their health service organizations have led most provinces to the conclusion that (1) these public service organizations should be restructured in order to improve cost control through better linkage of the parts, and (2) consumers should be brought into policy discussions so that there will be a better understanding of the problems of providing services. The mechanism that most provinces have chosen for reform and restructuring is regionalization.

Finally, the question which must be answered is whether Canadians in all provinces still want to support a collectivist organization of health services within a welfare state restructured to be a welfare society. The obvious doubts in some provinces about the extent of this commitment are explored.

Vancouver, BC
September 1995

Preface and Acknowledgments

This book was developed in response to a call for research grant submissions to the National Health Research and Development Program (NHRDP) in 1989. NHRDP asked for researchers to come forward if they were interested in examining the literature on specific strategies for strengthening community health services. In making this examination, it was said that attention should be given to documentation of effective linkage and collaboration between:

- social and health community-based services;
- community-based and institutional services;
- community-based services and the education, social services, municipal, housing, judicial and the voluntary sectors;
- multidisciplinary models of delivery of community services. (pp. 1–2)

As well, the economic impact, both in the short and long term, of moving towards "models of service delivery which demonstrate the effective linkage and collaboration between community-based services for primary care, disease prevention and health promotion" should be analyzed under the general heading "strengthening community health services" (p. 3).

It was decided to seek a grant to look at "organizational models for community services" under these terms of reference.

There are a number of different reasons for the delays in publishing the information collected. However, those delays may have been fortuitous in that new stages of organizational development have been reached recently and we have been able to incorporate a discussion of these changes in the final chapters.

The basic literature review was funded by a National Health Research Foundation Grant 5-52047-2522. This paid for research assistance and secretarial help, with $1,000 for overhead which was to include cost of paper, phone calls, etc. There was no allowance for travel. We have tried to provide examples from as many provinces as possible while recognizing that we are most familiar with what is going on in British Columbia. Since it seemed to be impossible to locate all the important materials without visiting informants in the other provinces, the project was supported with travel monies from a University of British Columbia Research Fund for the Comparative Study of Health Systems. This enabled brief visits to be made to other provinces and to Victoria, British Columbia to find materials which were used for this and other research projects on Canadian health care. We are most grateful to those people who provided free accommodation and fitted their schedules to our hectic travel timetable.

The chapters were written by four different authors with four different styles, so there is some unevenness in the overall presentation. Chapters 12 and 13 were written by Ann Robertson, Chapter 11 by Christine Gordon and Chapter 10 by Wendy Farrant who died two years ago. Anne Crichton planned the book and wrote the other chapters. Ann Robertson helped with the editing. Despite the unevenness in styles, it was thought best to permit each author's own thinking to come through.

We must thank particularly our eleven consultants who opened doors in their special areas of expertise and helped us to understand their approach to problems:

Mr. Michael Clague, then Executive Director, Social Planning & Research Council BC, 106 — 2182 West 12th Avenue, Vancouver, BC V6K 2N4

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Ms. Rita Stern, then Director, Health Promotion Directorate, 750 Cambie Street, Suite 425, Vancouver, BC

We should add to this list Dr. Marc Renaud, Professor, Groupe de recherche sur les aspects sociaux de la prévention (GRASP), Université de Montréal, 2801 rue Edouard Montpetit, Suite 162, Montréal, PQ H3C 3J7, who ensured access to sources in Quebec which would not have been found without his help. Lynda Hessey, Executive Director, Durham District Health Council, enacted the same role in Ontario.

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We also acknowledge the useful comments of three reviewers from the Social Science Federation of Canada, Aid to Scholarly Publications Program and two university press reviewers for their suggestions on revision of the manuscript. This book has been published with the help of a grant from the Humanities and Social Sciences Federation of Canada, using funds provided by the Social Sciences and Humanities Research Council of Canada.

Laurel Slaney typed the manuscript many times. We thank her for her patient cooperation.

Material in Chapters 13–15 was published in *Medical Care Review* 51, no. 2 (1994): 148–78. Material from Chapter 16 was published in the *Canadian Journal of Public Health* and material from the literature review generally was printed in the *International Journal of Health Planning and Management*.

A summary of all the literature reviews funded by NHRDP was published in 1993 under the following titles:

"Service Models in Community Based Health: Some Findings from a Literature Review." *Canadian Journal of Public Health* 80, no.1 (1995): 26–28.

"A Critical Analysis of Recent Canadian Health Policy: Models for Community Based Services." *International Journal of Health Planning and Management* 8 (1993):295–314.

Canadian National Health Research Development Foundation Summaries of Literature Reviews on Strengthening Community Health Services. Ottawa: Supply and Services, 1993.

We have listed below, in alphabetical order, those who were willing to be interviewed or to discuss matters by phone and those who sent us materials on request. We were seldom refused help, and many people put themselves out to provide assistance.

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Acronyms

ACHP	Association Canadienne d'Hygiene Publique (Canadian Association of Public Health)
ACIP	Ambulatory Care and Incentive Payments
ACMC	Association of Canadian Medical Colleges
ADM	Alternative Delivery Models
AFN	Assembly of First Nations
AMA	Alberta Medical Association
B.C.	British Columbia
BCMA	British Columbia Medical Association
CAP	Canada Assistance Plan
CBA	Cost Benefit Analysis
CC	Community Clinic
CCHSE	Canadian College of Health Services Executives
CCSD	Canadian Council on Social Development
CEA	Cost Effectiveness Analysis
CEIC	Canadian Employment and Immigration Commission
CESBES	Castonguay-Nepveu Report
CFPC	College of Family Physicians of Canada
CHC	Community Health Centre
CHEPA	Centre for Health Economics and Policy Analysis
CHHRC	Community Health and Human Resources Centres (BC)
CHST	Canada Health and Social Transfer
CIAR	Canadian Institute of Advanced Research
CIMR	Canadian Institute for Mental Retardation
CLSC	Centres locaux de services communautaires
CMA	Canadian Medical Association
COPOH	Coalition of Provincial Organizations for the Handicapped
CPHA	Canadian Public Health Association
CRB	Community Reseouce Boards (BC)
CROP	Centre des Recherches sur l'Opinion Publique
DHC	District Health Council (Ontario)

DNHW	Department of National Health and Welfare
DSC	Départements de santé communautaires
EMH	Extra Mural Hospital
EPF	Established Programs Financing Act
FMOQ	Fédération medicale omnipracticents du Québec
FCLSC	Fédération de CLSCs
FSU	Family Support Unit (Great Britain)
GAI	Guaranteed Annual Income
GB	Great Britain
GHAA	Group Health Association of America
HIDS	Hospital Insurance and Diagnostic Services Act
HITH	Hospital in the Home
HSO	Health Service Organization
ICBC	Insurance Corporation of BC
IHCCF	Institute for Health Care Facilities of the Future
IR	Interorganizational Relations
IYDP	International Year of Disabled Persons
MCSS	Municipal Health and Social Services (Ontario)
Medicare	Medical Care Insurance (but often used to describe Canada's health care system services as a whole).
NACA	National Advisory Council on Aging
NAFTA	North American Free Trade Agreement
NCW	National Council of Welfare
NDP	New Democratic Party
NFER	National Foundation for Education Research in England and Wales
NGOs	Non-governmental Organizations
NHRDP	National Health Research and Development Program
NHS	National Health Service (Great Britain)
NIMR	National Institute for Mental Retardation
OD	Organization Development
OECD	Organization for Economic Cooperation and Development
OEO	Office of Equal Opportunity (United States)
OHIP	Ontario Health Insurance Plan
OPEC	Organization Petroleum Exporting Countries
OSIS	Organization de soins integrés de santé
PC	Progressive Conservative Party
PDIG	Program Development and Implementation Group (Ontario)
PEI	Prince Edward Island
PQ	Parti Québécois
QHIB	Québec's Medical Plan

SAR	Search and Rescue
Socred	Social Credit Party
SSHRC	Social Science and Humanities Research Council
UBC	University of British Columbia
UCSN	Urban Core Support Network (Great Britain)
UN	United Nations
US	United States
USSR	Union of Soviet Socialist Republics
VHB	Vancouver Health Board
VON	Victorian Order of Nurses
VRB	Vancouver Resource Board
WCB	Workers' Compensation Board
WHO	World Health Organization

PART I

Themes of the Book

CHAPTER 1

An Explanation of the Approach

Three themes will be developed in this book:

1. Because the present organization of health care delivery is less efficient and effective than it could be, there is a perceived need for reform and restructuring
2. That understanding how the health care system may be reformed depends upon a better understanding of the context of its organization, that is, the Canadian welfare state and our commitment to it
3. That one aspect of reform and restructuring is community involvement.

As an introduction to an exploration of these themes, the first four chapters will present, first, the framework which will be used for analysing the health care system in its context and second, three brief summaries of the themes which will be discussed more fully later.

The Reasons for Taking This Approach

In 1986 the federal Minister of Health, Jake Epp, called an international conference in Ottawa (WHO 1986) in conjunction with the World Health Organization's (WHO) European office, to discuss the concept of health promotion. He had become interested in this extension of Canada's approach to health care delivery because the previous government had passed, in 1984, the Canada Health Act,[1] which can be seen as bringing to a close the first stage of development of publicly financed health care. The passage of this act ensured that all provinces receiving federal grant aid would provide

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[1] This act brought together the legislation in 1948 for the National Health Grants, the 1957 Hospital Insurance and Diagnostic Services Act and the 1966 Medical Care Insurance Act (see Chapter 2).

access to universal, comprehensive, portable, publicly administered and equitable medical and hospital services. But the effectiveness of emphasizing *access* to crisis care as the principal goal of the public system had begun to be questioned much earlier in *A New Perspective on the Health of Canadians* (Canada 1974a) which had argued that lifestyle, a good physical and social environment and biological risk were more likely to affect health status *outcomes* than medical care itself, and that a preventive approach would be better than funding crisis care.

Following the 1986 Ottawa conference, the Department of Health and Welfare developed a new emphasis on health promotion and persuaded the National Health Research and Development Program to fund a series of literature reviews on the strengthening of community health services, which were seen to be vital components of the health promotion approach.

This literature review, as part of that series, takes a broad brush approach in attempting to show how the Canadian health care system has developed its goals and objectives and how the organization and management of services has lagged behind policy changes. It was thought that in order to understand where the system stands today and why it needs reform and restructuring, it would be necessary to take an historical approach which would trace the successes and failures in moving away from an individualistic entrepreneurial medical care organization, first to a collectivist biomedical model, and then to a social model for health care in Canada.[2]

So it seemed to be necessary to find an analytic framework which would link policy to service provision and help us to tease out the complexities of the evolution of the system. The setting of broader goals for the health care system, which had gradually taken place between 1974 and 1986, led us to examine discussions of Canada's social policies as a whole. The *New Perspective* (Canada 1974a) had resulted in an examination of the social determinants of health. Reassessments by WHO of its goals during this period had led to a new emphasis on primary care at very basic levels and the development of countries' social programs rather than promoting more specialist medical care. Canada worked closely with WHO in developing this reassessment of policy direction.

A framework established by Ismael and Vaillancourt (1988) for examination of changes in social policy approaches seemed to help us to tease out the different parts of the system which had an impact on each other – the range of social services, the different levels of government which were involved in providing and administering these services and the different kinds

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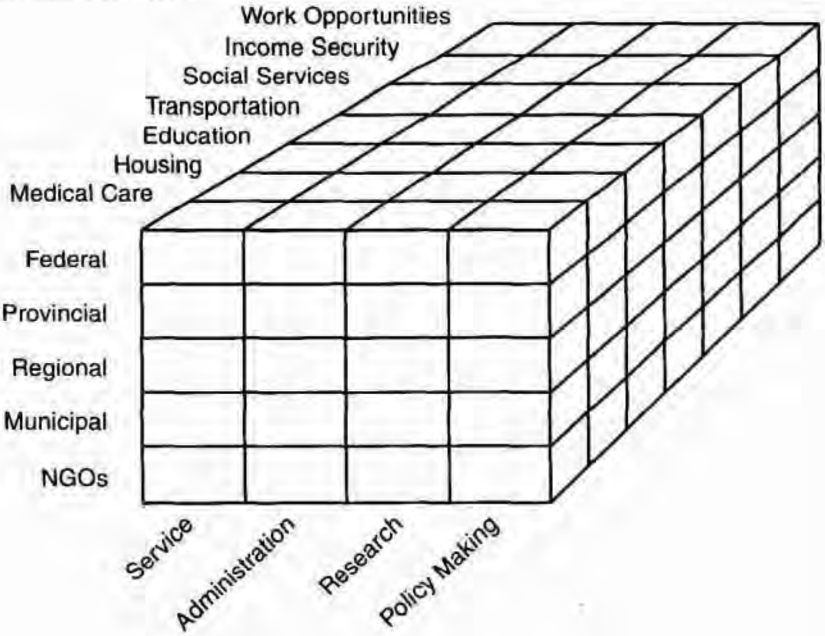
[2] See Appendix A for definitions.

Chart 1.1
A Framework for Analysis of the Canadian Health Care System in the Welfare State



Source: Adapted from Jacqueline Ismael and Y. Vaillancourt, *Privatization and Provincial Social Services in Canada: Policy, Administration and Service Delivery* (Edmonton: University of Alberta Press, 1988). Reprinted with permission.

of analysis of activities which would be necessary (i.e., of service giving, administration, policy making and research). Their framework was adapted by us to fit an analysis of the development of the health care system in the welfare state. It demonstrates (Chart 1.1) the formidable commitment which the Canadian government took on when it decided to move to a publicly financed model of providing health care for all its citizens.

This framework lists, at the top, the different welfare state programs identified as being important in determining health and enhancing education, work opportunities, income security and housing as well as transportation, social support services and medical care. How these programs are organized can be separated out into federal, provincial, regional, municipal and non-governmental organizations' jurisdictions. Activities within each of the programs and within each of the jurisdictions can be divided, too, into service provision, administration, research and policy making.

It was decided that the concept "literature review" should be interpreted broadly since the project was clearly focussed on potential changes in organization. Consequently any documents in circulation at policy discussion levels were sought out, whether in print, duplicated form, or letters, for these last two forms of documentation are often found to be at the cutting edge rather than older materials printed in books or refereed journals. A massive range of background materials was examined in order to relate current policy proposals to their historical origins.

The book follows the plan at the foot of Chart 1.1. It looks at the organization of service delivery, organization of bureaucratic administrative authorities, and some research contributions as well as health and welfare state policy making. Before presenting those literature reviews, however, we put forward a short statement of the arguments for writing this book – a summary of changes in the health care system since 1900, a brief discussion of Canada's decision to become a welfare state during the Second World War (with some questions about that approach) and the reasons for the emergent development of concern about the exclusion of consumers and community members from real participation in the policy-making process with respect to health care.

It would seem that Canada is now moving toward greater community involvement, better understanding of the meaning of collectivist health care and ways of reforming and restructuring social organization to increase community participation and to provide better health services to those who need them most. However, one major problem is the Canadian national deficit situation which is leading to federal withdrawal from social program support. As well there are questions about commitment to collectivist ideology today which need to be addressed. Thus the final section on policy development is concerned with the reforms and restructuring which are putting the Canadian "welfare society" in place and the shift away from financial redistribution policies. These recent reforms are greatly concerned with giving consumer/community members a place in the formal structures of collectivist health service organization so that they may be able to contribute more effectively to policy making in Canadian society.

It will be noted that the literature review concentrates on the period 1940–93 when the research was first undertaken. The last chapters form a postscript to bring the discussion up to early 1996.

CHAPTER 2

Canada's Publicly Financed Health Care System

Canada's health care system is a matter of pride for the majority of Canadians, for while it is not at the very top of the national morbidity and mortality indicators, it is not far off and it provides satisfying care for most citizens (Blendon et al. 1990). In the last ten years, however, the system has come under scrutiny in almost all provinces (Angus 1991; British Columbia 1991) and all governments have been concerned with the need for reform and restructuring.

In the first half of the twentieth century the growth of scientific medicine changed perceptions about the new importance of doctors' expertise in providing diagnosis and treatment for illness and this resulted in major changes in the organization of doctors' offices and hospital practice. Small communities in rural areas struggled to attract doctors to provide care and many worked out ingenious solutions (such as the Municipal Doctor Schemes on the prairies). Charity hospitals, which had often been a refuge for indigents in the nineteenth century, gradually separated out fee-paying patients from those who sought free care and became important treatment centres after they had managed to cope with infection control (Andrews 1979).

Most hospitals were in the cities, where they had often been set up as charitable foundations, though there were municipal hospitals in some rural areas and mission stations, usually on Indian reserves. By 1933 there were 589 public hospitals with 45,000 beds and approximately 300 private proprietary hospitals.[1]

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[1] The term public hospital includes charitable foundations as well as municipal hospitals. Most of these public hospitals were subsidized by taxes. There was little development of hospitals during the depression so this is a reasonable

In addition, there were two publicly financed health care services – asylums for those who were mentally ill or mentally handicapped or for those who had offended society in some way, such as mothers of illegitimate children, or vagrants;[2] and public health departments which had begun as infection control agencies but which later had taken responsibility for the health education of high-risk groups in the community, such as pregnant women and mothers with young children, as well as providing school health services.

In the first half of this century individual patients were expected to choose their own doctors, to pay them directly for their services and, when admitted to a hospital, to pay hospital fees as well (Shortt 1981). In the 1930s the main difficulties for Canadians seeking care were payment problems. The standards of medical practice were satisfactory by international criteria but the costs of care were rising steadily as new technologies were introduced. Agnew (1974) has suggested that those who had the greatest difficulties in paying were the middle classes using proprietary hospitals, for the poor could usually get help from their doctors, charity hospitals or the local municipalities if they needed it.

Private prepayment schemes for both hospital and medical care had begun to be offered in the early twentieth century (Shillington 1972). However, if the payors had to make a choice of prepayment schemes, hospital insurance took priority because breadwinners feared the effects which a serious illness might have on their families.

During the Great Depression of the 1930s, even middle-class patients found it difficult to pay doctors' bills and hospital fees. Now the idea of prepayment began to catch on and, particularly after the Second World War, there was a universal demand for prepaid insurance.

In 1935 the British Columbia government had tried to introduce a provincial publicly financed insurance scheme but the act, although passed by the legislature, was never proclaimed because of the resistance of doctors and businessmen. However, the idea of publicly financed insurance, as a means of improving the health of Canadians by making medical care services

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indication of available services in 1948 when National Health Grants provided funding for a review of hospital and health services and led to major construction projects in the 1950s.

[2] By the mid 1960s a strong movement had grown up to decrease the numbers of persons in institutions and, if at all possible, to treat those with mental illnesses in the regular health care system. Most provinces had moved the care of persons with mental handicaps over to their social service departments by the early 1970s and the care of many persons with mental illnesses over to the regular hospital and medical care insurance programs. By 1996 almost all persons who had been institutionalized resided in the community.

available to all, was taken up by the Saskatchewan and federal governments which were anxious to reform health care in the 1940s.

Saskatchewan's socialist government provided models of health planning and service delivery for the rest of the country. It was the first jurisdiction to introduce a hospital insurance program, in 1946, and a medical care insurance scheme, in 1962. The federal government had been anxious to provide conditional matching grants to the provinces for improvements in health and post secondary education services, rather than giving them higher unconditional equalization grants (which were traditional). It had become aware of the needs for improving services across Canada, on the one hand through the report of an investigation of the impact of the depression on the provinces (Canada 1940) and, on the other, through reports on the health and educational levels of recruits to the armed services in the Second World War. It was thought that conditional grants would force the provinces to increase provision of social programs and bring about greater standardization across the country. But the federal government was held back by Ontario and Quebec at the Dominion-Provincial Conference on Social Reconstruction in 1945–46 on the grounds that it did not have the constitutional rights to interfere in social affairs which were a provincial matter (Taylor 1978).

Because of these constitutional challenges the federal government was unable to introduce its proposed health insurance schemes in 1945–46. However, it was able to offer National Health Grants in 1948 so that the provinces could develop health care and hospital plans, begin hospital construction to fill gaps and set up demonstration programs in mental and public health.

There were no trained health planners at that time except in Saskatchewan; the other provinces used consultants to develop plans, but they were seldom able to stick to the plans because back-benchers lobbied for hospitals to be built in their own constituencies – for at that time hospitals were a major symbol of caring and they brought jobs to an area. Overbuilding of hospitals and, in some provinces, naiveté in copying Saskatchewan's hospital insurance scheme (Detwiller 1985) led to great financial difficulties in maintaining hospital services without federal help. So in 1957 Ontario was persuaded to join the eight smaller provinces to get the federal government to pass the Hospital Insurance and Diagnostic Services Act which provided matching grants for operating costs. (Quebec finally accepted federal hospital insurance grants in 1961.)

In 1962, after settling a doctors' strike, Saskatchewan introduced a provincial medical care insurance scheme. Seeing that other provinces might want to follow, the Canadian Medical Association had asked the federal government to set up a public inquiry. A Royal Commission on Health Services, 1961–64 (Canada 1964) recommended that the federal government introduce a national medical care insurance scheme. This was enacted in 1966 and instituted in all provinces by 1970, but not without some resistance on the part of the medical profession (Taylor 1978).

Although the federal government was aware that other countries had introduced a wider range of free health care schemes, which included, for example, dental services[3] and prescription drugs, it was decided to leave any further program development after 1970 to the provincial governments alone. Most provinces brought in Pharmacare schemes for disabled and elderly persons, and some provinces provided dental care programs for children. All provinces started to bring in long-term care programs which later developed into continuing care schemes bridging institutional and community care for frail elderly and disabled persons.

The regional hierarchies of the medical profession's organization[4] have been challenged since 1920 by government medical advisers who did not see this form of organization to be in the general interest (Saward 1976). When collectivist health care systems were to be introduced into Saskatchewan to replace individualistic health care, public health service advisers pointed out that any government involvement in the funding of health services should focus on primary care which might help consumers avoid specialist services and hospital care if they followed preventive advice.

However, few governments were able to listen to these advisers on collectivist service organization who were bucking the trend toward greater and greater specialization and ever-increasing support for the scientific hierarchical model. As well they were backed up by the consumers of care who regarded preventive medicine by primary caregivers as less important to them than crisis medical care provided by specialists.

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[3] For further information about dental services see Stamm et al. (1986).

[4] The technical power of the doctors and other health professionals had been growing since a commitment to scientific medicine was made by the western world in the mid-nineteenth century. In 1910, Abraham Flexner, who had been engaged by the Carnegie Foundation, reported on the quality of medical schools in North America (Flexner 1910). He assessed their worth by their commitment to biomedical research and development. His report was extremely influential for it ensured that university medical schools became the high status centres. The number of medical specialists grew and the pastoral care of general practitioners became less important than their biomedical skills in diagnosing and treating disease. As in other more developed countries, the medical profession was structured into "regional hierarchies" (Fox 1987). Primary care physicians (general practitioners) who were placed at the bottom of the pyramid were expected to refer their more difficult cases on to secondary or tertiary care specialists in hospitals in the larger towns.

As a result of welfare state legislation all provinces had by 1970:

1. accepted National Health Grants for health service planning, contributions to hospital construction and limited support for existing public and mental health services
2. agreed to implement the Hospital Insurance and Diagnostic Services Act, 1957, which provided payment for care of patients in acute care hospitals. This act was based on the principles of universality, comprehensiveness, portability and public administration
3. agreed to set up medical plans following the Medical Care Insurance Act, 1966, which was based on similar principles and authorized the payment of doctors' fees. (Taylor 1978)

It will be recognized that these programs were all concerned with improving access to medical services through providing more treatment facilities and ensuring ability of consumers to get free care.

A new federal Deputy Minister of Health, Dr. Maurice Le Clair, appointed in 1968, took office just as the medical care insurance provisions were being brought in. He was not convinced that increased access to medical care and hospital services was going to result in better health outcomes for Canada so he introduced a number of inquiries into the system of care. Some of these questioned management efficiencies — such as the study of health care costs (Canada 1970b) (mainly focussing on hospital operational activities) and the matching grants method of funding — but others questioned goals and objectives.

In 1977 conditional matching grants were withdrawn in favour of block grants for health and higher education under the Established Programs Financing Act (EPF). These federal-provincial transfers were to be reviewed every five years. Some systems research (as well as biomedical research) was funded, and some financial consultants were seconded to help the provinces to manage their funds better.

As mentioned above, *A New Perspective* (Canada 1974a) argued that medical care was less important than lifestyle, a good physical and social environment, and biological risk factors in determining health outcomes. Le Clair thought that there needed to be more research on health care systems, not only on biomedical matters. *A New Perspective* took a long time to make an impact. Canadians were still determined to ensure universal, comprehensive and equitable *access* and it was not until after the Canada Health Act, 1984, was passed to stiffen up previous legislation that they were prepared to look further at *outcomes*.

The Alma Ata Conference on Primary Health Care called by the World Health Organization (WHO) in 1978 shifted the emphasis in that organization from promoting scientific medicine to examining basic social organization issues. Canadian civil servants began to work closely with WHO on concepts of health promotion based on a broader concept of health as a function of good social organization (rather than focussing on medical care alone). As mentioned in the previous chapter, Canada called the first conference on health promotion in 1986 and presented a changed set of goals in its policy statement *Achieving Heath for All: A Framework for Health Promotion* (Canada 1986c). This set out the health challenges as reducing inequities, increasing prevention and enhancing coping, thereby laying out a health agenda based on a social model of health care.

In deciding to make a commitment to collectivist health care in 1945–46, the Canadian federal government did not at first recognize what collectivism meant.[5] In the postwar reconstruction period the federal government saw itself solely as a redistributor of funding across the provinces and it relied on the professional experts to develop the best system of health care for Canadians. What it did not realize was that the medical experts with their scientific training could not see further than improving and expanding the scope of the biomedical model of care. As well, as a group, these professional experts, mainly doctors, did not wish to become employees of the state, preferring to remain as individualistic subsidized entrepreneurs rather than working together with governments to develop an optimal collectivist health care organization. This resistance to change has continued over the years.

There are many reasons for the less than optimal organization and management of the system of health service delivery in Canada. Politicians were unsophisticated and provincial bureaucracies had to be built up gradually to administer Canada's social programs. Mistakes were made. Programs were introduced incrementally, and this led to an imbalance between acute care and community care. At the start, the emphasis was put on gap filling for crisis care rather than the coordination and balancing of crisis care with primary care. The need for greater attention to this has now been recognized because a greater appreciation of the social determinants of health has developed.

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[5] See Appendix A for definitions.

CHAPTER 3

The Welfare State in Canada

It was not until the Great Depression of the 1930s that Canada's evolving social organization broke down. Until then neighbours, municipal governments or charitable organizations had managed to help poor or dysfunctional people who lived in their communities (or to get them institutionalized). Or these people could be encouraged to move on to find other opportunities in a developing nation. However, with the breakdown of the world's economic system in the interwar years, Canada could no longer sell its products and thus keep its resource and manufacturing industries afloat. Some townspeople sought refuge back on family farms, young men rode the rails across the country looking for work, and camps were set up for displaced people. Much later than in other countries, Canada's federal government decided that it must act, and in 1935 it tried to bring in a new unemployment relief system. But this intervention was challenged on the grounds that the Canadian Constitution had made social affairs the responsibility of the provincial governments.

The federal government decided that the only alternative was to set up a royal commission to inquire into dominion-provincial relations (Canada 1940), to make known the situation in all the provinces and to seek recommendations for change. This commission did not manage to finish its work until the Second World War had begun, and so action on its proposals for reform had to be postponed. In the meantime, agreement was reached between the provinces to bring in a national unemployment insurance scheme in 1940 and a temporary tax rental (federal-provincial revenue redistribution) scheme was put into place until after the war.

Canada joined Great Britain in the Second World War, 1939–45, as soon as it was declared and began to recruit for the armed forces. This provided more information about the needs of the country for better health, education and social services.

Its close relationship with Great Britain in the war years led Canada to take an interest in the social reforms being proposed in that country. Sir William Beveridge had published a report on *Social Insurance and Allied Services* (Great Britain 1942) which set out plans for a British welfare state. One of Beveridge's research associates, Leonard Marsh, came to Ottawa to work on the development of plans for social reform in Canada.

The federal government initiated two inquiries by bureaucrats, the first into social security (Canada 1943b) and the second into health care (Canada 1943a). Following these inquiries and taking into consideration the Rowell-Sirois report (Canada 1940), preparations were made to put proposals before a postwar reconstruction conference of federal-provincial representatives.

Canada's wealth is unevenly distributed. A major factor in this diversity is geography. Canada's rich natural resources, upon which it has relied to bring in its national income, are mainly to be found in Ontario, the prairies and the West. Quebec and the Atlantic provinces lie on the Canadian shield, land which was scraped bare by glaciers in the ice age and which is now relatively poor farming country, compared with southern Ontario and the prairie provinces. Alberta found its riches in oil, British Columbia in its forests, and both coasts in fishing. And by the 1940s some manufacturing industries in Quebec and Ontario and mining in a few other provinces had been developed. Canada was still a very thinly populated country with only eleven million inhabitants registered in the 1941 census.

The Slow Development of the Welfare State

The agreement at the time of federation in 1867 had been for the federal government to collect taxes and to undertake some redistribution through equalization grants, but how these were to be spent was at the discretion of the provinces. Now the federal government decided to change its policies relating to grant aid, to offer conditional matching grants for particular kinds of services in order to get the provinces to develop social programs in areas where they were lacking. As mentioned earlier, there were protests by Quebec and Ontario against these conditional offers in 1945–46 at the Dominion-Provincial Conference on Social Reconstruction (Taylor 1978).

The other provinces wanted to have the promised redistribution of these matching grants as soon as possible and the federal government was anxious to move ahead with its plans. But no steps could be taken until the majority of the population supported the change, and this meant that at least one of the two central provinces must agree to cooperate.

So Canada's welfare state was established in two waves. The first federal efforts to bring about change in the 1940s and 1950s did not result in much significant legislation, as the problems of legitimizing the new federal role had to be worked through. However, in time, the objections of Ontario and Quebec were sorted out. Ontario's rejection policy, based on a reluctance to share its wealth, was changed to acceptance of conditional grants in the 1950s when a new premier came to power (Taylor 1978), while a separate deal was negotiated with Quebec in 1963 (the Fulton-Favreau agreement), in which it was accepted that the province would establish its own programs similar to those developed in the other provinces but not subject to the federal matching grant conditions which the others had to meet (Granatstein et al. 1983).

In the early 1960s a second wave of reform arose out of a new Liberal election platform, worked through while the party was in opposition (Kent 1962). This resulted in major changes in income security legislation and the introduction of new redistributive programs in health and post-secondary education. In addition two other federal-provincial transfer programs were created with the special objective of improving provincial equalization: regional economic development grants, mainly directed toward the poorer Atlantic provinces, and the Canada Assistance Plan, which was designed to assist all provinces to improve social welfare programs for the needy. The decision to undertake regional economic development programs is discussed in several books on the welfare state evolutionary period (e.g., Harp and Hopley 1971; Mann, 1970). Newfoundland also embarked on a policy of the relocation of people living in remote communities which seemed to have no economic potential (Iverson and Ralph 1970).

By the end of the 1960s Ottawa had committed itself to six different programs of social redistribution in order to reduce inequalities between Canadian provinces and individual Canadians:

1. Equalization grants by which the richer provinces shared their financial resources with the poorer provinces through tax transfer agreements
2. Regional economic development schemes for disadvantaged areas
3. Matching grants offers which the provinces could pick up for designated programs in health care and post secondary education
4. Contributory social insurance programs for individuals as a protection against social risks: unemployment, widowhood, orphanhood, old age and disability
5. Family allowances which were a recognition of the extra costs of child rearing
6. The Canada Assistance Plan which provided, *inter alia,* financial support to provincial governments for their social assistance schemes for individuals who were in need and had no contributory insurance and for supportive housing for disabled persons

Cameron and Dupré (1983) have described how the amount of funding provided for the equalization grants schemes was quickly overtaken by the matching grants programs once the provinces had recognized that they could not afford to ignore them. They reported that, by 1977–78, conditional grants formed seventy percent of the funds redistributed to the provinces for health, education and welfare; equalization grants accounted for twenty-five percent; and other programs five percent.

The federal government laid considerable emphasis on supporting health and education programs, for it was clear from the evidence collected that if Canada were to take its place as a western developed country, it would need to improve its basic social organization so that its citizens could compete in world markets. The development of health care programs was outlined in the previous chapter. So far as education was concerned, primary and secondary schooling was left to the provincial authorities' discretion but the federal government offered grants for the development of post secondary education.[1] Again there was initial resistance by Quebec to this intervention into social affairs, but in due course matching grants, providing "equality of opportunity," became available and were taken up all across the country (Granatstein et al. 1983). By 1967 agreement had been reached whereby universities could expand and community colleges could be set up in more remote areas as well as the metropolitan centres.

There was, of course, a second form of redistribution through social insurance programs, family allowances and the Canada Assistance Plan. The postwar social reconstruction reformers were concerned about ensuring that all Canadians would be protected against social risk (Guest 1980), and that a social minimum would be established. Unemployment insurance was introduced in 1940, some other income support programs in the 1940s and 1950s, and the contributory Canada and Quebec pension plans in 1965. And to encourage the provinces to improve their social assistance programs for the needy, the Canada Assistance Plan, another matching grants' program, was enacted in 1966. Banting (1982) has shown how the introduction of these welfare state social security policies raised the incomes of many marginal communities (and thus their standards of living) towards the Canadian average.

Servicemen returning from the war were anxious to establish families, and so mortgage support policies were developed to help them to buy homes. Then in 1954 the new director of the Canada Mortgage and Housing Corporation turned his attention to public housing policies, having recognized the

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[1] The western countries were all spurred on to question their education programs further by the launching of Sputnik by the USSR in 1957.

need to provide for those who could not buy their own homes (Hallendy 1986). Goldberg (1983) has argued that housing policy has always been closely related to economic development, and in the mid 1970s, the main emphasis on providing public housing was replaced by new programs to encourage private investors.

Coordination of Social Programs

Even in the more experienced and sophisticated countries, while it was recognized that there were links between what the British reformer Beveridge called "want, disease, ignorance, squalor and idleness," how to bring the range of programs necessary to solve social problems together was too complex to understand clearly. Canada had additional difficulties because it was a federation of ten provinces and two territories — a nation which had a constitution that gave power over social affairs to the provincial governments.

We have seen how difficult it was to link different health programs which were brought in at separate times. Hospital construction funding was separated from hospital operations funding, and clinical medical care was not linked to public and mental health activities because of separate legislation and separate administrations. There was a lack of clarity about the real goals of bringing in a publicly financed system until questions began to be asked about health outcomes. And even after the Established Program Financing Act (EPF) was brought in in 1977, it seemed to be difficult to bring the programs together as they had become established in their separate spheres.

Similarly, it took a long time before questions began to be asked about welfare state goals and how they were linked. Why had Canada decided to have a welfare state? What kind of a welfare state had it chosen? There was a basic understanding that there were important connections, but these were not adequately spelled out for citizens to discuss.

By 1980 a number of other countries, which had decided to set up welfare states, were questioning whether they were functioning well enough as organizations and whether this was the best form of social organization for a nation state. An international conference of the Organization for Economic Cooperation and Development (OECD 1981) recommended that the politicians and bureaucrats responsible for policy development and management of welfare states should widen their consultation processes and develop closer partnerships with businesses and researchers. Later this concept of partnerships was broadened to include community members generally. Canada followed through on increasing formal consultations with business managers and researchers in the 1980s and is now exploring community involvement in policy making.

But what should the goals of a welfare state be? Was redistribution of resources all that mattered? Canada's welfare state underwent a number of changes in the 1980s. Prime Minister Pierre Elliot Trudeau had made it his mission to develop a Charter of Rights and Freedoms which was appended to the constitution that had been patriated in 1982, and enacted into human rights legislation in 1977 and 1983. This new emphasis on rights broadened the concept of the goals of the Canadian welfare state. In 1983 the revised Human Rights Act designated four groups as disadvantaged people (women, native peoples, visible minorities and persons with disabilities). The purpose of that act was to enhance the citizenship rights of these minority groups, a change which could not be accomplished by transferring money alone. It required a change of attitudes across society.

At the same time as these rights changes were being introduced, financial redistribution polices were coming under further scrutiny. The global marketing system had begun to alter old ways of earning a high level national income. In Canada primary resource extraction as the main way of earning income was challenged. In the postindustrial society the future lay in competing in technological developments. It began to seem more important to many politicians that, as a leading capitalist country, Canada should encourage entrepreneurs to maintain and increase their earnings in order to finance social programs rather than continue to put the highest emphasis on sharing diminishing resources. Was there a changing commitment to collectivism in this new world order? Was the new emphasis on business success undermining the concept of sharing resources which had come out of wartime experiences?

The federal government had let the national deficit climb steadily since the mid 1970s and EPF grants (block grants substituted for conditional matching grants introduced in 1977), which had been hoped to make provincial governments more responsible for organizing social programs, had not been successful in controlling overspending of national revenues. Then under the Mulroney government of 1984–93, major cut-backs of federal transfers to the provinces were brought in and policy makers were asked to rethink how to streamline social programs.

It was thought that if rationing were to occur, it might be best to increase involvement of the public in making cut-backs. And it was also known that there could be greater streamlining of services — the development of a more rational welfare state redistribution. So how could reform and restructuring best be brought in?

In the next chapter we shall examine the development of community involvement in social policy making in this changing welfare state.

CHAPTER 4

The Redistribution of Power Away from Local Communities and the Prospects for Its Return

Canada was settled mainly by farmers and fishermen who lived in scattered rural communities. In order to survive the rigours of life in a harsh climate, they helped one another in times of need. In Quebec mutual aid was always strengthened by the parish church; when the prairies were settled in the twentieth century, by cooperative action; and in the mining towns, by union activities.

Desrosiers (1979) has explained how, on the farms, family members of all ages were expected to earn their keep and to help each other with their tasks. Gradually with industrialization young adults moved into the cities to set up their own families and to look for paid employment. But then there was only one breadwinner for each family and if he were ill, disabled or out of work there was no extended family to fall back on. Neighbours continued to help one another as much as they were able, but their resources were insufficient to deal with all the problems which arose.

In the cities philanthropists established charity agencies to help the poor and the sick, and when these were unable to provide enough support, the municipalities would offer relief to the poor. Professionals often gave free services to those who could not afford to pay.

On the prairies farmers were influenced by the cooperative movement (which had started in Great Britain). They worked together to solve marketing problems and used their elected municipal governments to establish programs to support educational, health and social welfare services in their communities.

Changing Social Structures

With industrialization, social organization was changing in another way. The development of science and technology was creating a demand for experts in business and service provision. From the late nineteenth century onwards the numbers of professional persons began to grow as their expertise was seen to be valuable. There were, of course, many different kinds of professional skills which countries wanted to have and Canada encouraged immigrants with these skills to come in as settlers before it was able to produce a supply of its own. At the top of the hierarchy of professionals are medical doctors and they were much sought after. People no longer wanted doctors to provide pastoral care only (as they had done for some years in the more settled parts of Canada): they wanted to consult trained professionals who had learned about scientific diagnosis and treatment and who could be expected to cure, not just comfort their patients. Small communities tried to find ways of bringing these and other experts into their midst.

Canada's adjustment to these scientific and technological changes was interrupted by the First World War and then the Great Depression of the 1930s. The federal government and some provincial reformers (particularly on the prairies[1]) wanted to set up a publicly financed social safety net to ensure free health care for all who needed it and to improve educational provision.

The previous chapter has described the evolution of the welfare state in Canada. This new form of social organization put power over social programs into the hands of elected representatives of the communities. They were sent off to sit in legislative chambers in the federal and provincial capitals. Governments were expected to work closely with the growing bureaucracies to set up these new social programs. This decision by the federal government to take over new powers of funding health, education and welfare services took some time to work through, but it meant that most of the financial power was removed from the local communities and placed in the hands of a few people who were not always readily accessible.

Some provinces maintained strong municipalities (Manga and Muckle 1987) but others removed authority for many social programs to the provincial level. In either case the old established authorities had to learn new ways of relating to higher levels of organization and how to conform to new rules.

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[1] In 1933, a group of reformers, the Cooperative Commonwealth Federation (CCF), published the Regina Manifesto proposing collectivist changes in social organization and social services, but it was not until the CCF was elected to power in Saskatchewan in 1944 that changes could be brought in.

After the major welfare state programs were brought in in the 1960s, the charitable organizations found they were less able than before to raise money to provide services, and they often became partially dependent on higher-level governments for contracts or subsidies. Board members of philanthropic organizations in the larger cities, following American examples, usually formed Community Chests or United Way organizations to try to rationalize the remaining charitable activities and to dovetail them in with the government-funded services. But not all of them agreed to cooperate in this way, some preferring to raise their own funds. Major cities set up voluntary planning councils to determine local priorities for charitable efforts in their communities (Canadian Council on Social Development 1972). However, Govan (1966) noted that as the welfare state was put in place, the old style charitable voluntary organizations for health care were often being replaced by mutual aid organizations (such as disease groups helping one another to cope). The meaning of non-governmental community involvement became less clear to the ordinary citizen.

As well, the new welfare state programs were using professional experts to provide services. These professional experts were not prepared to give up total control over their practices and so they bargained with the provincial governments' representatives on terms and conditions of service. Thus community members were now given little opportunity to contribute to policy making. They could talk to their elected representatives, use complaint mechanisms (where these existed) or sue through the courts, but as consumers they were put into a position of dependency to the formal authorities and experts.

Power in the Welfare State

Robert Dubin (1974) analysed the distribution of power within industrial organizations but his analysis can be applied to the new welfare state organization in Canada. He discussed four types of power: technical, formal (i.e., legal authority), non-formal (i.e., knowing "how to work the system") and informal (i.e., using one's social connections in society generally to bring influence to bear).

The medical professional groups had been given the authority to select their own recruits to membership early in the nineteenth century on the grounds that no one else could judge competence. This had given them a monopoly and when the governments decided to fund hospital and medical services, it put them into a strong collective bargaining position. Taylor (1978) and Badgley and Wolfe (1967) have discussed how the Saskatchewan doctors (who were hostile to the provincial government's reform plans) formed "a separate government" with their own agenda of resistance to change. They found considerable support from the public when there was a doctors' strike in 1962 because people were concerned that many doctors would leave the province and there would be a shortage of those with enough technical knowledge to care for them.

The provincial politicians had previously been very part-time workers with little authority. Now they were given new responsibilities which they had to learn how to handle. It took many years for the cabinets to become reasonably competent at policy making and administration.

And of course there have always been grumblings about the insensitivity of bureaucrats in interpreting the rules, and as there were more bureaucrats and more rules, there was more grumbling.

Some Challenges to Professionals

Gradually, however, some challenges built up to counter the doctors' claims for overriding technical power. The concept of reviewing "consumer power" to combat the activities of "disabling professionals" was brought over the border from the United States in the late 1960s (Illich 1974). The idea was taken up by many groups — for example, by radical youth, by the Quiet Revolutionaries in Quebec and by some lawyers and economists in Ontario (Slayton and Trebilcock 1978).

Efforts to reform professional regulation in Quebec (Quebec 1970–72), and Ontario (Ontario 1970) failed to dislodge the experts from their dominant position or to increase their concern for consumer interests at that time. There were a number of superficial or temporary solutions to this surge of radicalism — the federal Local Initiative Projects and other schemes for involving young people in community activities, changes in medical school admission policies to give recognition to the demand for more female and ethnic doctors, or the recruitment of lay members to boards of professional associations to represent consumer interests.[2] But radicalism decreased and finances grew tighter in the mid seventies and this demand for reform faded away. Much of the discussion then moved towards establishing patients' rights (Rosovsky 1980), increasing risk management in hospitals and improving complaints procedures.

It was perhaps in "the disabled community" or among its advocates that the challenge to medical professionals grew most strongly. The CELDIC Report (Commission on Emotional and Learning Disorders in Children 1970) argued that psychiatrists would be unable to tackle the adjustment problems of *One Million Children*. Paraplegics and polio victims began to assert

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[2] But in the seven top professional organizations they found it difficult to compete with expert opinions.

their need for independent living (Hahn 1985). More broadly, the limits of medical power were set out by a bureaucratic task group in *A New Perspective on the Health of Canadians* (Canada 1974a), but it took some time for a response to develop.

A Learning Time for Politicians and Bureaucrats

It is perhaps not surprising that there was resistance to consumer involvement by politicians and bureaucrats who were having to adapt to the new terms and conditions of working in the 1970s, for they must have been unsure of themselves as they struggled to cope with the new demands upon them. Because the politicians saw themselves as the formally elected representatives of their constituents, they did not seem to be willing, during this learning period, to let community groups into the power structures. For example, a report on increasing community inputs (Saskatchewan 1973) was taken no further once the MLAs decided they did not want to move on it. However, other discussions on community inputs into health policy decision making did result in the development of District Health Councils in Ontario from 1973, and in the establishment of management boards of Centres locaux des services communautaires (CLSCs), Centres d'accueil and Conseils régionaux de la santé et des services sociaux (CRSSS) in Quebec, in 1971, but in both provinces the powers of these local forms of health care organizations were somewhat limited at first.

Other Forms of Power

We shall not discuss non-formal and informal power here but we should give recognition to other ways of influencing persons in formal power positions. Until the provincial governments' Cabinets really learned how to take charge, back-benchers were very responsive to their constituents and they brought nonformal and informal power to bear on cabinet policy makers. The plans developed in the National Health Grant programs were seldom followed through because of back-bench interventions.

Changes in Welfare State and Health Policies

In the previous chapter, we discussed how the emphasis on financial redistribution in the early years of the welfare state had changed, and how the human rights initiatives in the 1970s and 1980s made people more conscious of the meaning of citizenship and the need for general and professional attitude change towards disadvantaged groups. The importance of inter-personal relationships began to be reinstated after the years of impersonal financial redistribution.

In health care the health promotion movement focussed on the need for increasing personal responsibility for healthy living and the importance of physical and social environment. There were strong reactions against professionals who treated consumers disrespectfully and against other members of the community who stigmatized persons with disabilities. Support grew for the healthy cities and healthy communities movements, wellness groups and other community-based organizations, concerned not only with better lifestyles and better community networking, but also with an improved health systems' organization which should take into account consumers' views.

The provincial reviews of health services which were carried out in the late 1980s recommended that community involvement should be increased. This increased involvement will be discussed in later chapters.

PART II

The Context of Health Policy Development

CHAPTER 5

Development of Canada's Welfare State Programs

Differences between Nations' Approaches to Welfare State Organization

Welfare states set up by most western developed countries as well as the communist states were not alike; what they had in common was some commitment to social redistribution. To give some idea of the differences in this commitment we can review Field's Typology of Health Systems (Field 1989) in which he differentiates Canada's approach from those of the United States and Great Britain (see Chart 5.1).

The Differences Are Ideological

George and Wilding (1976) have reviewed the ideas of four groups of ideological thinkers who have influenced social welfare development: (1) anti-collectivists, (2) reluctant collectivists, (3) Fabian (democratic) socialists, and (4) Marxists. Social reconstruction models were established between 1945 and 1975 in all western developed countries. Although these models varied to some extent according to a particular nation's commitment to capitalism or socialism, in every case there was a welfare state component. As Canada decided to adopt British models, Canada's post-Second World War federal welfare state was influenced, to a large extent, by the Fabian socialists who had influenced British thinking. Canada's centrist Liberal party was also strongly influenced by Saskatchewan's agrarian socialists,[1] Quebec's Quiet

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[1] Marchak (1975) has discussed the *counter-culture* of democratic socialism which challenged classical liberalism, the traditional ideology in Canada. The Liberals who were in power for most of the time between 1935 and 1984, were strongly

Chart 5.1
Field's Typology of Health Systems

	Type 1	Type 2	Type 3	Type 4	Type 5
Health system	Emergent	Pluralistic	Insurance/ Social Security	National Health Service	Socialized
General definition	Health care as item of personal consumption	Health care as predominantly a consumer good or service	Health care as an insured/guaranteed consumer good or service	Health care as a state-supported consumer good or service	Health care as a state-provided public service
Position of the physician	Solo entrepreneur	Solo entrepreneur and member of variety of groups/ organizations	Solo entrepreneur and member of medical organizations	Solo entrepreneur and member of medical organizations	State employee and member of medical organization
Role of professional associations	Powerful	Very strong	Strong	Fairly strong	Weak or non-existent
Ownership of facilities	Private	Private and public	Private and public	Mostly public	Entirely public
Payments	Direct	Direct and indirect	Mostly indirect	Indirect	Entirely indirect
Role of the policy	Minimal	Residual/indirect	Central/indirect	Central/direct	Total
Types described in the book		Switzerland, USA	(Canada), (France), Japan, New Zealand Spain, Yugoslavia	Scotland, (Great Britain)	USSR

Source: M.G. Field, *Success and Crisis in National Health Systems.* (NY: Routledge, 1989), 7. Reprinted with permission.

Revolutionaries, and its own social reformers (Kent 1962), but it was at heart a party representing strong capitalist interests, which is to say that it was reluctantly collectivist.

In the 1940s Canada designed its welfare state using the British model Sir William Beveridge had proposed — a model in which priority is given to promoting *Full Employment in a Free Society* (Beveridge 1945), with a backup social security system to provide for those at social risk (Great Britain 1942). There were to be five separate thrusts to correct what Beveridge called the Five Giant Evils: want, disease, ignorance, squalor and idleness. Thus in Britain the National Health Service (NHS) would try to clean up "the pool of ill health" while other departments were working on these other problems. They were seen to be connected, though only in a broad general way. Through providing full employment and by improving education and housing, disease would be reduced and there would be less demand on medical care. Then doctors would have more time to build up good health rather than only dealing with sickness. Marsh, who chaired Canada's social security planning group, had been one of Beveridge's research assistants, and he adapted Beveridge's ideas to the Canadian situation (Canada 1943b).

Pierson (1991) has described these approaches to welfare state planning as bourgeois.[2] They were built on decisions by the middle classes to

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influenced during these years by the Cooperative Commonwealth Federation (democratic socialist) party.

[2] Therborn has presented two typologies of welfare states, the first of which Pierson quoted: (1) In 1986 he differentiated between those with proletarian and bourgeois origins. The first of these was promoted by working men seeking greater social security, the second by the nation's middle classes who were willing to share some of their wealth with poorer people but who also wanted social programs to meet their wants. (2) In 1987 he distinguished, as Field (1989) and George and Wilding (1976) have done between:

Strong interventionist welfare states	(extensive social policy, strong commitment to full employment)	Sweden, Norway, Austria, (Finland)
Soft compensatory welfare states	(generous social entitlements, low commitment to full employment	Belgium, Denmark, Netherlands, (France, West Germany, Ireland, Italy)
Full employment-oriented, small welfare states	(low social entitlements, but institutional commitment to full employment)	Switzerland, Japan
Market-oriented welfare states	(limited social rights, low commitment to full employment)	Australia, Canada, United States, United Kingdom, New Zealand

share some of their wealth in order to ensure that the poor were provided with "a social minimum." This is known as the "equality of condition" approach to welfare. At the same time, there was a belief that making *universal* provisions for family support, education, health and employment opportunity were important for the middle classes. The concept of "equality of opportunity" with respect to access to state services was the idea underlying many welfare state programs in which they were interested.

The Social Division of Welfare

While the policy makers openly discussed the welfare state legislation which provided for improvement of the social minimum and pushed towards establishing equality of opportunity programs, it was not until 1958 that Titmuss (1958), a British academic, challenged the bourgeois welfare state over hidden financial redistribution. He revealed that there was a whole range of financial benefits going to business organizations through "revenue foregone."

His concept of the social division of welfare is shown clearly in a chart developed by Graycar and Jamrozik (1989) to explain the welfare state redistribution system to Australians (see Chart 5.2). Although the federal-provincial divisions of responsibility are different in Australia, the principles are the same. This chart shows that although there has been a move towards sharing the national earnings across the collectivity, it has never been an even redistribution. As Graycar and Jamrozik pointed out, the financial benefits in column 1 are relatively low, the financial benefits in column 2 go as much to the service providers as to the consumers, and the financial benefits in column 3 are likely to be more substantial for upper income earners than for the working classes.

Focussing on the Social Minimum versus Collective Allocations

One Canadian study would seem to support the point made by Graycar and Jamrozik (1989) that the bourgeois welfare state is likely to profit the middle classes more than the poor. How the economic situation changed in Newfoundland was chronicled by Brown (1981) who provided a useful review of the history of health care in that colony and province from the turn of the century to 1980:

> During this time there were considerable changes in social conditions, political arrangements and the availability of public monies, all of which influenced the development of the health care sector. In general terms Newfoundland's health care system shifted from one involving low expenditures and many British type institutions to high expenditures and American type institutions. The

> evidence suggests that the changes have been particularly beneficial for Newfoundland's merchant class, including the doctors and dentists, although some benefits have also accrued to patients and fishermen. (p. 210)

The Liberal government in Ottawa took some time to get its welfare state in place. There were continuing struggles with Quebec over post-secondary education and Ontario over hospital insurance, but small gains were made throughout the 1950s. However, after a period in opposition the Liberals returned to power in 1963 with new energy and a new determination to pass the legislation necessary to provide for improved collective services and a satisfactory social minimum. The Medical Care Insurance Act, 1966, followed

Chart 5.2
Public Expenditure (Commonwealth) of Australia and Its Beneficiaries

Selective in favour *of low income groups*	Universal *provisions*	Selective in favour *of high income groups*
1 **Direct allocations** (means tested)	2 **Collective provisions**[a]	3 **Taxation expenditure** (revenue forgone)
Unemployment benefits	Family allowances	Superannuation concessions
Family income supplement	Dependent spouse rebate	Occupational welfare concessions
Invalid pensions	Public transport	Assistance to industry
Supporting parent benefits	Public schools	Concessions to business
Widows' pensions	Public health system	Tax-free dividends
Age pensions	Technical (TAFE) education	'Condoned' tax avoidance[b]
Public housing	Early childhood services	'Condoned' tax evasion[b]
	Employment in public sector	
	Colleges of advanced education (CAEs)	
	Universities	
	Culture, recreation	
	Private health system	
	Private schools	

Source: Adam Graycar and Adam Jamrozik, *How Australians Live: Social Policy in Theory and Practice.* (Melbourne: Macmillan Company of Australia, 1989), 70. Reprinted with permission.

[a] Some of these benefits/provisions entail taxation expenditures, but they are available to recipients on a universal basis, irrespective of income. Some are means tested, most are not.

[b] "Condoned" because the complexity of the taxation system enables some people to take advantage of loopholes and to minimize, avoid, or (illegally) evade payment of tax.

through on the recommendations of the Royal Commission on Health Services, 1964, that there should be matching grants offered for the payment of medical fees, while the post-secondary education grants, 1967, ensured the development of a wide range of community college courses.

Provision of a "Social Minimum"

So far as providing a social minimum was concerned, Canada made the same decision as Great Britain and the United States to provide income security to workers in its contributory unemployment insurance, pension schemes and other protection programs but this led to the development of a two-tier system of providing for those in need of income support. There continued to be need for local social assistance programs for those who had not contributed to these or benefited from other workers' income support schemes.

Recognizing that there were great differences between social assistance programs in different parts of Canada and between social assistance and social insurance programs, the federal government decided to try to bring more congruity into these schemes by developing a Canada Assistance Plan (CAP) 1966. Its objectives were:

1. The creation of a reasonably consistent national welfare apparatus
2. An extension of assistance to anyone who might need it — need being the only criterion.

Hum (1983) said: "The Canada Assistance Plan dramatically expanded the scope of federal involvement in social policy. In addition to encouraging an integration of assistance programs, CAP extended cost-sharing to a wide variety of social services and to most costs of administration incurred by provincial welfare agencies. However, because responsibility for social programs resides with the provinces and because of certain inherent shortcomings in the CAP legislation itself, these goals remain elusive" (p. 28).

However, the conservative provinces were still very judgemental about social assistance clients. Their reluctance to give generous help was identified in the *White Paper on Income Security* (Canada 1970c). Hum continued: "A fundamental weakness in the administration of social assistance in Canada is the failure to recognize that persons unable to support themselves have a right to assistance.... Judgements of whether a person is 'deserving' or not still enter into decisions about eligibility and the amount of assistance. People are often denied assistance even when the alternative options of employment, training or rehabilitation are not really available" (Hum 1983, 40).

The federal officials recognized that there were shortcomings in the CAP legislation if the objectives of developing an institutional rather than a residual scheme[3] were to be reached. Working together with the Minister of Health and Welfare they developed proposals for new legislation in the early 1970s (Canada 1973c) but cabinet refused to move further at the time. It was proposed to reconsider the original CAP provisions immediately after a social service review. Johnson (1975) reported on the proposals put to the review. He said that there were already two relatively successful strategies for dealing with income insecurity: an employment strategy and a social insurance strategy. Health and Welfare Canada wanted to introduce three more strategies for tackling the problems of poverty. Johnson described these as:

> *income supplementation strategies* designed to meet, by way of a guaranteed income, inadequacies of income, whether that income came from employment or from social insurance plus private savings. ... The fourth strategy [was a] *social services strategy*. [Under this] the handicapped would receive regional rehabilitation and employment assistance services; single parents with pre-school children would be eligible for day-care services; others might receive, at one time or another, required counselling and job placement services.
>
> A final strategy had to do with the realization of these four policy strategies through a new approach to the development and harmonization of federal and provincial social security programs. This *federal-provincial strategy* ... advanced the proposition that the prime responsibility for setting ... [income] levels should reside with the provinces. (p. 459)

Although provincial norms might vary, the federal government would set the national norms and minima by which the provinces would be bound.

But these proposed changes came to naught because of the OPEC crisis and the economic recession of the mid seventies. At the same time as the Established Programs Financing Act, 1977, was brought in (limiting the open-ended matching grant programs), plans for increasing social assistance support were cut back. And in 1978 block funding was reduced, putting many hitherto secure programs at risk (Van Loon 1979). Splane (1987a,b) has argued that the days of the reformist bureaucrats who first conceptualized CAP were ended with the appointment of more conservative thinkers.

The CAP Welfare Services

The CAP Act, 1966, committed the federal government to paying one half of any increase in provincial expenditure on welfare services[4] for "the lessen-

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[3] Guest (1980) has explained that institutional schemes meet the needs of *all* applicants while residual schemes apply judgemental criteria.

[4] Welfare services are a subgroup of the provinces' personal social services provision.

ing, removal or the prevention of the causes or effects of poverty, child neglect and dependence on public assistance. Eligible services include services related to rehabilitation; casework; counselling; assessment and referral services; adoption services; day care and homemaker services; and community development services" (Hum 1983, 70). This monetary support enabled the provinces to provide a wide range of supports for those who previously had been institutionalized and for the prevention of the institutionalization of others.

In 1975 the conference of welfare ministers had agreed:

> first, that social services should no longer be looked upon as attached solely to 'people in need or likely to become in need'; secondly, that it should be recognized that the degree of universality of social services — their availability and the charges made for them — will change over time and, thirdly, that the priority accorded to social services, both to assist people in entering into employment of 'useful endeavour', and to enable them to manage at home instead of being placed in an institution, should be greatly increased. (Johnson 1975, 463)

Van Loon's (1979) explanation of the proposal was: "Welfare services [should be] divided into categories according to whether they should be universally available without cost to the user (crisis intervention and referral), free to those who needed them because of some long standing problem (rehabilitation) or income-tested (residential care, day care or some forms of home care)" (p. 489).

In 1977 the Minister of National Health and Welfare was expected to introduce a new social services act to extend federal matching grants, not only in respect of social services being provided to people on guaranteed incomes, but to the public generally. The first priorities were to be day care services, homemaker services, child welfare services and a greatly expanded range of rehabilitation services. However, the financial crisis, ever deepening, put an end to this proposed federal action. These moves to improve the administration of minimal income support programs and to reconsider the funding of social services by the federal welfare state were ended.

Health Services

The development of health services will be discussed further in Part III. There was not the same negative feeling towards health and post secondary educational developments — two universal programs — as there was towards social minimum programs at this time, though they were brought under tighter control by the introduction of block grants rather than open-ended grants under the Established Programs Financing Act in 1977.

Summary

There are identifiable differences in the way in which nations chose to set up their welfare states. This chapter considers some analyses of these differences:

1. Canada's welfare state appears to be "reluctantly collectivist" in a nation with strong capitalist interests
2. Canada is a welfare state built on the decision by the middle classes to share their wealth — a "bourgeois" welfare state
3 Three sectors of the social division of welfare were analysed by Titmuss: providing for a social minimum, enacting universal programs of social redistribution, and helping businesses to create more wealth. It has been argued that the bourgeois welfare state helps professionals and businessmen more than poor people
4. Efforts were made to improve the provision of the social minimum (through revising the Canada Assistance Plan) until the mid 1970s but this collapsed when there was an economic recession
5. There was not the same feeling about the need to curtail the universal programs of health and post secondary education at this time, only to bring their financing under tighter control

Canada's attitudes to this division have been changing over time. Just after the war the emphasis was upon improving the social minimum, now it is upon helping businesses to survive. Probably the middle classes have profited most from the universal programs of the welfare state.

CHAPTER 6

From Welfare State to Welfare Society?

Crisis in the Welfare State

By 1980 many of the western nations' welfare states were being challenged because they seemed to be too costly. Nor did they seem to be achieving the positive outcomes for society which had originally been anticipated. Socialist and Liberal ideologies were under attack from the neo-conservatives who wanted less of the social redistribution to go into social welfare programs and more into support of business investors.

An international conference of the Organization for Economic Cooperation and Development (OECD) countries was held in Paris to discuss the welfare state in crisis (OECD 1981). This conference was not focussed on ideological or political differences between the nations' approaches. Instead, its concerns were the narrowness or broadness of consultation on policy issues. The opinion leaders there concluded that the more successful welfare states were those in which the governments consulted with other power groups in society such as business leaders, trade union representatives, researchers and so on. The countries with Westminster systems of debate, where policy decisions were customarily taken in Parliament after discussion between government and opposition politicians, were thought to be less successful than those which sought "partnerships" with other community leaders.

At this conference a wide range of countries took part in a discussion of their financial problems and the difficulties of getting consensus on the way to address them. In the conference report, considerable attention was paid to the decision-making structures of European corporatist democracies (e.g., Sweden and West Germany) as compared with the decision-making structures of the parliamentary democracies (e.g., Australia, Canada and Britain). The crisis, as Benson (1982) and others saw it, had to do with the shift from feudalism to corporatism.

> Feudalism refers to an interorganizational structure dominated by central (federal) government organizations. Corporatism involves initiation and control of policy arenas by the central government, including the incorporation of interest associations and the orchestration of the division of labour between organizations. Control from the center is not necessarily exercised by bureaucratic authority. Rather, such control can be exercised through the manipulation of incentives and funding formulas, through the distribution of authorizations (mandates, domains), through the control of information. (p. 174)

According to Benson this crisis could not be understood by analysis at the administrative level only; it was necessary to dig deeper, to look into the basic power structures of society, as the neo-Marxists (e.g., Habermas 1975; Offe 1984) had tried to do.

At the OECD conference, Wilensky (1981) described corporatist welfare states as being:

> characterized by the interplay of strongly organized, usually centralized interest groups especially labor, employer and professional associations with a centralized or moderately centralized government, obliged by law or informal arrangement to consider their advice. In essence we see a consensus-making machine operating within a quasi-public framework to produce peak bargains involving the major issues of modern political economy — economic growth, prices, wages, taxes, unemployment and the balance of payments as well as social policy ... In these countries social policy is in some measure absorbed into general economic policy. (pp. 190–91)

Partnerships

The concept of partnership is still somewhat unclear[1] but, following the OECD conference, the Canadian federal government gradually adopted the corporatist form of partnership, that is, developing more cooperative discussions with business and research leaders. Later as federal finances grew tighter, this corporatist concept was developed to include greater federal-provincial cooperation. A restatement of the federal government's approach to health policy development was entitled *Building Partnerships* (Canada 1991a). The federal government said that provincial governments must now

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[1] For further discussion see Appendix A.

bear more of the responsibility for organizing and managing (and of course funding) health services. The word "partnership" is also used by research funding bodies to mean the development of joint projects with other potential funders or potential participant groups. And it is used particularly by the mental health services to describe network supports in the community for those with social support needs (Gottlieb and Selby 1989).

New Paradigms for Social Policy Making

Kuhn (1965) has discussed how scientists tend to work within a paradigm which provides a general explanation for their approach to problem solving, how every now and again this paradigm is challenged and a new paradigm is proposed, and how scientists both adapt to and adopt this new paradigm. Kuhn's ideas can also be applied to social policy changes.

Some European analysts have suggested that welfare states which were almost entirely concerned with financial redistribution have been forced to reconsider their position. Pleiger (1990) proposed that the new paradigm for thinking about social policy should be called "the welfare society." This shift in the relationship between governments and their peoples has taken place at various points on the partnership continuum.

On the one hand governments have worked to develop corporatist relationships with businessmen, researchers and others following the OECD conference, and on the other, they have recognized the necessity for community participation and social networking if they are to work towards equality of consideration for all citizens (for this cannot be achieved by financial means, only by attitude changes).

Corporatist Partnerships

Pleiger (1990) reported on a European conference on social welfare, which had accepted the need for a new paradigm in this way:

> The political organization of advanced industrial countries seems to be in process of profound change. ... In the last decades overly large and centralized organizations and production structures have become increasingly transformed into loosely coupled profit centres. A quite similar development is taking place within contemporary structures of policy making. Policy-making arrangements seem to be developing into the direction of more decentralization and a higher degree of informalism as more and more governmental and non-governmental actors become sometimes formally, but very often also informally, integrated into policy making. Informalism, decentralization and sectoralization in policy making, by the creation of policy networks, can be understood as a political strategy for coping with increasing societal complexity. As

> public resources become increasingly limited — despite the increasing scope of state intervention — governmental intervention into modern societies becomes more and more dependent on resource exchange networks. Through these networks financial resources, support and expertise can be mobilized from non-governmental actors. In such a context the formulation and implementation of government programs can therefore no longer be understood as the result of isolated governmental legislative and administrative action.
>
> These relationships, institutionalized communication structures, and task/resource interdependencies, tying different policy-making actors into the policy process (agenda building, issue creation, program formation, implementation), recently have been conceptualized as the "policy network" — a network of organizations and institutions that virtually "generates" a given public policy.[2] (pp. 37–38)

In this new idea of "a welfare society," the former power holders have to share their power with other groups of corporate decision makers.

And how else should a Canadian "welfare society" be organized?

Enhancement of Citizenship

When Prime Minister Lester B. Pearson brought some Québécois Liberals into his Cabinet in the mid 1960s, one of them was Pierre Elliott Trudeau, who became Minister of Justice. Trudeau was concerned about the way in which less powerful minority groups in Canada were treated by others and made it his cause to bring in changes. In 1968 he proposed that a charter of rights should be introduced into Canada (Canada 1968). When he became Prime Minister one of his principal aims was to patriate the constitution. (The British North America Act, 1867, was an act of the British Parliament and any constitutional amendments had to be approved by the British Privy Council.) It took many years to reach agreement with most of the provinces on the change. (Quebec still refuses to sign.) However, in 1982 a new constitution was established under Canadian legislation. Appended to this constitution was the Charter of Rights and Freedoms which sets out the meaning of Canadian citizenship (Canada 1982a; Axworthy and Trudeau 1992).

While Trudeau was primarily responding to unrest in Quebec when he published his original proposal for a charter of rights, he hit other chords in Canadian society. There were a number of groups who were unhappy with the position allocated to them in the power structure, and the late 1960s and early 1970s was a time of radical challenge not only in Quebec but particularly among young persons and women across the country.

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[2] See Appendix A for definitions.

The United Nations had begun to designate some years as being those which should focus on special groups' human rights. There had been years designated as such for women and children in the 1970s. The year 1981 was to be the International Year of Disabled Persons. By then in Canada leaders of the group of persons with disabilities had become well organized to press for change. They took full advantage of a parliamentary inquiry into social policies relating to their position in society (Canada 1981b,c) and were very successful in turning the recommendations of the special committee into reform activities.

A Human Rights Act had been passed in 1977 but it was revised (following the constitutional changes of 1982) in 1983. Four groups were picked out as disadvantaged persons whose needs should be given special attention if they were to realize full citizenship — women, native peoples, visible minorities and persons with disabilities.

Social Networking

The International Year of Disabled Persons made it clear that the problems of this particular disadvantaged group[3] were related to the physical and social barriers which had long been taken for granted by the rest of society. It was pointed out in public inquiries into this group's situation that many of these barriers were attitudinal. Leadership was now provided about the way to make public attitudes change (as well as giving attention to physical barriers) and very different prospects opened up for persons with disabilities.

A major part of this change was seen to be related to the development of social networking with other members of the community — another form of partnership. There was a rejection of professional authority generally, a feeling that it had overstepped the bounds of expertise, had expected people who were in disadvantaged groups to make all the adjustments, and made them overdependent. It was thought that if community supports could be redeveloped then there were good chances that disadvantaged persons could realize their citizenship potential more fully.

Reviewing Ideology

As indicated earlier, Canada's commitment to the redistributive welfare state was relatively weak. The Canadian welfare state was market oriented, providing limited social rights and having low commitment to full employment (Therborn 1987). Like the other market oriented welfare states it was readily open to challenge from neo-conservatives.

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[3] The social needs of persons with disabilities, native peoples and visible minorities are discussed in Chapter 25.

The Liberals had been in power in Ottawa from 1935 to 1984 with only two short interruptions. The first of these — the Diefenbaker years 1958 to 1963 — happened during what has been called "the post-war consensus" on the importance of having a welfare state and the second — the Joe Clark government of the early 1980s — was a brief interregnum in which the consensus was not challenged.

The Liberals had some second thoughts about the Canadian welfare states' financial redistribution policies when they really became aware that they were financially over-committed (Canada 1970a). Taylor (1978) has discussed the hesitations of the Finance Minister about the introduction of Medicare (1966). Johnson (1975) has described the outcomes of the social service review. By then the government had decided not to go through with proposals to introduce a guaranteed annual income or to improve the Canada Assistance Plan. At the same time housing policies came under review and the government withdrew from its earlier commitment to support public housing generously (Hallendy 1986). However, until they were ousted in 1984, the Liberals concentrated on finalizing the other collectivist programs which they had set out to implement. The health insurance principles were firmly restated in the Canada Health Act, 1984, and the post-secondary education programs were being set in place in universities and community colleges all across the country.

During the 1970s the Liberals had struggled to find ways of controlling the open-ended funding programs. They passed the Established Program Financing Act (EPF) legislation in 1977 and tightened conditional grant aid from the early 1980s onwards.

Revenues now fell short of expenditures. The national deficit grew and the federal government was forced to cut back its transfer payments to the provinces.

The Liberals were replaced by the Progressive Conservatives (PCs) in 1984. In 1985 the government's concerns swung across to economic development and prospects (Canada 1985a), to supporting the Employment and Immigration Commission on developing new job strategy programs, to promoting technological advance in Canada. The redistributive programs of the Canadian welfare state began to create an enormous national debt as companies were relieved from taxes and national revenues dropped. The national deficit escalated very quickly from this time onwards.

The PCs found it difficult to cut back on transfer payments rapidly enough to prevent the national deficit from growing exponentially, and when they were voted out of office in 1993 the Liberals returned to power. They had to face the challenge of dealing with this issue, continuing to adapt to the changed trading situation in which Canada now found itself and considering how to reform and restructure the welfare state.

A Shift to the Welfare Society Concept?

In the meantime the concept of a viable welfare state had been changing internationally. The idea that financial redistribution alone was enough had been challenged in the late 1970s. But although there was more emphasis on attitude change towards a partnership society, the need for minimal income support of many Canadians continued. Nor was Canada anxious to cut back its support of universal social programs.

In Canada since 1980 there has been a broadening of the groups involved in policy making, for both federal and provincial governments have taken up the idea of partnerships. This term has a wide range of meanings from corporate collaboration to social networking. The idea of partnerships implies the destruction of big bureaucracies or, if these are to continue to exist, the bringing of other interest groups into planning and decision-making sessions. It argues for the empowerment of more citizens and the recognition of the contributions they can make to policy development as well as to service provision.

Further development of the welfare state/welfare society ideas will be addressed in Parts VI and VII which will consider reform and restructuring of Canadian and provincial social policies. The next two chapters will show why it is important to understand this wider context for discussing health service developments as Canada has moved towards implementing a social model of health care.

Summary

By 1980 all the welfare states set up after the Second World War were having some problems. At an international conference it was argued that, in those which functioned more effectively, politicians had set up structures for consulting with businesses and other interest groups.

At the beginning Canada's welfare state had been mainly concerned with financial redistribution across the provinces and from richer to poorer individuals. In the 1970s Prime Minister Trudeau re-focussed attention on attitude changes, towards issues of human rights. He managed to append a Charter of Rights and Freedoms to the constitution which was patriated in 1982. Subsequent revision of the Human Rights Act, 1983, identified four disadvantaged groups — women, native peoples, visible minorities and persons with disabilities, who were to be given special care.

After 1980 the concept of partnerships at a number of different levels began to be explored (see Appendix A for definitions).

At about the same time as these significant changes were being brought in, Canada was beginning to face problems of overspending. Proposals to improve social minimum programs were not finalized as reformers had hoped. Greater progress was made in introducing health and post secondary education schemes but there was even more concern about finding the best way to encourage business developments in a changing global market economy. And as the years went by the federal government kept reducing its commitment to federal transfer payments to the provinces for paying for social programs.

PART III

Canada's Publicly Financed Health Care System Evolves

CHAPTER 7

Developing Federal and Provincial Organizations for Providing Collectivist Health Services 1948–66[1]

Health Services in the Immediate Post War Years

It would have been possible to allow the Canadian health care system to evolve in the same way as the American system. In the 1930s private insurance schemes had been developed to facilitate prepayment of hospital and medical fees and these schemes had crept across the border.[2] However, Canada decided to pursue welfare state policies modelled on the British proposals for postwar reconstruction and to introduce a publicly funded collectivist health care system.[3] The *Report of the Advisory Committee on Health*

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[1] There is some repetition in this chapter from Chapter 2.

[2] Routley (1967) has described the early prepayment schemes in Ontario and Shillington (1972) has shown the steady growth of medical care insurance between 1945 and the introduction of the Medical Care Insurance Act, 1966, implemented between 1968 and 1970.

[3] Studies continued to be published in the postwar years which showed how far some provinces were behind others in their provision of health care. Three studies in Nova Scotia (Davidson and Davidson 1969; Leighton 1959, 1960; Canadian Council on Social Development 1972) identified community responses to poor working and living conditions, showing that adaptations to the stresses of daily life were not positive in that province.

The response of the Quebec reformers in the 1960s to the prospects of planning new health and social services shows that they, too, were concerned with the health of the poor. Two conflicting approaches to CLSC development, described by Lésémann ([1981] 1984), were both attempts to remedy social disintegration. The epidemiologists proposed that CLSCs should be set up where the

Insurance (Canada 1943a) reviewed the situation from a federal viewpoint as part of the welfare state plans and the government then encouraged its bureaucrats to develop conditional grant proposals to put to the 1945 Dominion-Provincial Conference on Social Reconstruction.

As discussed earlier these grant offers made at the dominion-provincial conferences of 1945–46 were not taken up at that time because of the hesitations of Ontario and Quebec to allow the federal government to move into the funding of social programs. They claimed their constitutional rights to control social affairs. But the federal government persisted with its offers, and in 1957 Ontario agreed to accept the federal proposals for funding hospital insurance and diagnostic services (Taylor 1978) while in 1963, a special agreement on cost sharing all social programs was reached with Quebec.

Development of Health Service Organization in Saskatchewan

While federal funding of health care programs was delayed, Saskatchewan had decided to bring in health care reforms at the provincial level.

In 1944 the Cooperative Commonwealth Federation (CCF) party was elected to power in Saskatchewan. Its primary objective was to introduce a publicly financed health care system and it began immediately to plan to introduce change. The Saskatchewan government brought in a consultant, Henry E. Sigerist from Johns Hopkins University, to advise it on how best to develop its plans (Roemer 1960). The public health officers had endeavoured to persuade the government to give priority to the development of primary care but the electorate made it clear that, beyond all else, people wanted protection from the high costs of hospital care.

Much of the early learning about health service planning in Canada was done in Saskatchewan where the government set up a planning commission separate from its existing administrative departments. The Saskatchewan government had hoped to get comprehensive financial support from Ottawa to develop a broadly based health care scheme all at once following the Rowell-Sirois recommendations (Canada 1940) but it was disappointed by the offers made at the Dominion-Provincial Conference on Social Reconstruction and the outcomes of this conference (Feather 1984). It had to accept incremental development as the only possibility.

Saskatchewan had a well-directed cabinet, clear about its direction and strong in its control. Although the Saskatchewan scheme could not be brought in as a total program from the start, the conception was one of a total health

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health status indicators were worst, while the social activists focussed on unstable poor communities in the large cities and proposed that the CLSCs should focus on community development.

care organization which would ensure that all citizens were able to get good medical care. The government had to make concessions to the electorate about priorities and to the doctors on whom they were dependent for technical services, thus it could not establish this total organization according to its rational plans but it tried hard to do so.

Sigerist advised the government to go along with the electors' priorities and so the introduction of hospital insurance was tackled first. A survey of existing hospitals was conducted and gaps identified (Wahn 1952) while plans were developed to raise money for operational costs from a head tax. A hospital insurance scheme was introduced in 1946.

At the same time the Saskatchewan government was endeavouring to ensure that medical care in the doctors' office would be provided when necessary. Before the war a number of rural communities had developed municipal doctor schemes. The government wanted to develop further schemes of this kind and established pilot regions in the Swift Current and Weyburn areas. Although these regional plans seemed to be very successful so far as the local people were concerned (Canada 1964) the idea met with great hostility from the doctors who did not wish to work on salary and be responsible to an elected board of management. Proposals for the development of two more regions which were subject to referenda were turned down in 1951 because the doctors persuaded the voters that it was not a good model of organization (Badgley and Wolfe 1967).

Despite growing hostility from the doctors in the province, the Saskatchewan government continued to plan for the introduction of medical care insurance which it was able to consider after the federal government provided matching grants for hospital insurance from 1957 onwards. A Medical Care Insurance Act was passed in 1962, precipitating a doctors' strike for twenty-three days. Then some compromises were worked out. Already the concept of salaried employment had been abandoned — doctors were to be paid fees for items of service — but there were struggles over the process of monitoring payments and the organization of community clinics (which had governing boards of community members). In the Saskatoon Agreement, reached with the help of an outside negotiator, it was accepted that the medical association would monitor payments, that these might be charged through insurance carriers, and that the boards of clinics would have a landlord–tenant relationship only — that they would not determine policy or management issues (Badgley and Wolfe 1967; Tollefson 1963).

In addition to these programs, the Saskatchewan government established a strong research department with good data banks — a model for all other provinces. It developed regional health services for community psychiatry in the 1950s, a provincial laboratory service, a subsidized pharmaceutical scheme and dental care for children. It already had special cancer services as well as care for tuberculosis patients, which had been set up as public health services before the war. The province continued to investigate other areas of concern such as rehabilitation services and child health services, and gave a lead to all other provinces on what could be done to improve health care.

Pragmatism in Other Provinces and in the Federal Government

Elsewhere among the provincial politicians of this period, there was usually a pragmatic approach to picking up federal grants and the cabinets were subject to pressures from back-benchers to respond to local needs. Unlike Saskatchewan they did not stick to rational plans.

The electoral appeal of a provincially financed hospital insurance scheme led other provinces to copy the Saskatchewan model but they did not always understand how to control it effectively. While a head tax on the stable farming population of Saskatchewan was a good way to raise revenues in that province, it was not suitable for ensuring that the mobile loggers and miners of British Columbia paid their dues. In that province, hospitals tended to "cook the books" on patients' eligibility criteria when they arrived for crisis care and, in consequence, British Columbia's hospital insurance scheme did not pay its way at first. In 1952 newly elected Premier W.A.C. Bennett decided to abandon the collection of premiums and to finance the scheme from a provincial sales tax, thus moving away from the insurance principle.[4] By 1957 several provinces (British Columbia, Alberta, Newfoundland) had developed their own hospital programs (Taylor 1978).

Further Federal Moves

Unable to get acceptance of its proposals for the development of a federally supported health care insurance scheme at the Dominion-Provincial Conference on Social Reconstruction (Taylor 1978) the federal government did not give up. In 1948 it offered four National Health Grants: for provincial planning of health services, for hospital construction, and demonstration grants for innovations in public and mental health services. Saskatchewan was the only province with a health planning bureaucracy. The other provinces brought in consultants or set up committees to help develop their plans (Taylor 1953) though some used experienced public health officers to make forecasts (e.g., British Columbia 1952).

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[4] Gradually most provinces have abandoned collecting premiums. British Columbia still collects them for medical care insurance and Alberta for hospital insurance but others now fund health care from general revenues (Crichton, Hsu and Tsang [1990] 1994).

In consequence, the health plans were not often carried out as they were written. There was much hospital building, for the back-bench MLAs who put pressure on governments to vary the plans did not look beyond the offer of construction grants to calculate operational costs. By the mid 1950s many provinces realized they needed federal help to continue to provide hospital services.

The federal government responded to their request for help in funding operational costs of hospitals by beginning a protracted negotiation with Ontario (Taylor 1978). (In order to pass an act the federal government had to have support of the majority of provinces and the majority of the population.) By this time the new Premier of Ontario was willing to accept federal funding for hospital insurance programs provided it could be on his terms — that is, that contributions to hospital insurance schemes should be optional not compulsory. Since it was assumed (correctly) that over ninety percent of Canadians would wish to be insured, the federal government gave way on this point and the Hospital Insurance and Diagnostic Services Act, 1957, was passed.

As discussed above, the grants, which now became available to Saskatchewan through this act, enabled that province to move towards bringing in medical care insurance. In 1961, the Canadian Medical Association, foreseeing that policies developed in Saskatchewan were likely to be adopted by other provinces, asked the federal government to set up a Royal Commission on Health Services. This commission reported in 1964, recommending that the federal government should go ahead with implementing a medical care insurance scheme. An act was passed in 1966 to bring in such a scheme but it was not implemented until 1968. However, all provinces had agreed to set up Medicare by 1970.

Although Saskatchewan had brought in other provincial programs such as Pharmacare (subsidized prescriptions for seniors and persons with disabilities) and children's dental care, the federal government decided that it would go no further with its grants-in-aid. Adding any other programs was to be left to provincial discretion. All provinces have added Pharmacare to their publicly funded programs but dental care remains in the private system except for limited provision under the school health service or in hospitals where oral surgery is provided (Stamm et al. 1986). Many provinces have private laboratories where the doctors are paid by the medical plans.

The emphasis was on gap filling. It was difficult to try to coordinate and streamline a system which was developed so incrementally and with so many interferences to the original plans (if there were any plans).

The delays in reaching agreement had unfortunate results for Canada. Grant-aided health care programs were introduced in a scattered way over a long time period so that the first programs became overdeveloped while the other programs were still in the pipeline. Thus hospitals were overbuilt and took on work which could have been done in the doctors' offices while medical care was still privately funded.

By the end of the 1960s some federal politicians and bureaucrats were becoming concerned about the costs of the collectivist organization which had evolved. In the next chapter the questions which arose then will be considered.

Summary

The federal government wanted to bring in conditional grant aid for health and post-secondary education programs in 1945–46 but it was challenged on constitutional grounds. Meanwhile, Saskatchewan pioneered health planning but because of lack of resources it had to introduce services incrementally, and at first it followed the wishes of the electors to bring in free hospital services rather than primary care. An attempt to introduce regional programming was defeated in a referendum and when medical care insurance was introduced there was a doctors' strike. However, agreement with the doctors was reached after twenty-three days.

These defeats of government resulted in concessions to the medical profession which moved the organization of services away from an optimal collectivist model, though there were a number of successful innovations in the province such as a Saskatchewan data bank and provincial laboratory provision.

In other provinces there was no clear model of organization of collectivist health services. The politicians were pragmatists, looking for electoral advantages in introducing programs.

Nine provinces reached agreement with the federal government to accept matching grants for hospital insurance and diagnostic services in 1957. Quebec made an overall agreement with federal government in 1963 to provide health and social services similar to those of the other provinces provided it could decide on the policies. These delays in reaching agreement on funding resulted in overfunding of some programs while others were still in the pipeline and as a result, poor coordination of service provision and wastefulness in management resulted.

CHAPTER 8

Questioning Canadian Health Care Organizational Policies 1967–86[1]

After the welfare state programs had begun to be implemented, the federal Deputy Minister of Health and Welfare, Dr. Maurice Le Clair (a Québécois who was perhaps better attuned to the idea of collectivist care[2] than were some of his colleagues), raised questions about their impact. Were programs which provided *access* to medical services the best means of improving health *outcomes* for all Canadians? And were the programs well managed? Could their organization not be improved?

Le Clair made a number of very significant moves. On the one hand he questioned the open-ended funding which had resulted in overbuilding and poor management of hospitals, and because hospital funding had preceded medical care funding, he realized that there was some unnecessary use of these facilities. He terminated hospital construction grants and set up the Task Force on the Cost of Health Services (Canada 1970b) to inquire into possible savings. He established a national inquiry into the possible development of community health centres (Canada 1972) as an alternative form of medical care organization. He set up a long-range planning group which in its report, *A New Perspective on the Health of Canadians* (Canada 1974a), proposed that the boundaries of the health field be extended and the objectives of the programs be reconsidered. This new approach, which was strongly supported by the Minister of Health and Welfare, took time to be

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[1] Some points made in Chapter 2 are repeated here.

[2] Quebec had spent much of the 1960s investigating the future of its social programs after reaching agreement with the federal government in 1963 on a special form of grant aid to be provided. The emphasis was strongly collectivist.

accepted, but Canada led the world in the 1980s by developing, with WHO, a health promotion movement.

As well, Le Clair set aside some of the national health research dollars for studies of the health care system instead of permitting it all to go to biomedical research. He cooperated with the Science Council of Canada on redirecting some health research towards organization and management issues (Robertson 1973; Canada 1974c).

But perhaps one of his most significant contributions was the bringing together of federal and provincial health policy bureaucrats to discuss how to change the open-ended matching grant funding to a more streamlined system — one in which provincial governments would be forced to take more responsibility for coordinating and managing the development of the health care delivery system which was still very wasteful and costly.

Intermediate Responses.

It took a long time for the provincial governments, their bureaucrats and the professional service deliverers to respond to these ideas. Neither the hospitals nor the doctors were keen to make changes to their sectors of the health service organization, though public and mental health departments were more open to change.

Provincial governments were asked to accept a new funding formula in 1972, but at first they refused to cooperate. In 1977 the federal government decided, unilaterally, to substitute block grants for open-ended grants and to limit the amount provided for funding programs in health and post-secondary education under the Established Programs Financing Act (EPF). Federal contributions were to be based on previous levels, with the addition of a special per capita grant for the development of "home care" and with adjustments for inflation and population growth. Grants were to be reassessed every five years.

There were several new objectives in the EPF. A special grant for home care was to encourage the provinces to develop more community-based services in lieu of institutional care and the substitution of block grants for matching grants was expected to make the provinces responsible for managing their grant aid more efficiently and effectively. The provinces were being pushed towards thinking about better coordination of the different aspects of care which had been developed under separate budgets in the early stages of development. And the federal government was now anxious to hand further program development over to the provinces.

So far as the governments were concerned they were still focussed on access issues and continued to work towards gap filling. It was not only the provincial governments which were struggling to bring services to rural areas or other unfilled spots. The Liberal government, in power in Ottawa until 1984, was still attempting to ensure that legislation providing for equal access to existing medical services in the cities was carried out. The last Liberal Minister of Health, Monique Bégin (1984), was particularly concerned that the principles of access to medical care — universality, comprehensiveness, portability, and public administration — should be observed. The medical profession, which had at first been cooperative, had begun to demonstrate its dissatisfaction with its terms and conditions of service in the 1970s and 1980s by "extra-billing" patients above and beyond the amounts they were paid by the medical plans. Health Minister Bégin decided to develop the Canada Health Act, 1984, restating the already agreed upon principles and adding equity of access. By 1987 the provincial governments had all agreed to stop charging user fees and to forbid extra billing, or else they would have had to forfeit federal grants dollar for dollar for any charges they allowed to be made.

The Moves Towards Health Promotion

A New Perspective on the Health of Canadians (Canada 1974a) was welcomed by the public health community but the strategies proposed in the report were not deemed viable, and, in any case, as Hall et al. (1975) have pointed out, program development takes time, for a newly proposed policy must be legitimated before feasibilities can be worked out and support can be found for its implementation. But some of the federal bureaucrats were working on the development of the health promotion concepts which came out of *A New Perspective*. This report had highlighted the issue of health status and proposed that health care should be regarded as more than medical care, because lifestyle, environment and biological risk were more likely to affect health outcomes than access to medical care. The report leaned on the arguments of McKeown (1971), who suggested that nutrition, infection control and birth control were much more powerful determinants of health than was medical care (which was likely to account for only about ten percent of improvements to health).

As Edginton (1989) pointed out, each person, each group and each nation socially constructs its own definition of health. "Scientific as well as social definitions are constantly changing and reflecting the concerns of a particular culture at a specific time in history" (p. 29). What Canadians began to see after 1974 was a reconstruction of the definition of health from a biomedical to a social model.

At first there were new initiatives within public health departments to step up education concerning lifestyles. While in general this was well received, there was some concern that putting too much emphasis on individual responsibility might lead to "blaming the victims" for their illness (Crawford 1977). It was not until the 1980s that the concept "environment" began to be closely analysed. In 1958 the World Health Organization (WHO 1958) had defined health. This definition was restated and developed in the first paragraph of the Declaration of Alma Ata (WHO and UN 1978).

> The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well being, and not only the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (p. 1)

The means to this end were outlined in Paragraph VI:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (p. 2)

For many years, WHO had been concerned with what it saw as the wastefulness of specialist health care provision in underdeveloped countries. The Declaration of Alma Ata provided a basis for a new worldwide policy known as *Achieving Health for All by the Year 2000* (WHO 1981a,b) by emphasizing primary care. But how should this policy be applied to the more developed countries? The European office of WHO published *Health Promotion: A Discussion Document on Concepts and Principles* (WHO 1984), which formed the basis for proposed new strategies. It suggested defining health as:

> The extent to which an individual or group is able, on the one hand, to realize aspiration and satisfy needs; and on the other hand, to change and cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capacity. (p. 10)

This definition stresses the importance of environment as well as of lifestyles and has led to the reconsideration of the work of both health professionals and community members (both respectively and in partnership with one another).

In Canada it was not until the federal Conservatives took over in 1984 that the Minister of Health and Welfare, Jake Epp, was persuaded by some of his staff to develop the ideas of *A New Perspective on the Health of Canadians* (Canada 1974a) into policy by setting out his ideas on *Achieving Health for All: A Framework for Health Promotion* (Canada 1986c). This was presented at the first international conference on health promotion which resulted in the publication of the *Ottawa Charter on Health Promotion* (WHO 1986).

This policy statement took a strong collectivist approach to health care (note the main challenges: reduce inequities, increase prevention and enhance coping [see Chart 8.1]).

At this time, the newly elected Conservative government did not have a strong general strategy for Canadian policy development; it seems that each minister was able to pursue his/her own interests. The sponsorship of the health promotion conference seems to have been partly a matter of personal interest on the part of Jake Epp and partly a matter of ongoing pressure (supported by WHO) from within his department.

The publication of the *Framework* was followed up by a discussion paper on the needs of those with mental disorders (Canada 1988e) which spelt out the distinction between the need for medical care and the need for social supports to achieve optimal mental health (see Chart 8.2). The second half of the chart shows how it is necessary not only to provide professional support for the client, but also to change public attitudes to those with physical and social disabilities.

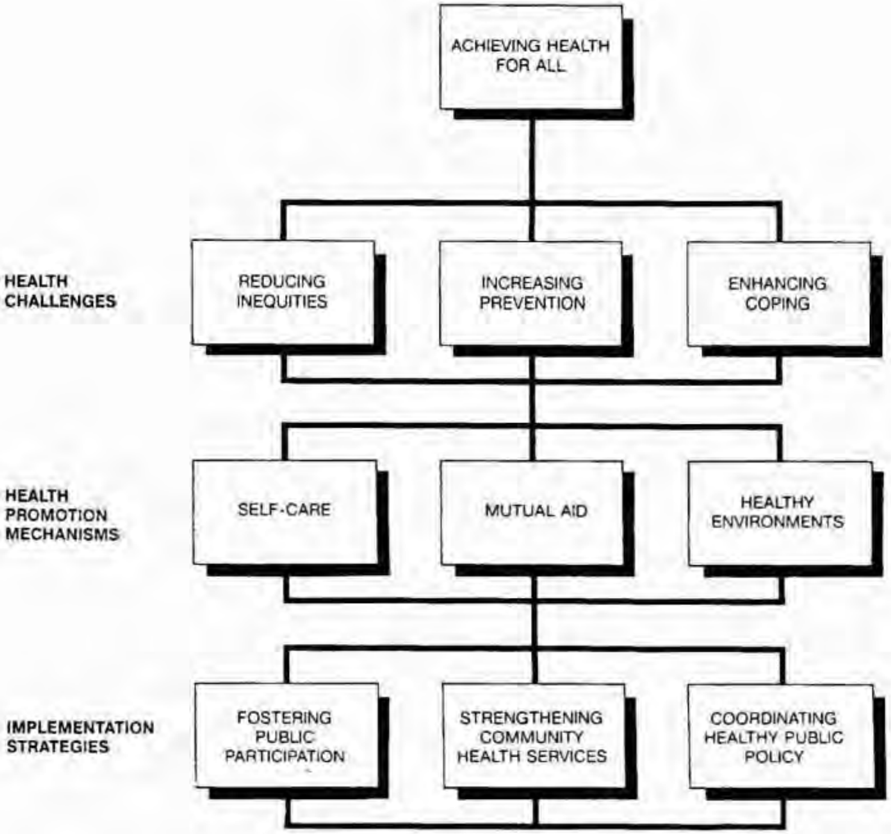
Throughout the 1980s interest in health promotion had been growing. Milio (1981) had urged the necessity of thinking through all public policies in terms of their impact on health. Hancock and Duhl (1986) had discussed the better coordination of social policies at the local level in their proposal for establishing "healthy cities" and, more broadly, Brundtland (1987) had set out proposals for sustainable development. Labonté (1987) produced a chart (see Chart 8.3) showing three coexisting viewpoints on health and stressing that all were important for health promotion.

Labonté's first two lists describe traditional programs, but his third list, of needs for socio-environmental support, challenges the old boundaries of health service provision. The existing structures of clinical care and public health services do not provide the full range of supports necessary to maintain many sick or frail people in the community. Not only was the lack of coordination within the existing health care system being challenged but also the lack of coordination with other social programs.

A New Vision of the Meaning of Collectivist Health Service Organization

By the mid 1980s Canadians had been forced to revise their ideas about the kind of health service organization which was required in order to realize optimal health for all citizens. They were not willing to give up the idea of access to medical care (and hospital care if necessary) in case of illness, and the Canada Health Act, 1984, was seen as an important guarantee of that. At the same time they were beginning to realize that good health was not dependent on having professional medical care always available, that the

Chart 8.1
A Framework for Health Promotion



Source: Canada, Health and Welfare. *Achieving Health for All: A Framework for Health Promotion*. (Ottawa: Ministry of Supply and Services 1986), 8. Reprinted with permission.

determinants of health were much broader. Health was related to lifestyle, environment (both physical and social) and biological factors which put some people more at risk than others.

The provincial governments decided that it was time to review their current health care organization structures to see where they could be improved, and all provinces except Prince Edward Island set up public inquiries into their health service organizations. The reports of these inquiries are discussed in Chapter 24. Meanwhile it is important to consider what was happening within service organizations and in government bureaucracies and what research was being used by health service planners so that it will be possible to assess the prospects for changing the organization to fit the new vision in the 1990s.

Chart 8.2(a)
Mental Disorder Continuum

Maximal Mental Disorder (greatest severity, frequency and range of psychiatric symptoms)	*Range of impairment and distress (from severe to negligible)* ⟷	Absence of Mental Disorder (freedom from psychiatric symptoms effective prevention or cure)

Chart 8.2(b)
Mental Health Continuum

OPTIMAL MENTAL HEALTH	Individual, group and environmental factors work together effectively, ensuring • subjective well-being • optimal development and use of mental abilities; • achievement of goals consistent with justice; • conditions of fundamental equality
↕	
MINIMAL MENTAL HEALTH	Individual, group and environmental factors conflict, producing • subjective distress; • impairment or underdevelopment of mental abilities • failure to achieve goals; • destructive behaviours; and • entrenchment of inequities

Source: Canada. Health and Welfare, *Mental Health for Canadians: Striking a Balance* (Ottawa: Supply and Services, 1988). Reprinted with permission.

Note: Chart 8.2(b) shows how it is necessary not only to provide professional support for the client but also to change public attitudes to those with physical and social disabilities.

Summary

A new Deputy Minister of Federal Health and Welfare, Dr. Maurice Le Clair from Quebec, appointed in 1968, who had been exposed to the thorough reviewing of social programs in that province, set up a series of task forces to examine whether Canada's health care system was trying to move towards the right objectives, whether it had the most effective structures and whether it was well managed.

Chart 8.3

Coexisting Viewpoints on Health

Labonté's Chart of Coexistent Models of Health Care, 1987

	"Clinical/Technical" (examples)	"Public Health" (examples)	"Socio Environmental" (examples)
	Heart Disease	Substance Abuse: smoking alcohol other drugs	Housing
	Hypertension	Poor Eating Habits	Employment
	Diabetes	Fitness and Exercise	Work Conditions
	Obesity	Stress Management	Family Violence
	Depression	Unsafe Sex	Social Stress
	S.T.D.s	Teenage Pregnancy	Isolation
	Arthritis	Parenting Skills	Literacy
	Acute Malnutrition	Self-esteem	Education
	Neoplasms		Food Availability
	Trauma Injuries		Transportation
Target	Individuals	Family/Group	Systems and Populations
Focus	Disease	Risk Factors	Causal Factors
Role	"Provider"	"Change Agent"	"Facilitator"
	Strengthen Community Health Services	Foster Public Participation Health Promotion	Healthy Public Policy

Source: R. Labonté, "Community Health Promotion Strategies," *Health Promotion* 1, no. 26 (1987): 5–10. Reprinted with permission.

(Note Labonté's distinction between the strengthening of community health services and the development of healthy public policy).

Le Clair questioned whether the emphasis on access to medical care was likely to result in the best health status outcomes. He shifted some of the emphasis in research from biomedical to social issues in health care. As well, he focussed on wasteful funding and management and the need to examine the organization of the system of care.

A new federal-provincial funding formula was introduced in 1977 in the hope that provincial governments would be forced to take more responsibility for organizing services. This also increased federal control over the total amount of transfers. This EPF scheme provided incentives for the development of community-based services.

But Canadians were still concerned about access to care rather than outcomes and it was not until 1984 that the Canada Health Act ended doctors' extra billing and restated the principles of universality, comprehensiveness, portability, public administration and added equity to guaranteed access (M. Bégin 1984). Then the government was able to move forwards.

Working together with WHO, the federal government now moved towards emphasizing primary care rather than specialist crisis care services (which had been steadily growing since the end of the nineteenth century). In 1986 the federal Minister of Health sponsored the first international conference on health promotion and by 1990 the provincial governments had accepted the importance of this policy.

A new vision of the kind of health service organization, which was necessary to realize optimal health for all citizens, was now built on top of the access model. Provincial governments set up commissions of inquiry to examine where they should be trying to go in building better service organizations.

PART IV

Service Delivery Systems and their Response to the Need for Change to a Collective Care Organization

CHAPTER 9

Care in the Doctor's Office

When national health insurance legislation was enacted by the federal government in 1957 and 1966 there was already a medical care delivery system in place. The purpose of the health insurance legislation was to provide more adequate and better distributed funding to support this system of care. It was not until the whole new funding system was in place that questions began to be raised about the health outcomes of this subsidized traditional structure of organization (Le Clair 1975), for until then, the main thrust of government policies had been towards improving universal access of individuals to hospitals and physicians' services.

The Model Is Established: Regional Hierarchies of Organization

The medical model of health care was firmly established in Canada in the nineteenth century. Desrosiers (1979) associated its rise with industrialization in Quebec, but elsewhere demand for medical services was not confined to the cities. When the prairies were settled early in the twentieth century, one of the principal objectives of the farmers' cooperatives' policies was to encourage well qualified physicians to serve rural communities (Badgley and Wolfe 1967).

In 1910 Flexner reviewed the work of medical schools in North America and made it clear that they should provide teaching based on scientific research in laboratories and teaching hospitals. The effect of this study was to put medical schools at the top of a pyramid — a "regional hierarchy" (Fox 1987) — with quaternary care specialists working in university health science centres at the peak, tertiary specialists providing service in metropolitan areas, secondary specialists working in hospitals in the larger population centres in the middle (although often these secondary centres in the provinces are known as regional centres) and primary care giving general practitioners at the bottom. The influence of the biomedical scientific paradigm as the predominating concept of medical care led to the diminishing valuation of magical, religious or pastoral care (Field 1973).

Competitors,[1] such as chiropractors or midwives, were excluded from this hierarchy. They were able to continue in practice only where public support was very strong. Other health professional groups, such as nurses, therapists and technicians, usually were employed in hospitals working under medical direction.

Reversing the Pyramid? Putting Primary Care First?

Early health planners concerned with the health of the population generally (e.g., in Great Britain 1920) wanted to turn this pyramid around, to establish the importance of primary care (Saward 1976) as the entry point to the system of care. They were unsuccessful in doing so for a number of reasons, but mainly for lack of public and medical professional support. By the end of the second decade of the twentieth century, the medical profession had convinced the public that doctors were able to prolong life, decrease disease incidence and reduce discomfort, and that their system of medical care organization was the most appropriate structure to achieve good health.

When Canada first turned to governmental planning for health in Saskatchewan in 1944 the Cooperative Commonwealth Federation (CCF) party accepted the introduction of hospital insurance as a priority rather than state-funded primary care services, as advised by their public health officers (Taylor 1978). This set the pattern for all other provinces except Quebec (Desrosiers 1987).

Payment Systems as a Conservative Influence

Changes from direct payment by patients to third party insurance schemes began to be introduced just before the Second World War. Hospital insurance took priority, but in the early 1950s doctor-sponsored third party prepayment schemes became available all across Canada (Shillington 1972). The Saskatchewan CCF government (1944–62) had made government-sponsored health insurance the major thrust of its policies. Having introduced publicly financed hospital insurance in 1946, it was ready to bring in medical care insurance after 1957 when it received federal grants to support hospital insurance and had enough resources to embark on its next initiative. The en-

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[1] Medical Health Officers in the public health service were not expected to treat the sick but to prevent disease outbreaks. There were conflicts over immunization and maternity care, and sometimes school health activities, as these were not clearly in clinical or preventive territories.

actment of provincial legislation in 1962 resulted in a doctors' strike. A provincial Medicare scheme was finally brought in, although concessions were made by the government regarding policing of the doctors' billings. As well, the community clinics in the province, which had adopted an alternative form of practice organization with consumer advisory boards, were forced to reduce their connection with these boards to a landlord/tenant relationship (Badgley and Wolfe 1967).

The Canadian Medical Association, anticipating that other provinces might follow Saskatchewan's example, had asked that a Royal Commission on Health Services be appointed in 1961. This commission (Canada 1964), recommended the introduction of federal funding to support Canada-wide provincial medical care insurance. The Medical Care Insurance Act (Medicare) was passed in 1966 and medical plans to administer the scheme were established in all provinces between 1968 and 1970. Before attempting to legislate its provincial program, the Saskatchewan government had recognized that the doctors would not accept salaries or capitation methods of payment and had decided to negotiate fee-for-service payment methods).[2] Blishen (1969), the research director of the royal commission, confirmed that this was a necessary condition for professional cooperation in implementing Medicare, but since then, governments have been searching for other ways of making payments. These alternatives will be reviewed in discussions of different forms of organization of medical services in Chapter 11.

In setting up the medical plans it was not made clear, except in Quebec, whether the doctors were in contract with governments or were subsidized entrepreneurs. At the beginning the medical associations' bargainers were able to establish generous and well accepted fee schedules (Evans 1984), but as time went on and inflation eroded income levels, dissatisfaction grew. Some provinces (e.g., British Columbia) negotiated large increases in the early 1980s with the condition that no additional charges be made. Others permitted the practice of "extra-billing" to creep in. At about this time the doctors in certain parts of Ontario, in particular specialists (Heiber and Deber 1987), began to bill their patients over and above the provincial rates. This practice appeared to open the door to "two tier" medicine and created visible opposition groups. The federal government decided to put a stop to extra-billing by passing the Canada Health Act (1984). This gave the provincial governments three years to decide whether to eliminate all additional charges (extra-billing and hospital user fees) or to forego grant aid from the

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[2] The defeat of two regional referenda in 1951 had resulted in the government abandoning further attempts to introduce a salaried regional medical service responsible to consumer representatives.

federal government dollar for dollar on an assessment of these charges.[3] All provinces had conformed by 1987 to eliminating all fees, though the Ontario doctors had staged a prolonged protest strike against the Ontario Health Care Accessibility Act (1986), which ended "extra-billing" (Heiber and Deber 1987; Tuohy 1986).

The medical professional organizations are usually separated into two bodies with different functions: the Colleges of Physicians and Surgeons which regulate admission and professional conduct (e.g., ethical relationships with patients, professionals' substance abuse), and the medical associations which are interest or lobbying groups. In Saskatchewan before 1962 these were combined into one body which led to continuing strife between the doctors and the elected government.[4] Since then the two functions have been separated in all provinces and it is the associations which appoint committees from their membership to bargain with the governments on fees. Quebec is the exception, being the only province which has permitted self-regulating professionals to form unions. In that province there are two separate unions for specialists and general practitioners (Gerzina 1976).

Reform of the Professions?

In the late 1960s to early 1970s strong critiques of the use/abuse of medical power were put forward in the United States. This radical movement affected Canadian attitudes and investigative committees were set up in Quebec and Ontario (Quebec 1970–72; Ontario 1970). Quebec established new structures for professional control and greater protection of the consumers' interest and Ontario set up a standing review committee. Consumers began to be appointed to these regulatory boards and there were a number of studies of patients' rights (e.g., Saskatchewan 1973). However, these investigations made a very minor impact on traditional behaviours (Slayton and Trebilcock 1978).

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[3] In early 1990 the Conservative federal government indicated it might have to retreat from enforcing the Canada Health Act sanctions because it was no longer able to provide the amounts of funding required by the provinces to ensure common standards across the country. However, it later affirmed a commitment to the act in *Building Partnerships* (Canada 1991a). The Liberal government which took office in 1993 has indicated that it wishes to preserve Medicare but some provincial governments (e.g., Alberta) have shown willingness to permit some degree of privatization, i.e., two tiers for some aspects of medical care.

[4] Taylor (1978) and Badgley and Wolfe (1967) have discussed the way in which the combination of the college function of registering doctors with the association function of collective bargaining led to the formation of a "separate government" which could oppose the wishes of the elected political party in power.

Coburn, Torrance and Kaufert (1983) have argued that the medical profession dominated the health care delivery system until 1962, but since the settlement of the doctors' strike in Saskatchewan, this dominance has been eroded (see also Milbank 1988). On the other hand Tuohy (1986), comparing the Canadian and American medical professions, has argued that the terms agreed between doctors and governments on the introduction of health insurance in Canada has enabled doctors there to maintain greater clinical autonomy *vis-à-vis* administrators rather than doctors in the United States, and clinical autonomy is at the core of their professional power. Coburn, Torrance and Kaufert (1983) thought that another aspect of power — their control over service organization — was gradually being removed. While this may be happening in hospitals it has certainly not touched office practice yet. In fact, Tuohy (1982) perceived struggles with hospital administrators over budget crunches and fee battles "as attempts to keep a technologically outmoded system working" (p. 190). Her comments would suggest that medical dominance is not yet ended. Yet the profession is not monolithic. Apart from divisions between generalists and specialists, Marsden (1972) identified a growing rift between academic physicians and practising clinicians while others have noted struggles between reformists and conservatives in collective bargaining and in setting policy directions generally.

Physician Supply

The decision to recommend the introduction of universal medical care insurance led the Royal Commission on Health Services, 1961–64, to inquire into the supply and distribution of physicians available to provide services to patients (Judek 1964). Shortages were identified and steps were taken to increase the supply of doctors through encouraging immigration and increasing the numbers of medical schools and places within existing schools. The new medical schools were expected to emphasize training of family practitioners who would take up practice in underserviced rural areas. All schools moved to establish specialty training in family practice.

It is not possible within the scope of this review to provide a detailed discussion of planning physician supply. Efforts were made throughout the 1970s to determine the numbers of specialists and general practitioners which would be required to provide a universal service to the Canadian people but there were major miscalculations about population growth (Evans, Barer and Marmor 1994). The planners were unable to keep control of the supply which soon became excessive. The medical schools are part of provincial education services, not their health services, and the policies of health and education departments may differ markedly. The federal government was able to intervene in only two areas — control of immigration and control of postgraduate residencies — but admissions to medical schools remained in the power of universities funded by provincial governments. They were not willing to cut back on medical school admissions. Nor have efforts at physician substitution succeeded. Even with successful demonstrations of the work of nurse practitioners, Spitzer (1984) failed to convince medical practitioners that they should continue to delegate when special pilot program grants ended, for the fee-for-service system does not usually pay for nurse practitioners' services. Contandriopoulos, Laurier and Trottier (1986) did not foresee a willingness of Canadian general practitioners to change their attitudes, though in the United States, there appeared to be growing interest in "collaborative practice."

Inglehart (1986) reviewing the Canadian health care system, said that "medical manpower planning" was its greatest problem. About this time, Canadian health economists began to take a strong stand. Barer and Evans (1990) demonstrated how capital investment in equipment leads to further capital investment in personnel and that there were no effective controls on either. Lomas and Barer (1986) suggested that reforms in physician supply policy were necessary in the public interest, but the politicians were not yet ready to listen. However, in 1990, Barer and Stoddart (1991) were asked to prepare a report for the Council of Health Ministers. The health ministers then decided to act in January, 1992 and medical schools were asked to cut admission by ten percent.

Medical Education

The courses in the medical schools themselves are still developed by faculty, assessed through peer review and restricted by tight time schedules. Consequently in eleven of the old established Canadian schools, there have been no major changes in curriculum emphasis after the federal decision to introduce collectivist policies, although at McMaster University and four new foundations established in the 1960s following royal commission recommendations, more room was made for experiment.

The new foundations were expected to put more emphasis on primary care, to ensure that more physicians geared to family practice in rural as well as urban areas were produced in the system. The traditional schools then made some modifications to their first and second year curricula. Later the Council of Universities of Ontario held a national conference with representatives present from all Canadian medical schools to consider future directions for health science centres (Squires 1982) and to discuss the changing structure of the health care system in Canada and new issues brought forward since the introduction of the last health insurance program. The emphasis was put on the social model of health care (i.e., population health, inequalities in health, the determinants of health, pressures of funding and regulation of the health care system, ethical matters).

It is not easy to change the curriculum in medical schools where there is a heavy emphasis on biomedical technology and a general lack of concern for issues such as better management of health services or "the social responsibilities of practitioners" (Murray 1990). White and Connelly (1991) have suggested that medical schools, worldwide, lost public trust and confidence by failing to recognize the social problems surrounding them. They said they needed to reset their goals, re-planning curricula to those designed to meet the public's needs and renegotiating their contracts with society.

There have been some adjustments, particularly in teaching methods (pioneered by McMaster University) but there is still a need for development of greater understanding of health service organization. In 1991 the Association of Canadian Medical Colleges endeavoured to help its members to refocus the mission of the schools to prepare physicians to deal with new challenges by adopting community oriented approaches (already adopted by McMaster University, University of Calgary, and Université de Sherbrooke) and to take an integrated view of health care. Valberg et al. (1994) have proposed new ways of planning academic medical centres to meet changing needs.

The Specialty of Family Practice

The sixteen medical schools in Canada have all embarked on providing postgraduate residencies in family practice since 1970. One of the first needs of the new practice units was to define the scope of their activities. Wolfe and Badgley (1972) set out a model based on the work of family doctors in a community clinic practice in Saskatchewan. Others (e.g., McWhinney 1975; MacDonald 1981) have also stressed the commitment "to the whole persons" of the patients — to a group of people rather than to a body of knowledge. Because of this the family practitioners want to keep close links with the hospitals when their patients are admitted (Vancouver Hospitals Department of Family Practice 1990; Hennen 1990). McWhinney (1989) has now produced the standard textbook for Canadian family practitioners and Dean (1990), reviewing the new specialty, listed the following concepts as its special concerns: family dynamics, continuity of care, comprehensive care, humanistic care, health maintenance, preventive medicine, lifestyle changes and health promotion.

At first the new family practice units had difficulties in establishing teaching and research activities[5] which could be taken seriously by their academic

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[5] A research network has now been established among family practitioners in British Columbia. Within the College of Family Practice a national research committee has also been formed.

colleagues steeped in the Flexner scientific tradition.[6] They remained at the bottom of the totem pole in the hospital teaching centres and the older medical schools. However, efforts are now being made to escape this position by setting up teaching units in rural regional centres (e.g., University of British Columbia Department of Family Practice 1989; Longhurst 1987). These units are struggling to train competent generalists for practice in more outlying areas[7] but they have difficulties in getting the specialist teachers to provide basic courses in obstetrics, general surgery, etc., sufficient to enable the family practitioners to cope with emergencies but certain to ensure referrals when possible and necessary.

Practice Variations

While there may be improvements in theoretical approaches and in the work situation there are wide variations in the way medicine — primary, secondary and tertiary care — is practised. These variations have been reviewed by Wolfson, Tuohy and Shah (1978), Battista, Spasoff and Spitzer (1986), Sheps, Scrivens and Gait (1990), and MacLean and Richman (1989) who concluded that across Canada "practice decisions are closely connected to resources" (p. 370). How can this situation be better managed? Evans (1989a), who examined the prospects of greater public involvement, increasing pressure on overall health resources, and the effects of organizational restructuring, concluded that: "Unless and until research and researchers on practice variations begin to offer ways of relieving the endless pressure for more health spending" (p. 54) little will change, because the providers will always argue the necessity to give the best quality of care to their patients. Consequently more resources will be used as more diagnostic tests become available, more drugs are marketed and more manpower is introduced into the system. Many attempts have been made to stop this escalation of spending even though the final crunch between governments and service providers has not yet come. However, some controls over overall health care spending have been introduced into Saskatchewan and Alberta and they are forcing reductions in the numbers of consultations with patients. There has been considerable interest in the Oregon study of clinical priorities which lists medical services in order of necessity.

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[6] Carol Herbert, personal communication, 1990.

[7] See also discussion on rural health care in Chapter 14. The new emphasis on preparing family practitioners for rural areas has sparked some concern for urban family practice training (Gruson and Bates 1990).

Quality Assurance Issues

What then of the quality of primary medical care? While the royal commission was sitting, Clute (1963) had carried out a survey of the work of general practitioners. The researchers thought that only sixty percent of Ontario physicians surveyed and forty percent of those in Nova Scotia (the two provinces in the study) were practising at a satisfactory level. There was in their view inadequate continuing education to maintain standards. This study led to the establishment of a College of Family Practice with certification examinations (along the lines of the specialists' Royal Colleges), increased activity by universities and medical associations in providing continuing education courses and the establishment of hospital libraries for lending books, journals and teaching tapes. Since almost all Canadian physicians had hospital privileges, the hospital libraries and doctors' coffee rooms became local centres of informal continuing education.

Quality control over office practice is minimal. By tradition control is left to the professional ethics of the individual physician or to malpractice suits in the courts. It is recognized that there is some economic fraud (Wilson, Lincoln and Chappell 1986) which is, in theory, kept under control by the professional colleges (or associations) when these are provided with information by the medical plans about billing practices (Tuohy 1982). But the controls over volume of practice permit two standard deviations from the norm and the norms continue to change as more technology becomes available and intensity of servicing increases.[8]

Professional activities conducted in the hospitals are subject to peer chart review but this technique has not been introduced into office practice in Canada. The College of Physicians and Surgeons of Ontario conducted a peer survey of physicians' work in 1984, finding 30 of the 255 practitioners to be deficient (McAuley and Henderson 1984). Follow-up assessments showed that recommendations for improvements had been followed through in most cases.

At a national quality assurance conference in Toronto, Fletcher (Ontario 1989f) proposed a new funding model for primary care with knowledge-based information systems to support it: "Likened ... to an ongoing clinical trial, this would provide us with the opportunity to evaluate outcome information on a large scale and even permit an on-the-spot assessment of the most appropriate treatment, based on information already retrieved" (p. 40).

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[8] The medical plans of Saskatchewan, Alberta and British Columbia have imposed cuts on high-level service providers in the number of consultations with patients.

The Ontario Medical Association appointed a strategy group to consider the concept of establishing guidelines for practice. Linton and Peachey (1990) believed that these should be set by appropriate panels which would make "a synthesis of existing scientific data ideally obtained from randomized controlled trials. However, at present, we may have to rely on less satisfactory data and the views of experts in the field" (p. 629).

One effort to change clinical practice has been the work of the Task Force on the Periodic Health Examination (Canada 1979) which set out guidelines for patient examinations. As Morgan suggested in this report, this should have improved the focussing and targeting of preventive advice, but it is dubious whether this proposed change in practice activity has been widely implemented (Abelson and Lomas 1989).

Practice Organization: Implications for Cost and Quality

At one time it was thought that encouragement of group practice organization (Canadian Medical Association 1967) would result in greater sharing of information between practitioners and thus, improved quality of service, but the development of more rental premises and the introduction of computerized billings led many to engage in looser forms of association — agreements to share overhead costs rather than entering into partnership arrangements where clinical work is conducted on the same premises (Taylor, Stevenson and Williams 1984).

Williams et al. (1990) developed a typology of medical practice organization in Canada from a national survey of 2,014 physicians in 1986–87. Their typology identified six different types of practice. Their practice type criteria are reproduced in Chart 9.1. They found that almost half were in fee-for-service solo and group practices but a substantial proportion were in partnership practices involving income and expense sharing arrangements without shared arrangements for patient care.[9] They said that "increasing attention has been directed towards establishing and assessing alternative modes of practice organization, which may produce cost-efficiencies in health service delivery while ensuring a high standard of care ... there have been fewer incentives in Canada to explore alternatives to traditional solo practice than exist in the competitive medical marketplace of the United States" (p. 996).

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[9] This typology is concerned with doctors' relationships. Different forms of organization for dealing with doctor-patient relationships are discussed in Chapter 11.

Chart 9.1

Professional Characteristics of Physicians by Practice Type[1]

	Percent Income from Fee-for-Service[2]			Sex[2]		Year Graduated[2]				
Practice Type	0–33% (%)	34–65% (%)	66–100% (%)	Female (%)	Male (%)	25–55 (%)	56–65 (%)	66–75 (%)	76–84 (%)	Number of Physicians
Private										
Solo	2.4	.8	96.9	7.2	92.8	29.3	25.6	33.3	11.8	516
Group	3.1	1.3	95.6	15.5	84.5	20.7	25.7	34.1	19.5	390
Partnership	3.1	2.2	94.7	15.2	84.8	17.5	23.7	34.7	24.2	323
Institutional										
Hospital	31.8	17.8	50.4	10.9	89.1	21.5	28.0	36.1	14.4	368
CHC/HSO/CLSC	72.0	8.0	20.0	19.6	80.4	6.0	24.0	28.0	42.0	51
Mixed	21.7	13.7	64.7	10.7	89.3	21.9	28.7	32.8	16.7	366
Chi-square			600.9[3]		20.3[3]				65.9[3]	
Percent of Physicians	13.2	6.7	80.2	11.7	88.3	22.2	26.2	34.0	17.5	2014

Source: A.P. Williams, E. Vayda, H. Stevenson, M. Burke, and K.D. Pierre, "A Typology of Medical Practice Organization in Canada," *Medical Care* 28, no. 11 (1990). Reprinted with permission.

1. Figures exclude physicians working fewer than 30 hours per week.
2. Cell entries are row percents.
3. Significant at 0.01.

Resistance to Change

In 1986 Hastings and Vayda said:

> Medical and health care services are largely fragmented and uncoordinated. ... Fragmentation has persisted despite repeated exhortations for coordination. ... The rhetoric calls for a pluralistic system with multiple models[10] but, to date, the reality has been that the political, social, economic and legislative structures in Canada have, in effect, bolstered the prevailing system based on independent fee-for-service practice. In other words, we have public payments for a private system. Coordination and integration, when they have occurred, have been *ad hoc*. The political, economic and social pressures have not yet reached a critical level and there have been relatively weak incentives for the present system to change." (pp. 348 and 358)

International studies by social scientists (e.g., Marmor and Thomas 1971) have made it very clear that the medical profession everywhere is still in control of payment and physician distribution systems.

In some provinces the medical associations are reviewing other payment systems such as capitation. The changes in Ontario's payment system are discussed in the following chapters but as yet shifts in practice organization are minor.

There is, and will continue to be, conflict between the medical profession and the governments over all of these issues of autonomy and control outlined above. While Stevenson, Williams and Vayda (1988) suggest that efforts should be made to break out of the institutionalized forms of conflict which have "characterized the relations between governments and organized medicine thus far" (p. 99), Evans (1990), comparing Canadian and American medicine, saw the institutionalized conflict as a positive development, for it provided a framework for the two interdependent parties in the continuing struggle to continue to discuss their demands/needs with one another.

Two Variations of Office Practice

Student Health Services

In addition to the services provided by general practitioners, there are two other primary care services which should be considered. These are associated with work situations but they differ in kind from one another. Student

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[10] By this they mean alternative models such as community health centres, Comprehensive Health Organizations and other alternative models to be discussed in Chapter 11.

health services are a variant on doctors' office services. The doctors are salaried but they bill for their activities and the universities are remunerated by the provincial medical plans. To the earned fees, the university adds twenty percent to cover additional services such as inoculations, coordination with vocational counselling services, recreation and fitness, and disability support programs. Outreach is regarded as high priority. Dr. Farquhar of the University of British Columbia[11] pointed out that specific student health service reviews had been conducted over the past twenty years and amendments had been made, but as yet no general assessment has been published.

Occupational Medical Services[12]

With the growth of interest in environmental health, there has been a growth of interest in occupational health services. Guidotti and Fredona (1987) reviewed the scene:

> There is a consensus that there is a shortage of facilities and trained practitioners capable of providing services beyond the most rudimentary. This shortage is felt in all metropolitan areas and many rural parts of the country. It is particularly reflected in the scarcity of services, beyond acute medical care for injuries, that are available to small business. ... Employer sponsored health and safety or medical departments are not feasible for small businesses with limited resources. Labour-sponsored clinics are few in Canada and may not be acceptable to all employers. Health care facilities serving several employers are the most obvious solution. ... While publicly-supported or sponsored occupational health clinics have their merits, it is difficult to imagine governments committing to this model in times of fiscal constraint. ... One alternative is for provincial governments to adopt a policy encouraging the private sector to meet this need." (p. 26)

Guidotti and Fredona (1987) thought there could be development of hospital-based occupational health clinics, multi-specialty group medical practices and industrial medical clinics, as in the United States, which would ensure better care.

There would appear to be considerable concern in occupational health units about disability prevention and rehabilitation after injury in the larger companies. Gibson (1990) explained the policy at a large steel works:

> [We] try to keep people at work, not simply to avoid compensation claims but because it has been our feeling that they get better faster. ... As soon as you get ... a reported injury things fall apart.

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[11] Dr. Donald Farquhar, personal communication, 1990.

[12] Occupational safety and disease prevention services are discussed in Chapter 15.

> ... In [a] time lost injury study we counted a minimum of 12 other individuals or agencies that became involved. So life for the worker becomes very complicated. ... There is a fear of rejection by peers ... if it becomes a compensation claim. [And there is] a fear of the job itself. ... Supervisors are genuinely concerned about re-injury. ... Coworkers will have to work harder ... [and] if this goes on and on ... then this becomes a very silent problem." (pp. 405–6)

Gibson (1990) also described how the medical officers tried to combat psychological depression which was, perhaps even more troublesome than the physical injuries. Nevertheless, when Walters (1984) reviewed the activities of some company doctors working in Ontario, her report began: "Company doctors do not enjoy a positive image." She added: "Two themes run through these negative images. One is that company doctors are biased because they are employed by companies. ... The other is that doctors are less than competent" (p. 811). Her sample consisted of full-time doctors in large companies and part-timers on contract, mainly with small companies.

This image does not seem to have improved over the years, and trying to make cost savings during hard economic times, a number of companies have shut down their industrial medical services.[13]

Summary

Biomedical care had replaced magical, religious and pastoral care early in the twentieth century and was confirmed as the best model of health care by Flexner who was appointed to inspect existing American and Canadian medical schools in 1910. The growth of medical specialization which followed the adoption of this model led to regional hierarchies with specialists in teaching hospitals at the top and practitioners in primary care at the bottom.

Although health planners concerned with population health wanted to establish the importance of primary care as the entry point to the system, the public and the medical profession preferred that doctors should treat individuals needing crisis care. Thus when health insurance was introduced into Canada, hospital insurance was given priority and then medical care insurance was brought in.

Payment was based on fee-for-service and at first it was not made clear whether the doctors were in contract with governments or were subsidized entrepreneurs. The development of "extra billing" (or charges to patients on top of insurance rates) led in due course to the Canada Health Act, 1984, which stopped this practice by imposing penalties on provincial governments which permitted any user charges for acute hospital or medical care.

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[13] C. Hertzman, personal communication, 1995.

The medical profession has been self-governing since the mid nineteenth century. In the late 1960s there were radical challenges to its monopoly power. Commissions of inquiry in some provinces suggested more consumer appointments to professional regulatory boards but these have had little real effect. However, Coburn thought that the introduction of publicly financed medical care insurance marked the beginning of a reduction in medical power.

The supply of physicians in Canada was increased by the expansion of medical schools in the 1960s. However, it was not until 1990 that governments were prepared to accept that there was an oversupply and that medical school entries should be reduced.

The curricula in the established medical schools emphasized specialist skills. New schools were expected to promote more interest in primary care. Gradually, departments of family practice have been opened up; however, there are great variations in medical practice activities across Canada.

Since the mid 1960s efforts have been made to improve quality of care in office practice but there is as yet no standard method of reviewing medical work outside the hospitals.

Practice organization has hardly changed since publicly financed care was introduced. At one time there were moves towards group practice but computerization of billings and availability of rental accommodation have enabled physicians to keep their own patients while negotiating with others to share overheads.

International studies have made it clear that the medical profession everywhere is still in control of payment and physician distribution systems despite public financing.

The chapter ends with two brief reviews of student health and occupational medical services.

CHAPTER 10

Support Services for Physicians in General Practice

At one time family practitioners used to perform their own diagnostic tests and mix their own drugs but now they are dependent on external support services. As well in the past, most family doctors were prepared to work around the clock. Now most provide a telephone answering service after office hours and, as a result, some patients prefer to look for help from other sources. We shall now review these support services and their organization.

Diagnostic Services: Laboratories and Radiological Services

In recent years there has been extensive development of diagnostic services — laboratories and radiological services — which enable general practitioners to decide whether they can treat cases themselves or may need to seek further advice. The growing intensity of the use of diagnostic services and their increasing costs cannot be ignored (e.g., Elston 1987).

Laboratory development policies differ from province to province. The first well-developed laboratories were part of the government funded public health services concerned with controlling infectious disease. Then with the state funding of hospital insurance and the development of hospitals, most diagnostic tests for other conditions began to be carried out in hospitals. Community-based for-profit laboratories did a minor business until Medical Care Insurance provided for their doctors' fees to be paid by governments.

Most provincial governments have a laboratory advisory committee to help them to make decisions about the proportion of research funding versus service funding and how to balance profit and non-profit services (Crichton, Hsu and Tsang [1990] 1994). Some provinces have been more ideologically committed to privatization of services and others to government provision of laboratories, so this has created differences in their approach to structuring.[1] Saskatchewan is at the government end of this continuum, Ontario at the other (Morrison 1984). In British Columbia, which lies somewhere in the middle, the private laboratories provide the bulk of the cheaper common tests for general practitioners and most laboratory companies have set up offices next to practice groupings in order to save patients' travel time. More esoteric tests are carried out in hospital or public health laboratories.

Similarly, radiologists have set up community-based offices. However, their office expansion has not been as extensive as the laboratory expansion. The provincial medical plans do not always approve the opening of new radiological service centres next to small group practice offices. While they may have been willing to permit private laboratories to do bulk testing at negotiated rates, they have usually baulked at paying the more entrepreneurial radiologists for expensive scans and have restricted many tests to the hospitals where they had more control over the purchase of equipment and so, its deployment.

Pharmaceutical Services

The organizational models for the manufacture and distribution of drugs lie in the private sector — the drug research and production companies and the local pharmacies which are required to employ qualified pharmacists to dispense prescription drugs are business organizations.

In treating patients, general practitioners rely largely on drug therapy. Studies of the need for prepaid insurance for drugs (e.g., Evans and Williamson 1978) showed that the chronically sick and elderly were most likely to need financial support for drug purchases. Universal insurance coverage was not recommended nor was it provided.[2]

Ronald Lang (1974) indicated that after the introduction of medical care insurance, at first the Canadian governments had been relatively successful in controlling the costs of drugs to all purchasers through promoting generic substitution or formulary policies. However, led by Saskatchewan (Harding 1981) in 1975, the provincial governments decided to introduce so-called Pharmacare or Prescription Drug Program schemes to provide subsidized drugs

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[1] Frances Pitcherack, personal communication, 1990.

[2] The federal government did not develop matched grant programs for drugs. Although pharmaceutical products are not covered by government insurance schemes, an estimated eighty-five percent of the population is estimated to have some form of third party insurance (Canada 1990o).

for those over sixty-five years of age or who were chronically sick.[3] These schemes vary from province to province (Canada 1987a). As well, provincial governments looked for ways to reduce the cost of drugs, generally through facilitating generic substitutions for brand name drugs.[4] However after much pressure the Conservative federal government gave way to the drug companies on patent law (Canada 1985d). This led to protests by seniors and an attempt by the Liberal-dominated Senate to block the legislation.

Klass (1975), Harding (1981) and Lexchin (1984) have taken strong positions against the drug companies. Some articles by Lexchin (1987, 1988)[5] put the onus for excessive spending on pharmaceuticals on the drug companies and the medical profession:

> The Canadian medical profession has a long history of allying itself with the Canadian pharmaceutical industry. This alliance exists on two levels: medical associations and medical journals. As a result of the alliance the traditional emphasis on the primacy of the welfare of the patient has been subverted in favour of the profit motive of the drug industry. Elements of the medical profession promote useless pharmaceutical research, poor physician prescribing and physician involvement in educational activities controlled by the industry. Specific reforms to loosen the alliance are outlined, but ultimately the alliance will only be broken when the values of Canadian physicians change. (Lexchin 1988, 603; Lexchin 1990a,b)

Archer (1984) found it necessary to refute allegations that pharmacists, too, were involved in a "consumer rip-off," following studies of prescription drug use in Saskatchewan in 1983 and Alberta in 1984.

Recently the situation has become very difficult for the provincial governments. In British Columbia, for example, Pharmacare costs have doubled over the last five years. This led to studies of the situation by a review panel which has recommended the introduction of a provincial computer program (Pharmanet) to track prescription use by individuals. It is hoped that this will reduce inappropriate or dangerous drug use and prevent duplication and fraud in the use of prescriptions. There have also been recommenda-

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[3] Saskatchewan provided subsidized drug services to ninety-four percent of its residents under two programs — the Medical Services Division and the Saskatchewan Aids to Independent Living. By using formularies, the cost of drugs was kept as low as possible (Saskatchewan 1990a). Manitoba also had a generous scheme. Other provinces have had more restrictive programs.

[4] Lexchin (1989) thinks that governments might go further to provide formularies to be used by general practitioners. Their effectiveness has been demonstrated by groups such as the Saskatoon Community Clinic (Wolfe and Badgley 1972).

[5] These articles have extensive bibliographies.

tions that patients should be charged according to their ability to pay but this has not yet been brought in (British Columbia Annual Report Ministry of Health, 1995).[6]

The executive director of the College of Pharmacists[7] attributed the escalating costs to skillful marketing by the drug companies and the lack of attention by doctors and patients to small changes in drug composition which has led to a lot of waste. There has also been much higher cost to the Pharmacare programs for new, more effective drugs.

In 1993–94 the distribution of Pharmacare expenditures in British Columbia was as follows: seniors 55.5%, social assistance 17.1%, families 13.3%, long term care 6.9%, medically dependent children 4.5%, home oxygen 2.5%, administration 0.4% (British Columbia Annual Report Ministry of Health, 1995).

The Science Council of Canada, having become aware of public concern at the rising costs of pharmaceuticals, called a conference in 1990 to discuss the issue. A background paper for the conference (Canada 1990o) put together the evidence available at the time:

> Not only do Canadians spend a larger proportion of their total health expenditures on drugs but they also consume more drugs than do residents of other industrialized countries. This is one conclusion of a report (Corruthers et al. 1987) on drug utilization that reviewed 2,500 current articles from the literature. (p. 4)
>
> Medication now accounts for a larger share of total health care expenditures than ever before. As health care resources stretch to cover more services, there is an increasing need to demonstrate that drugs are used appropriately, that benefits from medication are commensurate with costs and that health care providers have the information they need to better manage this health resource. Much of the necessary information and knowledge is already available but now there is need to share that information, to build on it and to act on it. (p. 2)

The Science Council of Canada conference was called in order to influence the development of a more coherent and comprehensive policy on drug use. The issues were identified as demographics: the aging of the population and the greater consumption of drugs by the elderly,[8] good health status of the population, problems of managing medical technological developments, costs of health care and uncontrolled demand.

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[6] The charge to seniors and persons with disabilities for the filling of prescriptions in 1994 has been raised by fifty percent.

[7] Bob Kushneran, talk to students at the University of British Columbia, 1994.

[8] The National Advisory Council on Aging (Canada 1990l) has been concerned with overuse of medications by the elderly and has been trying to develop

Proposed shifts in health policy were listed, including the following, with immediate implications for control over pharmaceutical use:

1. Enhanced post-marketing surveillance involving the federal and provincial governments and a proposal for the continuous review of drug products as a condition of marketing
2. Formal drug utilization review studies for selected drugs
3. Research into criteria for cost-effectiveness evaluation as applied to drugs and other health care components
4. Improved information systems and the possible use of "smart card" and other technologies to track drug utilization
5. Analysis of the impact of user fees and co-payment schemes on drug benefit programs
6. Strategic links between universities, industry and governments for pharmaceutical R&D
7. National initiative on risk/benefit management of drugs

In May 1991 the federal government announced the creation of a National Advisory Committee on Pharmaceutical Research to advise the minister, particularly on the funding of research and development following further changes in patent protection for drugs. But the federal government had disbanded the Science Council of Canada and agreed to extend the years of patent coverage in return for some research jobs being set up by the drug companies.

Non-Medical Fee-for-Service Activities

Services which *may* be paid for by the medical plans other than medical services are chiropractic care, psychological counselling, nurse practitioners' services or physiotherapy.

The medical profession does not recognize the scientific basis of chiropractic and has tried to keep it out of the system of care but it has been able to survive because of public demand (Mills and Larsen 1981).

Psychological counselling and nurse practitioners' services, too, are not well liked by medical practitioners, many of whom see these professionals as competitors and may discourage the plans from paying fees to them. However, in the far north where doctors are unwilling to practise, there are nursing stations staffed by nurse practitioners.

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education programs to moderate behaviour. British Columbia held an invitational workshop on *Medication Use and Elderly People* (British Columbia 1989c) and has developed a number of programs to assist seniors in the management of drug use (British Columbia 1989e).

All provinces have private practice physiotherapists. They may work without a physician's referral in British Columbia and Quebec. They usually work in their own community-based offices. In British Columbia there is a ceiling on the number of treatments allowed for each patient by the medical plan; in Ontario there is a ceiling on the number of available billing numbers, but patients may pay for private care.

Hastings and Vayda (1986) list others — social workers, nutritionists and pharmacists — who are professionals in community health care, but they are likely to be salaried (not fee-for-service remunerated) unless they have their own businesses and set their own fees.

Twenty-Four Hour Coverage: Emergency Services

In general family practitioners do not offer office services on a twenty-four hour basis though there are some group practices which make exceptions to this rule. Most doctors offer telephone advice after working hours, although this advisory service may be staffed not by one of the practice group members but by an answering service doctor. In consequence hospital emergency departments are often sought out after hours, not only for real emergencies but for general counselling by those who cannot, or do not wish to, use the services of general practitioners during their office hours (Béland et al. 1990).

Emergency departments may also be used to bypass the regular referral system and its waiting lists, or as in Quebec, to make a new attempt to break into that system when regular channels are blocked (Steinmetz and Hoey 1978). The crisis in emergency service use in Quebec put pressures on the Minister to hasten restructuring of primary care (Quebec 1990b).

A Medline search of Canadian articles on utilization of emergency departments, over the period 1980 to 1990, has not been very revealing. The emergency departments of children's hospitals are most frequently studied (eight articles) while there is only one article each on use by elderly and mentally disturbed patients. Four articles deal with victims of abuse brought to emergency departments and two look at the handling of major disasters, while ten are concerned with spatial organization or stress among staff members. The appointment of salaried physicians to the larger hospital emergency departments during this decade seems to have relieved some of the pressures on the system (which were very severe in the early 1970s) and improved the response to demand. Crichton, Lawrence and Lee (1984) have discussed the information required to organize an effective emergency department. Garza (1992) has reviewed emergency services across Canada. It is clear from other studies (e.g., Stone 1994) that these services are not well coordinated with other clinical activities.

Voluntary Organizations Supporting the Medical Care System

Before the public health departments began to provide home care and other support services, help was usually provided by non-governmental organizations to those patients needing additional care which could not be given by family doctors, and many of these organizations continue to provide social supports.

Govan (1966) described the evolution of charitable organizations which were concerned with helping people who were diseased or disabled in Canada. At first these were organizations with a broad general approach such as the Red Cross, but from the late 1930s onwards, voluntary organizations associated with specific diseases began to emerge — the first being cancer societies. While some of these bodies may give priority to research over support to patients, many provide specialist treatments (e.g., Canadian Arthritis and Rheumatism Society), vocational counselling, help in resettlement into the community after medical treatment and peer group support, as well as engaging in advocacy activities.[9] There are now many mutual aid organizations. Current local listings are usually available in public libraries. Where there are Kinsmen societies they may coordinate information on support services for persons with disabilities and provide technical assistance.

Since the voluntary organizations have provided many support services, which are becoming more expensive, they have started to look to the provincial governments for financial assistance to carry on their work. In many instances this has been granted but in a totally uncoordinated way (sectors of the health departments would make grants or offer contracts as would social service departments, neither consulting with the other). Korbin (British Columbia 1993b) appointed by the province and Rekart (1994) have reviewed the situation in British Columbia, and Raines (1994) has made an inventory of Vancouver agencies. It is clear that coordination has been totally lacking there in the past but efforts are beginning to be made to change this.

Rescue Services, Ambulance and Other Transportation Issues

There are emergency services other than those based in hospitals — search and rescue services,[10] paramedic services (Copass and Eisenberg 1987) and road and air ambulance services (Garza 1992).

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[9] In 1988 Saskatchewan Health, Mental Health Division developed a plan for cooperation with voluntary organizations (Saskatchewan 1988).

[10] There are search and rescue services provided by different authorities in different situations. The Canadian Coast Guard provided information about its officer training plan, safety handbooks for inshore fishermen, for small fishing vessels, for safe boating and a summary of Search and Rescue (SAR) incidents,

Most cities now provide free transportation on small buses for registered persons with disabilities who want to get out and about, and parking spaces are reserved for disabled car drivers in many places.

However, although there are improvements, not all transportation problems have been solved, because there is no provision for subsidized travel from remote areas to see specialists about elective care nor is there transportation for families of these patients taken into hospitals for emergency care. However, to help with relocation problems, hostel accommodation may be provided for those who need intermittent treatment in tertiary care centres or for family members from out of town who have come to be with emergency admissions.

Summary

This chapter has dealt with the organization of support services required to assist primary care physicians in carrying out their work: laboratory testing, x-ray investigations, prescription drug availability, emergency services. There has been some concern on the part of provincial governments about the ever growing cost of these services and the failure of medical professionals to control this escalation.

The organization of laboratories and radiological diagnostic services varies from province to province. Some have been more willing than others to allow private laboratories to take on all the work, others want to keep diagnostic tests in the public sector. Some make compromises.

Pharmacy services are not insured but provincial governments subsidize drugs for seniors and chronic sick persons. Governments have struggled to control the costs of pharmaceuticals which have been growing rapidly in recent years. A Science Council of Canada conference in 1990 called for a national policy but this recommendation has not been followed through. Local efforts to control prescription drug overuse have not yet been very successful in cutting back rising costs.

Non-medical fee-for-service activities are listed here: chiropractic care, psychological counselling, nurse practitioner services and physiotherapy. Other community care services are salaried.

A review of emergency services indicates that these are not well coordinated with doctors' office services and may be used unnecessarily by some patients.

There are, as well, a large number of subsidized voluntary organizations which deliver services. These are not well coordinated with one another or with publicly provided services.

1989. Similarly there are land rescue programs to deal with emergency situations.

CHAPTER 11

Medical Practice Organization: Alternative Medical Care Delivery Models

This chapter is divided into two sections: discussions of Community Health Centres and other alternative delivery models.

Concurrent with the planning to introduce Medical Care Insurance in 1966, there was some interest in the prospects of restructuring medical care organization. The Canadian Medical Association (CMA 1967) gave its support to the group practice model. How this concept was developed was discussed in Chapter 9. It was not developed far because computerization of billing enabled many doctors to choose loose forms of individualistic practice organization with commitment to sharing overhead and backup services while maintaining their own patient lists.

The Community Health Centre Model of Practice/Centres locaux des services communautaires

Some practitioners and community members questioned all individualistic forms of practice organization whether solo or partnership practice.[1] They thought this form of organization did not have a place for consumer inputs other than through individual doctor-patient discussions, nor did it have any

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[1] For example the Saskatchewan Community Clinic physicians, the Community Health Services Association of Saskatchewan and the Canwood Association (Crichton and Anderson 1973) as well as the United Steelworkers of America, the Sault Ste. Marie and District Group Health Association and St. Catharines' Group Health Centres (Lomas 1985) *inter alia*.

incentives built into it for delegation to other health professionals (because the doctors were still paid by fee-for-service — with minor exceptions), nor were there any financial incentives to encourage disease prevention or health promotion approaches or to discourage the use of hospital referrals.

These reformers became interested in the concept of a "community health centre (CHC)" which is a form of group practice. It relies on teamwork among professionals — doctors and others — focuses on prevention of illness and promotion of health and works with a community board.

Canadians began to look across their borders for new models of practice organization which might not only be more economical but also provide better service to patients. Different provinces tended to be influenced by different models. The response from provincial governments reflected the ideologies of political parties in power as these reformers challenged the established medical profession for room to develop these alternatives.

The Ontario Experience with CHCs

Three United States Health Maintenance Organization (HMO) models were of special interest to Ontarians — the Kaiser-Permanente Medical Care program (Somers 1971; Saward, Blank and Greenlick 1967) the Health Insurance Plan of Greater New York (Dailey 1959) and Group Health, Puget Sound (Bloomberg 1969). Capitation payments are required to define an organization's population and budgetary resources and all staff are likely to be salaried, though bonuses may be paid for obvious cost savings. Health Maintenance Organization models save costs by keeping more patients out of hospital beds than traditional practitioners do.

Another HMO model which influenced Canadians in Ontario was that of the Group Health Association of America (GHAA). Lomas (1985) explained that the GHAA was established by the amalgamation of the Group Health Federation of America with the American Labor Health Association. The GHAA was based on four principles: "prepayment of the cost of medical care, group practice of medicine, comprehensive health care of a high quality under the direction of qualified professional personnel, control of policy and administrative functions by, or in the interest of, consumers of health services."

In all of these models, hospitals were part of the group practice organization and physicians were given incentives to keep their patients from using hospital beds unnecessarily.

Although health planners were interested in HMOs generally, this GHAA model was particularly influential on Ontario's thinking. Lomas has described how the trade unions in Ontario were concerned to protect their members' health in the postwar years before Medicare came in. Miners in

Sudbury, Kirkland Lake and Thunder Bay, autoworkers in St. Catharines and steelworkers in Sault Ste. Marie sponsored the establishment of family practice clinics for their members. Funds were raised from capitation payments and salaried doctors were hired. The miners' clinics did not survive when the hostile, traditionally oriented medical profession decided to close them down (Lomas 1985, 25) but the autoworkers and steelworkers and their supportive physicians resisted traditionally oriented medical opposition to their pioneering efforts to change the organization of services.

> In these early years the health centre doctors [at Sault Ste. Marie] found themselves almost universally excluded from the local medical society, from hospital committees ... from almost any referrals from downtown physicians, from social, cultural and recreational organizations in the city and generally from any decision making regarding local medical matters. On an official level everything possible was done to make the health centre doctors feel like second class citizens. (Lomas 1985, 72–73)

Opened in 1963, the Sault Ste. Marie Group Health Centre decided to ask for an independent study of its activities in 1966. Hastings et al. (1973) compared the work of that health centre with that of doctors in other forms of practice and found that "the Sault's consumer-sponsored prepaid group practice did indeed reduce the demands on the local hospital facilities, partly by greater use of their own diagnostic facilities."[2] The study concluded, "although the group practice had no financial incentive to economize on inpatient care, its rate of hospital utilization was lower by about a quarter ... it appeared that the group practice placed somewhat greater emphasis on health protection as against the investigation and treatment of disease, but utilization of both laboratory and radiologic services was certainly higher in the population served by the group practice" (Lomas 1985, 71).

With the passing of the federal Medical Care Act, 1966, and its provincial implementation in 1968, the situation for the Sault Ste. Marie and St. Catharines' Group Health Centres changed. They were no longer independent financial entities. They needed to negotiate how they could fit into the new provincial funding system. As well, the provincial government had to decide what attitudes to take and policies to develop regarding all alternative forms of primary care organization in order to see where the group health centres could be fitted in. Bayne (1988) has traced the development of policy in the 1970s in statements of the Ontario Health Council (an advisory body) and the Health Planning Task Force (Ontario 1974), both of which took an

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[2] It will be recalled that public hospital insurance had been legislated in 1957, so in Canada, hospitals were not part of a group practice organization.

evolutionary approach to the emergence of new models.[3] But these bodies were not the implementers of policy. Specific decisions had to be made by government for the existing centres. A Program Development and Implementation Group (PDIG) was set up to work out a resolution. Since the minister did not want to crush any new initiatives for structuring alternative organizations, the PDIG was instructed not to consider consumer sponsorship or community involvement issues as the major principle in restructuring. Instead it was to focus on alternative methods of payment to anybody proposing a different way of delivering primary care. One official was reported as saying: "Government is not in the business of providing services, it's in the business of paying for services" (Lomas 1985, 150). Vayda (1977) and Lomas (1985) have described how the Sault Ste. Marie centre struggled with officials for nearly twelve years before they were able to reach agreement on a relatively satisfactory framework of funding. The Health Service Organization (HSO) funding formula which was finally agreed upon, said Lomas, "was far from perfect, restricting, as it did, the possibilities for the development of new truly 'community' health centres ... the HSO program was still clearly subordinate to the fee-for-service system" (pp. 122–23).

Bayne (1988) has explained the HSO/CHC funding agreements which had been reached by trial and error over the years. There were, she said, six different models of organization:

> Ontario health centres are differentiated along two dimensions, (1) funding: capitation or budget and (2) sponsorship: physician, university/hospital, community, giving rise to six different types. Centres financed on a capitation basis receive funding according to the number, age and gender of the people who have enrolled and agree to use the centre. The amount the centre receives per enrollee is calculated on the basis of average costs for care for individuals with similar characteristics. Enrollees are at liberty to use services outside the capitation funded centre but payments to the centre are withheld for the month in which they do so. (p. 10)

This was the first set of rules worked out for payment of all centres whether community health centres or private practices funded by capitation rather than fee-for-service.

But Lomas (1985) said that these conditions of funding, the so-called capitation negation rules, were so tough on the city-based community health centres (CHCs) (which had to cope with much local competition) that many went under.

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[3] The Health Planning Task Force built on the recommendations of the national investigation of CHCs (Canada 1972, 1973b) conducted in 1971–72, to be discussed below.

Bayne (1988) described the second form of funding which was then introduced:

> Centres financed on a budget basis receive an annual global budget to cover anticipated costs of a range of services. Supplementary funds may be sought from other sources. This funding method is better suited to the Community Health Centres' perceived role of providing health promotion, education and preventive services to the broader community, not simply to those enrolled as clients.
>
> Both capitation and budget funded centres are eligible for ambulatory care incentive payments (ACIP) if hospitalization rates of their clients are lower than average. (p. 159)

The terminology began to change. Health Service Organizations were capitation-funded group practices, CHCs were funded on a global budget.

After years of solitary struggle (because none of the centres found the conditions of funding were supportive and they had no room for outside activities), in 1981 the nineteen HSOs and thirteen CHCs still in existence decided to form an Association of Ontario Health Centres to maintain communication with one another. And in 1982, the new Minister of Health, Larry Grossman, met with the association to discuss his interest in CHCs.

A health planning task force (Ontario 1982) was set up to review HSOs and CHCs and to make recommendations on role, scope and funding: "the health centre was perceived by the Task Force to be an organizational arrangement which satisfied multiple objectives. ... Within a climate of cost consciousness, the health centre was a particularly appealing service model" (p. 56).[4] Nevertheless the need for a pluralistic approach to health care delivery was emphasized.

Following the task force report, a new branch of the ministry was set up to develop CHC policy but it was made clear that CHCs were expected to serve only high risk areas. And guidelines on global funding indicated that CHCs need only have "consumer input," not necessarily consumer boards. Bayne summed up the position in 1988: "The small number of health centres which exist in Ontario employ fewer than one percent of the general practitioner population and provide service to only 3 percent of the population."[5]

In another paper (Bayne 1988) argued that, in Ontario, the CHC concept had not caught on. HSOs (i.e., group practices remunerated on a capitation

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[4] In a study of CHCs and hospital costs in Ontario, Barer (1981) had shown that CHCs were more economical than other service organizations.

[5] Daly (1989) has discussed the marginalization of CHCs, using the decision to set up a CHC for native people in Toronto as an example.

basis) were growing in numbers but CHCs seemed to have reached stable numbers. The CHC paradigm had not been accepted in the province.

Further development of the HSO idea is discussed later in the chapter. The next section continues to explore the CHC idea.

The Saskatchewan Community Clinics' Experience

In 1962 a Community Health Services Association[6] was formed in Saskatchewan just before the Cooperative Commonwealth Federation (CCF) government enacted the provincial Medical Care Insurance Act. This provincial cooperative association sponsored the development of local associations wishing to set up clinics with consumer boards. By March 1973, thirty-seven of these local associations had been established, although only nine had been able to find clinic premises and doctors to staff them (Feingold and Tauberhaus 1968). By the end of the decade this had been reduced to five practices, of which only three could be considered to be conforming to the community clinic model (Crichton and Anderson 1973). These three were city-based clinics in Prince Albert, Saskatoon and Regina — clinics which worked closely together to define the meaning, and work out the feasibility, of CHC development.

The Saskatchewan community clinics were influenced by British models of practice. In the 1930s a CHC model had been developed in Peckham, South London and, although it had closed in the war, it was regarded as an ideal demonstration of a multi-facility health and social service centre (Pearse and Crocker 1945). Later in the 1960s the British National Health Service (NHS) moved to integrate general practice with public health nursing and social work services in local health centres. Another strong influence on British family practitioners was the work of Balint (1957) who was teaching "whole patient medicine."

Like the Sault Ste. Marie centre, the community clinics were embattled organizations determined to make their case against the strong opposition of the traditional medical profession (Tollefson 1963). There had been a doctors' strike over the introduction of the provincial medical care insurance plan. Settlement was finally reached between government and the organized medical profession in the Saskatoon Agreement, 1962 (Badgley and Wolfe 1967). The establishment of the community clinics (CCs) as alternatives to traditional practice at this time was so greatly resented by the established profession that they made sure that the agreement specified that there should be no payment method other than fee-for-service and that the community

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[6] There is a long history of cooperative community involvement in health planning in the province.

clinic boards' role must be limited to that of landlord in the rental of premises and equipment. As well, most established doctors refused to speak to the clinic physicians using the same hospitals, and tried to influence the hospital boards to deny privileges to newcomers joining CC staffs. Consequently, the boycotted doctors decided to appeal to the world at large to justify their stance. Wolfe and Badgley (1972), sympathizers, published a review of their work to show that they had a different philosophy which could only be realized through a form of organization other than traditional practice. Their approach was to "whole patient medicine" which emphasized physical, emotional and social care, in the context of family. The clinics' staff thought they could best provide this care by teamwork — general practitioners and specialists working closely together, backed up by allied health professionals — and working through consumer boards to educate their clients on good health practices. They published studies of teamwork (e.g., Wolfe and Teed 1967; Ghan and Road 1970; Mossing 1966) but were limited in developing their relationships with their consumer boards and vice versa.

Then they sought to put forward another justification of their work, their cost effectiveness. In 1969 the federal government responded to their request for an economic study, appointing D.O. Anderson, an epidemiologist, to review their patterns of practice as compared with other medical groups in the province. Although Anderson and Crichton (1973) found cost effectiveness difficult to prove, there were clear differences in practice organization which could be explained to the government (Crichton and Anderson 1973). Officials were then persuaded to change the method of funding to a line budgeting agreement which made it easier to finance the allied health professional staff.

A study by McPhee (1973) of hospital utilization by the clinics created some controversy. It was dismissed by CMA critics as "showing greater expenditure" (Korkok 1973a,b; Baltzan 1973a,b; Brandejs 1973a,b) although the government drew the opposite conclusions.

In 1973 the Canadian Medical Association (CMA) launched several other attacks on the clinics (Korkok 1973b; McTaggart 1973).[7] And in 1975 when the doctors at the Regina clinic walked out and set up a private fee-for-service practice nearby, many of the opposition doctors were not surprised at the defection. However, Young (1975) had reported that similar behaviour had occurred elsewhere when disagreements with community boards had become too much to bear. In time new doctors were found to restart the clinic. There are now four CCs in the province: another has been opened in Wynyard.

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[7] These attacks followed the national study on CHCs (to be discussed below).

In 1983 a further study of cost effectiveness showed that CCs made clear savings (Saskatchewan 1983), although the results of this study were not made public for six years for political reasons.

Texeira (1987) has drawn attention to the existence of eleven rural so-called CHCs in Saskatchewan. These will be discussed again in the chapter on rural health care (Chapter 14). Their approach differs ideologically from that of the community clinics. These community health centres are a redevelopment of rural hospitals. Texeira explained that any hospital board could open a centre staffed by a resident nurse on twenty-four-hour call and recruit part-time staff for laboratory, x-ray and maintenance services. Social services could also choose to use the facilities. Saskatchewan had been trying to close rural hospitals since 1970 or even earlier, and this was one way of cutting back the costs of maintaining an inpatient acute care facility.

Quebec's Centres locaux des services communautaires (CLSC)

The development of Quebec's CLSCs can only be understood when considered as one aspect of social restructuring brought about by the Quiet Revolution. The CLSCs were to be the point of entry to primary and community care. They were proposed by the Castonguay-Nepveu Commission (Quebec 1970–72) which reviewed Quebec's health and social services and recommended change.[8] Lésémann (1984) has argued that they were an amalgam of two models, that is, local health centres and community service centres (multiservice health and social service centres):

> The local health centre was the product of a theoretical model [which] ... reflected changes in the philosophy of health care aimed at overcoming the dominant logic of providing care only after a person had become ill, and promoting in its place a preventive, comprehensive, continuous approach that took the surrounding environment into account. Such an approach implied major changes in medical methods of practice along with changes in the patient's or "client's" expectations of the health care system. (p. 236)
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> The list of planned CLSCs was, in fact, drawn up on the basis of studies of public health and social indicators using mortality and morbidity rates to identify the most well off areas and the areas with the most serious shortcomings of care. (p. 241)

But in addition to this epidemiological approach, there were external influences brought to bear by social activists concerned with community

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[8] The national study of CHCs to be discussed below, was set up by Maurice Le Clair in 1971. He was influenced by the Quebec approach to system reorganization.

development. These external influences were American. They stemmed from the neighbourhood health centre (Office of Equal Opportunity) models of the war on poverty (March 1968) rather than the HMO models which influenced Ontario. Lésémann (1984) said:

> The new type of local health centre ... was based on the principle of polyvalent health teams which would be active on the neighbourhood level and which could increase the effectiveness of health care by adapting it to the particular needs and "culture" of the local area. (p. 68)
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> But, ... the two kinds of centre belonged to two different institutional traditions and the attempt to combine them ... seriously distorted and even undermined their evolution and development. ... Delivery of service and public participation rapidly appeared antithetical; planning and programmes conflicted with peoples' anticipation of their own needs; medical and community action soon became poles that were often diametrically opposed. (p. 237)

This dual objective for the CLSCs created problems of priorities. Should they be seen principally as centres for promoting health and delivering health care or as community development centres?

Lésémann (1979) reported that eleven of the first twenty-five centres were explicitly allocated to the major disadvantaged neighbourhoods in Montreal and Quebec City and certain other underprivileged towns or rural areas. In most of these areas there were already active citizens' groups. The other fourteen were set up as part of the reorganization of health care to replace the hospitals or other health facilities that were lacking, especially in isolated areas.

> The community service centre was identified with strategies for dealing with poverty and the need for a coordinated and integrated approach to this problem by all service organizations. ... [This model] relied heavily on public participation as a strategy for the social integration and organization of a people whose disintegration and disorganization constituted a danger. The ruling class sought, in fact, to "reach out" to the people. (pp. 236–37)

It should be noted that the CLSCs were at the foot of a hierarchical model in which the next level up was the Department of Community Medicine (DSC) in the district hospital. The old public health service had been abolished: the DSCs were to be the bodies responsible for policy analysis and development of community health programs and the CLSCs for carrying out their policies.

Lésémann (1984) saw the Quebec government's support for the CLSCs as an attack on the established medical and social work professionals by the rising technocrats who were now in the position to make health and social service policy. He said that this new power elite (politicians and bureaucrats), which had planned and were beginning to implement a different provincial structure of health and social services, appealed to the radical left in the professional groups, to the community organizers (animateurs sociaux), and to some unionized general practitioners, to support the Quiet Revolution's changes in health and social service organization in the province but they were unsuccessful in winning over many members of the medical profession.

Lésémann (1984) identified two main objectives of CLSCs:

1. The search for the greatest productivity in the organization of services
2. The use of health and social service organizations as an instrument of social and political control of the population groups excluded from production (p. 236)

As in the other provinces where CHCs were set up, there was strong resistance from the majority of the medical profession, despite the fact that the government had tried to appeal to the lower status general practitioners for cooperation. Rodwin (1984) described how:

> The service oriented CLSCs provoked a strong response from the Quebec Federation of General Practitioners. In order to counterbalance the competition of CLSCs, it organized the creation of roughly 450 polyclinics in which physicians are sovereign and are reimbursed on a fee-for-service basis by the QHIB [Medical Plan]. The polyclinics range from small group practice offices to large multispeciality organizations. Often their distinguishing characteristic is the quality of their twenty four hour reception services. … The bulk of ambulatory care in Quebec … is still provided largely by solo practice, polyclinics or outpatient hospital departments. Although many of the CLSCs have made remarkable improvements in the direct provision of primary health care and social services to various communities that were poorly served previously, they have thus far failed to significantly re-allocate health resources towards comprehensive medicine. (pp. 145–46)

Desrosiers (1986a) has analysed general practitioner resistance on three levels — the FMOQ (union) wanted to be the sole negotiator for all general practitioners whether working in polyclinics or CLSCs, so they bargained to get direct payment for doctors from the medical plan, not payment through CLSC administration, and they worked to get a committee of doctors set up where three or more were employed in CLSCs. Thus, said Desrosiers, they managed to differentiate the doctors from all other CLSC employees and drove in a wedge. Now there was an association of CLSC doctors with a specific contract.

As well many clients bypassed the CLSCs completely. They went directly to the hospital emergency departments for care, believing that, if necessary, this portal would give them more effective entry into institutional services.

The government, committed to the development of the new structure of service organization, had to sort out its priorities for CLSCs. In 1974 the ministry reorganized and made it clear that it was more interested in providing expert services than in promoting advocacy activities. Community development was to be set aside in favour of functional integration into the social affairs network as "a complementary resource." By that it was meant that all CLSCs would have to take responsibility for serving certain "basic needs" such as home care and care for the handicapped (which had emerged as being important services following deinstitutionalization). These were to be organized out of the CLSCs (as was occupational health and safety, dental care, school health, etc., at a later date).

There was some resistance to this move of the ministry. The CLSCs formed a federation which at first expressed strong opposition to the emphasis given to service delivery over community development issues. However, within the next year, the federation became caught up in union negotiations as the employers' representatives and as such became more prepared to accept the ministry directives.[9] It became a strong lobby group for expert service delivery (Fédération des CLSC du Québec 1986a,b, 1988a,b, 1989; Poupart 1986; Gingras 1988).

There was a slow but gradual growth in the number of centres. In 1981 the minister (Quebec 1981) committed himself to providing complete CLSC coverage of the province (166 centres were to be set up, although this seems to have been an overestimate as there are now 159). A review of the position was made by the province in 1989 and 1990 (Quebec 1989b, 1990a).

In 1985 the Parti Québécois government decided it was time to review the restructured provincial health care system first introduced by Castonguay in 1971. The period from 1971 to 1985 had seen many struggles. Lésémann (1979) and Renaud (1981, 1987) were concerned about the growing power of the technocrats (politicians and bureaucrats), who thought they could change society through using the mechanism of state regulation. But the technocrats were not always successful in gaining control. One group which the technocrats had challenged were the self-regulating professionals whose

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[9] In 1977 the government and the federation tried to reach agreement on a joint definition of the meaning of CLSC. This was publicized in the FCLSC information bulletin (although the ministry refused to ratify the agreement). Rodwin (1984) noted that the Parti Québécois would not take a clear position at this time whether in favour of or against defining responsibilities or encouraging the growth of CLSCs (p. 137).

monopoly position was closely examined. New regulatory legislation was brought in (with the intention of protecting consumers more adequately). Yet it was found to be impossible to get much closer control over the seven self-regulating professions where only the experts could judge the quality of work of other experts and where the professional organizations had exclusive power to admit and discipline members.

Lésémann thought that during the seventies there had gradually developed a recognition that it was impossible to control medical power and that the CLSCs should operate only in the non-profit sector. Had the government accepted the coexistence of two parallel structures of medical care by the end of the 1970s? Were CLSCs to provide only for rural areas and the urban poor?[10] Renaud (1977) had justified their existence "as an essential sort of social movement representing human concern for others in a capitalist society." He had also shown (Renaud et al. 1980) that the CLSC physicians were more careful in their diagnostic work.

There was of course a third group in the power struggle, as identified by Alford (1975): the consumers of services, the community members. But they had little power *vis-à-vis* the professionals or the technocrats. Brunet and Vinet (1979) had shown the lack of power of the community representatives in the CLSCs, theoretically jointly managed by consumers and producers, though Godbout (1981) was less pessimistic about consumers' ability to influence change. However, he too was concerned that both users and producers of services were being told what to do by an ever-increasing central technocratic power. Unless there were another wide-scale consumers' social movement, he thought, a challenge to the bureaucrats was not likely to be effective.

Toward the mid 1980s there was a general desire to take stock of the Quebec health care system as it had developed in the previous fifteen years. The government set up the Rochon Commission in 1986 (Quebec 1988) to inquire into the total structuring of services[11] and Brunet (1987) was commissioned to review the CLSCs independently. There had been considerable changes in attitude to the situation and to some of the ideas about organization which did not seem to work very well.[12]

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[10] A study by Delude (1985) indicated that they were not much used by anglophones but before 1985 there were not many CLSCs in anglophone areas because the CLSCs had first been opened in the poorer areas.

[11] Rochon was appointed by the Parti Québécois. When the government changed, the Liberals set up a committee to inquire into privatization (Quebec 1986), but this was not followed through and Rochon was reappointed to finish his inquiry.

[12] Marc Renaud and Claude Larivière, personal communication, 1992.

There were some who said that the CLSCs should abandon providing personal medical care services. Demers (1987) argued that they should leave medical care to the polyclinics and focus on health promotion activities. Trying to do both was "mission impossible." Brunet also proposed that services should be streamlined. They could not be all things to all people and the crisis of identity needed to be resolved. He recommended that priority should be given to servicing high risk groups, to reducing inequalities and to providing supportive community services.

Following the Brunet report, Bozzini (1988) wrote an evaluation of the model. He concluded that the government had accepted the two models of medical care, that CLSCs offered a different kind of medicine: "more community oriented, nearer to holistic medicine, tied in with the psychosocial components of basic primary care, more attentive to complex problems such as family violence, mental health, sexual abuse." Brunet had proposed that there should be complementarity, harmony with the private clinics and avoidance of duplications. "In brief," Bozzini said, "one enters the era of the alternative-complementary sector. ... It is too early to make predictions on how this co-habitation will develop" (p. 370). But he saw the CLSCs as the attempt to create a new society, a new culture, and so their discussions on policy within the Fédération de CLSCs and within the province generally were very important.

Later the Rochon report confirmed that service objectives should prevail, for there was no end to the growth potential of advocacy groups and streamlining should take place. The Rochon committee recommended a change in policy which built on a commissioned research paper by Quiviger (1987). This argued that government should recognize the resurgence of voluntary organizations since 1971. At that time the old charitable organizations had been swept aside in favour of funding community development through CLSCs. Now more consideration should be given to subsidizing independent voluntary bodies and linking their activities into a coordinated community approach, after consultation at the regional level.

In due course the Minister of Health and Social Affairs (Quebec 1989a) responded to the Rochon Report. *Improving Health and Well Being in Quebec: Orientations* set out the policy directions of government and identified several changes. There was to be a new policy for funding voluntary organizations:

> The network of services [that was established in the 1970s] took over from private institutions and charities. Methods of intervention were gradually assimilated into the public system's models. Mutual aid and voluntary work then found little place in a system that enhanced modernity by adopting values often opposed to the spirit of voluntary action. ... Today we no longer believe that pub-

> lic services have all the answers. ... The present day community movement is no longer confined to the traditional networks that once fostered it. ... The scope, quality and originality of its contribution attest to the impossibility of interpreting health and well being solely through the prism of public intervention. (p. 77)

This statement distinguished the work of voluntary community service activity from that in the established state services. Then the report went on to define the responsibilities of each level of the government structured service beginning with the CLSCs, which were to offer: medical and nursing services, psychosocial services, home care, services for children and families at risk, services for young people in trouble, mental health services and services for high risk groups.

Another response was produced by the minister's successor (Quebec 1990b). Disincentives were to be brought in to change public behaviour in demanding medical care. There was to be an introduction of charges for attendance at emergency departments for non-emergency consultations. Instead patients were to be encouraged to go to primary care physicians in the CLSCs or to polyclinics.[13] The CLSCs were to provide more information about their work and to be open for longer hours of service. Physicians in private practice were to undertake preventive activities, provide or link up with home care services and collaborate in providing a twenty-four-hour service or lose financially. In this reform CLSCs were expected to be the big winners: their revenues would be substantially increased. They were to replace the emergency departments of hospitals and to become the main portal of entry to the health care system.[14]

In both reports the ministers proposed new organization structures for community participation. The governing bodies of regions and CLSCs were no longer to be joint consumer/professional structures, but in future, to be composed of consumers only. Bill 120, an *Act Respecting Health Services and Social Services and Amending Legislation* (Quebec 1990), was passed in 1992, implementing these recommendations.

A National Investigation (1971–72)

Discussion of the national investigation of CHCs (John Hastings, chairperson) has been postponed until now so that the models chosen in three prov-

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[13] A profile of physicians available to give primary care was published early in 1990 (Maheux et al. 1990). Quebec, unlike other Canadian provinces, had followed the American pattern in which patients could choose their own specialists and go to them without referrals from general practitioners.

[14] Marc Renaud and Claude Larivière, personal communication, 1992.

inces could be considered as the basis for that investigation. The story of the CHCs in Ontario, Saskatchewan and Quebec has been told both before and after the Hastings committee investigation as it seemed best to discuss these developments without interruption. It should be noted, however, that this national investigation (1971–72) came midway in the Ontario negotiations some time after the sides had been taken in Saskatchewan and contemporaneously with the establishment of the Quebec CLSCs.

A new Deputy Minister of Health had joined the federal government soon after it had affirmed its commitment to Medical Care Insurance, 1966. Dr. Maurice Le Clair decided that it was time to take stock, to review what should be the next move forward in health policy making (Andreopoulos 1975). Le Clair was influenced by his previous experience in planning primary care in Quebec. Among other investigations he decided to commission a national inquiry into community health centres as part of a possible restructuring in order to implement a comprehensive system of care. The committee was to make recommendations regarding the development of the model in Canada and whether it should be on a demonstration or more general basis (Canada 1972).

The committee took into consideration the CHC models developed elsewhere, not only in Canada (Roemer 1973; Badgley 1972; Kohn and Radius 1972), and consulted with a number of experts on the feasibility of introducing the concept into Canada (Fish 1972; Alix 1972; New 1972). Special attention was given to the idea of consumer participation (Klein 1972; Haughton 1972).

The sociologists on an advisory subcommittee identified the following problems as likely to have a negative influence:

> 1. Community involvement: citizen participation. There was ambiguity about the degree of participation which would be tolerable to health professionals, administrators, politicians and citizens
> 2. Priorities: Spectrum of Medicine and Social Services: Ambulatory Care. There was ambiguity about the range of services to be provided, the mix of health and social services and the self sufficiency of the centres in providing primary care
> 3. Staffing: New Categories of Health Workers. The relationships of health professionals were likely to change in the proposed clinics. There were ambiguities about team work
> 4. Funding. Traditional methods of funding would need to be changed if the centres were to become viable, but in what direction should changes be made? How should doctors be paid?
> 5. Structures. The concept of "CHCs" implies decentralization but who, then, should be in control — doctors or laymen? How best could control problems be resolved? (Crichton, 1979, 21–22)

Despite the fact that many of the expert advisers had expressed their doubts about the feasibility of introducing CHCs (Canada 1973b), the committee reported to the Council of Health Ministers of Canada (Canada 1972) that there should be:

> 1. The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres ... as non-profit corporate bodies in a fully integrated health services system
> 2. The immediate and purposeful reorganization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assume a more economical and effective use of all health care resources
> 3. The immediate initiation by provincial governments of dialogue with the health professionals and new and existing health service bodies to plan, budget, implement and evaluate this system; the facilitation and support of these activities by the federal government through consultation services, funding and country-wide evaluation (p. i)

The rationale given was: "In summary, CHCs are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities and relationships which society wishes to establish for health care in the future" (p. ii).

Crichton (1979), reviewing the work of the committee in retrospect, argued that there had not been enough time for it to do its job properly. The chairperson, anxious to have a unanimous set of recommendations, assumed that there was a real consensus among the members, when in fact there were hidden disagreements. At one point there had been open conflict over a paragraph relating to payment systems, but a formula had been found which papered over the split. She thought that the recommendations were a reflection of the belief system of the chairperson and his supporters rather than a clarification of the true situation. This bias in the report did not become clear immediately, but hostility began to be shown within a short time after publication, a hostility which escalated quickly and divided the community of interest into two distinct camps — for and against. Some six years after the report was published, Hastings (1978a) was still optimistic, but by then he had identified the opposition — the medical profession, the hospitals and some of the provincial administrators. This was a formidable coalition of interests to have working against the model.

Experiences in Other Provinces

Manitoba

Manitoba had elected a New Democratic Party (NDP) government in 1971 and it quickly developed a new health policy (Manitoba 1972). Dr. Ted Tulchinsky, who had experience in CHC development in Ontario and on the federal investigating committee, was invited to join the government in order to develop a group of about fifteen CHCs. "There was some conflict between the medical profession and the Manitoba government at this time which went far beyond the issue of setting up health centres and was related to the broad question of professional autonomy and professional rewards" (Crichton 1979).

In 1991 Crewson[15] reported that the District Health Centres Act, 1972, enabled interested sponsors to choose a variation of the model which would suit local situations. Nine centres — four urban and five rural — were set up. One Winnipeg clinic became an outreach arm of the University of Winnipeg Health Sciences Centre. All were relatively small institutions. Though most chose to have salaried doctors, they had been given a choice regarding payment mechanisms.

How the health centres came through this period of struggle has not been documented. In 1978, an informed observer thought that the rural health centres came closest to the CHC concept, although the urban centres were more innovative in their ideas (Crichton 1979). With the election of a Conservative government in that year, all CHCs were challenged and expected to evaluate their services in order to get continued provincial funding. Meanwhile the labour movement in the province came out in strong support of the concept (Black, Cooper and Landry 1978). Presently there are five rural and ten Winnipeg CHCs.[16]

British Columbia

In British Columbia an NDP government was elected in 1972. The history of the CHCs in the province can be traced first from articles about the REACH Clinic and other health centres which had been started in 1969 before the government decided to take a hand in policy development. Tonkin (1979), Harrison (1982) and Clague et al. (1984) have described government interventions after 1972. The NDP commissioned a report on health needs of the province from Foulkes (1973) who recommended a broad restructuring of

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[15] Herman Crewson, personal communication, 1991.

[16] Phyllis MacDonald, personal communication, 1991.

services, including the development of CHCs. By the time Foulkes' report was published the government had recognized that there were going to be problems in implementation for he had been embroiled in heated discussions with community groups when he toured the province to sell his ideas.

In the meantime, however, the Community Health and Human Resources Centre (CHHRC) Development Group had been set up by the provincial government to examine requests for provincial support of CHCs. These requests were prioritized and funding was provided to start up services in five areas where there appeared to be need. (These were mainly rural areas, though James Bay in Victoria was an inner city enclave).

Tonkin (1975), reviewing the situation generally in the province, listed four other downtown clinics in Vancouver (the Fairmont Centre linked to a union-based insurance company, the downtown CHC in a depressed inner city area, the Pine Street Clinic — a public health outreach clinic for street people — and the Women's Health Collective). He also mentioned the student health service on the University of British Columbia campus. All these were functioning in addition to the provincially backed centres. Most of these have survived to the present day, though evolving over the years. The REACH Clinic has developed a subsidiary, the Mid Main Community Health Centre Association (1990).[17]

When the NDP government was defeated in late 1975, the Social Credit government decided to end further support for new CHC development and set up an audit committee to review the existing clinics. Unable to ignore the positive report of the audit committee (British Columbia 1977) the government decided to continue to maintain them, but there was only one further development of the CHHRC program after 1975,[18] until the present NDP government gave strong encouragement to the movement in its new directions policy. Clague et al. (1984) have indicated that it was not only political opposition which had killed the idea, but that the bureaucrats responsible for provincial public health policy had found that CHCs did not fit in with their plans for service delivery and had undermined any innovative proposals.

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[17] The Mid Main Community Health Centre Association is providing an opportunity for nurses from the Vancouver Health Department to develop their skills in community development. The clinic also works in partnership with the department on multicultural issues, youth clinics, prenatal and postnatal classes, immunization clinics, volunteer coordination and baby clinics.

[18] A provincially funded community health centre was set up in a new mining settlement at Tumbler Ridge in 1985 where there were no other services.

Other Provinces

The basis of this study was a literature review, and although efforts were made to visit and discuss developments with as many provinces as possible, those which did not publish discussions about their CHCs may be under-represented in this discussion.

These developments were brought to notice:

1. Alberta decided to not take action on CHCs but to revamp its outdated public health programs (Brunelle and Norquay 1978). However, through voluntary action, a downtown CHC was started in Edmonton serving displaced native peoples as well as inner city poor people (Kelly 1980; P. McClelland 1984). The Alexandra Community Centre was set up in Calgary
2. Nova Scotia has been conservative in its approach. There is one "anomalous clinic" (to quote the administrator),[19] the North End Clinic in Halifax, which serves an inner city clientele and has been in existence for more than twenty years. There is no documentation on this clinic except for a report on a health education project (Martell 1989)
3. Newfoundland already had its cottage hospital service when the CHC idea was promoted but it did start up a university coordinated CHC in an urban renewal area of St. John's (Brooks 1975)
4. Rural health centres are discussed further in Chapter 14. These are not necessarily CHCs which have an ideological base. They may be restructurings of rural hospitals

Canadian Council on Social Development (CCSD) National Conferences on Community Health Centres: Evaluations of Progress

In 1983 the CCSD called a national conference on CHCs to examine the reasons for their failure to evolve. Eschauzier (1983) listed these reasons as:

1. Lack of political commitment and uncertain and inappropriate methods of funding
2. Professional resistance
3. Inter-professional conflict
4. Unclear role for community participants
5. Resistance from other established organizations
6. Image problems re poor and under privileged
7. Lack of models and practical guidelines for operators
8. Lack of documented evidence re worth

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[19] Johanna Oosterveldt, personal communication, 1990.

The CCSD continued to keep the subject alive, holding another conference in 1985 on community-based health and social services, at which the problems associated with expanding the role were again reviewed and reported by Gilmore (1986).

The Future of CHCs?

Throughout the 1980s other people worked to keep the idea of CHCs alive. Rachlis and Kushner (1989, 1994) and Angus and Manga (1990) promoted the idea in their publications. Angus and Manga concluded their review of consumer sponsored health delivery as follows: "There does not appear to be much doubt that the system will change. ... Any alternative health care delivery model which stresses community participation, health promotion and disease prevention and different reimbursement mechanisms will form an integral part of that change. ... Hence it would seem fruitful to foster and enhance the community participation approach in health and health care" (p. 56).

In the last few years the context has been changing. The majority of provinces have set up regional boards of selected consumers and are working hard to develop community health councils with lay participation in policy development. It seems likely that some of these will want to promote CHCs in their areas.

Other Alternative Medical Care Delivery Modalities which Emphasize Coordination of Services

Angus, Tregunna and Dunne (1989) have identified eight alternative models of ambulatory medical care which can be substituted for the traditional patterns of practice, and all of these will be explored (though not under the same headings). Angus et al. point out that the medical care system is unlikely to change while incentives to physicians and other health professionals are not sufficient to encourage change. However, the failure of the CHC concept to become accepted as a major substitute for traditional medical care organization has led to a search for other models which might be more acceptable to the medical profession and more likely to succeed. Health economists and other planners have been trying to find what these other models might be.

Development of Health Service Organizations in Ontario

Adaptation of the United States' HMO model continues to be regarded as a distinct possibility, if only Canada can find the right modifications to make, so that it will fit in with the established structures (Boisvert, Gosselin and Pineault 1987).

After the introduction of Medicare, the Ontario government embarked on the process of funding HSOs rather than CHCs only (as explained earlier), thus opening the door to development of a wider range of alternatives than community sponsored clinics alone. The six types of HSOs and the two methods of funding were discussed above. All HSOs are funded by capitation and must provide general practitioners' services. Some may provide specialists' services. Other objectives of HSOs are: to create an environment supportive to physicians and other health care personnel which allows flexibility in meeting the needs of the HSO population, and to develop a coordinated health care delivery system that is accessible, economic and efficient, which emphasizes health promotion and prevention activities and decreases institutional care through using ambulatory care, self care and home care. However, there is no financial linkage between hospitals and doctors' offices as in the American HMOs.

Towards the end of the 1980s the Ontario government began to encourage more group practices to move into the HSO modality (Peachey and Linton 1988; Henderson 1990). Roch (1986) thought that the oversupply of physicians was making the concept of alternative delivery modalities more attractive to general practitioners, although specialists were less likely to be recruited. And the most difficult posts to fill in HSOs were those of managers. Weinkauf and Scully (1989) have also reviewed the reasons for the resurgence of interest in the concept, while Birch et al. (1990) made a critical appraisal of research on HSOs up to that time.

Towards Comprehensive Health Organizations in Ontario

Reviewing other possible alternative delivery modalities (ADMs), Stoddart and Lomas (1986) made it clear, that for funding bodies, the American HMO model is the most attractive alternative organization structure because it solves the problem of vertical integration. While improving the internal management structure of medical practices should not be underestimated, it is tightening the link between office practice and the hospitals that is the most important way to increase cost effectiveness. Decreased hospital utilization is the key issue, therefore, for establishing effective ADMs, "a minimum requirement will be some mechanism for control over hospital capacity" (Stoddart and Lomas 1986, 2). However, reformers realized that the absence of enrollment "lock-in" in the capitation funded (HSO) practices of Ontario[20] had made it difficult to achieve the savings of the American

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[20] The Canada Health Act, 1984, had reasserted the principles of free choice of physician and free choice of patient. This had been interpreted as preventing "lock-ins." The conference thought the act did not actually say that "lock-ins"

HMOs.[21] "Effective enrollment of patients is central to the concept of an organization which manages care in both its members' and its own interests" (Stoddart and Lomas 1986, 3).

Roch (1986) said that in order to move forward, governments would not need to introduce new legislation. And so in 1989 Ontario decided to sponsor Comprehensive Health Organizations (CHOs) (Ontario 1988b, 1991a), defined as non-profit corporations which undertake to provide or purchase *a full range* of health and related services to a defined population. A management team guided by a community board made up of patients, members, providers and community representatives was to run a CHO. Linton and Peachey (1990) later identified two emergent models of CHOs — the one which has attracted smaller communities' interests and the city hospital model (Mickevicius 1991). Another model has been developed in Ottawa where the hospitals have given up a part of their budgets to fund two community-based CHOs in the city.[22] Doctors have expressed some concern that the CHO model will result in underservicing because incentives encourage a decrease in referrals. They asked: was this quite ethical? (Linton, Peachey, and Boadway 1990; Brosky 1990).

Organizations des soins intégrés de santé (OSIS) in Quebec

Quebec decided to set up three pilot CHOs (based on the American HMO model) in Montreal, Quebec City and Sherbrooke (Beaudin 1989). These link primary care with hospital services. The OSIS are financed on a prospective payment basis within the provincial health care system (Levine 1988). The organizations take the responsibility for delivering directly, or contracting for, all publicly insured services for a voluntarily enrolled population over a period of time. Charrier (1989) indicated that opinions about their success were divided.

Multiservice Centres

Multiservice centres may provide all or some of the following services: medical care, pharmacy, physiotherapy, occupational therapy and social services. The work of these centres was reviewed by Hepworth (1976). Stewart (1982) has set out the objectives of multiservice centres:

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were illegal, but challenges were likely to be brought which would be disruptive if "lock-ins" were tried out.

[21] Fox, Heiann and Steele (1987) have assessed reasons for success and failure of American HMO models, and Abel-Smith (1988) considered international experience.

[22] Gail Peters, personal communication, June 1990.

1. To enable the gradual establishment of an efficient, effective and comprehensive network of accessible community services
2. To make maximum use of, and actively coordinate, existing services, programs and resources both in the professional and voluntary sector
3. To place an equal emphasis on promotion of healthy life styles and quality of services
4. To achieve maximum community participation in the planning of services

Stewart reported on the methods used to achieve those objectives of horizontal coordination in a suburban multiservice centre in Nova Scotia. The emphasis was placed on the horizontal integration of services which could be publicly or privately provided. The centre uses "team case management" to promote collaboration between service agencies, and interagency meetings and seminars to promote communication. The centre has set up a representative community board with subcommittees involved in planning, management, budget supervision and development of public relations. Marentette and Kurji (1988) have argued that multiservice centres can form a good base for community development. However, as noted in Chapter 9, doctors have not been very interested in moving into multiservice centres despite the fact that they can continue to be paid by fee-for-service.

Hospital Affiliated Ambulatory Care Centres

As Angus, Tregunna and Dunne (1989) pointed out, the need for more beds, the need to free up existing beds, and/or the desire to expand their market can lead hospitals to consider providing ambulatory health care services. These authors distinguished between hospital-based ambulatory care (clinics in the same building as primary, secondary and tertiary care hospitals) and free standing clinics in remote centres affiliated with a hospital. It was only the free standing clinics that they thought met the definition of ambulatory care centres. However, the 1991 program for the Canadian College of Health Service Executives' (CCHSE) Ambulatory Care Conference was concerned not only with community-based satellite clinics and extramural hospital care but also with hospital-based services.

Clinics attached to the hospitals usually provide care which cannot easily be given in doctors' offices: surgeries such as tubal ligation (Fraser 1990), or monitoring of serious chronic illnesses which require specialist supervision, such as haemodialysis treatment (Peters 1980). But there are diet counselling clinics (Schwartz, Bell and Webber 1987) and other educational services such as a blood pressure screening clinic (Abbott, Alstad and Yeo 1989) or a psychogeriatric monitoring clinic (Kral, Palmer and Yakovishin

1986) which may not have any good reasons for being hospital centred other than that the money to pay dieticians, nurses, psychologists and so on has been in hospital budgets.

Angus, Tregunna and Dunne said that there are many arguments for and against free standing clinics but the main ones they identified were (for) the wider range and better quality of care which may be provided by a hospital and (against) the irreconcilable differences in the goals and functioning of hospitals and ambulatory care services, including the hospital's focus on institutional care as opposed to community-based care.

Multi-Institutional Arrangements

Gelmon and Fried (1987) reviewed the literature on multi-institutional arrangements. Most of the studies were American but one section on the Canadian experience reviewed mergers of hospitals with other services across the provinces. Apart from three studies in Quebec, where there had been pilot projects of rationalization between rural hospitals and CLSCs these were not studies of hospitals with ambulatory care centres attached (C. Bégin 1977, 1984; Bégin, Bergeron and Joubert 1984). These were studies of coordination of acute and long term care institutions.

The Hospital-Community Partnership Project, British Columbia

The British Columbia government set aside a small proportion of its hospitals' budgets in the *Hospital-Community Partnership Program* (1989b) for:

1. Programs to assist in utilization management of hospital services, such as quick response teams; short term assessment and treatment centres' geriatric evaluation, assessment and rehabilitation units; adult day care centres and palliative care teams
2. Programs to prevent disease, promote health and generate healthy public policy such as prevention of heart disease

Although the main requests for funding were to improve hospital utilization, some breakthroughs were made in community development projects (Ryan, Rowlands and De Paoli 1991). Later following the report of a provincial inquiry into health services in the province entitled *Closer to Home* (British Columbia 1991), the government funded a series of projects in the community. These grants are to continue after the proposed projects come to an end for development of community services.

In 1990 the government of Saskatchewan also invited applications for monies from hospital budgets to be set aside for community projects (Saskatchewan 1990b).

However, one can regard these as interim activities. Most of the provinces have now restructured themselves into regions which will have the responsibility for improving coordination at the local level.

Walk in Clinics

In the opposite direction from improving coordination of services and continuity of care is the development of walk in clinics (Milne 1987). There has always been a continuum of primary care, at one end of which the family doctor stresses the importance of the continuity of the doctor-patient relationship (Biehn 1990) while at the other end, the physician asks no questions beyond the ones immediately necessary for making a current diagnosis. Walk in clinics are simply an extension of this continuum at the impersonal end, whereby service is provided quickly and without long-term commitment, in shopping malls or other centres of community activity. These walk in clinics may be community-based or hospital emergency department-based.

A study of a paediatric walk in clinic by Feldman and Cullum (1984) showed that clients came there for two main reasons: the broad range of services offered (laboratory, radiology and pharmacy in addition to medical care), and the hours convenient to them, outside regular office hours of paediatricians. Béland (1989) found that continuity of use of physicians' services varied with the volume and regularity of use. Low volume was associated with change. Rizos et al. (1990) examined the implications of walk in clinic developments for family practice organization (hours, competition for income, etc.).

Miller et al. (1989) described Ontario walk in clinics and reviewed the literature. They have questioned their cost effectiveness.

Independent Health Facilities

In most provinces walk in clinics appear to be working within the medical or hospital insurance plans but in Ontario at the end of the 1980s the government thought it was necessary to legislate to bring "the independent health facilities" under better control. In that province a number of entrepreneurs had started to offer day care services in an out-of-hospital setting, providing medical and surgical procedures in an environment somewhere between a doctors' office and a hospital. The Minister of Health decided that new legislation was necessary to ensure that such facilities were properly funded, that quality control was increased and that the proliferation of new diagnostic centres was curbed through regulating licencing and funding (Ontario 1989b). Examples of services which can now be given are:

1. Outpatient surgery procedures such as cataract surgery or orthopaedic procedures
2. Comprehensive and integrated services such as women's health programs
3. Diagnostic services such as bladder and heart investigations, radiology and ultrasound
4. High technology procedures such as laser technology in the treatment of diseases of the eye and uterus

The *Independent Health Facilities Act* was expected to eliminate user fees for regulated facilities.

This issue has now become a major concern for other provinces too. Should private clinics be allowed to charge the provincial government for services provided outside the public hospitals? If so, at what level should these changes be met? Should private clinics be allowed to exist at all? These questions will be addressed in the final chapters on policy development.

Summary

This discussion of alternative care delivery models is divided into two parts: a report on the evolution of community health centres and a listing of other alternative delivery models such as Health Service Organizations (HSOs) and Comprehensive Health Organizations (CHOs) in Ontario, Organizations des soins integré de santé (OSIS) in Quebec, multiservice centres, hospital affiliated ambulatory care centres, multi-institutional arrangements, the British Columbia and Saskatchewan Hospital-Community Partnerships, walk in clinics and independent health facilities.

The development of community health centres (CHCs) varied from province to province because different models were used — Ontario's based on United States Health Maintenance Organizations (HMOs), Saskatchewan's on the British Peckham community health centre model and Quebec's on the American neighbourhood health centre (OEO) idea but also on an epidemiological analysis of provincial needs and a provincial health plan.

Building on the experiences of these provinces, a national committee (Canada 1972, 1973b) recommended that provincial governments should encourage development of CHCs across Canada but the proposal met with considerable hostility from the established medical profession. Except in Saskatchewan and Quebec, the CHCs which have been established now tend to serve inner city or rural populations, though there is a renewed interest in the concept for overall use since regions have been formed.

This chapter goes on to examine how the Province of Ontario has developed its payment system for doctors to include not only CHCs but other forms of group practice (HSOs). And groups which reduce the demand for hospital services for their patients may be remunerated as Comprehensive Health Organizations.

After looking at other alternative practice organizations, such as walk in clinics, the chapter ends by raising the issue of independent health facilities and their relation to the mainstream system.

CHAPTER 12

Evolution of Public Health Departments

With the reduction in the significance of infectious diseases in Canada over the last twenty-five years, public health, like other sectors of the health care system, has been seeking to carve out new territory and a new role for itself within the overall context of the provision of community-based services. Several histories of the development of public health services in various jurisdictions in Canada exist (e.g., Lewis 1984). While a full exposition is beyond the scope of this chapter, a number of points are relevant to the present discussion.

In a very general way public health could be said to comprise those activities which are undertaken with collective responsibility for the protection of the health of the public, primarily through primary prevention measures.[1] Public health activities generally are directed toward particular population groups who are basically "well" but who could be considered to be "at risk" for health problems (well-baby programs and school immuni-

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[1] Primary prevention refers to those activities which are believed to prevent the onset of disease, for example, immunization, prenatal education, well-baby clinics, etc. Secondary prevention refers to those activities which are believed to minimize the effects or slow the course of existing disease, for example, screening and monitoring programs, nutrition counselling for diabetes, etc. Tertiary prevention refers to those activities which are believed to promote recovery from a disease, for example, cardiac exercise programs, back pain programs, etc. Generally, primary prevention is the domain of public health; secondary and tertiary prevention services are sometimes provided by public health agencies, but may also be provided by other jurisdictions in the health care system, such as other primary care settings (doctors' offices and community health clinics), and outpatient clinics of hospitals.

zation campaigns), or are directed at the protection of the public at large, as with environmental controls for clean air and water and food inspection.

Structural Arrangements

Public health in Canada had its earliest established structures in local communities towards the end of the nineteenth century (Manga and Muckle 1987). Prior to this there had been sporadic activity by local communities during the cholera epidemics of the mid nineteenth century (Bilson 1984). Representing one of the earliest attempts to establish an organized locally-based system of public health, the Ontario Public Health Act of 1884 required all municipal councils to elect a local board of health. This local board's powers included the control of "nuisances" (e.g., a badly situated privy), the prevention or control of the spread of epidemic disease, and the regulation of the conduct of certain businesses such as tanneries. These later evolved into the twentieth century public health activities of sanitation control, communicable disease control, and environmental and occupational health control. Initially power rested entirely in these local boards of health (Powell 1981).

In her analysis of how local municipalities in Ontario gradually lost control over local public health activities, Powell (1981) concludes that issues of provincial control and professional dominance were directly related. District medical health officers, who were provincial government employees, were effective in establishing provincial administrative control over local municipalities because of their power to enforce professional norms on local medical officers of health. Thus provincial policy was largely set by public health professionals whose objective, which became the objective of the provincial government, was to ensure that local public health activities were "conducted to the norms and scientific standards of the public health profession" (p. 26). According to Powell all subsequent provincial policy has been directed towards securing that professional control through a series of administrative and financial (as opposed to legal or judicial) controls over local municipalities. For an excellent review of the shifting administrative and financial role of local governments on the provision of health and social services see Manga and Muckle (1987).

Lewis (1984), in a comparative look at the role of medical officers of health in Great Britain, Ontario and Quebec, observed that community physicians, in general, see themselves first and foremost as physicians with a firm allegiance to the medical profession and the medical model of health and disease. This orientation of such a major player in the field of public health services has undoubtedly had a significant impact, not only on the nature of services delivered, but also on the way in which they are delivered, that is, on the organization of public health activities.

Public health services have emerged in the other Canadian provinces in a variety of ways (Manga and Muckle 1987). For example public health in British Columbia was initially organized not as a municipal but as a provincial concern because of the sparse population and the late development of municipalities (Ewan and Blatherwick 1980; Green 1984). However, for the greater part of the twentieth century, public health services in Canada have been delivered out of provincially or municipally administered health units with medical officers of health in the top administrative position, and with other public health professionals in subordinate positions.

There have been efforts on the part of some provincial or municipal governments to shift this organizational arrangement. Vancouver has gone through three different ways of structuring its public health service — under its different disciplines, under its different programs, and under geographic divisions into health units headed by administrators, not professional experts (Altman 1991). The Province of British Columbia also put the administration of health units under a non-medical director in the mid 1980s. Quebec, as part of the Quiet Revolution of the 1970s, brought all public health services under the jurisdiction of Départements de santé communautaire (DSCs), which themselves were put under the jurisdiction of designated hospitals; recently there has been a move to return some public health responsibilities to local community health centres, Centres locaux des services communautaires (CLSCs). In designated geographical areas, Ontario has established District Health Councils (DHCs) under non-medical directors. Although not part of the public health system, DHCs have a health planning and advisory role, and work primarily with the institutional sector and community agencies in order to rationalize resource allocation for health care services within a designated area. This is significant to the extent that changes in other health care sectors affect the role of public health.

Alberta, British Columbia and other provinces have recently moved towards regionalizing health care delivery. The impact of these structural changes on public health services is as yet undetermined.

The "New Public Health"

After the release of the Lalonde Report (Canada 1974b), public health began to focus more on "lifestyle" issues and risk assessment activities. Through the 1970s public health began to shift more and more of its resources towards identifiable "risk groups," that is, those population groups who were believed to be more "at risk" for compromised health, for example, women at risk for delivering low birth weight babies, adolescents at risk for drug and alcohol abuse, elders at risk for contracting influenza, etc. This orientation in the delivery of service towards designated population groups was still consistent with the organization structures of the public health units and agencies which delivered services.

By the late 1970s and early 1980s, fundamental changes in the definitions of health and recommended directions of health care efforts (WHO and UN 1978) prompted many in the public health field in Canada to question the nature and role of public health within a rapidly changing health care field. Sparked largely by the World Health Organization (WHO) European office on Health Promotion (1984), a social model of health was replacing a clinical or medical model of health, at least in theory and in discussion papers emanating from all health jurisdictions in Canada.[2] The main feature of the social model of health is that many of the determinants of health lie outside of the health care sector and are produced by the social, political and economic context within which people live, for example, poverty, inadequate housing, unemployment, etc. (Toronto 1988a).

What this has meant for public health practice and the organizational arrangements for the delivery of public health services has been a subject of discussion and debate for most of the last decade. Generally it has meant a shift, at least in the discussion within public health circles, away from the provision of traditional professionally determined public health services based on a scientific/clinical model towards provision of services based on a community-based planning and implementation approach.

One of the first jurisdictions to recognize the need for structural change in order to accommodate the new definitions of health, and hence the "new public health," was the City of Toronto (Toronto 1978, 1983, 1984, 1985, 1988a,b). With the publication of *Public Health in the 1980s* (Toronto 1978), the Toronto Board of Health, in addition to recommending a greater advocacy role for the Department of Health in a number of "non-health areas" (income, housing, etc.), also recommended a departmental structure which would allow its services to be provided by "service delivery teams." The make-up of these teams would be determined in a number of decentralized health units which would serve specific geographical areas of the city, thus providing for maximum flexibility and innovation in responding to local needs.

Throughout the 1980s, several initiatives in Canada were instrumental in reshaping the dialogue over what constituted public health (Canadian Public Health Association 1985, 1987; World Health Organization 1984; Canada 1986d). Of particular significance to public health was a series of

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[2] The health promotion movement is discussed later in Chapter 20.

nationwide collaborative workshops and meetings around the theme "Strengthening Community Health," co-sponsored by Health and Welfare Canada and the Canadian Public Health Association (Canadian Public Health Association, 1987). As a result of these workshops, many public health units and agencies are participating in the healthy communities movement.

These initiatives are dealt with in more detail in the discussion of health promotion research (see Chapter 20). What is significant here is the extent to which these initiatives have had an effect on the organization and practice of public health. Reviews of the more recent annual reports of several public health jurisdictions reveal earnest attempts to incorporate some of the notions of the "new public health." The 1989 *Annual Statement* of the City of Toronto Department of Public Health (Toronto 1989) has documented ways in which community development initiatives have been incorporated into public health services. However, it is difficult to determine how the daily practice of the public health professional has been affected.

The Health Department of the Capital Regional District in British Columbia has created a community development position; however, when the activities of this person are examined they appear to be similar to traditional health education activities, indicating that there remain gaps between the theoretical discussion of the "new public health" and its implementation at the level of public health practice in this and other public health jurisdictions.

Barriers to Implementing the "New Public Health"

The barriers to implementing the "new public health" are primarily structural. At the macro level, public health departments/agencies are legally constrained to deliver statutory services, many of which are based on a clinical/scientific model of public health. In addition existing administrative and financial arrangements at the provincial and local level structure the organization of public health services and their delivery.

Extensive interviews (for this project) with public health professionals in various public health jurisdictions across Canada provide further evidence for a disjuncture between rhetoric and practice at the service delivery level. This dissonance appears to result from attempts to graft a new rhetoric onto old structures, structures which originated in early public health efforts to deal with infectious disease. This is revealed in structural concerns, which were generally expressed as:

1. What will the lines of authority be, that is, who will report to whom?
2. Related to no. 1, but not identical, who will be accountable?

3. What about quality standards: what will they be and how will they be measured?
4. What will public health practice "look like" on a day-to-day basis, that is, what will public health professionals do?

On this last issue, there have been recent attempts to re-examine the role of public health professionals, especially public health nurses (Besner 1988; Canadian Public Health Association Task Force 1990; Mid-Main Community Health Centre 1991). Several attempts have also been made to articulate, not only the educational preparation of the public health professional for a changed role (Smithie 1990), but also the educational role of the "teaching health unit" in preparing public health professionals for a role more oriented towards community-based prevention and health promotion approaches (Calgary 1990a).

However, preliminary examination of these proposals reveals that there remains a confusion between the notion of community-based (that is, community driven) and community-oriented (that is, professionally driven) approaches.[3] This is similar to the confusions between the concepts of community development and community participation. These confusions may exist in part because of the traditional organization of public health activities around mandated services and programs as indicated above. For example, while the 1989 Ontario Ministry of Health's *Mandatory Health Programs and Services Guidelines* (Ontario 1989e) attempts to incorporate the new dimensions of health that have been discussed above, it is clear that public health practice is constrained by the necessity for meeting statutory requirements as laid out in the Health Protection and Promotion Act of 1983.

There have been several pilot projects to explore whether different financing arrangements would enable health units to develop innovative approaches to providing public health services. One such project was the Global Funding Pilot Project in the Milburn-Vermillion Health Unit in Alberta (Hancock 1990). One of the four barriers which prevented the project from meeting its stated objectives was identified as the organization of the health unit along program and discipline lines, representing "a hierarchical structure allowing little flexibility." On this issue the evaluators concluded: "When an organization moves towards monitoring its progress by results, the organization must be able to assign responsibility for the results to one manager. The traditional hierarchical pyramid organization does not facilitate this process" (p. 3).

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[3] See Appendix A for definitions.

Summary

Public health could be said to comprise those activities which are undertaken with collective responsibilities for the protection of the public primarily through primary prevention measures. These activities are directed towards particular population groups which are considered to be "at risk."

This chapter considers how public health departments have been restructured over the years. They became professionally controlled in the nineteenth century. The medical officers of health continue to have a firm allegiance to the medical profession and the medical model of health. Some efforts have recently been made to restructure under administrators but these efforts are still being tried out.

By the early 1980s there had been a shift in thinking away from the biomedical to the social model of health care. For the public health departments this meant the need for conceptual change from a clinical model of care to a community-based planning and implementation approach. This has resulted in much discussion about suitable structures for implementing the changes in orientation, but it is not yet clear whether changes are being made.

CHAPTER 13

Community Care for the Elderly

It is impossible to discuss the provision of community-based services to older adults without consideration of the range of services variously known as home care, continuing care, community care, long term care, *les services à domicile*, home support, etc. Part of the confusion over the use of terms is that they are used to refer to services organized for either episodic (acute) or chronic care. This linguistic confusion appears to reflect a confusion or conflict over the intended purpose of these services, a point which will be returned to later in the discussion. For the purposes of this discussion the term "community care" will be used to refer to the entire range of community-based services provided to seniors. Indeed as Jamieson (1989) has observed: "Before policies of community care there were no explicit [health care] policies for elderly people" (p. 450).

The major feature of these community care programs is their stated overall objective of supporting older adults to stay in their own homes as long as possible, with a wide variety of services depending on the jurisdiction but which can include: home nursing, involving a range of clinical services such as dialysis, IV therapy, etc.; homemaker services; respite care for family caregivers; some kind of meals program ("meals on wheels" or "wheels-to-meals"); supplements to public transportation; "friendly visiting"; handyman services; and other services depending on the community. These programs are also available to young adults with disabilities and to families with children with disabilities or in distress; by far, however, the over sixty-five group comprises the majority of the users of these services (Richardson 1990).

What characterizes these services from an organizational point of view is their overwhelming multiplicity, variability, public/private mix and lack of coordination at either a policy/planning level or a service delivery level (Marshall 1987; Richardson 1990; Ontario 1990a).

Home Care

Of all the components of community care, the oldest is home nursing care, alternatively known as home care. Home care originated in Canada almost one hundred years ago with visiting nursing services provided by the Victorian Order of Nurses (VON) and by public health nurses in urban and rural areas (Richardson 1990). After the Second World War home care programs were begun in several communities, combining other services with the nursing services, and often using local hospitals as a base. By the late 1970s all provinces and territories, except Newfoundland, had introduced some form of provincial/territorial-wide program.

Home care programs in Canada typically include home nursing and other clinical services such as physiotherapy, speech therapy, respiratory therapy, as well as a range of non-clinical support services. There is great variability across these programs in terms both of their organization and administration, and of the degree to which health and social services are integrated. As was noted by the Federal/Provincial/Territorial Sub-Committee on Home Care (Canada 1986e): "At this time there is no consensus on which services should be basic components of a home care program."

Richardson (1990) provides a good succinct overview of the characteristics of these provincial/territorial programs (Table 13.1).

Many reviews of home care programs in Canada have been conducted over the last ten to fifteen years (Canada 1975, 1977, 1986e; Shapiro 1979; Crichton 1980; Howell 1988; Striast 1989; Richardson 1990), and no attempt will be made to duplicate those reviews here. What is pertinent to the present discussion are the organizational issues that have been raised, particularly in the more recent reviews. These include:

1. Should home care programs operate on a medical entry model (demonstration of medical need) or on a social entry model (need for home support)? This issue is related to the issue of whether the program is organized around episodic (acute) care or chronic care. British Columbia, Manitoba and Quebec have social entry models; Ontario's home care program was originally a medical entry model but has recently incorporated chronic care, New Brunswick has a medical entry model (New Brunswick 1990, n.d.); Alberta has been moving from a medical to a social entry model (Alberta 1990a; Richardson 1990)
2. As a corollary of this, what is the most appropriate base of operation for home care programs: the hospital or the community? Many home care programs had their origin in the provision of hospital services in the home, and continue to derive their justification, in much of the discussion, from their role as hospital replacements. The implications of this will be discussed later in the conclusion to this section.

Chart 13.1

Current Status of Provincial and Territorial Home Care Programs in Canada, 1990

Program Variables	British Columbia	Alberta	Saskatchewan	Manitoba
1. Name	Continuing Care	Coordinated Home Care	Home Care	Continuing Care
2. Start date	1978	1978	1980	1974
3. Type: Eligibility, length of stay, administering body	both medical and social entry (ME, SE) components; acute and chronic; health units and municipal health departments	both ME and SE components; acute and chronic; 27 public health units	SE; chronic; 45 separate HC boards, plus 9 community boards in Northern Saskatchewan	SE, acute and chronic; no LOS limit, 17 coordinating agencies
4. Services provided	homemaker (HM), nursing (HN), physiotherapy (PT), respite care	HM, nutrition, handyman (HDM), speech therapy (ST), respiratory therapy (RT), PT, OT, HN	HN, HM, personal care, meals on wheels (MOW), home maintenance, volunteer services, assess and care coord. maintenance	nursing, personal care, medical supplies, meal preparation, household medical supplies, PT, OT, ST, volunteer services
5. Annual expenditure fiscal year	$77.6 million 1986–87	$31.4 million 1987–88	$22.9 million 1987–88	$35.6 million 1987–88 (direct services only)
6. Per capita over age 65 expenditure	$222.00	$158.00	$175.00	$259.00
7. Number of clients served during year	68,200 (1986–87)	23,800 (1986–87)	19,101 (1987–88)	24,800
8. Current caseload	37,000	15,000	11,000	15,000
9. Per cent clients age 65	58.1% (HN) 85.7% (HN)	87%	85%	80%

Chart 13.1: Current Status of Provincial and Territorial Home Care Programs in Canada, 1990 *(continued)*

Program Variables	Ontario	Quebec	New Brunswick	New Brunswick
1. Name	Home Care	Maintien à domicile, and soin intensifes de maintien à domicile (SIMAD)	Extramural Hospital	Short term and long term home care
2. Start date	c. 1972	1970, 1981	1981	1972 and 1980
3. Type: Eligibility, length of stay, administering body	ME; both acute and chronic; 38 agencies, 29 health units, 4 VON, 3 hospitals, 1 independent board, 1 regional government	SE; acute and chronic; 162 CLSC's	ME, acute care (ALOS - 45.9 days), 10 full service units and 1 palliative care unit, covering 56% of N.B. population	public health, nursing and voluntary agencies
4. Services provided	ST, social work, nutrition, ET, RT, homemaking, diagnostic and lab services, medical supplies, medical equipment	nursing, homemaking, meals, errands, companionship and support	nursing, PT, OT, respiratory, dietetic services, homemaker, MOW, basic equipment, patient care supplies, drugs	nursing, PT, nutrition, equipment and supplies, relief care, homemaker, heavy housecleaning, MOW, friendly visiting
5. Annual expenditure fiscal year	$245.1 million 1987–88	$119.7 million 1988–89 budget	$10.1 million 1987–88	$1.5 million annual expenditure
6. Per capita over age 65 expenditure	$364.00	$173.00	$124.00 1987–88	$19.00
7. Number of clients served during year	221,998 (1987–88)	6,236 (SIMAD only)	9,500 (1987–88)	N/A
8. Current caseload	62,965 March 1988	N/A	1,300 March 1988	N/A
9. Per cent clients age 65	62%	60%	51%	80% of clients are long-term care

Chart 13.1: Current Status of Provincial and Territorial Home Care Programs in Canada, 1990 *(continued)*

Program Variables	Nova Scotia	Prince Edward Island	Northwest Territory	Yukon Territory
1. Name	Coordinated home care program	Home care and support	Coordinated home care	Home care
2. Start date	1988 (start of phased implementation	1970	earliest start 1975 in Yellowknife	March 1988
3. Type: Eligibility, length of stay, administering body	SE; no limitation on LOS; 37 homemaker agencies and 2 municipalities are "access points"	SE; no limit on LOS; administered by department staff with some contract services	SE; no limit on LOS; programs in 6 centres, 5 are hospital-based	SE; no limit on LOS
4. Services provided	HN, HM, volunteers, housing services	nursing, homemaker, OT, PT, meals, transportation, household maintenance, friendly visiting, respite care, case planning	HN, personal care, HM, OT, PT, ST, MOW, equipment loan	HN, OT, PT, personal care, home management, housekeeping, respite services
5. Annual expenditure fiscal year	$8.5 million 1988–89 (8 months only)	$20.0 million 1987–88	$1.0 million 1988–89 budget	$450,000 1989–90 budget
6. Per capita over age 65 expenditure	$79.00	$124.00	$667.00	$500.00
7. Number of clients served during year	estimated 10–17,000 at full implementation	N/A	estimated 400	74 (1988–89)
8. Current caseload	N/A	1,300–1,400 1988	estimated 35–40 clients per program	46 May 1989
9. Per cent clients age 65	estimated 80% at full implementation	80% are over age 60	N/A	56% 1988–89

Note for Chart 13.1: **Newfoundland.** There is no universal program. The regional Home Care Program for St. John's started in 1973. It has three components: acute, continuing and Home Support Program for seniors. The 1986–87 budget for acute and continuing care was $1.8 million. the 1986–87 expenditures for home support were $366,000. A number of hospitals, nursing homes and public health nursing-based programs exist in rural areas, and provide HM, HN services. The Department of Health is planning to provide on a regional basis. The Department of Social Services also provides home support services through community district offices.

Source: Blair G. Richardson, "Overview of Provincial Home Care Programs in Canada," *Healthcare Management Forum* 3, no. 3 (1990): 3–10. Reprinted with permission.

The Verdun Hospital in the Home and the New Brunswick Extra Mural Hospital are clearly home care programs based on this line of reasoning, which are driven by the hospital sector (New Brunswick 1990, n.d.; Marshall 1989; Bouchard 1990). On the other hand, efforts in Quebec to designate the Centre locaux des services communautaires (CLSCs) as the site of delivery of home care programs reflects a community orientation (Fédération des CLSC du Québec 1988b). Several documents from many jurisdictions have argued for a non-institutional base for home care programs (Alberta 1990a; British Columbia 1990a; Ontario 1990b).

3. How should the community/acute care hospital interface be managed, regardless of which is the lead sector in home care? This appears to be handled in a variety of ways. Many hospitals have discharge planning committees (Marshall 1989), while Alberta and the City of Vancouver, where the provision of home care is located in public health units, have public health nurses located in hospitals as "liaison nurses," who coordinate the discharge planning (Alberta 1990a; Vancouver 1981–84). The Capital Regional District of Victoria, British Columbia has responded through the Victoria Health Project — a project developed to facilitate hospital/community partnerships — by creating "quick response teams" which essentially provide hospital-based geriatric assessment and treatment in the community (British Columbia 1988; Marshall 1989; Finnie and Layton 1990).

Long-Term Care

In contrast to home care which often emphasizes professional clinical services, and which may or may not be provided on an episodic or ongoing basis, "long-term care" has been used to designate all those home support services provided on an ongoing basis to assist people with chronic disabilities to remain in their own homes. As such their general purpose is to prevent premature and/or permanent placement in a hospital or a care facility such as a nursing home or other long-term care facility.

The Federal/Provincial/Territorial Sub-Committee on Long-Term Care (Canada 1990i) has produced an extensive overview and program description of long-term care programs across Canada. As with home care programs, there is considerable variability in the range of services provided, client eligibility and the extent of public/private mix of providers. Kane and Kane (1985, 1988) have published detailed descriptions and comparisons of long-term care programs in Ontario, Manitoba, and British Columbia.

Coordination across a range of long-term care services appears to be left to the service delivery level. Marshall (1989) has conducted an excellent analytical review of the organizational models which are used across Canada in the provision of long-term care services. That effort will not be duplicated here except to outline briefly the conclusions of that review, all of which are familiar themes and all of which have some bearing on the organization of delivery of community-based services to older adults:

1. Long-term care services in Canada are disorganized and fragmented. As discussed earlier, this is largely a result of jurisdictional, bureaucratic and professional territoriality
2. Long-term care services are undermined by cost-benefit analyses which seek to justify long-term care on the basis of its effects on reducing cost in other sectors, especially the institutional sector

As Shapiro (1989) has pointed out: "it is hard to understand why home care is always being studied when home care budgets consume from 2.3 to 4 percent of provincial health care budgets. Why are we not studying the big spenders as assiduously as we studying home care?" (p. 23).

With expenditures on long-term care as proportionately low as they are,[1] cost reductions can only be at the margins (Finnie and Layton 1990). Marshall (1989) and others (Canada 1988f; Institute for Health Care Facilities of the Future 1990) have argued that long-term care should be evaluated on its own terms, that is, because it is a preferred method of delivering service.

3. Related to the above is the fact that the provision of community-based long-term care is threatened by "medical and hospital-based interests, who are the most powerful players in Canadian health (and social service) care [and who] increasingly seek to develop initiatives in the area" (Marshall 1989, 91)

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[1] Several provinces have taken steps to revise their funding formulae (e.g., Saskatchewan 1991) in order to increase economies.

Several documents have argued that the physician is the most appropriate single-point-of-entry (Canadian Medical Association 1987; British Columbia Medical Association 1973, 1990). Binney, Estes and Ingman (1990) have cautioned that the increasing medicalization of home health services for older adults in the United States suggests that: "there is a substitution mechanism in effect, wherein the increased provision of highly medical services is replacing the provision of other non-medical or less highly medical services" (p. 770).

There are indications that the same sort of phenomenon may be occurring in Canada; in a discussion paper, one Canadian interest group has emphasized "physical need" as the criterion for eligibility for long-term care (British Columbia Medical Association 1990). In combination with the demand that long-term care prove its effectiveness by reducing other health care costs, such as hospitalization and physician visit rates, this may have the effect of emphasizing a medical rather than a social model of long-term care.

Continuing Care

In many respects, the separation of home care services and long-term care services is an artificial one on both a policy/planning level and a service delivery level. In some jurisdictions, home care and long-term care are administratively combined. Both British Columbia and Manitoba administer and finance both kinds of services, which are delivered from, or contracted out of, regional public health units and municipal health departments, through a provincial Continuing Care Program. The whole range of home support services in Quebec is provided on a coordinated basis through a network of 159 community health centres (CLSCs). Saskatchewan combined the Saskatchewan Home Care and Long Term Care in Special Care Homes and Hospitals programs into a Continuing Care Branch (Saskatchewan 1989).

In many jurisdictions, such as the Province of British Columbia, the Continuing Care Program includes the long-term care facilities and, thus, manages the community/institution interface (British Columbia 1989f, 1990a). In other jurisdictions, the two sectors are administered and financed separately.

Other provinces are moving towards more integrated and coordinated systems of continuing care. As a coordinating mechanism at a service delivery level, Alberta Health is implementing a network of regional Single-Point-of-Entry Committees which will comprise all providers of home care and long-term care services in the region (Alberta 1990a). Ontario's opposition (1986) has recommended an integrated and coordinated provision of community-based health and social services through fourteen local offices of the new Community Health and Support Services Division (which combines programs of the Ministry of Health and the Ministry of Community and Social Services); the intention is that these offices will work with already existing agencies in the community — District Health Councils, municipalities, local planning organizations, service providers and consumers — in order to "build a coherent integrated service system on the foundation of existing in-home, community support and long term care facility services" (p. 3).

Many jurisdictions are using a single-point-of-entry case management approach[2] to coordinating the continuum of services for older adults (Richardson 1990). Again Marshall (1989) provides a good review of the literature on case management models.

Chambers (1985) has reviewed instruments for measuring the quality of long-term care by examining the actions of direct providers.

At the time of writing it was still too early to determine the impact on the structural models for continuing care of recent moves towards regionalization in several provinces.

Day Care, Respite Care and Caregiving

The Ontario Ministry of Community and Social Services (Flett 1990) has reviewed day care programs and respite services in that province and explored the literature. Palliative care is mostly hospital-based but may sometimes be provided at home (Institute for Health Care Facilities of the Future 1990). These services provide important relief for family caregivers and may provide support to workers in the community care services.

Gallop et al. (n.d.) who reviewed the literature on caregiving said: "It is clear that the formal health care system depends on the care these informal care givers provide. ... Evidence of the psychological burden of care giving is well documented. ... It is [also] clear that caregiving is a financial burden to many families" (Executive Summary).

Mohide et al. (1990) found that caregivers looking after demented relatives were suffering from above average levels of depression and anxiety.

Rural hospitals do not always provide outpatient follow-up services for elderly, chronically sick or disabled patients who need intermittent therapy unless special arrangements are made (as in British Columbia for physiotherapy for arthritics) (Pack 1974).

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[2] Canada (1988c) have put out *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* in which four coordinating mechanisms are suggested: (1) determining the catchment area; (2) single entry delivery systems; (3) case management; (4) case registries for patient tracking.

Preventive Approaches

New Horizons Grants from Canada Health and Welfare support the development of projects and activities which intensify contacts and links between seniors, and partnerships between seniors, groups and community organizations. Provincial organizations such as the British Columbia Seniors' Resources and Research Society (1991) are promoting wellness programs. The National Advisory Council on Aging (NACA) is encouraging elderly persons to plan ahead for dependency (Canada 1990k). NACA has been lobbying for continuation of adequate seniors' income support by the federal government, noting the poor financial position of some elderly non-married women (Canada 1991c).

Toronto Senior Link (1991) is a voluntary agency which endeavours to provide neighbourhood services in order to make the transitions from independence to dependency gradually.

Discussion of Community Care Models

Of all the health issues facing Canada in the last decades of the twentieth century — with the possible exception of AIDS — it is the challenges to the health care system of providing for an aging population which highlight the need for a reconsideration of the structural arrangements for the provision of community-based health care services. Several good overviews discuss many of the issues that arise as a result of the "aging of the population" in Canada (Chappell, Strain and Blandford 1986; Marshall 1987; Rathbone, McCuan and Havens 1988; Kane and Kane 1985, 1988; Lewis 1989).

While many have cautioned against a crisis mentality (Evans et al., 1989; Hertzman et al. 1990; Evans, 1989a,b; Barer et al. 1987), nevertheless, an "apocalyptic demography" rhetoric (A. Robertson 1990) appears to drive much of the discussion around health care for older adults. Indeed it is important to consider under what social, political and economic conditions the population group over sixty-five becomes a significant group to health care planning. As Jamieson (1989) says: "The increase in the interest in older people does not reflect a sudden upsurge in the concern with the well-being of this section of the population as such. Rather it reflects a concern with how society in general is to respond to and cope with some major changes which have taken place and are still happening, first in the demographic structure, but also in the economy" (p. 445).

It is clear that more attempts are being made to determine needs and reconsider community service provision for the elderly all across Canada (Hodge and Collins 1987; Canadian Consensus Conference 1989; Joseph and Cloutier 1990).

One positive aspect of this increased interest in older adults as a population group is that many of the issues which arise around health care for this group have been present for other population groups — children with disabilities, young adults with disabilities and persons with mental health problems. However, it is the sheer size of the over sixty-five group, a group with the ability to wield considerable political power, which has forced consideration of the major barriers to the effective delivery of community-based health care services into the discussions of all health care jurisdictions in Canada. In the course of reviewing the literature for this study these have been almost universally identified — in documents prepared by federal, provincial and municipal governments, as well as by research institutes, professional organizations, and academics — as:

1. The inadequacy of a clinical/medical model of health when addressing the health care needs of older adults. Many of the influences on the health of older adults (as indeed with other population groups) have to do with non-medical issues — isolation, the loss of role and status, the death of family and friends — as well as being issues traditionally considered outside of the health sector — poverty, lack of suitable housing, poor transportation (Canada 1982b, 1988c,f; Ontario 1990b, 1991a; British Columbia 1986; Institute for Health Care Facilities of the Future 1990)
2. Bureaucratic and professional territoriality which results in the lack of coordination of health and social services at an overall policy/planning level as well as at a service delivery level (Canada 1982b; Ontario 1990b; Marshall 1989; Schwenger 1989)
3. The institutional bias in the provision of health care services in Canada which inhibits the development of appropriate community-institution interfaces (Marshall 1989; British Columbia 1986, 1988)

In short it is the legislative and financial entrenchment of a medicalized acute care model of health care in Canada which constrains all discussion of the provision of community-based services to older adults. Various documents produced by several governmental and non-governmental jurisdictions in Canada, which have examined the issue of health care in general for older adults, have universally recommended a combined health and social services approach to support the autonomy of older people (Ontario 1986, 1990b,f; Canadian Medical Association 1987; Canada 1988f; Fédération des CLSC 1988b; Dartmouth, Nova Scotia 1989; British Columbia 1990a; Alberta 1990a).

All of these reports also point to the inherently intersectoral nature of the health needs of older adults, not only at central government policy/planning levels but also at local service delivery levels. As one document (British Columbia 1986) observes: "While not all issues involving seniors are under the control of local communities, their very existence is likely to affect local discussions and planning" (p. 3).

In addition the administrative and financial arrangements put in place at the level of central governments defines and constrains the boundaries of practice at the service delivery level (Marshall 1989).

As discussed above, there are several indications that community-based services to older adults are moving towards a social model of health and towards being coordinated and integrated at both policy/planning and service delivery levels. However, these developments also appear to be occurring in the context of several countervailing trends which have arisen in the context of the cost-containment rhetoric of the 1980s and 1990s:

1. The increasing expectations of home care and long-term care programs to reduce costs in the institutional sector, which may result in:
   A. An increasing medicalization of home care and long-term care services
   B. The proliferation of a rhetoric stressing the "independence" of older adults, and the responsibility of local communities and families for the care of elders, in spite of the fact that families already provide about eighty percent of the care for their older members (Jutras 1990)

All of these trends can be regarded as attempts on the part of federal and provincial governments to reduce collective responsibility for the provision of certain kinds of services, in other words a retreat from the welfare state.

The apparent contradiction in the discussions of health care for older adults have significant implications for the nature of community-based services for older adults and for the organizational arrangements for their provision. The outcome will ultimately be a political one. It will be necessary for the provincial governments to decide on policies and their implementation.

Summary

This chapter reviews the development of programs in the community for the care of the elderly. There is great variability in the programs from one province to another and no consensus on what should be the basic components of these programs.

There are a number of organizational questions for the provinces to answer. Should home care (principally nursing care after an acute care episode) be based on a medical or social model? Should it be hospital- or community-based? How can the hospital/community interface be managed well?

How can long-term care be better coordinated? Does it always have to be justified in terms of cost savings? Can hospitals be persuaded to let go of this sector?

Some provinces have combined home nursing and long-term care into a service called continuing care which manages the hospital/community interface better. Some are using case management models. Some have developed day care and respite care.

There is a real concern about the pressures on caregivers.

Preventive services are available in some provinces.

It is in this service area that ideas about adjustments relating to the shift from a biomedical to a social model of care can most readily be observed. But the problems of cost containment are constraining the governments from moving ahead from the medical into the social model of care.

CHAPTER 14

Rural Health Services

Because of its vast extent, its harsh winter climate and in some provinces, geographical features which make travel very difficult, Canada has major problems in providing universal and equally accessible health care to all citizens.

Although the emphasis in the early days of the shift to collectivist health care organization was put upon universal access to medical and hospital services, this has not been easy to achieve. The provincial inquiries into health service provision conducted in the second half of the 1980s (which will be discussed in Chapter 29) reported that rural dwellers were not satisfied with what was being provided for them. The population is unevenly and widely spread. There are far fewer people living in rural areas than in metropolitan centres and so it is difficult to meet the promise of providing readily available comprehensive care to all Canadian citizens.

As discussed in Chapter 9 the clinical medical care system is organized into regional hierarchies. Tertiary care is given only in metropolitan centres where there are medical schools (or regionally by some arrangement with them), secondary care is available in larger towns and primary care is at the base of the pyramid. But the primary and secondary care physicians are not evenly distributed. There is a clustering of most of them as near to the university teaching centres as they can manage to locate their practices.[1]

There was a growing concern about the distribution of care between metropolitan and rural areas in the late 1980s. Ontario (Rourke 1989), Quebec (Hirsch and Wooton 1990), and the Alberta Medical Association (1989)

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[1] It is not necessarily the doctors themselves who choose to live in the major cities; often it is their husbands, wives and families who want to be there (British Columbia 1991).

published studies showing how uneven this distribution was. British Columbia's Royal Commission (British Columbia 1991) received many complaints from people living in rural areas. Lee (1988) has reviewed the literature on rural health care. Lepurnam and Trowell (1989) provided information about the satisfactions of family doctors living outside the cities.

Hospitals in Rural Areas

The organization of rural medical care today is closely related to structures set up in the past to try to compensate for this uneven distribution of doctors. When National Health Grants 1948–69 made it easier for rural communities to build hospitals (because they had only to find one quarter of the capital cost) many did so in the hope of attracting doctors to their areas (Taylor 1978).[2]

The offers of grants for hospital construction (i.e., National Health Grants in 1948) were taken up more enthusiastically than the governments had expected, for hospitals, then, were the symbol of collectivist caring. Rational planning of hospitals was conducted by consultants or committees in most provinces (Taylor 1953). (Only Saskatchewan had its own professional planners.) But the plans were often swept aside by back-bench Members of provincial Legislative Assemblies (MLAs) anxious to see these symbols of caring set up in their constituencies. Most provinces found that they were pressured to build many small rural hospitals.

As the roads improved and modern technology was brought into the larger population centres, the smaller hospitals became relatively limited in what they could provide. The governments usually set up secondary referral hospitals in larger rural centres to provide services of specialists who were supported by laboratories and other diagnostic facilities. As well, they encouraged development of travelling clinics staffed by tertiary care specialists who saw patient referrals and provided further training for local doctors to follow up their cases.

Reorganizing the Hospitals

Because travel to the secondary centres is much easier than it used to be, provincial governments have often tried to close rural hospitals, but there has been tremendous resistance (Houston 1990). Hospitals are more than

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[2] Some places were too remote for a hospital. There the government might set up a nursing station or the Red Cross provide an outpost. Newfoundland decided on the opposite strategy — to bring people from the outposts nearer into civilization rather than trying to take services to them. That province is well provided with cottage hospitals in larger rural settlements.

treatment centres — they provide local employment and encourage local businesses.

Rural dwellers have argued the necessity for maintaining emergency services and birthing centres closer to home and for many years provincial governments kept the small hospitals open because it was politically suicidal to close them.

In 1993 Saskatchewan finally "bit the bullet." The province was in imminent danger of going bankrupt and it used this as the reason for closing many of its rural hospitals.[3] Although there were strong protests, the New Democratic Party (NDP) government was reelected in 1995 but with a smaller majority, which some have linked to the hospital closures.

Restructuring

If the hospitals could not easily be closed, then perhaps they could be restructured. Alberta and Saskatchewan redesignated some of their small acute care hospitals as extended or personal care homes (Canada 1986b). Texeira (1987) described the way in which Saskatchewan turned some of these small rural hospitals into "community health centres" (CHCs) from 1972 onwards. He said that, if the hospital board could arrange the services of a visiting physician, it could open a centre staffed by a resident nurse on twenty-four-hour call, and recruit part-time staff for laboratory, x-ray and maintenance services. Social services could choose to use the facilities, too, if they so wished. By 1987 there were eleven rural so-called CHCs in the province, three in the pipeline and seven others which, Texeira said, might qualify for financial aid.

Other provinces, such as Nova Scotia (1984), were also interested in turning rural hospitals into outpatient medical clinics. The Valley Health Services Association of Kentville, Nova Scotia, has established a Division of Community Health within the association to provide services to the Fundy region in order to increase the use of outpatient services and reduce hospital inpatient stays. The hospitals have been working together with the public health departments to evaluate the restructured services (Nova Scotia 1990a).

In Manitoba the government has had some success with its CHC policy. The five rural health centres have, by now, been incorporated into a hospital outreach system. The Hamiota District Health Centre provides one example of good horizontal and vertical integration: comprehensive care is

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[3] In 1971 the Deputy Minister of Health had been anxious to close some of these hospitals.

given through a medical complex attached to an acute care setting. Extended care, elderly housing and continuing care units are also available. All physicians in the area work through the centre and are salaried. A health care team manages individual patient's cases and the continuing care coordinator ensures linkage of services (Beaudin 1989).

Quebec's rational plan for health service development proposed that gaps in service in rural areas would be filled by Centres locaux des services communautaires (CLSCs). Although this took many years to achieve, it was thought that by 1991 there was complete coverage of the province through the provision of 159 CLSCs, many in rural areas.

Some Hospital Outreach Programs for the North

The University of Manitoba has a circumpolar medical centre in Churchill, set up to develop special concern for northern peoples and their particular problems (Medd 1978). Angus and Manga (1990) discussed the development of remote clinics in Ontario, affiliated with city teaching hospitals. These clinics claim to be bringing care to areas which would not otherwise have services. The authors were critical of the development of a hospital rather than a community base for providing such services.

Some Other Hospital Outreach Programs

At a British Columbia Health Association Conference for Rural Hospitals in 1990, five hospitals' outreach programs were described and help was offered to any other hospitals which wished to start up their own programs in outreach for rehabilitation,[4] treatment of chemical dependency, family support services, emergency response to family violence (Coleman 1990) and mental health outreach (Riverview 1990). It may well be asked whether the hospital is the most appropriate place to start these last four programs or whether there are other centres from which community development could be launched. In the British Columbia context these new outreach programs were linked into the experimental Hospital/Community Partnership Program which sought to turn over some of the hospitals' funds to prevention and promotion activities but they were still hospital-based. Now they will be taken over by the regions set up in 1993–94.

Community Home Support Services

If it has been difficult to get doctors to settle in outlying areas, it has often been more difficult to organize community home support services. Thus

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[4] Outreach rehabilitation services in Northern Ontario were cited as an example (Beggs and Lanthier 1989).

while the cities had the Victorian Order of Nurses (VON) to provide district nursing care, the rural areas were not often served. Consequently patients usually expected to stay longer in hospital. Utilization was likely to be related to availability of resources and there was often an oversupply of hospital beds in rural areas (Northcott and Rall 1983; Pope 1978; Robinson and Evans 1973; Bartel, Waldie and Rix 1970).

However, in the mid 1970s, home care services began to be provided by public health departments, and later, continuing care was organized in some provinces, usually out of health units. And although acute care cases might stay on in general hospitals for a few extra days, these did not always provide outpatient follow-up services for chronically sick or disabled patients who needed intermittent therapy, unless special arrangements were made.

Outreach Rehabilitation Services

Rehabilitation hospitals have argued that it is particularly important that they provide outreach, for many of their patients need extensive social support services to make their readjustments to society, as well as needing continuing medical supervision. Pack (1974) has described the development of rural community support services for arthritis patients in British Columbia, backed up by local hospital services. Attention is also being given to setting up similar programs for children with long-term care problems (Sunnyhill Health Centre 1994a,b).

Rural Mental Health Services

Mental health services in rural areas are usually provided by outpatient clinics of provincial mental health departments because rural hospitals seldom have psychiatric specialists on staff. Efforts are now being made to train family practitioners in psychotherapy (Trent 1990) and some universities have developed travelling clinics. Richman (1989) has discussed the problems of general practitioners in deciding how to cope with psychiatric problems.

Kyle (1985) listed a number of alternative approaches to rural psychiatric care — the psycho-educational approach, lay counselling programs, residential retraining programs in life skills, therapeutic caring for disturbed children, community supported housing for disturbed individuals in a rural centre of treatment. These British Columbia services have been well publicized by the federal government. A report on the conference of mental health workers from the western provinces (Canada 1984) addressed questions of personal, professional and program survival in rural areas.

Development of Greater Concern for Rural Health Care

The provincial health reviews of the 1980s have laid out the problems of providing egalitarian care in rural areas. Now it is an issue which governments cannot ignore.

The problem of rural health care is not only one of medical care distribution. Many rural dwellers are poor. They have gone to find cheap living accommodation out of the cities. The Active Health Survey (Canada 1985c) found that there were many Canadians with low incomes whose lifestyles were not healthy. This suggests that there is a need for other kinds of support services to help such minority populations. Because Quebec's provincial inquiry looked at both medical care and social services, this province has identified a number of social issues which need to be tackled together with providing physicians' services in rural areas if the population is to be kept well (Quebec 1988).

Summary

Canada has found it difficult to provide universal, comprehensive and equitable health care to people living in rural areas, partly because of the way in which the medical profession is organized into regional hierarchies located mainly in the larger cities, and partly because of the more advanced technology which requires complex services to be centralized. But great efforts have been made to establish up-to-date secondary level treatment centres and travelling clinics across the provinces. Public health departments have moved into providing community home support schemes in rural areas.

Hospitals were overbuilt from 1950 to 1969 when it was easy to get hospital construction grants. But it is politically difficult to close any hospital. Many rural hospitals have been restructured into outpatient clinics or extended care homes though some provinces are now committed to closing down unneeded hospitals.

The provincial health reviews, 1984–91, identified many gaps in their systems of rural health care. Some provinces have developed community health centres in rural areas and outreach programs have been established in rehabilitation and mental health sectors. Despite these changes it is known that many rural dwellers are poor and that they need social supports as well as medical care, and there is still much that needs to be done to provide comprehensive care for these people.

CHAPTER 15

Four Preventive Care Programs

Four issues have been chosen to show the scattered approaches to prevention outside the structures of the traditional health care system. In Chapter 17 the problems of horizontal and vertical coordination within the health service organizations will be considered. This material is presented to raise the issues of lack of coordination between different departments of the provincial governments and with non-governmental organizations in the preventive sector of health care.

Monitoring Accidents

Statistics Canada collects data about accident mortality rates which include suicides and homicides (Canada Statistics Catalogue, annual). These rates vary enormously between the provinces and, furthermore, considerable variation can be found from one year to the next. Fluctuations are particularly evident in provinces with small populations. These data may be used to justify the introduction of preventive programs (Canada 1990f). Accidents (including suicides and homicides) are the primary cause of death among young people above the perinatal age in Canada and the reason that many are impaired, disabled and handicapped. Consequently provincial governments are anxious to prevent accidents as much as they can.

A New Perspective on the Health of Canadians (Canada 1974a) identified health status risks as being related to lifestyle, environment and biological risk, but the health departments themselves can do little in these areas except to provide educational programs. Most of the preventive work is done by others who have a special interest in a particular area. Quite often this interest is related to the question "who pays for the results of accidents?" Insurance companies providing income support to the injured would prefer to reduce demands upon their funds.

The first two examples chosen — safety policies in occupational health and prevention of motor vehicle accidents — bring up problems of individual protection within an insurance context. The second two examples — prevention of substance abuse and prevention of suicides — raise different questions about the limits of choice of lifestyle in Canadian society.

The Interest of Insurance Companies in Prevention

Occupational Health and Safety

In the past the main focus of attention on health care lay in the work situation, for when Canada industrialized, families tended to rely on one breadwinner only (instead of all members of the family) and his ability to continue to work was of the greatest importance. Following the example of other western countries, Canada's provinces set up Workers' Compensation Boards (WCBs) in the decade following 1907. Employers were assessed according to the hazards of their work situation, using insurance principles. Guest (1980) has described the differences between these boards which used a range of European models of organization.

At first attention was given to the matter of income support for the families of injured or dead workers, but it was soon recognized that prevention of accidents could profit both employer and employee. It has long been recognized that prevention is better than having to compensate and rehabilitate those with occupational injuries, but since 1972 more questions have been asked about the adequacy of preventive activity in work situations. This is now the responsibility of the Minister of Health in Quebec, the Ministry of Labour in other provinces and the WCB in British Columbia. Most provinces have rewritten their occupational health and safety legislation[1] fairly recently or revised their workers' compensation laws (Nash 1983). The general thrust of these changes has been to ensure the rights of workers to have information on the hazards of particular jobs and to refuse unsafe work. Joint labour management committees on health and safety have been set up. They are expected to determine safe standards for work performance and working conditions and, subject to a review by a government appointed inspector, establish rules governing safe working conditions. More often, however, they are used to mediate complaints.[2] Despite these reforms, Sass (1989) did not think that there had been meaningful changes in workplace health and

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[1] The Ontario Ministry of Labour has developed a bibliography on occupational safety.

[2] Clyde Hertzman, personal communication, 1991.

safety. He wanted to see more involvement of workers in the overall policy decisions of their employing bodies.

Despite efforts to improve safety at work, the number of claims has risen in recent years. Some of this is due to persons with industrial diseases beginning to make claims, but these are only a small proportion (about six percent) of the whole number of claimants [Ison 1989]). Some (e.g., Maynard 1993; Schulze 1993) have suggested that while workers' compensation was appropriate to earlier forms of industrialization, it is not serving "the information society" well. Yet others believe that WCBs are in trouble because of poor management (Geary and Buchanan 1990; Alberta 1990d).

Quebec takes a different approach to occupational health and safety from the other provinces. New legislation introduced in 1979 linked the preventive activities of the old Workers' Compensation Board into the restructured public health care system. Preventive care was to be provided through activities of the Départements de santé communautaire (DSCs) and Centres locaux des services communautaires (CLSCs). Problems in integrating various sectors of the reformed occupational health care programs were discussed by White and Renaud (1987) in a report to the Rochon commission (Quebec 1988) which was reviewing provincial health services. White and Renaud explained that

> the system that was created by the Act provided for a purely supportive role for the [occupational health] network: the identification of health risks and the preparation and application of specific health programs for each enterprise ('secondary prevention'). 'Primary prevention,' that is the establishment of specific mechanisms to prevent illness and accidents, is the responsibility of the private sector. There is an interdependence between the two which should ultimately be ensured through the role of the health and safety committees in a work place. (p. 189)

But in the first eight years of restructuring, the tensions in Quebec were so great that a number of occupational health experts left the field, and power struggles between various interest groups delayed progress in establishing pivotal elements of the system. The researchers presented their analysis of the difficulties in bringing together Workers' Compensation Boards and public health organizational cultures and examined five possible models for modifying current problems. Their recommendations were concerned with improvement of linkages between different sectors of the system through appointment of liaison officers.

This approach has not been taken by the other provinces which have not seen occupational safety as a health service issue. But the whole area of occupational risks has become a matter of greater public concern. Much more research is now going on than even a decade ago. WCB structures are under pressure to bring in reforms.

Prevention of Motor Vehicle Accidents

Four provinces have taken over motor insurance as provincial responsibility — British Columbia, Saskatchewan, Manitoba and Quebec. These provincial motor insurance companies are strongly committed to prevention. For example, the Traffic Safety Education Department of the Insurance Corporation of British Columbia (ICBC) claims to have been involved in community development for several years. This five-stage process of community development is outlined in a paper by Coté and Cooper (1990) as: community profile development, community contact development, committee formation, planning and implementation, and review and evaluation. ICBC's community programs are particularly concerned with educating school children in bicycle safety and pedestrian safety and improving adult drivers' behaviour. Use of seat-belts has greatly improved, although it was said that the drunk-driving Counter-Attack Program was not yet having much impact.[3] It is recognized that there are insufficient recreational alternatives in small towns and this leaves room for drug and alcohol abuse to creep in. ICBC traffic safety staff have produced a series of booklets on aspects of drivers' behaviours in relation to specific kinds of accidents (Rothe 1986, 1987a,b, 1990; Rothe and Cooper 1987a,b). Similarly, Saskatchewan has produced studies of night-time drivers (Hieatt 1989), a seat-belt use program (Landry 1988; Medgyesi 1990) and senior drivers.

This does not mean that the other provinces are not concerned about motor vehicle safety, but they have decided to leave insurance to private companies. One of the larger issues for all companies is the discussion around the introduction of no-fault insurance which means that cases are settled out of court (as in workers' compensation). It is recognized that taking cases to court delays the start of the rehabilitation process as it is important to demonstrate the extent of injuries in order to increase the amount which may be awarded in a settlement. No-fault insurance is likely to reduce the total cost to the insurance companies and thus to the persons taking out insurance. Canada has investigated the possibility of following New Zealand's example (New Zealand 1967) and introducing a no-fault scheme for all accidents (Ison 1989; ICBC 1990), but in spite of considerable interest (Canada 1983–86), a national scheme has not yet found sufficient support from the experts or the public.

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[3] This is a program of the Department of the Solicitor General, responsible for the police and their activities in the province. Bill Hubbard, personal communication, 1991.

Helping Those with Problems to Adjust to Mainstream Canadian Society

In a rapidly changing world moving towards a global economy, just coping with daily life and fitting into the mainstream of Canadian society is not easy for everyone. Some people find that meeting day-to-day demands is very difficult, and they are tempted to use drugs and alcohol to escape their responsibilities. Others go even further and decide to commit suicide rather than go on living. Canada struggles to help these people through preventive and/or rehabilitative programs.

Prevention of Alcohol and Drug Abuse

The issue of drug and alcohol abuse came to wider public attention with the radical social movement of the late 1960s, when young people started to leave home, to trek across Canada and to explore the world. Unlike their parents, who used alcohol as their drug of relaxation, young people tried out a range of other drugs such as marijuana and heroin, shocking the establishment and creating a political furore. The response of the federal government was to set up a royal commission (Canada 1973) to explore the magnitude of the problem and to suggest solutions. The commission was divided in its response, reflecting the divisions in the community. However, the result was the establishment of provincial Alcohol and Drug Commissions where these did not already exist, with mandates to research the problems, advise on policies and administer programs for addicts.

Many of the problems were common to all provinces though there were some differences. For example, British Columbia had to cope with the highest number of heroin users. The political salience of drug abuse has decreased since that time, leading some provinces to change the organizational structures for dealing with substance abuse. British Columbia, for example, abolished its commission and put drug counteraction programs under its Department of Labour, though these programs have now been brought back into the Department of Health. Alberta has reorganized its commission, creating a simplified structure (Kearns 1984), and has moved into social marketing of programs to adolescents (Kearns 1986).

A national survey provided information on the need for services (Canada 1990g). How the problems were being dealt with at the provincial level depended very much on the success of the bureaucratic authorities in developing relations with local communities. For example, the Nova Scotia Drug and Alcohol Commission, which reports to the Minister of Health, set up five community-oriented regional advisory boards and established a number of strong program divisions: the employee assistance program division, which works with large companies; the documentation, evaluation and research division; the prevention and community education division; school services; the staff training and development division; library and media services; the treatment and rehabilitation division; and an employee assistance program (Nova Scotia 1988). However, as a result of recommendations by the provincial Royal Commission on Health Services (Nova Scotia 1990a), further restructuring to improve Nova Scotia's substance abuse rehabilitation services has been considered.

This list of activities in Nova Scotia gives some indication of the common policy problems. These were laid out by the government of Canada (1988a) in an action agenda — that is, counter-attack on drug abuse affecting driving, work performance, schooling, family life, native peoples, and efforts to moderate the cost to the nation in terms of law enforcement and medical services. Advisory pamphlets have been produced to help families with parenting (Canada 1990b,d,e), to help community groups to curb impaired driving (Canada 1990f) to help school children to work with peer groups (Canada Health and Welfare 1990a,b,c,d,e) and to give to those who want it general information about drugs (Canada 1990g).[4] One other area of concern has been the overuse of prescription and over-the-counter drugs by elderly persons.

It has become clear that the counter-attack against drugs will not be successful without community support. Considerable efforts are being made to work with local communities on drunk driving,[5] with industrial workers on alcohol use (McLatchie, Grey and Johns 1981), with school children and youth groups, with families at risk of violence and with native peoples (Hodgson n.d.). The Ontario Advisory Committee on Addictions (Ontario 1989a) has developed guidelines for establishing community action groups.

The emphasis on developing treatment programs was given greater priority in the mid 1970s. Underwood (1990) has argued that there are too few treatment programs in Canada and that addicts are having to go to the United States for care if they are desperate and can afford it. Most service providers would agree that more needs to be done in the area of rehabilitation (e.g., Nova Scotia 1987a).

As for long-term care, that can be successful only with community support. Alcoholics Anonymous, a self-help group (Maxwell 1964; Gallant 1987), assists large numbers of addicts in retaining their sobriety.

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[4] Drug information telephone lines have also been set up and are much used.

[5] Studies are beginning to be undertaken on alcohol related admissions to British Columbia hospitals. It has not been possible to access this evidence because it is not yet in the public domain.

The emphasis on improved coordination of services, which is a major thrust of the new regional authorities, seems likely to result in amalgamation of separately funded and structured community services being brought together under one management. Thus, for example, discussions are going on in Vancouver about combining, in 1995, public health, mental health and drug and alcohol services to form six restructured community service networks. Since these networks will have close links to community representatives who have the responsibility for planning and policy, it is hoped that more effective drug and alcohol programs will be developed.

Prevention of Suicides

Voluntary organizations often move in first when a social problem is recognized. In Canada the Samaritans set up a telephone service to counsel those who needed support for their depression problems. Most provinces still count on this service to meet these needs.

Alberta appointed a provincial suicidologist in 1978. The purpose of the appointment was, and is, to reduce self-destructive and suicidal behaviour and to reduce the impact of suicides and suicidal behaviour on individuals, families and communities. The reason for this appointment was the rapid increase in the 1970s in the number of suicides by young persons. The program was evaluated in 1987–89 after reviewing the existing situation and the general literature (Alberta 1989b) and it was recommended that it be strengthened by providing more time for contributions of the provincial expert and by increasing involvement of trained volunteers from the community.

However, the whole issue of suicide seems to be difficult for the policy makers to tackle. At the other end of the scale from the suicides of young people are the requests of those with incurable diseases for assistance to die. So far Parliament has not been ready to address this issue, despite growing concerns in the Canadian community. The response is much like that of the Le Dain committee, a division of opinion abut the rights of the individual to make individual choices of lifestyle and when to die.

Summary

This chapter has reviewed four preventive programs carried out by organizations other than the traditional provincial health departments. The first two of these, workers' compensation and motor vehicle insurance organizations, are spurred on to take safety measures by the costs of providing insurance to injured people. The second two, prevention of substance abuse and prevention of suicides, raise different problems about individuals' adjustment to Canadian society and the demands of society upon them.

This material has been presented in order to raise the issues of lack of coordination between different departments of provincial governments and with non-governmental organizations in the preventive sector of health care.

PART V

Developing Control by Formal Authorities

CHAPTER 16

Developing Provincial Policies and Building Up Administrative Structures

When Canada decided to set up a welfare state or, rather, a whole range of welfare states in the provinces which had constitutional authority over social affairs, there were two problems: the first was to legitimate the idea of collectivism, the second to implement it (Hall et al. 1975). In both cases it was necessary to organize structural support for the change in policy. In this chapter the problems of implementation — the need to develop the provincial governments and their bureaucracies to manage the funding and organization of a collectivist approach to care — will be explored. It will trace the development of the formal power structures for controlling funding and management of the system

Development of Provincial Governments

Before the Second World War provincial governments were relatively small authorities. Although under the constitution they had power to regulate health, education and social services within their jurisdictions, they did not expect to be the funders, organizers or providers of services. This was perceived to be the responsibility of the municipalities, hospital boards, school boards, charities or private enterprise. A major exception was the mental health service which was funded and managed directly by provincial governments. Otherwise there were small departments for standard setting in public health, education and social services and very small provincial budgets.[1]

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[1] Guest (1980) has discussed a few other provincial activities but these were fairly minor.

When it was clear that Canada was going to bring in welfare state funding, the provincial governments had to decide how much they themselves wanted to get into organizing service provision and how much they wanted to restrict themselves to being funding bodies only. Of course there is a middle position which they could take — delegation to others under strict controls. While not providing the services themselves, provincial governments can regulate service providers' activities very tightly by legislation, by offering funding on certain conditions, by standard setting and so on.

How the provincial systems were set up differed considerably, not only because of pre-existing organizational structures in the provinces, but because some governments decided to react positively to Ottawa's initiatives, or even to forestall them, while others were much less interested in collectivism. Many provinces were pragmatic in their response to federal offers or to other provinces' initiatives in introducing social programs. Thus different forms of organizational structures were set up. These structures then became established and could not easily be altered.

Provincial Moves in Saskatchewan 1944–62

It is not possible to examine what went on in all of the ten provinces[2] in response to the federal offers of grant aid. Some have been more carefully chronicled than others so it is proposed to limit the discussions to the development of the formal organization of collectivist care in Saskatchewan, Ontario, Quebec, Manitoba and British Columbia. Nor will this be a discussion of any depth, as only a small part of the history of the emergence of collectivist organization structures in Canada has been documented.

As recounted earlier, social reformers in the prairie provinces had developed the Regina Manifesto in 1932, proposing a socialist system of redistribution. Some of these reformers, in the Cooperative Commonwealth Federation (CCF) party in Saskatchewan, were elected to power in 1944 to bring in a collectivist system of care (Lipset 1968). Their first priority was to reform health care in the province. They had hoped to get generous help from the federal government following the Rowell-Sirois recommendations but this was delayed by the power struggles in the Dominion-Provincial Conference on Social Reconstruction, 1945–46 (Feather 1984).

The Saskatchewan CCF government politicians (1944–62) had a shared vision of social reform. The first point to note here is the total commitment of that government to the ideology of collectivism and its willingness to go ahead with incremental planning (to the full extent of its own resources) rather than delay the process of reforming the old system. The second point

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[2] Newfoundland did not join the Canadian federation until 1949.

is their recognition that planning/priority setting was important. On taking office the government's first step was to engage an international expert (Dr. Henry E. Sigerist) to advise on the best ways to proceed to reform the health care system, which was the top priority. Sigerist (Roemer 1960) took the province's difficult financial position into consideration and advised that reforms be phased in. The province did not take complete control over the health care system (unlike the British government's National Health Service). Apart from the mental health facilities which they had controlled from the start, they left the other service organizations to report back to their boards which already existed — the hospital boards and the municipalities.

The CCF government was convinced that the best health service could be achieved through state ownership and control of services. It proposed building up a provincial health care service along the lines of the pre-war Saskatchewan municipal doctor and hospital programs. This aimed to establish a salaried medical service supported by health teams and governed by regional boards representing the local communities' interests. A pilot project in the Swift Current region appeared to be functioning very successfully (Canada 1964) but when it was proposed to set up two more regions and these were voted upon in referenda in 1951, the government lost.

As Saskatchewan continued to develop its policies, the CCF government and its planners encountered growing opposition from the medical profession. Differences in their ideological approaches and the implications of the provincial government's ideology for the planning of organization structures resulted in a series of conflicts. The first came over regionalization. The medical profession successfully organized community opposition to the proposal.

Although the province had the formal powers conferred by legislation, the funding of it depended on arranging collective bargains with the medical profession which had the technical powers. In the 1950s the two groups holding the powers in the system drifted further apart and communication lessened.

Commentators have discussed the way in which the rules governing medical professional organization at that time enabled the doctors to "form a separate government" to fight the duly elected government of Saskatchewan (Badgley and Wolfe 1967).

In 1957 the passing of the federal Hospital Insurance and Diagnostic Services Act provided new financial resources to the province to move to the next stage in its planning (because now it could access grants for the federal cost sharing of hospital services). The government began to work on a provincial medical care insurance plan.[3] An act was passed by the legisla-

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[3] The doctors had made it very clear in 1951 that they did not want a salaried

ture in 1961. It resulted in the first doctors' strike in North America (Taylor 1978). The government brought in an outside negotiator from Great Britain who worked out a compromise with both parties. The doctors objected to the government taking direct control over payment (and therefore being able to monitor their activities), and it was agreed that payments should be made through the established insurance carriers. Community control through boards of management (which had been a major part of the medical hostility to regional structures) was to be banned. Community clinic boards were to be landlords only and to have no power to control the work of the professionals in the clinics.

A number of consumers had come out in support of the doctors during the strike (as they were afraid of losing them to other provinces) but that did not make doctors, politicians or administrators any keener on admitting community members to policy making.

Obviously the CCF in Saskatchewan was not altogether successful in establishing its vision of a comprehensive government controlled system of service delivery. Although the government took control over a number of areas where there were no entrenched interests at that time (e.g., laboratory services [Morrison 1984] and subsidized pharmaceutical services [Harding 1981]), it met with opposition where there were already existing structures.

Saskatchewan had been unable to introduce a total system of care (planned and managed by provincial or regional authorities) because of shortage of funds. The opposition had time to get organized and to set down its terms for cooperation.

A Contrasting Province

In contrast, Premier W.A.C. Bennett (1952–1972) of British Columbia was a pragmatist. He wanted to keep complete control over the MLAs and the public servants so that no major decisions were taken without his input. Because he had the interests of the province at heart, he used every opportunity to claim federal funding. Thus he found it was necessary to develop a large supportive clerical bureaucracy with a very few professional administrators at the top. This premier gave little discretion to his senior civil servants to plan. Instead he responded readily to open-ended offers of conditional grant aid and to the pressures of his backbenchers. Detwiller (1985) has discussed this period in which the medical and hospital administration professionals in the metropolitan areas tried to find funding to keep abreast of medical technical developments while the back-benchers in rural

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system of remuneration so the provincial medical care insurance plan provided for payment by fee-for-service.

areas pushed successfully for more unplanned hospital building in their local communities.[4]

The Development of Provincial Public Service Organizations From 1944–70

Saskatchewan

In Saskatchewan, Henry E. Sigerist, the consultant who advised the government in 1944, recommended that a Health Planning Commission should be set up, separate from the operational departments (public and mental health). This Commission should begin by responding to public demand for hospital insurance, but should gradually bring in a total system of care.

There were no experienced health planners in Canada at that time and so the government had to build up its commission from scratch (Hall n.d.). By 1948, when the federal government offered National Health Grants to the provinces for planning hospital and medical services, Saskatchewan had assembled a strong planning team (Taylor 1953).[5] Although the first group of planners had moved on by the early 1950s, Saskatchewan had then been able to recruit some experienced administrators from the American New Deal programs and some young Canadian physicians eager to reform the public and mental health services. As well, the public health department in the province led the rest of the country in its concern for developing social supports for those in need of help and for improving disease prevention and health promotion. Similarly, the government was successful in reorganizing its mental health services by removing charges for institutional care and setting up regional centres for pioneering community psychiatry in the 1950s.

The Saskatchewan government was also successful in establishing a large health research directorate in the Department of Health, leading the country in setting up a computerized database for planning (Cassell et al. 1970). By the late 1960s this directorate had moved on from planning the restructuring of hospital facilities, and the introduction of hospital insurance and medical care insurance, to thinking about a wide range of issues in community care (Saskatchewan 1966, 1969, 1980a,b).

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[4] By 1966, however, Bennett had decided to control the demands for hospital construction by setting up a buffer group — hospital regional districts to do capital planning in their own areas.

[5] The other provinces had to rely on consultants or provincial committees in most cases. One exception was the report on the need for medical services in British Columbia written by a public health officer (British Columbia 1952).

Ontario

Ontario has a considerable quantity of documentation on the province's public service organizational changes. *The Service State Emerges in Ontario* (V. Lang 1974) describes how Ontario's long-standing Conservative governments developed a bureaucracy to administer the "service state" programs. Ontario liked to think of itself as the leader in Canadian social policy setting. The provincial government not only took responsibility for picking up federal cost-shared programs, but moved into new social service areas on its own. Novick (1980) examined the way in which the historic role of Ontario's government

> to regulate the private service system, to finance the use of private services by lower income groups, and to contribute to the development of capital facilities [changed] when the capacities of the voluntary sector to finance needed services were strained to the limit. ... The rapid growth in social spending ... was situational and reactive. Whenever new problems were identified, or the capacity of the private sector was exhausted, government was persuaded to respond. Intergovernmental roles were never clearly pursued. The concept of a 'direct response' to a specific problem was easier to get into a political system of negotiation and compromise than a general reshaping of programs, or the rationalization of intergovernmental and public/private roles. Thus in the early seventies a social policy system had emerged in Ontario, whose parts were scattered within four levels of government (federal, provincial, municipal, metropolitan) with a decreasing proportion organized and financed through private sources. (pp. 383–84)

Tindal (1980) has indicated that this was a large clerical bureaucracy concerned with regulating the ongoing system. It did not think through policy development issues.

The Second Wave: Developments in the 1970s and early 1980s

Quebec

After the death of Premier Duplessis and the negotiation of special terms of funding for Quebec's social services with the federal government, the province began to plan reform — a total rational plan for all social services including health and welfare programs.[6] The Castonguay-Nepveu Commission

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[6] In Quebec control over social programs was much wider than in other provinces. The province had negotiated with the federal government to set up its own pension plans as well as its other social programs.

(Quebec 1970–72) proposed the establishment of a structured hierarchical organization. Unusually, as Lee (1979) pointed out in a review of the decade, the members of the commission were subsequently appointed to carry out their own recommendations. Whether as elected politicians or appointed bureaucrats, they set about trying to implement the grand scheme.

The plan was to replace the existing private health and welfare systems with a state funded and managed hierarchical organization. Quebec was more thorough in its planning and more intense in its attempts to operationalize a policy of state ownership and control of services than any other province. The development of Quebec's provincial services provided the opportunities for which French Canadians had been waiting, to move up into the middle classes through joining the bureaucracy (Baccigallupo 1978).[7] Renaud (1984) has argued that the government tried to take on too much responsibility for the lives of its citizens — that these new technocrats were too anxious to gain control and that they had not allowed for resistances to change in the medical profession and other sectors.

Thus the rational plans for a four-tier system of health and social service organization — CLSCs at the bottom, then DSCs, regions and provincial government funding and administration of services — has had only partial success. The government did not want to recognize that a system was already in place — a system made up of a whole series of resistant established or emergent sub-organizations (e.g., the medical profession or the community activists) which did not necessarily want to be fitted into the new plan.

There seem to have been endless analyses of the parts of this new system in Quebec, how it was working and how it was not working — in the 'bilans' of the CLSCs. Another set of analyses was concerned with the reorganization of community medicine (Lewis 1984; Pineault, Contandriopoulos and Lessard 1985; Desrosiers 1986b; Pineault, Champagne and Trottier 1986; Brunelle 1986) for plans for its development were very different from the incremental moves in the public health services in any other Canadian jurisdiction. As well there were relatively frequent conferences on decentralization and regionalization, with the participants at these conferences always looking over their shoulders at Ontario's progress.[8]

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[7] It was not until the 1980s that business opportunities for this group started to open up and MBA courses flourished in Quebec, then providing alternative careers.

[8] Renaud (1984) has stated that despite all the rational planning by Quebec, Ontario may have been more effective than Quebec in its health care reforms.

Rodwin (1984) and de Kervasdoué, Kimberley and Rodwin (1984) produced two critiques in which they discussed the problems of implementing Quebec's plans, the former entitling his study *The Health Planning Predicament* and the latter critique being called *The End of An Illusion.*[9] However, it was not until 1990 that it was formally recognized that two systems were existing side by side — the planned public delivery system and the traditional organization of medical care provided in the doctors' offices and polyclinics now paid for by the medical plan.

Manitoba

Meanwhile two other provinces, Manitoba and British Columbia, had taken over the socialist leadership from Saskatchewan (where the CCF government had been defeated in 1962 after passing and implementing the provincial Medical Care Insurance Act). Both now published their plans for developing collectivist care (Manitoba 1972; Foulkes 1973).

Manitoba had recruited a number of committed bureaucrats to develop its health care plans. An earlier election had enabled it to get ahead of British Columbia at this time, to replace its clerical bureaucracy with some experienced civil servants. They developed a White Paper which

> concluded that the rising costs [of health services] were attributable in large part to an outmoded delivery system, characterized by fragmentation and inefficiency, and went on to recommend a number of reforms to remedy this situation — including development of community clinics employing a broad range of personnel ... paying them on a salary basis; establishment of district boards, representative of the district population to determine the allocation of, and administer, health care budgets; and measures to divert resources from acute care hospitals to lower cost facilities (Black, Cooper and Landry 1978, 85)

Commenting on the work of this government, they said:

> Unfortunately, the commitment to major reforms ... was subsequently only very partially carried out by the NDP government. While on the one hand, the home care program and the personal care home insurance and construction programs[10] represent ma-

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[9] The Quebec system of administration interested these writers because it was not a passive clerical bureaucracy like those which had grown up in many of the other provinces.

[10] Roch, Evans and Pascoe (1985) explained: "The insured personal home care program was introduced in Manitoba in 1973. People who qualify for nursing home care are categorized by one of four levels of need, and if placed in a personal care home, have the majority of expenses paid by the insured program. Resi-

> jor initiatives, on the other hand the government was reluctant to confront the vested interests which had to be tackled in order to move ahead with the health centre and regionalization proposals. (Black, Cooper and Landry 1978, 85)

"In short; the government had hardly begun the fundamental reforms demanded by the White Paper and made very little real impact on the problems of fragmentation, inefficiency and unequal access" (Black, Cooper and Landry 1978, 56) before the opposition took over in 1977. Nevertheless it is very clear that the Manitoba socialists' years in office did result in the development of more effective programs by a more effective bureaucracy which was able to follow through with further planning in the 1980s.

British Columbia

After twenty years in office, the Social Credit (Socred) government of British Columbia was dismissed in 1972 and the New Democratic Party (NDP) gained power. When the new democratic socialist government took over, it was encouraged to embark on major reforms of the health care system by the examples of Manitoba and Quebec. As well, there was strong pressure from a cadre of social workers to bring about major reforms in the social welfare sector.

British Columbia inherited Bennett's clerical bureaucracy and so was not able to move fast on introducing change. When the NDP was defeated in 1975, the bureaucracy had not been greatly changed as most of the NDP policy advisers, who were not politicians themselves, had been appointed as temporary assistants to the ministers and left when they did.

R.G. Foulkes, a physician, who had been the administrator of a large hospital, was engaged to prepare a report on health care system reforms (Foulkes 1973). His proposals were long and complicated. They consisted mainly of recommendations for the integration of health and social service departments at the provincial level; for setting up operational regions (six or seven) with coterminous boundaries for health and social service divisions; for reorganization of the provincial Health Department — the closure of its separate program-oriented divisions (tied to the matching grants

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dents of a personal care home subsidize care by a per diem charge. To augment the insured personal care home program, an insured continuing care program was introduced in 1974. The purpose of this program was to provide services in the homes of individuals, thus prolonging stay out of institutions or to facilitate early discharge from a health facility" (p. iii).

As well, Manitoba introduced insured Pharmacare services, chiropractor services, orthotic and prosthetic services and eye glasses for the elderly.

arrangements) and substitution of three new divisions focussing on finance, standards and service administration; for establishment of human resource and health centres at the local level; for creation of a Health Advisory Council at the provincial level, representing producers and consumers, and the organization of similar inputs at regional and local levels; for revision of professional regulation; for the setting up of regional task forces to help with development of plans and encouragement of public participation; and for the creation of program task forces to fill gaps in the system (e.g., in rehabilitation, maternal and child care).

When the Foulkes report was published, it was found that he had already roused the opposition of many groups. The ministers could see that the chances of implementing such major changes as he suggested were poor. He was sidelined into planning community health and social service centres and restructuring health care for the elderly while the ministers in the operational roles were allowed to proceed with their own agenda. While the Minister of Health struggled with hospital planning in Vancouver and the introduction of school dental programs across the province, the Minister of Human Resources was undertaking major reforms in the social welfare system attempting to reinstate community members in policy making (see Chapter 26). But the NDP was dismissed in 1975 after three years in office. The province returned to Socred pragmatism in policy making.

The Changes after the Established Programs Financing Act (EPF), 1977

The EPF legislation of 1977 replaced matching grants for health and post-secondary education with block grants. This forced the provincial governments to decide how they wanted to spend the federal transfers.

Instead of using clerical staff to apply for open-ended grants, they now had to make their own decisions about the allocation of restricted funding. Before 1977 there were few professionally trained provincial health administrators. The few senior health bureaucrats making policy decisions were usually medical health officers who had come up from public health departments in the municipalities or psychiatrists out of the mental health service. A very few others were trained in hospital administration,[11] for remuneration in the provincial public service was relatively poor compared with that for positions in the larger hospitals.

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[11] The courses for health administrators before about 1970 were courses in hospital administration. Later they changed their titles and, to some extent, modified the content to give consideration to health care system issues.

Tindal (1980) has described how in Ontario in the late 1970s, "the bureaucracy was transformed from a cautious body of clerks, inspectors and auditors to a body of administrators, policy advisors and law makers."

The provincial governments had already recognized the growing problems of paying for care. Describing the difficulties which were being encountered in Ontario, particularly after the OPEC-induced recession, Novick (1980) said: "Initiatives by the Ontario government in the seventies have been largely attempts to redirect, manage and restrain the social policy field. The responsibility for developing and implementing appropriate strategies has fallen to professionals recruited from the industrial sector" (p. 384).

Other provinces were put under similar pressures to reform their bureaucracies, but they did not all react in the same way. At first British Columbia's Health Department looked to the hospital administration and public health sectors for new recruits for the senior positions in health. But these were later replaced by accountants and experienced civil servants who had taken part-time courses in public administration.

There was a marked change for the better in the quality of the public service after 1977. However, even after the introduction of the block grants, which made financial issues a priority for provincial governments, there was a long time lag before the need for accounting and overall policy making skills was recognized (University of British Columbia Health Policy Study Group 1982).

By 1981, Hastings et al. (1981) found that most senior health bureaucrats had degrees in health administration, public administration or accountancy. Cost pressures and the need to respond to EPF had led to the restructuring of the provincial public services from a clerical to a professional administrative cadre.

Another issue arose in the early 1980s — it was decided to politicize the most senior public service positions. This was the result of two separate pressures: on the one hand the unions demanded the right to recruit members throughout the organization but the governments insisted that the senior positions be excluded; the second pressure was the influence of neo-conservatism which brought an end to the idea of civil service neutrality, an idea which had persisted since 1865 in British colonies. In consequence the trend towards recruiting those with the best educational and experience qualifications at a low price was modified to some extent, when officers sympathetic to the political ideologies of the government in power were appointed to senior positions.

Another change should be noted. Better educated administrators were able to persuade the governments that the cabinets should be in charge of decision making and that they should follow consistent plans. Earlier, many governments had been at the mercy of back-benchers who brought pressures to bear on every decision (such as varying the hospital construction plans). Now the ministers could, if they were able, take better charge of their departments and work on more coordinated policies for providing collectivist services.

Summary

At the end of the Second World War the provincial governments were very weak bodies which were now expected to take responsibility for developing welfare state organizations. Saskatchewan pioneered the planning and implementation of a collectivist health care system, in the process developing a strong cabinet and a well organized administration, but it met with resistances from the medical profession when these reforms were introduced incrementally.

Other provinces responded to pressures to change in a different way. They had no overall plans and responded to federal and other provincial initiatives without thinking them through properly. Some (e.g., British Columbia) had problems in managing to control back-bench inputs and failed to develop a strong civil service. Most had large clerical bureaucracies from 1950–77, set up to collect federal matching grants.

By the early 1970s, Quebec, Manitoba and British Columbia had worked out their plans for provincial welfare state developments. All of these provinces met with resistances to their plans, some from opposition politicians, some from organized professionals. This planning led to changes in attitude to the need for better bureaucratic support but changes were not brought in in most provinces until after 1977 when federal matching grants were replaced by block grants. Then a more professional civil service began to be appointed because the provincial governments had to make their own decisions on the allocation of resources to social programs.

CHAPTER 17

Some Issues in Horizontal and Vertical Coordination

When it decided to set up a collectivist organization for delivering care the federal government introduced new programs *as and when it could*, so that these programs can be seen as an incremental accumulation of bits and pieces of reform and restructuring rather than parts of a well planned and coordinated policy for restructuring. In any case the emphasis in the first twenty-five years of the welfare state was gap filling rather than streamlining of services. The key words were ensuring access to services. This meant that many new facilities had to be opened up. Less attention was given to service integration.

The federal Minister of Finance, Mitchell Sharp, had raised the matter of the costs of commitment to the Medical Care Insurance Act in 1966 (Taylor 1978) but the government was determined to go ahead with this legislation. It felt it had to follow through on implementing this component of the health care system as recommended by the Royal Commission on Health Services (Canada 1964). However, the new Deputy Minister of Health and Welfare, Le Clair, took Sharp's warnings seriously. He initiated the process of questioning the current policies and service organization on two levels — the first was concerned with the rational organization of access to care, the second was a review of the mission.[1]

Streamlining the collectivist organization of health care (rather than gap filling which had been the primary concern at the start) took a long time to become accepted by the provincial governments. It is now more than twenty years since Le Clair's questioning process was begun, but the message of

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[1] See Chapter 8.

the federal government — that there is need for economy, for better management of service delivery, for priority setting in case rationing is necessary — is just beginning to get through to the people of Canada. In consequence much has still to be done to improve horizontal and vertical coordination of decision making about service provision. Services have continued to be provided in their separate compartments, but a new vision of coordination is creeping in. Regionalization is seen as the mechanism for working towards the mission and achieving economies.

The first stage in the process of streamlining was to pass the Established Programs Financing Act (EPF) in 1977. Instead of continuing to provide open-ended matching grants, the federal government told the provinces that they were to have block grants for insured health and post-secondary education services. Block grants were intended to improve coordination between different programs by forcing the provincial governments to recognize the limits of their budgets and to realign them more effectively. However, as discussed in Chapter 16, the provincial governments were not ready to cope with this change. They took some time to develop professional bureaucracies which could respond to the challenge, but by then separate program funding divisions were strongly entrenched.

Horizontal Coordination

Across Government Departments

One of the problems which has had to be addressed by all governments is how to divide up the ministers' portfolios. Quebec decided to have one Ministry of Social Affairs which brought together health and welfare. Other provinces were less willing to let one minister control more than one third of their budgets by putting these two departments together, although some (e.g., New Brunswick) tried it out for a while.

Novick (1980) discussed one attempt by Ontario in the 1970s to improve coordination between departments of government. Following an investigation into government productivity (Ontario 1973), a Social Policy Secretariat was set up to bring together the work of the ministries of Health; Education, Colleges and Universities; Community and Social Services; Culture and Recreation; but this mechanism was not very successful because it did not have the authority to control the larger powerful ministries. Novick said that its function became, instead, that of testing public opinion "often with a view to limiting the scope of public responsibility" as the government faced more cost pressures in the late 1970s. Thus in response to the critical policy question, "whether there was a need for new social spending in the form of community services support [to promote] the integration of the retarded, disabled, frail elderly, unwed mothers and the socially deviant (ex-offenders, the addicted) ... the inability of the Social Policy Secretariat to initiate, plan and coordinate has been transformed from limitations into the virtues of public non-intervention" (p. 386).

Other governments have tried various ways of coordinating the programs of the ministries of social affairs. British Columbia, for example, has a committee for prioritizing issues before they are taken to the cabinet, and it has set up a number of interdepartmental committees to work on special issues, such as the problems of physically handicapped children. Then there are the negotiated responsibilities for joint programs. Two examples are the home care program in Nova Scotia (Guidelines 1987) and the child abuse program in British Columbia (1979). Yet these joint programs are few and far between.

Most governments have spent some time working out the respective responsibilities of health and welfare departments in dealing with individual clients — for example in most provinces the impaired (but not sick) mentally handicapped children were handed over from the health departments to the care of the social welfare departments in order to take advantage of the Canada Assistance Plan (CAP) grants to deinstitutionalize them and settle them in community residences.

So far as arrangements for the four designated disadvantaged groups (women, native peoples, visible minorities, and persons with disabilities) are concerned, some provincial governments have set up separate ministries or offices of women's affairs, native affairs, multicultural activities or Premiers' Councils to review the status of persons with disabilities. However, these do not always manage to function very effectively as they must work across into the well established departments. To take some examples from the disability policy areas, Ontario has an Advisory Council on Disability Issues and an Office of Disability Issues. These both try to keep the problems of persons with disabilities before the cabinet and the executive branches. The staff are particularly concerned about the fragmentation of services and are trying to create a greater awareness about the lack of professional and bureaucratic coordination in the provision of care as well as the lack of a rational continuum of care. Alberta set up a Premier's Council with a chairperson who relates closely to the premier and an executive director (who works with the senior bureaucrats) on a wide range of problems (such as cut-backs to the special social assistance program for the severely handicapped, the redevelopment of medical rehabilitation, etc.). Alberta's council appears to be the most successful coordinating agency among all the provinces working on disability issues.[2]

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[2] The work of the Premiers' Councils and other advocacy groups was reviewed by Crichton and Jongbloed, 1990.

Saskatchewan has a Premier's Council and an office too, but the former has not been very effective and the latter has decided to concentrate on employment problems only. Manitoba has found it best to respond to advocacy groups outside the government rather than to a Premier's Council.

There seem to be no easy answers to interdepartmental cooperation at the provincial level. In every case a great deal of preparation has gone into all cooperative moves.

Coordination Within Government Departments

It has been difficult for governments to decide how to structure the work within their Health Departments. Deber and Vayda (1985) mentioned the frequent adjustments in the structuring of the Ontario Ministry of Health which at the time of writing had three divisions: Institutional Health Services, Community Health Services and Administration of Health Insurance. Principal long-term planning activities lay with the Ontario Council of Health, "a semi-autonomous source of long term advice," and an internal Strategic Planning and Resource Branch. Short-term planning was carried out within the divisions.

Frequent restructuring has gone on in other provinces, too, as new problems have emerged (e.g., caring for the frail elderly), or old problems were reconsidered (e.g., caring for the mentally ill). Mental health services, once the largest provincial activity, has now been cut back to being a subdivision of Family and Community Health in several provinces as most acute care services for those with mental illnesses have been taken over by family doctors and specialists in the general hospitals.

Alberta is one province that has had frequent reorganizations of its bureaucratic structures in order to improve direction and coordination. In 1990 the Alberta Health Department took responsibility for policy development and the funding of institutions, community health and the Drug and Alcohol Commission; Labour was to supervise occupational health and the Workers' Compensation Board (WCB); and the Family and Community Social Services Department was to be concerned with relief of poverty and family support; but these are arbitrary divisions which may well be changed at any time. Similar restructuring has taken place in other provinces.

No literature could be found providing arguments for these provincial government restructurings.

Interprovincial Coordination

There have also been a number of federal-provincial standing committees to share information on such topics as the development of policies for seniors or development of data banks. From 1989 to 1990 the federal government held three national conferences on topics it believed to be the most important issues in health policy in these years — health promotion, quality assurance and acquisition of technology. This enabled senior officials to meet to exchange views.

Provinces may look across to other jurisdictions struggling with the same problems for information and advice. For example, Alberta's Department of Family and Social Services looked to Ontario for models of community involvement in child development as a basis for implementing primary prevention.

Vertical Coordination

Federal-Provincial Relationships

The provincial governments have clearly felt that they are caught in the middle. Some believe that they were lured into providing health and social services by federal grant aid offers which could not be refused and that they are now expected to maintain high standards of care.[3] There have always been difficulties in reaching agreement on federal-provincial funding matters from 1945 onwards. As often as not, the federal government seems to have taken the matter into its own hands and has changed the rules to suit its own policies without regard to the contract which the provinces understood it to have made. (For further discussion see Chapters 23 and 28.)

The reduction of funding for welfare services in the late 1980s led some provincial governments to sue the federal government in the courts for breach of this contract which, they understood, still existed. However, their suit was denied. It was deemed that the federal government had the right to change its offers of grants as and when it wished (Canada 1987b). The federal government then set out its position on health care in *Building Partnerships* (Canada 1991a) in which it argued that new relationships between the two levels of government need to be worked out again. But the Conservative government which wanted to do this was dismissed in 1993.

The Liberal government which replaced the Conservatives promised to preserve social programs, but it has been overwhelmed by the deficit issue. This will be discussed further in Chapters 23 and 28.

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[3] Particularly British Columbia, Alberta and Ontario, whose welfare grants were reduced more than other provinces' grants in 1989 because they were judged to be richer provinces. See Chapter 23.

Relationships between Governments and Service Agencies

The provincial governments have seldom delivered services themselves. The main exception is the mental health service, although the Ministry of Health of British Columbia has also been very much involved in organizing and monitoring its provincial public health services.[4] The governments would prefer to be concerned with policy development and overall service coordination than with service delivery itself. Thus the governments have had to negotiate with the service deliverers to ensure that they will do the work. In health care there are four main groups of service deliverers — the established health professionals, the hospitals, the municipalities and the non-governmental service organizations. The structuring of these relationships will be reviewed each in turn.

The Established Health Professionals

The attempt by provincial governments to gain control over medical professionals has so far been relatively unsuccessful. Tuohy (1986) attributed their lack of power to the agreements negotiated by the profession's representatives at the time that the provinces brought in their medical plans. There have been continuing conflicts over fee schedules and their administration, and physician supply and its distribution since the doctors' strike and the Saskatoon Agreement of 1962. It is clear that, at the start, doctors saw themselves as subsidized entrepreneurs. Some still do despite their defeat in the battles over the Canada Health Act, 1984–87 (Heiber and Deber 1987).

The bureaucrats in charge of the medical plans have had few means of influencing the organization of medical services and, although some have used financial incentives to encourage better geographic distribution of doctors and better distribution of fees among the specialties, these have been minor victories. The Canadian Charter of Rights and Freedoms has been used against them to assert individual doctors' power to choose where to work. Yet each party to the negotiations recognizes its dependency on the other.

Most provinces have reviewed and revised their legislation on professional regulation since 1970. As this has been relatively unsuccessful in improving accountability and professional concern for consumers, new efforts are being made to find ways to gain greater control (e.g., Ontario's Health Professions Act, 1990). However, it seems likely that restrictions in funding will bring about greater changes in organization than legislation of this kind.

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[4] In British Columbia the provincial health department sets standards and recruits personnel for the public health service outside the few municipalities. This is exceptional.

Apart from medical professionals, most other health professionals are employees and, as such, are part of the other organizations to be discussed below. There are few entrepreneurial health professionals except dentists (who are outside the orbit of government funding except where employed as school dentists) and pharmacists who are affected by the terms of subsidized drug programs.

The Hospitals

Although the hospitals were outside this study's boundaries, except in relation to their ambulatory care or extramural programs, their influence over the development of community-based services cannot be ignored. Therefore their struggles against provincial governments are of considerable importance. Provincial governments have not found it easy to gain control over hospitals' spending, and hospital standards are mainly a matter of peer group surveillance through accreditation procedures.

The Established Programs Financing Act, 1977, forced the provincial governments to define more clearly the role of hospital boards in the hierarchical system. To take one example, in British Columbia in 1979–80 there was a tremendous battle for autonomy on the part of the hospital boards, a struggle which the government won (Ernst and Whinney 1979; British Columbia 1980) as the line-by-line budgeting appropriate to the original Hospital Insurance and Diagnostic Services Act was replaced by zero-based or annual global budgeting. Hospital allocations were recalculated and it was made clear to the boards that overruns would not be tolerated without good cause.

Deber and Vayda (1985) were not convinced at the time of writing that governments had gained very good control over the hospitals. They concluded that:

> The government of Ontario was able to have, at best, an incremental impact on the size of the institutional sector. The desires of its planners to 'deinstitutionalize' health care had mixed results. The direct attack on hospitals failed, while the indirect methods employed have had some impact. The 'alternatives' to institutional care have generally been additions rather than replacements.... Greater success will require better communications with the public about reasons for alternatives to unpopular policies. (p. 460)

Ontario struggled with a number of control issues. The government found it was not easy:

1. To privatize hospitals — they seemed to prefer being corporatized
2. To re-privatize any services after government takeovers

3. To introduce alternative delivery modalities in medical practice
4. To control the supply of physicians and therefore the number of services generated
5. To coordinate voluntary organizations

The struggle between hospitals and governments continues and the hospitals are determined not to lose any of their budgets if they can possibly help it. Hospital associations have redesignated themselves health associations and hospitals are developing outreach services. While the search for increased control over hospitals may not seem immediately relevant to a study of community-based services, it is full of significance for all service organizations, because it is concerned not only with controlling medically generated costs and shifting funding across from inpatient to outpatient care, but also with community involvement in service planning and organization. The hospital associations and the hospital boards have been the most successful community organizations operating in the health care field and they have been mainly made up of businessmen. But this is likely to change with regionalization (see Chapter 29).

Provincial-Municipal Relations

Manga and Muckle (1987) reviewed the roles of the municipalities in providing health and social services across Canada. These were the original authorities responsible for providing public health services and in most provinces they remain important service deliverers.[5] There had been a move in the 1930s by the Rockefeller Foundation to regionalize public health services (to form larger units), and a form of regionalization based on school districts took place in several provinces. Union Boards of Health were now expected to provide services to several municipalities which could not afford to staff adequate services on their own. In Alberta, for example, twenty-seven autonomous health boards were set up, establishing an independent spirit at the local level and a strong sense of local identity. The provincial government was restricted to funding and standard setting. This structure has now been changed again through new regionalization policies.

British Columbia was the anomalous province which never had powerful municipalities except in the big cities because of its mobile working population. However it set up Union Boards of Health more closely linked to the provincial government than the Union Boards in other provinces because the staff of the public health service (except in Vancouver and Victoria) were pro-

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[5] Quebec's public health services are no longer governed by municipalities but are part of the restructured provincial service delivery system.

vincial employees who moved around from one health unit to another as jobs become available. (This helped isolated units to deal with recruitment problems.) Provincial manuals and consultants maintained standards of practice.

In Ontario municipalities have remained powerful bodies in the political community. Novick (1980) said: "Ontario has preferred to avoid planning leadership under the guise of promoting municipal autonomy" (p. 386). Describing the position in Ontario in 1987, Manga and Muckle said that the municipalities funded twenty-five percent of public health services (metro Toronto sixty percent) and provincial government the rest. Traditionally health units operated under control of municipal boards of health (although four reported directly to regional councils). They said that Ontario municipalities might own ambulance services and provide care for the elderly under cost-sharing formulas with provincial government. Some owned hospitals, some provided community mental health services usually through the public health units. They provided welfare assistance to the poor, and organized children's services (financed twenty percent locally). However, day care subsidies were being phased out when they wrote.

Ontario's public health departments were brought under closer control by the province in 1980 by the passing of the Health Protection Act which linked provincial subsidies to the observance of standards, but the structures remained the same. A recent review of municipal health and social services (Ontario 1990a) examined the municipalities' roles and responsibilities other than health protection in order "to clarify and realign the responsibilities of the two levels of government" (provincial/municipal) in terms of legislation and policy development, service management and service delivery in five areas: children's support services, income and employment support services, facility-based care for persons with developmental disabilities, child care, and community-based support services. The last of these includes: accommodation with care, transitional care, emergency housing, home-based care (homemakers and nursing services, attendant care and life skills development for persons with developmental disabilities), community/family support (community and neighbourhood support services, elderly persons' centres, counselling, information and referral). It was recommended that a funding envelope be established for each sector and that a mandated community planning process be introduced for each sector and for the whole. "Placing this responsibility in municipal hands puts the planning process close to the community, where its effects will be felt. The local planning process should be a collaborative one that involves all the key players in the system, including governments, the voluntary sector, clients and residents. The plan should set community priorities and influence service managers and funders" (p. 31).

The municipalities in Ontario undertook another more general review of their activities in the early 1990s. This review has been conducted within the boundaries of vertical coordination of provincial/municipal relations. Similarly, Alberta established a Ministers' Council on Local Development to consider how to stimulate local development and local involvement (Alberta 1990b).

The issue of community participation in health planning, ignored for many years as a major concern, has now gained greater prominence and will be discussed more fully in Chapter 26.

Relations with Non-Governmental Organizations

So far as the non-governmental organizations are concerned, there has not been an overall review of their composition, structures and activities since Govan (1966) made a study of health services for the Royal Commission on Health Services, and Carter (1974, 1975) analysed their work for the Canadian Council on Social Development. However, Robichaud and Quiviger (1990) made a sample survey of health and social service organizations with community boards more recently. More important for understanding current problems may be two studies conducted in British Columbia by Rekart (1988, 1994) on privatization and by the Korbin Report (British Columbia 1993b) on human resource use.

It is difficult to know how to begin to discuss what Korbin called "the public sector" (i.e., subsidized private agency services) because it differs from one province to another. Some provinces have had much greater commitment to philanthropy than others. Govan (1966) distinguished between these so-called citizen member organizations and mutual aid associations. Growth in both sectors has resulted in a tremendous proliferation of sub-organizations within this non-governmental area. The Korbin report identified 1,800 social service organizations and 675 health care organizations within British Columbia alone.

Many of these organizations are dependent on government funding for service provision whether this be given as a grant or a contract for services. Others are mainly concerned with fund raising for other objectives such as medical or technological research. Some operate as advocacy agencies, some are non-profit organizations and some look for profit (particularly private hospitals in the long-term care area).

As we have already shown, some parts of this territory are quite well organized in some provinces — the continuing care area for example. Other parts are not. Patients discharged from mental hospitals may end up on "skid row" because they fail to get help from such services as are available. Dear and Wolch (1987) have described service inadequacies in *Landscapes of De-*

spair, and Fallis and Murray (1990) have suggested that homelessness may be due to failures to coordinate provincial shelter programs.

The British Columbia government tried to set up community resource boards to undertake such coordination in 1975 but the initiative failed (Clague et al. 1984).[6] The Korbin report has recommended establishing another kind of coordinating committee to look at human resources issues at a time when care givers are joining unions and costs are rising. At the time she wrote there did not seem to be any desire to take over these non-governmental service organizations. In fact Rekart (1988) showed how the British Columbia Socred government of the 1980s had moved from grant aiding to offering contracts instead — to further privatizing the agencies. The New Democratic Party (NDP) government which has since taken power has not yet altered this policy. Rekart (1994) pointed out that privatization did not necessarily mean restraint, though it seems that this will come soon with the deficit pressures being so high. Regions are likely to become concerned with coordination.

There is another aspect of policy regarding service organizations which has become noticeable in recent years. Consumers in advocacy organizations such as the Coalition of Provincial Organizations for the Handicapped (COPOH) have been protesting the efforts of philanthropic or professional organizations to speak for them about their needs (Derksen 1987). They claim that only those who have particular problems know what they want and need. Nevertheless there are current examples of cooperation between philanthropists, professionals and consumers to work for policy change (e.g., Tefft 1987). But the voluntary organizations are having to come to terms with new ways of looking at citizen participation in the Canadian state. The struggles to do this have been considered by Ng, Walker and Muller (1990).

Functional Decentralization

There has been very limited coordination between the activities of the four established sectors of the health care system except between doctors and hospitals. Successful collectivism requires collaboration within and between all of these groups and this has not yet occurred though, again, it may be helped by regionalization.

Summary

Because the early emphasis in collective health service organization was on open-ended funding, governments concentrated on gap filling rather than

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[6] See Chapter 26.

streamlining of services. However, in 1977 Established Programs Financing changed the method of federal-provincial funding from these open-ended matching grants for health and post-secondary education to block grants which put the onus for resource allocation on to the provincial governments.

Governments had to decide how to organize their ministries with regard to administration of the whole range of social programs. They did not find it easy to bring health and social programs together in most provinces. Even within health departments it was difficult to decide how to divide up the work and frequent restructuring took place.

Efforts were made to share information on structures and programs across the provinces with some successes.

Relationships between federal and provincial governments has also been difficult and is now particularly bad because of reduction in transfer payments.

Because the provincial governments saw themselves as funding agencies, not service deliverers, they have had to work out relationships with these contracting bodies — the established health professionals, the hospitals, the municipalities and the non-governmental agencies providing services. In recent years they have become more conscious of the need to improve organization and management of the system of care, and to bring these parts of the system which have been functionally decentralized into a more collaborative organization.

PART VI

Research on Organizational Issues

CHAPTER 18

Development of Research and Planning Activities

Does research and/or demonstration help the governments in their decision making or are they more likely to seek guidance from the work of public inquiries or commissioned studies?

Saskatchewan's Planning

Saskatchewan was the first province to set up a Health Services Survey Commission, appointing Dr. Henry E. Sigerist as the leading commissioner.

> Throughout September, 1944, he travelled through the province, consulted with scores of organizations and individuals, and worked with other members of the commission representing the medical profession, hospitals, dentists, nurses and the government. On October 4 his report was presented to the Minister of Public Health. Dr. Sigerist was not, of course, a professional health administrator and yet the realism of his report is reflected by the fact that within ten years most of his proposals were in effect. (Roemer 1960, 209)

In 1974 at a national conference on health care research, Badgley (1974) pointed out that commissioned inquiries by federal and provincial health departments were being produced in considerable numbers and were at least as important as research activity for formulating health care policy. It can be argued that commissioned reports are more likely to be used than peer reviewed research studies, which may be more innovative but are less closely connected to immediate policy development. Although a proportion of these commissioned studies are prepared by academics (e.g., Shapiro 1979), many are the work of consultancy firms (e.g., Ontario 1988–91).

Despite the importance of commissioned inquiries, Saskatchewan was convinced that it should also develop research activities and set up a research division within its Health Department at an early stage (Cassell et al. 1970). Its unique data banks were used by many researchers to explore trends in utilization and other aspects of care before other provinces began collecting similar information.

Saskatchewan made careful studies of available hospital resources (Wahn 1952) and how to set up its hospital insurance scheme (Taylor 1978) before introducing its first insurance program. This careful attention to planning was continued until its medical care insurance act was introduced in 1962.

The Royal Commission on Health Services, 1961–64

The federal government, which was equally committed to the development of collectivist care, did not have data banks to help with its planning in the 1940s. It had collected some statistical information on hospitals from 1929 onwards (Agnew 1974) and there were some vital statistics available in the provinces, but the government was well aware that more data were required for good planning. Yet, although it sponsored the Canada Sickness Survey (Canada 1953–61), these data took many years to be analysed properly (for lack of funding). They were used in the end at the request of the Royal Commission on Health Services 1961–64.

This royal commission was anxious to base its recommendations on available demographic data, manpower figures (Judek 1964), discussions of experiences of provincial governments (such as McKerracher's report [1966] on community psychiatry as tried out in Saskatchewan) and historical information about voluntary organizations (e.g., Govan 1966). Kohn (1965a,b) provided a profile of the health of the Canadian people *inter alia* which convinced the commissioners that they should recommend the finalization of Canada's hospital and medical care insurance programs.

Quebec's Planning

As discussed in Chapter 7, most of the other provinces were not interested in planning or research in the early days of Canada's health service restructuring. But after Quebec had sorted out its federal-provincial financial relationships, the government of that province embarked upon an extensive study of health and social services. The Castonguay-Nepveu Commission, which reported in 1971, took a very different approach from that of other, English-speaking, provinces which had decided on pragmatic, incremental moves. The Québécois thought that their approach should be to research and plan the health and social service system as a whole. Their health plans were based on two assumptions: that there should be an epidemiological basis for planning and that attention should be given to community development. This led to proposals for a complete restructuring of the system with special attention being given to providing primary health care in Centres locaux des services communautaires (CLSCs) which would report upwards through districts and regions to the provincial government. Their problems were similar to those of Saskatchewan. Claude Castonguay, chairperson of the Commission of Inquiry who became Minister of Health and Social Services, found that the medical profession was strongly resistant to the proposed plans. It forced the government to allow the doctors to continue in traditional forms of practice organization. Rodwin (1984) and de Kervasdoue, Kimberley and Rodwin (1984) have pointed out that rational planning has its limits and cannot succeed if the political resistance is too strong. Renaud (1984) also thought that the technocrats in government had tried to encompass too much in their plans for change.

Reorganizing Research Funding at the Federal Level

The impact of federal Deputy Minister Dr. Maurice Le Clair on research activity was discussed in Chapter 8. He sought support from the Science Council of Canada to initiate research into health care organization and he was able to set aside some funding for this purpose. In due course the National Health Research and Development Program (NHRDP) was established and this provided support to epidemiologists such as Sackett and Baskin (1973), Sackett, Spitzer and Gent (1974) and economists such as Evans (1984) as well as other clinical and social science specialists who were funded in order to produce studies relevant to better understanding of structures and processes in providing health care. However, the volume of studies was relatively small compared with those in the biomedical area.

Reorganization of research resources for funding social scientists under the Social Science and Humanities Research Council (SSHRC) in the 1970s provided another source of funding for academics interested in health care. One example of the studies funded by SSHRC is that of Coburn (1988) on medical dominance.

Funding Demonstrations

Health care research is not a purely academic exercise but is closely tied in to the political decision making process. The connection between research and implementation has been addressed by the bureaucratic advisers to the policy makers in several ways. One of these is to fund demonstration grants to try out pilot schemes. But unless the funding authority is also the implementing authority, these demonstrations may not always be successful. The federally financed *Burlington Randomized Controlled Trial for the Nurse Practi-*

tioner (Sackett, Spitzer and Gent 1974) failed. The findings were not accepted by medical practitioners (who did not want the competition of nurse practitioners), nor by the paying authorities, the provincial medical plans.

Other demonstrations have been more successful. For example, British Columbia funded pilot projects on quick response teams (Finnie and Layton 1990) and care for handicapped children. These were not evaluated until after the event (unlike the carefully researched nurse practitioner project), but they have been well received by all service personnel.

Participatory Action Research

A large number of research organizations have now developed the idea of partnerships between community members and researchers and have encouraged the development of participatory action research in which those who will be affected by proposed changes can have input into the research (e.g., Green et al. 1995).

Funding Literature Reviews

Another approach used by the federal government over the years, when new policies are under consideration, is to commission reviews of the literature (e.g., on home care or disability). This book is based on a literature review of community health service organization.

Development of Provincial Research Activities

The relationship of research to policy making and planning has always been difficult to sort out. By the early 1980s most provincial governments had set up their own research departments, but later in that decade, many of the governments decided to reduce their in-house research activities, to set up separate independent research funding bodies, to commission research or to fund extramural research on policy through government funded but independent research centres. This allowed their internal research departments to concern themselves with troubleshooting and to put long-term or commissioned research outside the walls where it did not commit the government to immediate action. For even when reports are produced by bureaucrats or commissioned experts, they may not be acceptable to the government in power (e.g., Saskatchewan *Community Clinic Study* [1983], British Columbia study of handicapped children [Sheps et al.1981]) and may not see the light of day for some years until their recommendations have been overtaken by other events. Or they may never be published.

One move has been to set up external policy research centres funded by the government but working out of universities. The first of these external policy research centres was set up fortuitously in British Columbia at the

University of British Columbia when there was a ban on bureaucrats' travel and a provincial representative was needed to keep in touch with Ottawa. Anderson (1976) has described the evolution of this unit. The unit has now produced many reports. This example of a policy research unit financed by the government at a university has now been copied in Ontario at McMaster University (see Centre for Health Economics and Policy Analysis [CHEPA] Reports since 1985) and in Manitoba (Health Advisory Network 1989–90). Nova Scotia expressed interest in this model in its royal commission review (1989b) and Alberta set up a unit in 1995.

Centres of Excellence

A new organizational model recently developed by the federal government is the Network of Centres of Excellence, centres chosen for their expertise in particular areas and their expected contribution to problem solving through research activity. For example, research on AIDS and health promotion are involved in this collaborative process of deciding what to research and sharing results as the research progresses.

The National Alzheimer Study (although not a part of the Network of Centres of Excellence program) is another example of top down mobilization of the research community on major policy problems in the health care field.

The Work of One Foundation

The Canadian Institute of Advanced Research (CIAR), a privately funded research body, has brought together a number of researchers from different disciplines to look at health care issues in Canada. CIAR has been particularly interested in researching and publicizing information on the determinants of health, as have Evans, Barer and Marmor (1994).

> Arising out of this concern for better understanding of such determinants, from which presumably to develop more effective health policies, are two major corollary interests. One is the measurement of health at the population level, and the development of extended an improved data systems, to permit us to know how health is evolving and what factors are affecting it. The second is improved understanding of the role of the formal health care system both its strengths and its limits — as a vehicle for mobilizing our resources to improve our health. (Evans, Barer and Marmor 1994, xi)

Linking Research to Policy Making

There have been a number of discussions about the difficulty of linking research to policy making, for this does not seem to get any easier over time.

Of course some researchers have had great success in getting their ideas across, particularly the health economists who have been able to suggest methods of cost control. Others have been less successful, such as the organization theorists or analysts of public administration whose work seems to be rarely used.

Bulmer (1982) and Kallen (1982) have discussed the applications of research to social policy making and have considered the many difficulties in getting through what Pringle (1989) has called "the semipermeable membrane."

Summary

This chapter asks the question whether research or commissioned inquiries are more likely to influence health policy development. Commissioned inquiries were more important at first, but most provinces have now set up data banks as a basis for informed decision making.

It then goes on to review the development of research on health care organization in Canada particularly by Saskatchewan, the federal government and Quebec in the early years and the way in which the federal government influenced research on health care systems issues. Today most provincial governments have their own research departments and contract, as well, with independent research agencies. They fund demonstrations, participatory action research and literature reviews and may fund local universities to do policy research.

The federal government has also tried to coordinate research activities better through funding the Network of Centres of Excellence. The Canadian Institute of Advanced Research (CIAR) has, *inter alia*, published information on the determinants of health, which has given greater prominence to the social model of health care.

Considerable efforts have been made to coordinate research activities and to make them more applicable to problem solving, but there are still many barriers between doing research and applying its findings in practice. The work of Hall et al. (1975) on successful policy making pointed out that ideas must first be legitimated and support found for them before they can be implemented.

CHAPTER 19

Research on Organization Theory and its Relevance for Canadian Health Policy Development

The decision of the Canadian federal and provincial governments to establish collectivist social policies was made without realizing the structural implications of such a decision. The framework of analysis presented in Chart 1.1 gives some indication of the complexity of the organization of the welfare states which would have to be set up. Not only was there a variety of social programs to be brought in, but there were a number of different levels of government involved in their funding and delivery. The need for coordinating policy making, service delivery, administration and research was barely understood. And it might have been easier to start from scratch, but some professional and social services were already being provided under the individualistic system of care which existed in Canada in the 1930s. As well the postwar reconstruction plans for a collectivist system of care were introduced in a piecemeal manner as, and when, they could get political support.

The chapter which follows outlines the theory of reconstructing organizations and should enable the reader to see what might be expected in moving first from an individualistic system of health care to a collectivist biomedical model and then, after a review of the mission, to a social model of care. No one seems to have seen the whole picture or understood the adjustments that would have to be made in moving from one model to another as the existing subgroups were brought into one larger new organization. And they were resistant to making the necessary changes for the system to be optimally successful.

Can Organization Theory Be Used to Understand Collectivist Social Organization?

Although all the masters' programs for health administrators have courses on organization, when we asked our respondents in administrative positions whether they used research findings on organization to guide their decision making about policy choices, we did not usually get positive answers. Nor did we find much research in the health care sector by sociologists with interests in organization theory. It is only very occasionally that one finds Canadian studies on health service organization (e.g., Leatt and Frank 1988).

Perhaps this is not surprising when one looks at the organization theory literature, for it is complex and difficult to read and more so to apply. Evans (1990) prepared a literature review of interorganizational relationships (IOR) for the Vancouver Health Department, following publication of the study by Pederson et al. (1988) on *Coordinating Healthy Public Policy*. However, it seems unlikely that those from disciplines other than sociology would use such a review because of the esoteric language. And anyway, in his summary Evans said: "The 'rules of logic' linking different analytic levels have yet to be identified and empirically verified, although much progress has been made in clarifying processes by which IOR can be achieved" (p. 1).

It was not possible to review the whole range of applicable organization theory for this chapter; however, the citations are from studies which appeared to be relevant and useful explanations of health service organization in Canada.

Organizational Transformation

The decision by Canada to develop a collectivist approach to caring for its people was a decision to make an organizational transition of major proportions after the Second World War. Bartunek and Reis (1988) have developed a theory about organizational transitions. They set out two charts to explain what may be expected in such transitional situations. Chart 19.1 outlines the pre-birth crises and problems of organizational emergence such as: (1) "the need to find the right niche," (2) "the lack of coordination and cohesion," (3) "disorganization" and (4) "the desire of members to settle down." It identifies the characteristic experiences of such an emergence and lists "effectiveness criteria." Chart 19.2 shows these same problems at the post-birth stage.

Taylor (1978) has dealt with the pre-birth and immediate post-birth stages of the collectivist health care system development in his history of the introduction of health insurance programs into Canada, and this can be matched up with the charts.

Chart 19.1: Transformational Problems/Crises, Characteristic Experiences and Critical Issues of the Pre-birth Stages of Organizational Emergence

	Crises/Problems	*Characteristic Experiences*	*Effectiveness Criteria*
Entrepreneurial Stage	"need to find the right niche" "need to deal with the liabilities of newness	• leader is centre of attention • little planning and coordination • little differentiation by position • crude information processing and decision making • considerable risk taking	• flexibility of the organization • acquisition of necessary resources • development of external support
Collectivity	• lack of coordination and cohesion	• informal communication • development of a sense of collectivity • innovation and commitment • slight formalization of structure • broadening of produce-market scope	• extent to which human resources development, morale and cohesion development
Formalization Stage	• disorganization • lack of effectiveness of informal communication • desire of members to settle down • pressure towards formalization	• formalization of rules • emergence of bureaucratic structure • emphasis on efficiency and maintenance • institutionalization of procedures • consolidation of strategy and slower growth	• goal setting and achievement • efficiency of information management • stability and control

Source: Jean Bartunek and Louis Meryl Reis, "The Interplay of Organization Development and Organizational Transformation." In *Research in Organizational Change and Development*, vol. 2, p. 104. Greenwich, CT: JAI Press, 1988. Reprinted with permission.

Chart 19.2: Transformational Problems/Crises, Tasks and Effectiveness Criteria of the Post-birth Stages of Organizational Emergence

First Ideas

Crises/Problems	*Characteristic Experiences*	*Critical Issues*
Originator perception of a problem not being adequately addressed	• initial ideas of organizational arrangements that might address the problem • conception of a mission • tentative informal testing and revision of the ideas	• creativity and thoroughness of formulation of the first ideas • originator's relationship with the ideas

Commitment and Early Planning

Crises/Problems	*Characteristic Experiences*	*Critical Issues*
• need to incorporate planners and members of the surrounding community into the planning process	• originator makes a commitment to develop first ideas into an organization • development of plan for the organization • establishment of relationships among originator, planners and environmental groups	• creativity and thoroughness of the community planning process • depth of commitment of originator and planners to the organization • internal dynamics among originator and planners • quality of planners' relationship with the environment

Implementation Stage

Crises/Problems	*Characteristic Experiences*	*Critical Issues*
• need to give concrete expression to the plan	• translation of ideas into concrete organizational features such as selecting new members (including a new leader) and choosing and preparing the physical setting	• adequacy of resources • mechanisms to ensure correspondence between use of resources and mission • manner in which the best ideas and plan are transmitted to new members, especially the new leader • relationship between leader and new members

Source: Jean Bartunek and Louis Meryl Reis, "The Interplay of Organization Development and Organizational Transformation." In *Research in Organizational Change and Development*, vol. 2, p. 104. Greenwich, CT: JAI Press, 1988. Reprinted with permission.

Some time after an organization becomes established, its effectiveness is likely to be questioned. When this starts to happen there will probably be first or second order changes in organization structuring.

Bartunek and Reis have distinguished between these:

> first and second order changes in organizations — the former being incremental modifications in ways of acting, improvements that take place within already accepted frameworks; second order changes represent discontinuous shifts in frameworks in which organizational members come to understand constructs in new ways. (pp. 100–101)

The changes may be comparatively narrow or comparatively wide.

> Changes in the understanding of an organizational function such as participation are quite narrow. Overall changes in the organization's mission and identity are quite wide, implying changes in several other organizational functions as well. (pp. 100–101)

Bartunek and Reis continued:

> The major difference between first and second order organizational change is in whether or not a particular framework for understanding is altered. In first-order change the framework remains the same but in second order change it shifts in some way. The alterations of the framework in second order change have an effect on the assessment of change. In first order change some particular content is affected in a specifiable direction that can be thought of as better or worse in itself: commitment to the mission becomes greater or less. Because the primary shift in second order change is the framework itself, it is more difficult when this type of change occurs to determine whether the change results in better or worse outcomes than before. (pp. 100–101)

In Chapter 7 the development of the collectivist health care system up to and including the first order of change was outlined. At the start in most provinces the decisions to reorganize were mainly incremental, pragmatic, based on trial and error. Saskatchewan recognized early on the need for rational planning of change but was constrained by tight finances (which did not allow a total system of care to be introduced all at one time) and by the resistance of the medical profession to the proposed changes. Quebec decided that incremental planning was not good enough and developed a completely new rational organizational plan for improving service delivery. Again, the province met with strong resistances from the medical profession. The planning developed by these two provinces can be seen as a first order change. There was a new focus on gap filling and rationalization of existing biomedical services (coordination and integration).

The first order of change was concerned with reorganizing the existing services into a rationally planned system to provide access to medical and hospital services to all in need of them. The politicians and administrators who were developing the new system were at first very much more aware of the gaps in the system than concerned with its overlaps and the need for coordination. Rationalization, however, is usually thought to be concerned with streamlining of systems — cutting back rather than gap-filling activities. Much effort in the early years was put into hospital construction planning, for hospitals were the symbols of caring and a visible evidence of change, then payment for doctors' services became the next key move.

The next chapter will review research on health promotion. This was part of the second order of change for Canada. In Chapter 8 we discussed how Le Clair brought out the need for a shift of emphasis on system objectives from access to outcomes. He stressed the importance of research, not only for the better management of existing services. He stressed the need to review the mission and establish a new framework for the system if a satisfactory organization of collectivist care were to be achieved.

First Order Change: Transorganizational Analysis

A term that describes first order change which is used by organization theorists is "transorganizational development." Cummings (1984) presented a framework to explain this concept. He defined this as planned change concerned with creating and improving the effectiveness of organizations which have joined together for a common purpose. There are, he said, two streams of relevant research: *interorganizational relations* and *social problem solving* which started from different bases but have now "narrowed to concern over how organizations could join together to solve macro problems which could not be solved by organizations acting alone."

The interorganizational relations (IR) perspective:

> proposes that organizations enter into relations with other organizations in order to obtain needed resources. Moreover, because such resources are generally scarce, organizations tend to compete with one another, attempting to gain power and control over essential resources while trying to minimize dependencies threatening organizational autonomy. ... Starting from this resource dependence framework, IR researchers have examined voluntary exchange relationships between organizations ... relationships mandated externally ... and power-dependency relationships where one organization is coerced into interaction by a more powerful other. ... Much of this research has taken place in the United States' public sector, where a predominant concern has been coordinating activities, resources and information between agencies delivering

> related services. ... Although coordination of services has received some criticism in contrast to a more free market, competitive model ... a key research issue has been to discover those mechanisms ensuring organizations their individual autonomy in areas of conflict, while permitting unified effort in areas of agreement. Interorganizational coordination or conflict studies have focused on comparative properties of the relevant organizations, including domains, goals and membership, on relational properties of the exchange itself such as formalization, intensity, and standardization; and on how features of the larger context affect interorganizational relations, including the density of organizations, availability of resources and complexity and change rate of the environment.
>
> Generally this research has been oriented to describing existing, natural interorganizational relations with little attention to changing them or creating new kinds of relations. (Cummings 1984, pp. 370–71)

(See Marrett 1971; Van de Ven, Emmett and Koenig 1974; and Whetten 1981 for reviews of this literature.)

The social problem solving field has its major focus:

> [o]n helping organizations to cope with environmental complexity and change by forming multi-organizational collectives. Briefly, it is argued that, as the causal texture of organizational environments becomes more turbulent ... organizational actions produce unanticipated and dissonant consequences throughout the field ... requisite responses to turbulence rest on inter and multi-organizational action among those organizations sharing the environment. Such collective action is hypothesized to provide the initial conditions for a negotiated order to emerge among the organizations, hence reducing environmental turbulence to more manageable levels. (Cummings 1984, p. 372)

Cummings went on to suggest an integrative framework to bring these two approaches together. "A key premise of the model is the role of interaction processes in mediating input-outcome relationships" (p. 373).

Some have called this area of concern interorganizational analysis. Some time ago Benson (1975) suggested that:

> Interorganizational analysis ... is guided by relatively narrow practical concerns with the coordination of public services. As a result the field has a regrettable narrowness of scope, theoretical concern is focussed mainly on problems of coordinating public services, and the preponderance of empirical studies deals with coordination between public agencies. Only a few ... push beyond this concern to recognize the macro-structure issues embodied in their work. Meanwhile studies of greater potential relevance to

> interorganizational analysis go forward without much contact with the field. (pp. 137–38)

This comment is still valid. Benson cited studies of interlocking directorates, of bureaucratic politics, of individual market structure, of power structures and structures of the state which "deal with interorganizational issues crucial to the structure of advanced industrial societies; but they do so without much contact with, or influence upon, the interorganizational field" (p. 138).

He said that there were two main strategies for linking interorganizational analysis to broader concerns — *the strategy of abstraction* (Aldrich 1979) and *the strategy of contexualization* (Karpik 1978). Benson used the latter strategy: "a comprehensive mapping of the social world to develop a framework which will guide research to important issues and locate specific research problems in relation to more encompassing concerns" (p. 138).

He has tried to put transorganizational theories into vertical as well as horizontal context. He was concerned with bottom-up collaboration:

> Interorganizational relationships combine to form larger units, here termed 'policy sectors'. The policy sector is a cluster or complex of organizations connected to each other by resource dependencies and distinguished from other clusters or complexes by breaks in the structure of resource dependencies. Operationally, the connections and breaks between sectors would be a matter of degree. We term these 'policy sectors' because such independent clusters frequently become the target of public policy and are to a considerable degree created and modified by public policy decisions ...
>
> The correspondence between a policy sector as conceived in public debate and as measured by resource dependencies is always imperfect. In fact, expansion of policy debates often flows from the recognition of hidden dependencies. ... Reorganizations of administrative structures are frequently intended to bring coherence to a set of resource dependencies which have somehow gotten out of hand ... or to create a new focal concern for a set of agencies with previously defined mandates." (pp. 148–49)

Frost and Egri (1991) have discussed the necessity for understanding the political process of innovation — the framework of power and politics in organizations at individual, intraorganizational, interorganizational and societal levels — if successful change is to be brought about.

Several organizational theorists have published work on the importance of centrality and dominance in *resource networks* and the need to understand who has the power. This is likely to come from having control over money, control over a large number of people and good information, and from getting special interest group support (Karpik 1978; Pfeffer and Salancik 1978; Galaskiewicz 1979).

There were few financial pressures on provincial decision makers in the early days of establishing the collectivist health care system. The National Health Grants program of 1948 encouraged gap filling by its hospital construction grants, and the hospitals and medical care insurance programs were at first financed by open-ended grants. Although federal grants for hospital construction were terminated in 1969 it was not until 1977 that the Established Programs Financing Act (EPF) legislation brought these open-ended operational funding grants to an end.

However, even after block grants were brought in by EPF, the provincial governments found it difficult to streamline service delivery. By this time the separately financed programs were solidly established, and, though some efforts were made to transfer resources from hospitals to community care, these efforts were seldom successful on a large scale (e.g., British Columbia's hospital-community partnership and Saskatchewan's similar scheme).

It was not until finances became really tight in Ottawa and federal-provincial transfers were cut back in the late 1980s and 1990s that provincial governments really began to address the issues of streamlining services. But this has still not gone far, though it is a clear objective for the new regional authorities which have been set up recently. Alberta is now leading the country in its cut-backs to public services but all provinces are challenged to reduce their spending on health services.

Community Involvement

Chapter 4 has first traced the way in which the informal community networks of rural Canada were no longer able to meet the needs of citizens for social support when the Great Depression came in the 1930s and then how the welfare state was set up in order to provide help to those who needed it. However, questions began to arise later on about the welfare state's emphasis upon financial redistribution issues, its authoritarian professionals and bureaucrats, and its lack of involvement of ordinary community members. Policy analysts began to emphasize the need for greater community participation in Canadian society and what may be called the welfare society rather than the welfare state.

This new approach to social reorganization has been called the development of "partnerships" by the Organization for Economic Cooperation and Development (OECD) and the federal government, but what it really means is still rather vague. The definition of partnerships is set out in Appendix A; it demonstrates that there is a continuum from corporate collaboration to local community networking. In the section which follows, organization theory about networking is discussed.

Mulford (1984) applied interorganizational relations theory to community development, analysing the relevant studies made in business settings which might be applied to social services. He put particular emphasis on dyadic relations of organizations, boundary spanning roles and networks. He distinguished between the temporary nature of organization sets and action sets and the more permanent networks. The presence of networks, he said, is determined by finding the ties between all organizations in a population. He conceptualized the community as a network of interorganizational relations.

Networks today are most often conceived in terms of resource dependence theory (Pfeffer and Salancik 1978; Van de Ven, Emmett and Koenig 1974), or in terms of a political economy (Benson 1975; Galaskiewicz 1979), in which case greater emphasis is placed upon the impact of external forces in the network's environment, for example, influences from funding sources, regulatory agencies and legal mandates. However, Mulford said, there is a great need to look at the mobilization of networks for collective action.[1] For this "the conceptualizing of collective decisions and implementation is quite inadequate" (Mulford 1984, 142). Mulford wanted community developers to use interorganizational theory to make their interventions more effective.

There has been a growth of ideas about community partnerships which can increase the effectiveness of caring for those groups in the population who need more than brief consultations with experts. Gottlieb (1983) developed a typology of support interventions in which he listed the range of support providers: "individuals, dyads (support from a key network member); groups (support from a set of network members); social systems in which organized policy and structural changes are taking place (i.e., redefinition of roles for professionals and colleagues); and community (i.e., public campaigns)" (p. 66).

Miller (1987) has described networking by coalitions to build innovative institutions to address community and societal problems as "interpreneurship." He identified the interpreneurial factors likely to lead to positive change. Lockhart (1987) emphasized that community development is a process (in contrast with the customary outcome-oriented approaches of entrepreneurs). He said that this process approach is particularly important in dealing with northern development. Bennett (1987), too, saw community development as a process — as being concerned with second order change — change *of* the system rather than change *within* the system: "Change of a system involves a shift or a transformation from trying to solve

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[1] See also Laumann and Pappi (1976).

problems within a system, which itself remains unchanged, to a higher logical level of problem solving which considers changing the assumptions, values, structural relations and rules governing the system itself" (p. 13).

Community development is getting people to notice their assumptions and to examine them as part of an intervention strategy — a redefining of problems. Godbout (1983) was also concerned with the transformations which community participation can make and the escape from the dominance of professional politicians.

Ng, Walker and Muller (1990) have focussed on the relationships between community organizations and the state which arise out of demands for change. They said: "Community activities are not always progressive and do not always serve the interests of all community members. Similarly, state responses to demands from below are not unitary. At times they are extremely oppressive and coercive. At times ... [experiences] seem to indicate that grass roots struggles can find a place in state reforms" (p. 309).

The authors argue that there is still insufficient knowledge about community-state relations and that more needs to be discovered about these aspects: the relations of rulers and ruled (which do not take place merely in the formal state apparatus; they penetrate relations in community life), the documentary mode of action and community class struggle: "We suggest that the way in which these concepts are traditionally defined have restricted our ability to look beyond the confines of what constitute 'the community' and community development. It has restricted our ability to develop resistance and build alliances across traditionally defined community boundaries" (p. 318).

Charles and De Maio (1993) have presented an analysis of lay participation in policy making which is discussed in Appendix A. Chart A.1 proposes a wide range of possibilities for lay participants to make a contribution to community activities.

Organizational Development

Bartunek and Reis (1988) compared the concepts of organizational transformation and organizational development (OD). They said that the approaches of investigators to both processes are similar: they are concerned about the culture of an organization, its shared meanings, beliefs and values and how this culture may change. But the primary focus of OD is on processes through which to facilitate changes, while the focus of organizational transformation is on mapping the patterns of change in organizational form (such as changes in the organization's mission, values and structures).

OD is concerned with improving management practices within an organization and in improving the action orientations of agency administrators in their dealings with other agencies. The current literature on intra-agency management issues has not been reviewed here; however, interagency matters have been considered. Agency administrators at lower levels of the health care system usually have fairly limited concepts about the boundaries of "their organizations" — the agencies which are the substructures of the health care system and of the welfare state.

Benson (1982) has argued that there are four basic action orientations of agency administrators:

1. The fulfillment of program requirements
2. The maintenance of a clear domain of high social importance
3. The maintenance of orderly, reliable patterns of resource flow
4. The extended application of defence of the agency's paradigm

"Agencies taking other approaches constitute an implicit threat to the security of resource flow into that agency. Thus efforts are made to refute and discredit competing ideological claims and to establish the superiority of one's own technology" (p. 150).

While some analysts have focussed on "domain" (Kouzos and Mico 1979) or "defence of the agency's paradigm," others have been more interested in "the maintenance of orderly reliable patterns of resource flow." Understanding these ideas can help administrators to identify better ways to manage.

As Cummings (1984) pointed out, the shift into transorganizational systems requires more than traditional OD. It requires theory and practice commensurate with a higher level of social collectivity to be applied. However, he said, a transorganizational system is difficult to identify as the boundaries are vague, thus there are problems of identifying member organizations, convening them and organizing the change. Planning change is not easy because it requires sharing of norms about the higher level of social collectivity, modelling the change process and predictability.

How then can the use of OD hope to tackle the problems of defensive behaviours in order to move towards this new level of consciousness? On the one hand it can explain more clearly what is taking place, on the other hand it can help management to restructure.

Restructuring

Bartunek and Moch (1987) suggested that if a strong stimulus for change were not present throughout the reframing process, it would often be difficult to sustain the change even when such change is appropriate. Bartunek and Reis (1988) said elsewhere:

> One obvious stimulus comes from a manager's own development of new frameworks and understandings. ... The consistent pres-

> ence of factors supporting change, managers' abilities to stimulate and encourage new understandings on the part of organizational members, and external constraints all affect the organizational retraining process. (p. 110)
>
> A second stimulus which may usefully accompany this one is the presence of decentralized structural features such as collateral or parallel groups or matrix structures. ... These structures are more likely than traditional ones to foster the development of alternative viewpoints in an organization. If new viewpoints and structures that support them are not present at the beginning of change or do not emerge, the organization is more likely to enter into decline than a reviving transformation. (p. 110)

Agranoff (1988) described how some American local governments restructured services by setting up umbrella organizations to link tasks but

> once departments were combined it was discovered that in order to solve real management problems there needed to be further restructuring to align policy approaches or strategies with tasks, job design, people, information, as well as organizational form. The movement to create umbrellas needed to transcend the proverbial stuffing of boxes, so familiar to government reorganization, to include alignment around purpose. Policy and its implementation became important ingredients in organizational design ... As public organizations, umbrella departments are operational instruments of public policy driven missions. ... The local scene must be managed, it cannot only be reorganized. (pp. 11, 14)

The *National Services Integration Pilot Project* (United States Department of Health and Human Services 1989) in five states used integrated case management as its primary focus. There has been a growth of single entry assessments and case management schemes in Canada. These are umbrella models of organization. Green, McCormick and Ten Hoope (1990) emphasized the client-centred nature of this approach: "Case management can be provided by professionals, comprehensive service centres or non-professionals. Case managers function as care brokers and advocates to ensure appropriate use of health care and community services. Accountability is enhanced because the case manager is responsible for ensuring that the range of care and service options is considered and coordinated for every case. Appropriate care reduces the costs associated with redundancies and improves outcomes" (p. 1).

However, Prottas and Handler (1987) have raised questions about operating a voluntary system of case management. They said that professional expertise should not be underestimated.

Gage (1976) has said that it is critical to know how to determine which services are most compatible for potential integration, viewed from several perspectives: economic, social, administrative and political. Irving Rootman[2] advocated using collaborative methods, as developed by Gray (1989), for this purpose. Gray defined collaboration "as a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (p. 1).

Presenting their ideas in more specific practical terms, Hadley and McGrath (1981) proposed the reorganization of neighbourhood health and social services on a "patch" basis in which informal caring networks would be provided with more adequate support through social workers' ability:

1. To locate and be accessible to local networks
2. To develop responsiveness and flexibility
3. To identify with people and groups
4. To develop additional resources

This requires greater decentralization of authority to the service professionals in interaction with the networks and a different kind of accountability At the same time inspection units may be needed to maintain quality control (Heginbotham 1990).

Hadley, a British investigator, has sparked off a number of other studies of community health care restructuring, for example, Heginbotham (1990), Great Britain (1986a,b, 1988), Dixon and Disken (1991), and the National Institute for Social Work (1982).

Some Evidence of Canadian Concerns with Organization Theory

In the introduction to this chapter we said that we found little evidence that organization theory was being used to help administrators to adjust to the collectivist organizational transitions, although there are a few pointers to the contrary (such as Nova Scotia's use of organizational consultants for its provincial inquiry). There follow a few other examples of applications. The first is the report of a conference of senior bureaucrats concerned with the shift in the relationships in moving from "welfare state" to "welfare society"; the second is activity at the service level in public health departments expected to respond to the shift from prevention to promotion orientations; the third, helping staff to understand new ideas about organization.

Bureaucratic Practice

The complexities of keeping the welfare state together were discussed in a conference of senior Canadian political bureaucrats. Pitcherack (1987) thought

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[2] Irving Rootman, personal communication, 1991.

that officials were caught between politicians, staff and clients. They needed to expand their scope as managers, reduce political influence[3] and the rigidity of technological controls (e.g., over budgeting) in order to respond better to the clients. Some thought that the means to reduce political influence might be through privatization or establishment of consumer boards. Program evaluation might also be useful (Jacques 1987). At the same conference Mintzberg and Jorgensen (1987) argued that there was a need to enable more peoples' ideas to become part of realized strategies:

> Strategies can emerge — even effective ones — through a host of processes, some gradual, some collective, some spontaneous, many of these not even managed. (p. 220)
>
> Because it is organized to stamp out the emergent processes of policy making, the public sector today suppresses the capacity of public organizations to adapt and to learn. (p. 226)
>
> Not only must managers be allowed to manage, but all knowledgeable actors must also be allowed to think and so to influence the strategies that are in fact realized. For it is not enough that our public institutions be formally democratic: they must also be informally responsive. (p. 229)

The Healthy Communities Movement: Implications for Professionals

The encouragement of community development in recent years, by such movements as "healthy communities," has led to reconsideration of the roles of public health nurses and social workers in providing expert services. There are still very obvious defensive behaviours by health agency administrators, such as those described by Benson (1982), but there are some who have been seeking to ready their staffs to deal with integration and coordination with other community agencies (Martin 1991; Altman 1991). The Canadian Public Health Association has been reviewing how best to promote change in attitudes and activities of public health nurses (Canadian Public Health Association Task Force 1990).

Improving Explanations to Staff

The planning division of the Ontario Ministry of Health[4] has been circulating articles to health service workers showing new ways of conceptualizing

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[3] Rourke (1984) has noted that in the United States government there has been a trend to reestablish the primacy of elected officials in executive policy deliberations, making it very difficult for senior civil servants to penetrate the inner circles of executive policy making. Obviously senior Canadian bureaucrats were also feeling excluded.

[4] Jennifer Hill and her staff in the Planning Department, personal discussion with planners at the Ontario Ministry of Health, 1990.

problems. For example, one article is concerned with the need for development of skills in managing complexity:

> The obvious organizational solution to strategies that required multiple, simultaneous management capabilities was the matrix management structure. ... Its parallel reporting relationships acknowledged the diverse conflicting needs of functional production and geographic management groups and provided a formal mechanism for resolving them. ... In practice, however, the matrix proved all but unmanageable. Dual reporting led to conflict and confusion, the proliferation of channels created international log jams as a proliferation of committees and reports bogged down the organization and overlapping responsibilities produced turf battles and a loss of accountability ... managers [of complex organizations such as we are considering] found it virtually impossible to clarify the confusion and resolve the conflicts. ... The problem was that [the managers] defined their organizational objectives in purely structural terms. ...
>
> Companies must also concern themselves with ... the systems and relationships that allow the lifeblood of information to flow through the organization. And they need to develop a healthy organizational psychology — the shared norms, values and beliefs that shape the way individual managers think and act. (Bartlett and Ghoshal 1990, 143)

They found that those who undertook the task of managing complex organizations most effectively had these common characteristics: a clear and consistent corporate vision; effective management of human resources to develop identification with corporate goals; and the integration of individual thinking and activities into the corporate agenda by means of cooption. The matrix, they argued, is not in the structure but in the managers' minds.

Canadian provincial governments have become very much concerned with these matters. Every province except Prince Edward Island has organized one or more public inquiries into its health care system, to clarify its objectives and establish a corporate vision. Provincial governments are focussing on improving effective management of human resources, though this is not easy when major changes are being proposed, for there are bound to be resistances. They are trying to ensure that service deliverers accept and work towards the corporate vision.

But this new corporate vision is not often related to organizational theory. It is a practical approach to problem solving. More understanding of theory could help towards greater understanding of better policy making and management.

Summary

In this chapter some ideas of organization theorists which seem to explain the development of the health care system are reviewed. This theory is seldom used by Canadian policy analysts who prefer to take practical approaches.

The ideas reviewed relate first to transformation from one form of organization to another (as happened when the federal government decided to move from an individualistic to a collectivist system of care). The review continues by examining first and second order change in an existing organizations (such as happened when Canada reconsidered the mission of the health care system and switched its main objective from providing access to focussing on outcomes). These organizational changes create inter-organizational stress as executives try to defend their territories.

The chapter continues by providing some examples of successful restructuring in English-speaking countries and then looks at three Canadian approaches to organizational development.

CHAPTER 20

Health Promotion: Development of a Demonstration Strategy

In the previous chapter on organization theory and its applications, the concepts of Bartunek and Reis (1988) about the modification of organizations through first and second order change were discussed. The application of theory to first order change was explored in looking at transorganizational development of subsectors of the health care system. However consideration of second order change was not dealt with there. It will be recalled that Bartunek and Reis said:

> The major difference between first and second order organizational change is in whether or not a particular framework for understanding is altered. In first order change the framework remains the same but in second order change it shifts in some way. The alterations of the framework in second order change have an effect on the assessment of change ... Because the primary shift in second order change is the framework itself, it is more difficult when this type of change occurs to determine whether the change results in better or worse outcomes than before. (pp. 100–101)

In discussing the development of Canada's health care system it was pointed out that Dr. Maurice Le Clair set up a task force to examine whether access to medical and hospital care was likely to result in better health status outcomes. This task force produced *A New Perspective on The Health of Canadians* (Canada 1974a) which argued that good health was more closely related to lifestyle, environment and biological risk than to medical and hospital care. However, Canadians wanted access to health services more than anything else at that time (and still do). The Canada Health Act, 1984, closed off the discussions on the issues of universality, comprehensiveness, portability, public administration and equity of access (at least for the 1980s). The federal government was ready to accept the challenge of the World Health Organization (WHO) to review its policy on *Achieving Health for All by the Year 2000*. In 1986 the federal Minister, Jake Epp, presented Canada's policy statement on this topic (Canada 1986c) to an international conference on health promotion (WHO 1986). This statement proposed a second order change in health service organization for Canada. Health promotion was to be built on top of guaranteed access with a view to improving health outcomes.

Wendy Farrant (now deceased) prepared in 1991 the following chapter on health promotion research which has greatly influenced this second order of change in organization of health services in Canada.

The idea of health promotion is a response to increasing recognition of the limitations of conventional approaches to health care. To quote from the introduction to the *Report of the International Conference on Health Promotion* (held in Ottawa in 1986):

> In the industrialized countries inequalities in health are increasing between social groups while health costs continue to rise. The gap between the potential for health of people in industrialized countries and their current health status has indicated a need for new strategies and programmes. While there is growing concern about lifestyle-related disease patterns, there is also growing awareness of the links between the overall conditions of everyday life and behaviour that influence health. Moreover, the public interest in health, self-care and mutual aid has led to the questioning of professional approaches and definitions in health problems. In some countries these changes in health problems and perspectives have stimulated a shift in the emphasis of health policies; they have encouraged innovative intersectoral health planning and the development of advocacy approaches and enabling strategies. Health promotion is an effort to crystallize a wide range of activities that have contributed towards a changing model of public health. (WHO 1986, 407)

Canada is widely recognized (e.g., Kickbusch 1989; Milio 1988) as having played a lead role in its formulation of a national strategic framework for health promotion. The federal *Framework for Health Promotion* (see Chart 8.1) both reflects and has stimulated the evolution and growing acceptance, since the 1974 Lalonde report, of a broader concept of health promotion that incorporates the principles of the "Health for All by the Year 2000" (HFA 2000) movement (Hancock 1986; Labonté 1988).

The World Health Assembly in 1977 launched HFA 2000 and since then WHO policy has shown a progressive shift towards identifying community involvement as the cornerstone of a broad-based strategy directed at intersectoral action on the determinants of social inequalities in health (WHO 1978, 1981a, 1985a, 1986, 1987, 1988, 1990). This trend culminated in the adoption, by the 1986 First International Conference on Health Promotion, of the Ottawa Charter on Health Promotion (WHO 1986). Health promotion is defined as *the process of enabling people to increase control over, and to improve, their health.* The Ottawa Charter emphasizes that health promotion focuses on achieving *equity* in health, and works through concrete and effective *community action* in setting priorities, making decisions, planning strategies and implementing them: "At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies" (World Health Organization 1986).

Whereas the initial impetus for HFA 2000 came from demands for new approaches to health development in the Third World (primary health care), the WHO health promotion initiative can be linked, as indicated by the above quotation, to the health care crisis and social movements in advanced industrialized societies. Central to both the primary health care and health promotion approach is an emphasis on: *redressing inequalities; intersectoral collaboration;* and *community participation.*

These key HFA 2000 principles present a profound challenge to conventional notions of organization of community health services. Reorienting community health services in a health promotion direction, in accordance with these principles, means much more than adding on to, and/or coordinating, existing service provision. As Siler-Wells (1989) observes: "Behind the euphemistic phases of 'community participation and empowerment' lay the realities of power, control and ownership. To implement health promotion in communities requires changes in each of these three areas, accompanied by an entirely different set of principles, values, actions and processes from those commonly used by the health sector" (p. 142).

Health promotion is integral to the concept of strengthening community health services[1] advanced in *Achieving Health for All: A Framework for Health Promotion* (Canada 1986c). The *Framework* stresses that community health services "should be expressly oriented toward promoting health and preventing disease." This assumes that community health services will:

> focus more on dealing with the major health challenges ... there will be greater emphasis on providing services to groups that are disadvantaged ... communities will become more involved in planning their own services ... links between communities and their services and institutions will be strengthened ... [and] community health services will become an agent of health promotion, assuming a key role in fostering self-care, mutual aid and the creation of healthy environments. (p. 10)

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[1] Also discussed in *Strengthening Community Health* (Canadian Public Health Association 1990).

The *Ottawa Charter on Health Promotion* similarly emphasizes that:

> The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. (WHO 1986, 1)

The increasing support at the provincial level for the principles and strategic direction of the *Framework* is reflected in the *Proceedings of the National Symposium on Health Promotion and Disease Prevention* (British Columbia 1989d), sponsored by the provincial and territorial governments. Symposium participants agreed that five major challenges for health promotion in Canada are: placing health promotion on public, professional and political agendas; achieving equity in the determinants of health; enabling community participation; reallocating resources for health promotion; and increasing intersectoral collaboration.

Rhetoric and Reality

While the need for a health promotion approach has been strongly endorsed at international, national and provincial levels, the constraints upon translating the vision into reality cannot be overestimated. This review of the evolution of community health services in Canada has documented the gap between the principles of a health promotion approach and the traditional medical model that has dominated the pattern of service development. It has also documented some of the professional, organizational and political barriers that have militated against a shift to a more social model.

Asked whether the *Framework* was intended to be a guide to topics for research, Irving Rootman[2] (now Professor of Health Promotion at the University of Toronto) said:

> It was rather intended as a tool for integrating some of the ideas that were current in health promotion at the time and as a way of mobilizing the field and getting health promotion onto the larger health agenda. In other words it was basically a political device. In our view, it succeeded rather well in achieving its purposes. However, it still leaves those of us who have an interest in building so-called 'theory of health promotion' scratching our heads and wondering what to do now. My feeling is that the Centres and Institutes that are developing now might usefully take this on as a collective challenge.

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[2] Irving Rootman, personal communication, 1991.

Draper (1988a), in an editorial in the Canadian Journal of Public Health on "The future of health promotion in Canada," underlines both the significance of the *Framework* as a mandate to "move health promotion from the periphery to the centre stage of health policy" and also the "severe obstacles to overcome" in moving from rhetoric to implementation. In addition to the challenge of resolving "the inevitable conflicts of interest associated with healthy public policy," he notes that: "It is difficult to innovate in an environment of shrinking resources and health authorities have yet to find rational and effective means for reallocating money and effort to fit new priorities." While acknowledging that "[h]ealth promotion practice in Canada is complex enough to make any generalizations dangerous," he observes, "It seems clear, however, that the field is dominated by disease prevention concerns using programs addressed to specific health behaviours — fitness, diet, smoking, drinking and drug use. Information, education and promotion designed to sell prevention ideas are the strategies of choice" (p.75).

A trend has similarly been observed in Europe for health authorities to respond selectively to those disease prevention and lifestyle aspects of health promotion that can be accommodated within a conventional medical paradigm, while ignoring those aspects (particularly concerning confronting inequities and involving communities in policy development) that challenge existing ways of working (Farrant 1987). Even within such a medically appropriated concept of health promotion, Spasoff (1990) concludes that: "there has not yet been any significant adjustment to the health care service, which continues to spend almost the entire health dollar in traditional ways. … The health promotion movement now enjoys considerable support in Canada, especially in the public health sector and in the policies of several governments, but is almost completely detached from mainstream services" (p. 166).

Strengthening Community Health Services: From Rhetoric to Action

The problems and possibilities for reorienting community health services in a health promotion direction was the subject of the series of provincial level consultative workshops entitled "Strengthening Community Health Services," conducted by the Canadian Public Health Association (CPHA), in collaboration with Health and Welfare Canada (Siler-Wells 1987, 1988a.b), following the release of the *Framework* and a discussion paper (Canada 1986c). Approximately 400 health professionals and community representatives met across Canada to identify issues, needs and gaps in community health services and strategies to strengthen them. The consultation highlighted the idea that "one couldn't talk about community health services without defining what community health is. Furthermore, as we examined the interaction between community and health we realized that in order to strengthen community health we were talking about strengthening the community" (Siler-Wells 1987, 3).

Major barriers to implementation of a health promotion approach to community health identified by workshop participants were:

1. Lack of adequate planning at all levels
2. Little or no political will
3. Lack of or ineffective inter-agency or community linkages
4. Minimally effective community participation
5. Resistance of health care professionals to changing roles

Reorienting community health services in a health promotion direction was seen to require:

> changes in orientation and focus, changes in roles, ways of operating and in the locus of power and control. … Five conditions were identified as being fundamental to effecting such change:
>
> 1. Create a supportive policy focus and orientation. This requires a fundamental reorientation of services, based on community-determined needs and community-based planning and implementation and focussing on the determinants of health.
> 2. Mobilize political and community will. Both federal and provincial governments must be involved in a clear specification of policies and resources and identified actions that support and strengthen community health.
> 3. Support new partnerships. Strengthening community involvement and control requires new partnerships between citizens, professionals and governments.
> 4. Adopt a co-active approach. Co-action encompasses the activities of cooperation, collaboration and coordination among key players in community health.
> 5. Nurture our strengths. Strengthening community health services should build on the numerous examples of innovative community-based initiatives that were identified by the consultation workshops. (Siler-Wells 1987, p. 4)

Strengthening Community Health Action: A Way Forward

As indicated by the CPHA "Strengthening Community Health Services" consultation, the gap between a health promotion approach and mainstream community health services, contrasts with the wealth of community-based health action across the country that exemplifies health promotion principles. In Canada as elsewhere, community-based projects and initiatives are taking the lead in redefining health needs and developing action strategies in accordance with the principles of redressing inequalities, intersectoral collaboration and community participation. This burgeoning international community health movement has, in part, been stimulated by recent developments in health promotion, particularly the WHO healthy cities/ communities initiative (Tsouros 1990, 1990 [ed.]). It can also be seen as having provided an impetus for international and national health promotion policy developments (Farrant 1991; McKillop Farlow 1987).

The *Report of the International Conference on Health Promotion* (WHO 1986) notes: "Though this has been an international conference of local, national and international delegates, the deliberations were primarily a response to the rising and changing expectations of populations around the world, who are demanding assistance in achieving their self-set goals. ... People are seeking a broader social response to improving their personal, social and health environments" (p. 450).

The pioneering role of community-based health projects is referred to throughout the *Framework* — "People everywhere are demonstrating a willingness to act on matters of health. Each year, for example, federal funding programs receive thousands of applications for resources to be used in community health projects. Low-income women, seniors, native people, the disabled, immigrant groups and many others are expressing their own ideas on the health needs of their communities, as well as their eagerness to find ways of meeting those needs" (p. 12).

The potential and principles of strengthening community action as a key strategy for health promotion have been well documented (e.g., Brown 1989; Labonté 1988; McKnight 1984, 1987, 1990; Minkler 1985, 1989). Attention has recently focussed on possibilities for enhancing this potential through the creation of infrastructures for supporting and networking, community health initiatives and facilitating links with the policy making process (e.g., Blennerhassett, Farrant and Jones 1989; Smithies et al. 1990; Trojan 1990; Vienna Dialogue III 1989).

The importance of policy support for community health action has been noted in all major international policy documents on health promotion. The WHO (1987) publication on health promotion, *Concepts and Principles in Action: A Policy Framework* states that, "to increase control over their own health, the public requires a greater sharing of resources by professionals and government." This point is underlined in the Ottawa Charter (WHO 1986), which emphasizes that strengthening community action "requires full and continuous access to information, learning opportunities for health, as well as funding support." The Adelaide conference recommendations on healthy public policy (WHO 1988) noted that:

> Women's networks and organizations are models for the process of health promotion organization, planning, and implementation. Women's networks should receive more recognition and support from policy makers and established institutions. Otherwise, this investment of women's labour increases inequity. For their effective participation in health promotion women require access to information, networks and funds. All women, especially those from ethnic, indigenous, and minority groups, have the right to self-determination of their health, and should be full partners in the formulation of healthy public policy. (p.28)

Support structures for community health projects was the subject of the *Vienna Dialogue III on Health and Social Policy*, organized by the WHO Regional Office for Europe, the European Centre for Social Welfare Training and Research, and the Federal Chancellery of Austria (Evers 1989). The consultation noted that, in addition to making a direct contribution to the health of those involved in such initiatives, community health projects and initiatives are key "allies, partners and pioneers in reforming and restructuring public health, and have skills, knowledge and organizational structures that are essential in meeting the health challenges of modern societies. ... The new public health movement needs such partners to find and explore more efficient, effective and humane ways to deal with health problems, and to change the circumstances leading to such problems" (Vienna Dialogue III 1989, 261–62). Participants called upon governments at all levels to take note of WHO guidelines on community participation, and develop systematic policies to support and link community health projects and initiatives and strengthen their contribution to policy making. While funding and other support might originate from many sources, government funding was seen as the key that can open up other sources. The importance of community involvement in the formulation of appropriate funding policies was emphasized. Specific support needs identified by the consultation included:

1. The creation or reinforcement of intermediate structures to help community initiatives interact and develop a strong contribution to policy making at the local, regional and national levels
2. The establishment of clearing houses for the collection and distribution of resources and information
3. Local mechanisms to provide funding and other support to community health initiatives
4. Training, research and information dissemination aimed at helping participants in community projects increase their effectiveness, and helping health professionals and policy makers appreciate the vital role of such initiatives and develop the skills required to interact fruitfully with them

It is now important to look at progress made within Canada towards the development of such an infrastructure, in the five years following the publication of the *Framework* and the *Ottawa Charter*.

Building the Infrastructure

The need to create an infrastructure of support for community health action, along the lines suggested by *Vienna Dialogue III*, was endorsed by the recommendations of the CPHA "Strengthening Community Health Services" consultation summarized above. This has been reinforced by subsequent consultations with people involved in community health projects across Canada (British Columbia Healthy Communities Network 1989, 1990b; Sherwood 1988; Siler-Wells 1989; Canadian Public Health Association 1990).

Canada has been recognized as having taken a lead in instigating a policy of supporting community health action through the federal Health Promotion Fund (Milio 1987). The Health Promotion Fund (Canada 1988d) was first established in 1980 and is administered by the Regional Services Division of the Health Promotion Directorate. The objectives of the fund are:

1. To increase the effectiveness and impact of health promotion programs undertaken by the voluntary sector
2. To strengthen this sector in ways that will increase the opportunity for people to become actively involved in dealing with the health issues that most concern them

Some of the achievements and limitations of the Health Promotion Contribution Fund (the original core program) are summed up by Stern (1990):

> Throughout the years, the program has legitimized new issues such as independent living for the disabled, has worked with the women's health movement in re-defining health issues and has encouraged the beginning of a seniors' movement across Canada. Due to limited financial resources for community action, this program has and continues to be one of the most important mechanisms for innovation in the field. Sadly, the program has not provided a mechanism to influence public policies nor is it perceived as more than a simple funding program within its own institutional walls. (p. 228)

Support from the Health Promotion Fund has mainly taken the form of short-term individual project funding. The potential of the fund as a mechanism for coordinating community health action and facilitating links with the policy making process has not been realized. The more strategic approach to health promotion stimulated by the *Framework*, however, has opened up debate within the Regional Services Division about the potential of viewing the funding "in strategic terms, not as a project-by-project enterprise" (Canada 1988d, 17) and "developing, through and from the funding, a systematic mechanism for influencing public policies" (p. 23).

An important step in the direction of a more strategic approach to funding support for community health action has been Health and Welfare Canada's support, through the Health Promotion Fund, for the *Strengthening Community Health Program*, sponsored by the Canadian Public Health Association (Bhatti 1989; Canadian Public Health Association 1990; Harvey 1991) and the *Canadian Healthy Communities Project*, co-sponsored by the Canadian Institute of Planners, the Canadian Public Health Association and the Federation of Canadian Municipalities (Canadian Healthy Communities Project 1989; Berlin 1991).

The reports, publications and newsletters of these national healthy communities projects, and of the provincial and local healthy community initiatives that they have stimulated, together with the recent of the Strengthening Community Health Program (Harvey 1991), testify to their success in seeding the beginnings of a national and provincial infrastructure for coordinating, supporting and promoting local healthy community action in accordance with HFA 2000 principles.

The national evaluation of the Strengthening Community Health Program (Harvey 1991) strongly endorsed the potential of intermediate structures, in the form of provincial healthy community steering committees, as a catalyst and vehicle for coordinating and supporting community initiatives through such strategies as: community forums for health professionals and community members, workshops on community development, creation of a citizens' health forum, producing materials to document case studies of community action, a survey of needs of provincial agencies involved in community health activities, creation of computer-based networks and presentations to provincial commissions/task forces. While emphasizing the importance of decentralization of resources and control, respondents to the evaluation survey recognized a national role in resourcing and networking provincial infrastructures and providing support, through such functions as advocacy, and provision of a clearing house (for gathering and sharing such information as case studies of successful projects, resources and/or packages developed in other provinces, lists of funding sources and lists of resource people). The evaluation also showed that federal funding of the Strengthening Community Health Program had provided an important lever in legitimizing provincial healthy community initiatives and attracting resources from other sources including provincial governments, municipal governments, the Health Promotion Directorate, the private sector and foundations.

The evolving partnership between the British Columbia Healthy Communities Network Steering Committee and British Columbia Ministry of Health, Office of Health Promotion, provides one example of the potential of such collaboration for supporting new ways of working in accordance with health promotion principles, and facilitating links between community initiatives and the policy making process (British Columbia Healthy Communities Network 1989, 1990a,b; Gruno 1991).

The national healthy communities projects have also provided an important entry point for *reorienting professionals*. The HFA 2000 principles of redressing inequalities, community participation and intersectoral collaboration have far-reaching implications for the role, education and training of health professionals, as well as a the wide range of other people with a role in promoting community health (Bhatti and Hoffman 1990; Doucette 1989; Kickbusch 1989; Labonté 1989; O'Neill 1989-90; Rootman 1988; Swanson 1989). The report of the first evaluation of *Strategies for Health for All in Europe* (WHO 1985a) cautioned that unless measures are taken to reorient the work of health personnel with their consent and full support, the basic principles of the *Framework* are put at risk.

Martin (1991), discussing her personal evolution of a community development approach to community nursing within the Vancouver Health Department, describes the significance of the publication of the *Ottawa Charter* and *Framework* in legitimizing this approach:

> With the legitimization of health promotion, all my ideas and interests had found a home. My visions of working with the strengths of communities, rather than focussing on the problems of individuals was in, so were collective action and social justice. A social movement focussed on health promotion — and modelled on the effectiveness of the feminist, environmental and peace movements — *could* happen. Citizens, politicians and the new general public wanted to debate the new ideas around health. If the general public comes to understand the difference between health and illness, perhaps the medical model will (at last!) take its proper place in health care; hospitals and professionals will understand the limitations of their services; and the allocations of public funds will change. (p. 8)

She goes on to describe the importance of the emergent British Columbia Healthy Communities Network as a vehicle for developing intersectoral partnerships and alliances to support community health action.

An Evaluation of the Strengthening Community Health Program (Harvey 1991) concluded that: "Despite its non 'medical model' approach, the survey results indicate that the SCHP was reasonably successful in engaging at least some health professionals in new patterns of co-action. It is also evident that the program enhanced the presence of regional Health Promotion Directorates, provincial Public Health Associations, and universities and colleges in issues and activities related to community health" (p. 41).

The Registered Nurses Association of British Columbia (1990), for example, states that it is:

> an active participant in the healthy communities movement because of its belief in the value of public participation as a way to make health care more responsive to the needs of the community. The community forums and subsequent follow-up action initiated by several RNABC chapters ... have convinced the Association that local health advisory councils and community forums are effective ways of stimulating the public participation that is necessary to encourage the health care sector to identify and address the social determinants of health. Community members have demonstrated through the healthy communities process that they have insights into the factors affecting health in their communities; an understanding of ways to address these factors; and knowledge of the local resources that are available to do so. Community members have also demonstrated that they have a broad view of health and thus concern themselves with such factors as the environment and social and economic conditions. (p. 37)

The healthy communities movement has also played a significant role in developing *new organizational structures and mechanisms* for enabling communities to define their common health needs, articulate these needs to relevant policy makers, and participate in the planning, development and implementation of action strategies. While different organizational models have evolved in response to different local circumstances, these initiatives have typically involved the creation of some type of community forum for canvassing a wide cross-section of opinion, and the establishment of an intersectoral health council/committee/advisory group with a visible mandate to carry forward recommendations from the community forum into the policy decision making process (British Columbia Healthy Communities Network 1990a). Governments at local, provincial and national levels could usefully draw upon the experience, skills, networks and organizational structures of the healthy communities movement, for developing structures and mechanisms to facilitate effective public participation and intersectoral collaboration in community health policy development. Other examples of creating new organizational structures for multisectoral health planning in accordance with health promotion principles include the transformation of the city of Toronto Department of Public Health over the past decade (Hancock 1990) and the creation of the Ontario Premier's Council on Health Strategy in 1990.

Reorienting community health services in a health promotion direction requires *new strategies for research and evaluation*. National and international consultations on health promotion research have highlighted the need for a style of participatory action-research that incorporates within the research process the principles of redressing inequalities, community participation and intersectoral collaboration (Canada 1989b; Canada 1990a; Hancock and Draper 1989). This implies funding, supporting and promoting participatory research "that deliberately sets out to activate, mobilize and empower people. ... Participatory research agendas are set by the community, who use the research experts as a resource. Participatory research must transfer skills and resources to the community" (Hancock and Draper 1989, 87).

The Health and Welfare Canada Health Promotion Knowledge Development Project (Canada Health and Welfare 1989b, 1990a) has played an important role in legitimizing a more participatory, collaborative and empowering approach to health promotion research. Further legitimization and support for participatory action research has come from the CPHA *Strengthening Community Health Program* (1990) and provincial innovations such as the British Columbia Health Research Foundation Special Research Demonstration Program (aimed at encouraging collaboration between researchers and community groups) and the Ontario Prevention Clearinghouse. The recent growth of interest in participatory action research, among people who are active in community health promotion, has been reflected in an upsurge of inquiries to such bodies as the Participatory Research Network based in Toronto and the Vancouver Women's Research Centre.[3]

Constraints, Dilemmas and Contradictions

These steps toward development of an infrastructure for support of community health action demonstrate the potential of health promotion principles as a framework for reorienting community health services toward a social model. At the same time, however, in Canada as elsewhere:

> most of what has happened so far falls in the category of preliminary action and little has taken place that makes an immediate difference in the lives of people. We still run the risk of 'dynamics without change' on a massive scale. This is because [health promotion] runs counter to ... day-to-day practice. The social model of health on which it is based is different from the medical model of prevention and treatment. Community empowerment challenges the concept of expertise and professionalism that are now dominant. Public bureaucracies are based upon vertical divisions

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[3] J. Barnsley, personal communication, 1991.

> of labour that run counter to ecological concepts of policy. Hierarchical decision-making is still the dominant form of bureaucratic practice and in many institutions it seems to become more extreme as pressure on the institutions grows. (Draper 1989, 194)

Many of those involved with the international and national healthy communities movement have documented the constraints, dilemmas and contradictions of attempting to bridge the gap between the rhetoric and reality of community participation for health for all (e.g., Baum 1990; B.C. Healthy Communities Network 1989; Farrant 1991; Farrant and Taft 1989; Hunt 1990; Lord and McKillop Farlow 1990; O'Neill 1989a, 1989b; Rose 1990; Siler-Wells 1989; Stacey 1988; Stern 1990; Sturtevant 1990; Tester 1990; Tsouros 1990; Tsouros (ed.) 1990). Fear of co-option, professional dominance, turf protection, conflicting ideologies of participation and dangers of state-sponsored participation as a device for shelving government responsibility are recurrent themes. Concerns have centred on issues of power and control that have been integral to the historical relationship between the state and community action, both in Canada and in other countries (Barnsley and Lewis 1985; Ng, Walker and Muller 1990; Beattie 1986; Coburn 1988; Mayo 1975). Many of these issues have been extensively debated in relation to earlier experiments in reorienting community health services discussed elsewhere in this review, such as Quebec's Centres locaux des services communautaires (CLSC) and Département de santé communautaire (DSC), and the British Columbia community resource boards and community human resources and health centre (Clague et al. 1984; Lomas 1985; O'Neill 1989a,b, 1989–90, 1992; Randle 1985). A recent article in the newsletter of the Social Planning and Research Council of British Columbia noted that: "British Columbia has come full circle, returning to debate the appropriate framework for community based social services within the changing 'social contract' between senior governments, local communities, and citizens" (Murphy and Kilcup 1991, 11).

Participants at the Quebec workshop for the CPHA Strengthening Community Health Services consultation (Siler-Wells 1987) underlined the need for the health promotion movement to acknowledge and learn from the successes and pitfalls of the Quebec CLSC and DSC twenty-year experiment in community participation and empowerment. This point has been highlighted by O'Neill's (1989a,b) illuminating analysis of the relevance of the Quebec experience to current developments in health promotion.

An analysis of the relationship between health promotion and community health action in Great Britain cautioned about the need to see the current state of interest in community participation for health in the context of broader debates around such issues as retreat from the welfare state, community care and volunteerism, and to take note of the now well documented lessons from the implementation of primary health care in the Third World (Farrant 1991).

These observations reinforce the point made by Pederson et al. (1988), in their review of the literature on healthy public policy, regarding the importance of analysing current health promotion policy developments from a historical perspective, and locating them within a social, economic and political context.

Analyses of Canadian experiments in state-sponsored participation have demonstrated the usefulness of recognizing the multiple contradictions within state-sponsored community participation, including both their controlling and conservatizing tendencies and their progressive potential.

The contradictions of the *Framework* being launched in the absence of national policies to address the major challenge of reducing inequities did not pass unnoticed (McKillop Farlow 1987; O'Neill 1989b; Wharf 1989). At the same time, our review indicates that the *Framework* has provided a useful focus for legitimizing approaches that are rooted in community health action, and facilitating the development of progressive alliances for social change. While the absence of a significant reallocation of resources to back up the rhetoric about moving in a health promotion direction remains a major contradiction (Terris 1989), Milio (1987) has suggested that evidence of widespread public interest and support for the policy thrust "may in time make the Ministry's request for new funds to fully implement the strategy a politically feasible proposal" (p. 10).

McKillop Farlow's (1987) review of the *Framework* for the feminist periodical *Healthsharing* concluded that, despite the contradictions, the *Framework*

> indicates at least some movement on the part of government to incorporate health promotion into overall health strategies. It may provide a stepping stone to increasing budgets for health promotion activities. Certainly, it provides us, the public concerned about health issues, with a tool to pressure the government to continue in the direction implied by the release of the report. Within the document we find a clearly stated support for the goals and activities of Canada's women's health movement and we should use the Epp report to substantiate our position at the leading edge of health promotion. (p. 10)

Summary

This chapter reviews developments of health promotion ideas and activities since 1977. The burgeoning national and international healthy communities movement demonstrates a widely felt need for a more socially oriented approach to strengthening community health. The policy direction of the *Framework For Health Promotion* (Canada 1986c), and the federally supported

Strengthening Community Health Program and Canadian Healthy Communities Project, have provided useful stepping stones toward the development of an infrastructure for supporting increased local action. The recent evaluation of the Strengthening Healthy Communities Program clearly demonstrated an impressive return on investment and a strongly felt need for continuation and expansion of such support. The readiness of governments at all levels to develop systematic policies to support healthy community action *and* respond to the community health needs identified by such action provides a measure of the political will to reorient community health services in a health promotion direction.

CHAPTER 21

Economic Evaluation of Models of Community Services: A Critique of Applications of the Concept

The terms of the grant under which this project was funded required an economic review of community health services. The federal government had been trying to encourage that more emphasis be placed on community care since 1977, when a special grant was included in the Established Programs Financing Act (EPF) package to promote home care. It was argued by some politicians and bureaucrats that community care would not be less expensive than institutional care. The request for this chapter to be included was to provide some proof of this controversial area. This chapter was written by Christine Gordon in 1991.

Evaluation Methodology and Health Goals

Economic evaluation of alternative health delivery modalities must be seen in terms of the goals set for the evaluation process. These may range from the most narrow — cost containment — to the broadest concept of health promotion in the sense of the World Health Organization (WHO) definition. Evans and Stoddart (1990) express reservations about the usefulness of the latter approach:

> Such a comprehensive concept of health, however, risks becoming the proper objective for, and is certainly affected by, all human activity. There is not room for a separately identifiable realm of specifically health-oriented activity. The WHO definition is thus difficult to use as the basis for health policy, because implicitly it includes all policy as health policy. It has accordingly been honoured in repetition, but rarely in application. (p. 3)

However, it is also clear that a strict adherence to narrow concerns of efficiency in health care delivery cannot encompass adequately the full social costs and benefits flowing from alternative delivery structures. In this chapter the appropriateness of economic evaluation techniques will be discussed with regard to the goals set for the evaluation process. Significant results reported in studies on community health clinics and alternative delivery modalities for care of the elderly will be reviewed.

Evaluation Methods

Almost all studies evaluating the economic performance of health care projects are based on concepts of cost effectiveness analysis (CEA). Theoretically this technique allows for the evaluation of the economic performance of a given project in terms that allow for comparison with other projects. In practice, however, comparison between projects can be accomplished only if outcomes are similar. The reason for this is that CEA is not a full substitute for cost-benefit analysis (CBA). CBA requires that all costs and benefits be measured in monetary or equivalent terms. Monetary valuation supports the calculation of a project's net benefit, which in turn allows for direct comparison between projects. However, health project outcomes rarely are suited to monetary valuation, so that a single common measure of net benefit cannot be computed.

On the other hand, CEA "accepts the difficulty of money valuation of outputs such as health improvement, and instead compares the cost per outcome of different interventions" (Green and Barker 1990, 922).

This approach can be applied in a straightforward manner if a project's outcome can be defined in terms of a single outcome category, but if there are different types of outcomes then some method of comparing them is required. Fried, Worthington and Deber (1989) take a strict position on the valuation of outcomes, insisting that, like costs, benefits be measured in a single unit: "The most common effectiveness unit is the 'life year.' If morbidity is a greater concern than mortality, one could use such measures as 'symptom-free years.' ... The important matter is that all relevant consequences must be measurable in the chosen unit" (p. 634).

This approach may be applicable to projects investigating the effect of a specific intervention targeted to a single health condition, but many alternative delivery projects involve a wide variety of outcome categories, including, for example, psychosocial outcomes or the level of patient satisfaction.

Evans' view (1984) of CEA, which is closer to that utilized in practice, does not require a common unit of measurement for outcomes. He states that "at least some of the consequences of a project are measured only in terms of their natural units" (p. 252). This implies that projects with different categories of outcomes cannot be directly compared to each other, so that a purely economic evaluation cannot be made.

An example of this situation can be found in a review of thirty-one studies of long-term care alternatives by Weissert, Cready and Pawelak (1988). The authors state that "for home and community care to produce savings and avoid cost increases, the savings on institutional and outpatient services, plus an imputed value for patient benefits, must collectively be greater than the cost of new home and community care services" (p. 310). However, none of the studies reviewed actually attempted to impute values to patient benefits, but only reported findings in terms of morbidity rates, activities of daily living scales, cognitive function scales, etc.

The point here is that an objective economic evaluation of these projects is not possible — value judgements must be made to assess the importance of non-monetary benefits along with direct costs and monetary benefits. The authors of the study mentioned above were not impressed with these non-monetary benefits; even though they state that "increased life satisfaction appears to be a relatively consistent benefit of community care, caregivers and patients who use community care are more satisfied and, as a whole, community care users may also have fewer unmet needs" (p. 365). They emphasize that "for community care to operate at lowest net costs, the new costs of community care services must be substantially offset by savings on the use of existing services, such as institutional care" (p. 367). This suggests that whatever the potential benefits in terms of patient outcomes are, they are not worth very much.

This attitude is not unique; in general, studies evaluating alternative modes of care delivery emphasize the categories of costs and benefits that can be readily calculated in monetary terms. Green and Barker (1990) have argued that standard techniques of economic appraisal are inappropriate for setting health care priorities: "The major difficulty [CEA] faces stems from the need to have a single outcome measure, which is common to those interventions being compared. For it to measure the effectiveness of a service the outcome should be in terms of health objectives; if not, the analysis is reduced to measuring efficiency in service provision alone" (p. 925).

Efficiency in the delivery of health care is, of course, a critical element of evaluation, especially with current concerns about increasing health care costs. Indeed, the majority of evaluation studies of alternative delivery projects have focussed on efficiency concerns. Alternative delivery modalities can be viewed as substitutes for existing delivery systems, so that the level of efficiency obtained by an alternative structure can be determined by the extent to which the alternative can lower overall costs while providing a level of care that is at least equivalent to that currently available. From this viewpoint, evaluation can be split into two parts: the first is an economic analysis defining the net benefit as the difference between the costs incurred by the project and those that would have been incurred in the absence of the project; and the second is a non-economic analysis of patient outcomes, the purpose of which is to ascertain whether the project maintains current standards of care, and thus is an acceptable substitute for current delivery modes.

The weakness of this approach is that it does not allow for a specific evaluation of the potential of alternative delivery modes to improve the health of a community. This is true whether "health" is defined in the restrictive sense as absence of disease, or whether it is defined in the more encompassing sense of the WHO definition.

In the first instance, a number of studies have indicated that community health centres are more effective than are private practice physicians in disseminating health information and providing preventive services (Bozzini 1988; Battista, Williams and MacFarlane 1990; Abelson and Lomas 1989). To the extent that these services are successful in realizing improved future health status of patients, they will be responsible for producing reductions in future health care costs. Lomas (1985) states: "It might well be that the additional preventive and educational programs of alternative delivery facilities increase the overall general health of their population and decrease their future use of, and therefore costs to, the health system" (p. 164).

However, current knowledge of the effectiveness of preventive services is limited (Evans 1984), so that it is impossible to estimate the magnitude of these potential cost savings. But it is not clear that economic analysis could evaluate the importance of these services even if their impact were known. For example, the health care savings gained from treatment cost reductions would only account for cost savings and ignore the benefits (both economic and psychological) gained from improved health. This effect would be compounded if future health status improvements are not manifested over the near term, as the present discounted value that could be assigned to causal preventive measures would be small.

Net present valuation of health benefits would be even more distorting in the case where health status improvements crossed generational lines, as could be an expected outcome of improvements in maternity and pre-natal care. Green and Barker (1990) state: "Whilst it is clear that, as individuals, we view the future as of less importance than the present (partly as a result of uncertainty), there is an equally valid argument that a social view, as exercised in a public sector appraisal, should defend the interests of future populations, and should deliberately take a long term view" (p. 925).

The demonstration effect of alternative delivery projects can also provide significant benefits. In the case of the community clinic in Sault Ste.

Marie, Lomas (1985) notes that: "as a consequence of the competition from the health centre, the other physicians reduced their hospitalization rates below the provincial average (although still above health centre figures) and aggressively sought to increase the range of specialist services available for the community. Such benefits are not credited to the alternative when the cost-saving and quality-improvement potential is calculated in the evaluation process" (p. 165).

If we accept a broader definition of health, community-based health care may provide an effective means of empowering a community to participate actively in health care decision-making. "Community involvement may often lead to the provision of services more appropriate to the health needs of the population than services provided without such input. ... The general appropriateness of the care being delivered is not a factor which receives much attention in the current cost-oriented evaluation process" (p. 165).

In a study of the impact of consumer participation in the control of Centres locaux des services communautaires (CLSC) in Quebec, Godbout (1981) concludes that such participation is necessary to effect some types of change: "It is clear that participation becomes merely an instrument for the benefit of the organization when no formal power independent of the organization (in this case, legal power) is granted to participants. This has been shown by comparing the power exercised by users on the CLSC board of directors with the absence of real power in other types of bodies established by professionals, except when these bodies are responsible to the board of directors" (p. 165).

It is for these reasons that Green and Barker (1990) reject economic evaluation as a suitable approach to the setting of priorities for health expenditures. "[Economic evaluation] can be a powerful tool at the level of determining the most efficient way of dealing with a specified health problem, but as such is essentially concerned with questions of 'how,' not questions of 'what' — process not prioritisation" (p. 926).

Brown et al. (1990) agree with this assessment of the utility of economic evaluation, but for different reasons. They argue that the dichotomy between investment and consumption decisions in the private sector is paralleled in the public sector:

> While investment/management decisions are subject to evaluation, decisions based on consumer sovereignty are not. In the public sector consumption/expenditure decisions are ruled by 'cabinet' sovereignty.'
>
> The introduction of any cost-effective change in the health care system creates the potential for cost-saving in the system as a whole by freeing up resources in various parts of the system. It is then,

> in principle, a policy decision as to whether these freed-up resources should be withdrawn from the system, thereby capturing the potential cost-savings, or should be left within the system, thereby foregoing cost-savings in order to expand the total supply of health care and community services. (p. 26)

This implies that even if health outcomes were measurable in monetary terms, it would not be appropriate to use economic evaluation techniques to guide health policy decisions.

In the discussion which follows, emphasis is placed on the effectiveness of alternative delivery modalities in terms of the narrow evaluation goal of cost containment. Economic evaluation methods are suited to this level of analysis, and the results suggest that these delivery approaches offer promise for the realization of significant cost containment.

Community Health Clinics (CHC)

A number of studies have examined the efficiency of CHCs in Canada,[1] and overall, the results have been positive. The most thorough of these studies, conducted by the Saskatchewan Ministry of Health in 1983, looked at the experience of two community clinics in Saskatchewan. The costs of medical services and hospitalization incurred by patients of the clinics was compared to that incurred by patients of private practice physicians. The study indicated that higher costs for medical services were more than compensated for by lower hospitalization and pharmaceutical drug plan expenses, with reduction in hospital days and drug costs for clinic patients, most pronounced in the over sixty-five age group. Per capita total costs were found to be thirteen percent less for clinic patients in Prince Albert and seventeen percent less for clinic patients in Saskatoon. It should be noted that the major portion of total costs for clinic and private patients was made up of hospital costs (on average this category was sixty-four percent of the total).

Studies of the Sault Ste. Marie and District Group Health Association (Hastings et al., 1973; Mott, Hastings and Barclay 1973; DeFriese 1974) and the St. Catharines' community health clinic (University of Toronto and University of Michigan 1973) have shown similar reductions in hospitalization rates of clinic patients. In a review of these studies, Birch et al. (1990) state:

> The reductions in hospitalization seen in the three controlled studies and the current ACIP [Ambulatory Care Incentive Program] data were of the order of 30%. The St. Catharines' clinic was estimated to have approximately 20% lower rates of hospital utiliza-

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[1] The concept of health centres/community clinics/CLSCs is discussed in Chapter 11.

> tion for its patients. The studies of the Sault Ste. Marie clinic showed the lower utilization of hospital care was largely due to a lower number of admissions. The average length of stay for an admission was approximately the same. The study of St. Catharines showed the opposite trend: lower hospital utilization at that clinic was largely due to shorter lengths of stay, not fewer admissions. (p. 4)

A CBA of four rural community health centres in British Columbia undertaken by the Audit Committee on Community Resources and Health Centres found that each centre provided a net benefit, mainly from reduced hospitalization costs. Hospitalization cost savings were estimated by using incidence data from each community in years immediately prior to the opening of the centres, and multiplying the number of hospital days saved by the average per diem rate at area hospitals.

The Canadian studies indicate that the importance of hospital cost reduction to the cost-effectiveness of community health clinics cannot be overemphasized. In light of these findings, it is surprising that so few studies have been undertaken, and, in the case of CLSCs in Quebec, there appear to have been no systematic estimates of their effect on hospitalization rates.

A thorough investigation of the impact of community health centres on hospital utilization in the United States was conducted by Freeman, Kiecolt and Allen (1982). Five community health centres located in areas widely separated geographically were selected for study. The results confirmed the findings of the Canadian studies: "The rate of admissions for patients whose usual source of care is a community health centre is almost one-half that of hospital outpatient users, with patients of private physicians in between" (p. 256).

Similar differences between groups were reported for the average number of nights spent in a hospital. To test whether the results were due to differences in the populations of care groups, the authors used statistical methods to control for a number of social and demographic variables: "These analyses allow the simultaneous consideration of the effects of race, sex, education, poverty status, age, insurance status, chronicity, and source of ambulatory care ... the findings do add to the evidence: when selection variables are taken into account, source of ambulatory care still is associated with number of hospitalizations" (Freeman, Kiecolt and Allen 1982, 261).

The conclusions reached by studies of community health centres is reinforced by evidence from the Rand Health Insurance experiment. Newhouse (1993) states: "Although the experiment was primarily concerned with the estimation of the responsiveness of health-service utilization to the user price, the design of the study included service utilization under both fee-for-service and capitation based modalities. The researchers were therefore able to consider the impact of delivery modality on the utilization of health care and patient health status" (p. 52).

Studies based on the experiment concluded that the average cost of the patients enrolled in the group health co-operative (GHC) was twenty-eight percent less than the cost per patient in the fee-for-service plan (Manning et al. 1984, 53). "Lower hospital use was largely responsible for the lower total cost. GHC groups used almost 50% fewer hospital days than the fee-for-service group" (p. 54).

Home and Community Care for the Elderly

A number of projects in Canada, the United States and Great Britain have been established to provide ambulatory care for elderly patients in their homes. The primary aim of these projects is to reduce the demand for long-term hospital and nursing home care, both because institutional care is expensive and because the provision of care in the home allows patients to remain in familiar surroundings among family and friends, a situation believed to be more conducive to positive health outcomes than is the institutional setting.

A major impetus to the growth of government funding of these projects is the aging of the population. In a study of the demand for hospital and nursing home services by the elderly, Roos, Shapiro and Tate (1989) state: "How do [these conclusions] affect such often recommended policies as targeting the high hospital use by the elderly patient? They reinforce the importance of this approach and suggest a time frame for continued monitoring. Because future costs incurred by the high user group are so substantial (particularly when both future hospital and nursing home costs are considered), special interventions targeted at high hospital users make very good sense" (pp. 365–66).

Robertson (1987) notes that: "the approximate institutionalization rate of 9% in Canada is higher than figures reported in the United Kingdom and the United States" (p. 63). He calls for de-institutionalizing care for the elderly, both through home care funding and through centralized case management:

> Comprehensive geriatric assessment, both diagnostic and functional, is critical in any long-term care system since inappropriate or premature institutional admission may be prevented, remediable conditions may be detected and treated, and appropriate matches may be made between needs and services. ... 'Deinstitutionalizing' the elderly does not imply discharge of more than a few existing long-term care residents, rather it implies de-institutionalizing care by developing alternative methods for delivering health care to the elderly. (pp. 67–68)

Studies of the cost-effectiveness of alternative care for the elderly have shown mixed results. In Great Britain, a non-randomized study of the South Tees Family Support Unit (FSU), which provides daycare, respite care and occasional residential care, showed that, although FSU services were three times more costly than that which would otherwise be provided, the project resulted in a prolongation of life at home for elderly patients (Donaldson and Gregson 1989). However, FSU costs per patient day were forty-one percent of the per diem cost of a long-term hospital bed. The study indicated that these potential savings could be realized: on average, the study group remained in the community 172 days longer than did the control group (p. 204). It should be noted that the study design did not allow for a firm conclusion on this point. The authors discuss the type of data that would be required to make such an evaluation:

> To predict the resource consequences of this alternative it is necessary to have a much larger sample of clients than has been possible in this study and a longer time period over which data are collected. Data collected would be on whether each person in the group eventually enters some kind of long-term care before death, quality of life whilst maintained at home and in long-term care, and also on the number of life years gained by one treatment over the other. ... True cost effectiveness cannot be determined without such data. (p. 208)

It is important to note that if the number of life years is found to be extended by the alternative care project, this may result in an overall increase in per patient health care costs even if the project provides cost savings in other respects. Thus it is imperative that studies of alternative care for the elderly be able to evaluate health outcomes and costs together; otherwise projects which offer poorer health outcomes may be judged to be superior as they provide more overall cost saving benefits. It is unlikely that standard economic evaluation approaches are able to handle this situation in a satisfactory manner.

The evidence indicates that home care services are cost effective in the case where the patient would be institutionalized otherwise. In a British study the costs of intensive home care services were compared with costs for hospital care. The study was controlled so that patients in each group had comparable disabilities. It was found that in seventy-five percent of the cases, costs for hospital care was higher (Gibbins, Lee and Davidson 1982).

Studies in the United States have shown similar results, but indicate that alternative care for the elderly may be cost effective only when it is coupled with a strict screening process. Weissert, Cready and Pawelak (1988) examined the results of thirty-one studies, nineteen of which had obtained data critical to estimating cost effectiveness. They found that of these only seven exhibited net cost savings.

The authors concluded that the key to cost efficiency in alternative delivery of services to the elderly was in targeting appropriate client populations: "If home and community care programs are to avoid raising overall costs, they must serve patients who would have entered nursing homes for long stays. These admissions or stays must be avoided or shortened. ... But if patients served would not have gone to a nursing home anyway, or if they had gone would have stayed only a short time, costs must go up because nursing home use is not being avoided but new services are being used" (p. 321).

One approach to handling this problem (Robertson 1987) is through case management: "The services a client or patient receives may depend less on assessed needs than on the service array provided by the agency with whom contact is first made. Case management can facilitate appropriate utilization of community support and facility services" (p. 66).

A study by Davidson, Moscovice and McCaffrey (1989) analysed the allocative efficiency of case managers for community-based elderly in a preadmission screening program in Minnesota. The study results "implied that case managers were allocating alternative care services in a reasonably efficient manner" (p. 553).

Other Home Care Projects

It should be noted that the scope for effective and efficient home care delivery is not restricted to the provision of services for elderly patients. In a study of home care that was not oriented exclusively to elderly patients, Fenton, Tessier and Contandriopoulos (1982) investigated the cost-effectiveness of home psychiatric care as compared to hospital care in a pilot study in Montreal. The results indicated that home care costs were from sixty-four percent to eighteen percent less than hospital care costs, while providing equally effective treatment.

On the other hand, a study of the Verdun Hospital-in-the-Home Program (HITH) found that HITH is eight percent more costly than inpatient care (Beaudin 1989). However, the program was judged to be cost-effective overall due to benefits obtained by alleviating problems of hospital overcrowding and shortage of beds (p. 55). The study suggested that costs could be lowered by reducing the level of service integration offered, specifically social services.

A recent study of the New Brunswick Extra-Mural Hospital (EMH) found that the EMH has had some effect in reducing hospitalization utilization (M.G. Brown 1990; Brown et al. 1990). In addition EMH regions have had lower rates of increase in the utilization and costs of physician services than have had non-EMH regions in the province. While the authors emphasize that the study did not include a cost-effectiveness component, they feel that "the evidence collected suggests that the EMH might well pass a cost-effectiveness test if a comprehensive analysis is done, insofar as total health system and community service costs for EMH patients in regions served by the EMH may be lower than those for patients with similar conditions living in regions not served by the EMH" (p. 26).

Estimation of Hospital Costs

In all the studies cited above, the monetary value accorded to institutional (primarily hospital and nursing home) utilization is a critical element in calculating the net benefit obtainable. This aspect of economic evaluation is problematic.

For example, the practice employed to estimate hospital costs utilized in the Saskatchewan Ministry of Health (see Annual Report 1983) and British Columbia studies was to multiply total hospital days by the average per diem hospital rate. There are two sources of difficulties with this approach. The first is that the type and severity of illness affects the actual per diem hospitalization cost: "Actual costs for particular patients could be quite different from the per diem rate. First, diagnosis and illness severity affect cost. No reliable information was available on illness severity. Secondly, the first days of a patient's stay are usually more costly due to the work-up required initially. ... To gain a true picture of costs incurred, the costs of lab test, x-rays, special diets and special therapy should be included. Present hospital information systems do not provide this cost information" (pp. 30–31).

In order to estimate actual hospitalization costs for patients of both private physicians and community health clinics, utilization data related to individuals must be available. Lomas (1985) notes that the Ontario government discontinued individual identifiers in 1972, making it impossible to trace the health care received by an individual. "[The 1972 decision] demonstrated the government's lack of understanding and commitment to the use of the OHIP data bank as a health planning and evaluation tool, and confirmed it as simply a centralized billing system" (p. 165).

The second source of difficulty with the average per diem rate approach is that the hospital days saved are unlikely to be average days; savings in utilization will occur mainly at the margin. Hospital costs are affected by economies of scale, so that marginal costs should be significantly lower than average costs. Barer (1981) calculated that a twenty percent reduction in the number of hospital days might lead to a saving of only five to eight percent in hospital costs.

On the other hand hospital costs are based on supply indivisibilities; that is, capacity cannot be increased incrementally — once capacity has been reached, it is necessary to build a new hospital. If community clinics or hospital-in-the-home programs can reduce the demand for hospitalization sufficiently, it may be possible to at least delay the construction of new hospitals; in this case, savings in hospital utilization would be valued at more than the average per diem rate.

The evidence for benefits of this nature are mixed. In discussing the effect of Health Service Organizations (HSO) in Ontario on hospital utilization, Birch et al. (1990) state: "We would expect the savings to accrue mainly at the margin. In other words, the days of inpatient stay or the reduced admissions for a ward saved do not amount to enough reductions in any one community to close a hospital. It may be difficult to justify (on economic terms alone) laying off some staff or developing a community program on the basis of the bed-days saved by HSOs unless the market penetration of HSOs is greater than that seen in Ontario up to this point" (p. 11).

On the other hand, the British Columbia Ministry of Health recently transferred the funds allocated for sixty long-term care beds to the Victoria community care system. The president of the Greater Victoria Hospital Society stated: "Without a doubt, the Victoria Health Project is proving that coordinated changes in the health care delivery system can have a positive impact on the need for costly acute care facility beds." (Victoria 1990b).

Clearly the scale of the project to be evaluated is critical. Reduction in hospital utilization obtained from a small pilot project would be at the margin, while a full-scale project run along the same lines may realize significantly higher cost savings.

A final point on the difficulties of estimating savings due to decreased hospital utilization comes from Wennberg's study (1985) of the variability in hospital utilization by hospital catchment areas in Vermont. Utilization rates varied by a ratio of 1.9; Wennberg states that "in some areas, physicians are much more prone to admit a patient with a particular medical condition or to perform a particular operation in the hospital than are those in other areas" (p. 513). While it is possible that protocol variations are wider in the United States than in Canada, it is important to recognize that savings reported in a given study may not be generalizable geographically.

Summary

Economic evaluation techniques are useful in determining whether an alternative delivery modality is a cost-effective substitute for an existing modality if the evaluation criteria are sufficiently narrow. Evaluation goals that include measurement of health outcomes, especially those derived from the provision of health promotion or prevention services, cannot be handled properly by economic evaluation alone.

On the whole, studies of the cost-effectiveness of community health clinics, alternative delivery of care for the elderly and home care have obtained positive results. These studies indicate that cost savings can be gained through a reduction in the demand for institutional services, particularly hospitalization. The valuation of these savings, however, is problematic. The usual method of assigning average per diem rates to all hospital days saved may overestimate or underestimate the true savings, depending on the particular characteristics of the demand reduction and the scale of the project.

PART VII

Reform and Restructuring

CHAPTER 22

The Welfare State Approach is Questioned

In Chapters 5 and 6 the evolution of the Canadian welfare state, taking professional and social services over from an individualistic private enterprise organization to form a collectivist financial redistributive organization, was described. When these new redistributive programs had been legislated and implemented by the late 1960s, some Canadians started to ask questions about their validity.

Canadian Questions on Redistribution of Resources

Before going on to further discussions of the welfare state/society it may be useful to summarize these questions again:

1. How far should Canada go in developing minimum income policies?

In the early 1970s there began to be a backing off from expanding social welfare schemes (e.g., Canada 1973c), and critical discussions were held about the importance of developing more restrictive minimum income policies. (Seward and Iacobacci 1987; Johnson 1975).

2. Should Canada continue to promote public housing policies?

In the mid 1970s there was a major shift in housing policies away from the emphasis on providing subsidized public housing to encouraging investment in housing as an economic policy (Hallendy 1986).

3. Should the federal government develop other publicly financed health care programs?

It was decided to leave it to the provincial governments to consider whether to finance pharmacy or dental care programs. They all decided to provide subsidies for prescription drugs for elderly and chronic sick patients and some decided to provide dental care for children.

4. Should Canada continue to develop its post-secondary educational institutions?

By the mid 1970s most of these were already in place across the provinces.

5. How could Canada bring its open ended grants-in-aid to the provinces under control?

In 1970 the Economic Council of Canada had pointed out that Canada had become overcommitted to social spending and would be in great difficulties by the end of the century.

Throughout the 1970s negotiations took place between federal and provincial governments with regard to limiting the open-ended matching grants programs but agreement could not be reached. In 1977 the federal government enacted the Established Programs Financing Act (EPF) legislation by fiat. This brought in block grants in lieu of the open-ended grants. These block grants were to be reviewed at five-year intervals. This was intended to force the provinces to take more responsibility for social program funding and administration.

This questioning and the actions taken by the federal government to limit the redistributive programs did not solve the problem of overspending which has become more difficult to cope with in recent years.

International Questions

A second series of questions arose out of the international conference on Crisis in the Welfare State (Organization for Economic Cooperation and Development 1981). This reviewed the difficulties arising in those countries which had committed themselves to some form of collectivist redistribution in the postwar years. Some were much more committed than others (as was explained in Chapter 5). The conference did not explore the extent of commitment so much as the way in which redistribution policies were worked out. It was argued that those countries which consulted (made a partnership with) industrialists, trade unions and others involved in economic productivity were likely to be able to make better adjustments to their social distribution — economic development policies. Those least able were the parliamentary societies in the Westminster tradition in which governments worked out their policies in debate with the political opposition. They needed to keep more in touch with world market developments and technological changes through consultations with industrialists and researchers.

In Canada these recommendations resulted, in due course, in the making of so-called corporate partnerships: formal discussions with businessmen, unions and researchers about policy development were set up.

Canadian Questions on Citizenship Rights

A third set of questions was raised about ensuring the equal rights of all Canadian citizens, and the Charter of Rights and Freedoms was appended to the patriated constitution of 1982.

This instituted a very different approach from electing governments to carry out financial redistribution policies; it required all Canadians to become involved in accepting social differences in their society — racial, sexual, physical and mental disabilities of other citizens. This can be described as accepting a policy of "equality of consideration." In order to do so there was a need to make considerable attitude changes in society and to develop greater individual and community awareness of the needs of disadvantaged members of society.

First and Second Order Change

The decision to bring in financial redistributive programs across the provinces was a first order change from making Canadians responsible as individuals for their own survival to making them responsible collectively for others in need.

When it became clear that financial redistributive programs were not enough to provide "equality of consideration" for all citizens, there was a shift in the vision and a move towards reform and restructuring of social programs.

Each of the publicly financed programs reacted to the questionings of the welfare state policies in different ways. The social welfare programs began to focus on the barriers faced by disadvantaged citizens but stopped working towards the removal of residualism in meeting needs. Health care programs shifted to consider the need for social supports, the importance of health promotion and a social model of health. Other programs such as housing moved towards an economic investment rather than a social model of provision.

The clear commitment to collectivism in the financial redistribution model became cloudy as the economic situation of Canada changed.

The following chapters in Part VI examine how Canada went on to deal with the debt and deficit issues up to the end of the Progressive Conservative terms of office in 1993, how it reviewed its health care programs in the light of these questions and how it has addressed human rights' issues for three disadvantaged groups, before considering the implications of these new issues for consumer involvement in policy making and the new approach to the welfare state. Part VII ends with a further discussion of the context of health care systems — the new welfare society.

Summary

This chapter begins by recapitulating a number of question about the usefulness of concentrating on financial redistribution within a welfare state when the forecasts said that the nation had become overcommitted. Efforts were now made to control grant aid to the provinces under the EPF legislation of 1977.

A second series of questions relates to the breadth of corporate involvement in policy making and the need for governments to work more closely with businesses and unions.

A third series of questions was raised about equality, other than financial equality and the need to recognize the human rights of all Canadians.

This chapter traces two periods of organizational change in the welfare state after deciding to adopt the collectivist model. The first order of change to financial redistribution was questioned and a new vision adopted. This required restructuring to a second order of change.

CHAPTER 23

The Impact of the Federal Deficit and Accumulating Debts

The federal government's changing position in relation to revenue collection and social spending was discussed in Chapter 6. When the welfare state was planned, Canada was well able to consider extensive financial redistribution polices from central sources to individuals and provincial governments. But in the mid 1970s the situation changed, and gradually the federal government found that it was not able to meet the demands upon it without going into debt. There were many reasons for this change, both internal and external. Since then Canada has fallen deeper and deeper into an annual deficit and accumulating debt situation. At the beginning, this indebtedness was seen to be a management problem for the federal government to resolve, but as the debt has grown, it has now become the most discussed political issue at all levels of government across Canada. This chapter will try to trace the response of the federal government to the deficit and debt issue up to 1993 and the way in which this response has affected social programs delivered at provincial and local levels.

Response of the Liberal Party to the Deficit and Debt Situation 1975–1984

The Liberals were in power in Ottawa from 1935 to 1984 with only two short interruptions. The first of these — the Diefenbaker years, 1958 to 1963 — happened during what has been called the postwar consensus on the importance of having a welfare state and the second — the Joe Clark government of the early 1980s — was a brief interregnum in which the consensus was not challenged.

Taylor (1978) has discussed the hesitations of the Liberal Finance Minister Mitchell Sharp relating to the introduction of Medicare (1966) but it was decided to go ahead with implementing the legislation nevertheless. The Liberals later had some second thoughts about their financial redistribution policies when they were made aware that they were going to be financially overcommitted (Canada 1970a). But they continued to pursue further policies which would have improved social minimum programs for the next five years. By the mid 1970s, however, it had become clear that the finalization of the projected social minimum policies was unacceptable to the cabinet and that new pressures were emerging to change the direction of the welfare state. Johnson (1975) has described the outcomes of the 1975 social service review. By then the government had decided not to continue with the guaranteed annual income (GAI) experiment (piloted in Winnipeg) or revisions to the Canada Assistance Plan.

Concurrently throughout the 1970s federal negotiators struggled to find ways of persuading the provinces to let them amend the open-ended matching grants schemes for health and post-secondary education, but they did not succeed in finding a resolution. So the Established Programs Financing Act (EPF) was passed by fiat in 1977. This substituted block grants to the provinces for open-ended grants. Then federal government began to steadily tighten the block grant aid at each five-year review.

During the period between 1975 and 1984, when the Liberal government was still in power, the politicians concerned with tighter financial control seemed to grow more powerful, challenging defenders of social minimum programs, public housing policies, income security programs and so on. However, until they were ousted in 1984, the Liberals concentrated on finalizing the universal collectivist programs which they had set out to implement. The health insurance principles were firmly restated in the Canada Health Act, 1984, and more extensive post-secondary education programs were set in place in universities and community colleges all across the country in the 1970s and early 1980s.

Yet more important than any efforts to reduce financial redistribution programs were the equalization ideologies which were set out in the Human Relations Act, 1977. During the years when Pierre Trudeau was prime minister he tried to refocus attention on equalization (equality of consideration) rather than the social minimum (equality of condition) or universal programs (equality of opportunity). It does not seem to have been recognized (or perhaps not discussed) that this policy of equalization was likely to be very costly because it brought out the needs for better social support of previously neglected disadvantaged groups.

The Progressive Conservative Party Takes Over, 1984–1993

The Progressive Conservatives (PC) came to power in 1984 in a greatly changed situation. International doubts about the welfare state as the best mechanism for dealing with present day problems of western democratic societies were being expressed. More immediately pressing was the fact that Canada would have to deal with its severe financial problems if it wanted to keep its welfare state going. However, the PC party had little experience of office, and it seems to have taken the government some years to decide on its priorities. How else can one explain Jake Epp's support for the development of additional health promotion policies unless this is seen as a personal interest of a Mennonite health minister? (Though perhaps this policy might have been sold to him as a cost control strategy?)[1]

It was not until the second term in office that the government brought forward its overriding priorities — the first being the reduction of the national deficit and debt; a second objective was to resolve the constitutional deadlock (since Quebec had refused to sign the patriated constitution in 1982); and a third, free trade with the United States. These three new objectives resulted in a federal retreat from commitment to the redistributive welfare state through continuing withdrawal of funding for social programs and increased emphasis on economic development policies.

Meanwhile, during its first term in office when the government was looking for the right direction to take, there were a number of public inquiries into the future of the social welfare system.

A Commission of Inquiry on Unemployment Insurance was set up in 1985 (Canada 1986a). The committee recognized from its own internal struggles that reform of unemployment insurance would not be easy to achieve, but it recommended an overall strategy of human resource development of which unemployment insurance was to be only one part. There were three interlocking components: unemployment insurance, education and training, and income supplementation schemes. "The unemployed need jobs, money, skills and a broader set of options" (p. 295). In the same year the Canadian Employment and Immigration Commission introduced its Canada Job Strategy Programs to help unemployed citizens to get ready for new work opportunities.

In 1986 the Institute for Research on Public Policy set up a workshop to discuss the best way to go (Seward and Iacobacci 1987); another conference

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[1] Of course some people do see health promotion strategies as part of the cost control movement, although most people see health promotion as an add-on to costs in the short run, if not in the long run.

in the same year was called to bring together Canadian and British academic social policy analysts (Seward 1987). The reasons for calling these meetings were the dissatisfactions with current income security programs — they were failing to respond to the needs of the long-term unemployed. As well, there were concerns about the high cost of the programs and their possible negative effects on recipients who might not try to get paid work again, thus affecting Canada's economic efficiency and international competitiveness. Despite consensus on some issues at that time, there were many remaining uncertainties about the direction of reform.

In 1985 the recommendations of a public inquiry had retreated even further from earlier proposals for reform of social minimum policies. The recommendations of the Royal Commission on Economic Union and Development Prospects (Canada 1985a) were that a universal income security program (funded at a much lower level than the earlier GAI in order to increase incentives to work), a reform of unemployment insurance and the introduction of a transitional adjustment assistance program (to force workers to adapt to changing economic circumstances) would be more appropriate.

The federal government thought that a new emphasis on economic development was necessary because Canada's trading situation had changed. In the mid twentieth century it had been a country rich in natural resources, but these had been exploited to the full and there were many protests from environmentalists that this exploitation had been taken too far. Canada's trade relationships had also been affected by the technological revolution of the postwar years and the development of the global economy. Both of these had impacted upon that part of the job market in Canada which was not natural resource-based. Canada seems to have been slow to respond to the need for reform and restructurings of its industries, one example being the automobile manufacturers in Ontario who did not react as quickly to Asian challenges as did their American counterparts.

Agreements were made with some of the provinces to encourage social assistance recipients to retrain for return to work by providing them with financial incentives to do so. And in the next few years social assistance schemes were cut back to provide incentives to workers[2] to see periods of unemployment as transitional, necessary interruptions for adjustments to be made in a changing work situation.

As these changes in policy direction were being introduced, the National Council of Welfare, an advisory body to the federal government, struggled

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[2] Most provinces established separate social assistance programs for those who would never be able to go back to work.

to keep the issue of poverty in the news by publishing reviews such as *The Tangled Safety Net* (Canada 1987b), an annual update on welfare incomes, and other critical papers, but it had little success in modifying political attitudes.

For example, the Liberal government in Ontario now set up a provincial committee to examine its social assistance system (Ontario 1988a). The committee said that social assistance ought to be regarded as transitional. "The key to preventing individuals from becoming dependent on assistance lies in other areas of social and economic policy" (p. 11). However, a number of social researchers expressed concerns about the priority given to economic development over supporting those with social needs — those who were unable or unwilling to find a niche in the transitional society of the 1980s (Patterson 1987; Mishra 1987; Smith and Dobuzinskis1987; McNiven 1987).

Moscovitch and Albert (1987), explaining this value shift in Canadian society said: "In the 1960s the state offset the growth of social expenditures by borrowing against the future as well as shifting the revenue burden from corporate to income taxes. With the economic downturn since 1974, borrowing has become increasingly costly. Many business organizations have amplified their demands to shift the balance from social consumption to social investment, and simultaneously for cuts in taxes and the deficit, hence the pressure on the state to reduce social expenditures" (pp. 39–40).

In 1989 the federal government began to toughen up the benefits of the unemployment insurance program. Torjman and Battle (1990) were very critical of the way in which the work strategy was being given precedence over the needs strategy. These analysts pointed to the way in which funds had been diverted from the Canada Assistance Plan into the Job Entry and Job Development Programs of the Canada Job Strategy:

> Welfare administrators in every province and territory are trying to find ways to shorten the length of time recipients remain as beneficiaries and to keep people off the welfare rolls.... The assumption that underlies these programmes is that employable welfare recipients are lacking in some way. (p. 20)[3] [They said:] There is a wave of welfare reform sweeping the country. If it succeeds it will bring about some fundamental changes in our system of income security. At the very least it will strike the words 'safety net' from the vocabulary of social policy advocates. At most it will banish forever from the Canadian psyche the notion that the state will be

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[3] At the same time the government was explaining the need for Canada's work force to become more flexible, more adapted to new technologies and new trade patterns and agreements. Vocational training was to be the mechanism for change (Canada 1985b).

> there to protect vulnerable individuals who are displaced by the uncertainties of a rapidly changing economy. (p. 19)

So far as meeting individual citizen's human rights were concerned, Strain and Hum (1987) emphasized the importance of Section 36 of the Canadian Constitution which puts the onus on both levels of government for promoting equal opportunities for all Canadians; furthering economic development to reduce disparity in opportunity; providing public services of reasonable quality to all Canadians and (through federal equalization payments) ensuring that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonable levels of taxation. They saw this clause as putting the primary responsibility on federal government but said: "The actual fiscal arrangements do not provide for full national financial responsibility and there are not explicit, but flexible, national minimum standards" (p. 368).

By introducing welfare state legislation between 1940 and 1970, they asked, had the Canadian federal government set up a social contract with its citizens? This was tested in the courts in 1991.

The federal budget of 1990 set a two-year limit on increases in federal spending under the Canada Assistance Plan (CAP) in the three wealthiest provinces: Ontario, Alberta and British Columbia. "Ottawa said the growth in CAP transfers to the three provinces would be limited to five percent a year for the fiscal years 1990–91 and 1991–92. Increases in CAP expenditures above five per cent a year would not be cost shared, so the three provinces would have to cover any cost increases in excess of five per cent a year by themselves. ... The latest provincial estimates add up to losses of at least $865 million for the two fiscal years." (Canada 1991d, 18). Further restraints on CAP for three more years were brought in, in 1991.

The British Columbia government with the support of Ontario, Alberta and Manitoba and two native peoples' groups challenged the right of the federal government to make unilateral changes in federal-provincial funding agreements without provincial consent. The case against Bill C69 was won in the British Columbia Court of Appeal where Justice J.D. Lambert said:

> If Canada is willing to breach its agreements by passing legislation to authorize, or even require, the breach, then Canada cannot expect to conclude agreements with contractors to build airports, nor to settle Native land claims by agreement. Honest self-assessment by honest taxpayers is the basis of revenue raising in Canada. The foundation on which that type of taxation rests would be removed if Canadians could not trust their government to keep its agreements. I expect that the overwhelming majority of Canadians would say that this country must be as good as its word.

However, the federal government appealed the judgement to the Supreme Court of Canada which ruled in favour of the legality of its spending restraints. (Canada 1991d). The judges said that decisions to redistribute funding to the provinces were properly at the discretion of the federal government.

The Canadian Council on Social Development (1990), like the National Council of Welfare, expressed great concern about this decision of federal government to reduce transfer payments to the provinces.

Retreat From the Federal Welfare State

Neoconservatives in other countries (such as Prime Minister Margaret Thatcher in Great Britain and President Reagan and President Bush in the United States) had embarked on retreats from their welfare state policies, urging government pullouts from funding social programs. Among other policies they adopted were reduction of taxes on companies, corporate partnership discussions with industry, devolution of authority to lower levels of the funding system, reduction of government bureaucracies, greater privatization, and attempts to balance their budgets.

The PC government was very ready to adopt some of these policies. In more intensive attempts to increase economic viability of Canadian industry they adopted a policy of "harmonization" with their North American Free Trade Agreement (NAFTA) trade partner, the United States, and reduced taxes on manufacturers and service providers. It was at this point that revenues dropped while costs continued to rise and the deficit debt grew more quickly.

The concept of corporate partnerships brought out at the Organization for Economic Cooperation and Development (OECD) conference (OECD 1981) has already been discussed. Canada embarked on more discussions about policy development with industrialists and researchers. In 1991 the federal Minister of Health, Benoit Bouchard, published a policy statement entitled *Building Partnerships* (Canada 1991a) in which he proposed renegotiating relationships between federal and provincial governments. It was argued that provincial governments must now bear more of the responsibility for organizing and managing (and of course funding) health services.

Implications of Decentralization

Some commentators have been very critical of the retreat from the welfare state's centralized social program coordination. Tsalikis (1989) has argued that, in Canada, "recent proposals of decentralization are a continuation of reactionary tendencies to constrain social expenditures, but not a path to better quality of life." He took issue with those who "expect decentralization to result in holistic services adjusted to local needs" or those who "feel we are in the dawn of a new epoch in which major economic transformations are to bring about, through new class alliances and conflict, decentralization of power and a better quality of life in communities" (p. 293).[4] And Wharf (1989), reviewing the retreat from *Achieving Health for All: A Framework For Health Promotion,* said: "The challenge of reducing inequities is properly the task of federal government and it is indeed misleading and inaccurate to suggest that inequity can be eliminated or reduced by local level activities. ... While partnerships between three levels of government will be required in the future, the responsibility for taking the next step in achieving health for all clearly lies with the federal government" (p. 47).

Wharf thought the federal government should be responsible for overall programs and strategies. It should take on the challenge of developing a decent standard of living for all and share in the costs of promoting healthy lifestyles and creating healthy environments. He thought it should begin by heeding the advice of the National Council of Welfare on the need for an improved social security system and the need for tax reform. Unfortunately for social reformers, the moves are all in the other direction.

Summary

The redistribution of Canada's revenues appeared to be the right policy to pursue in the 1940s when the federal government was raising more from taxation than it was paying out, but in the mid 1970s the situation changed. Grant aid to the provinces and federal social security programs began to cost more than revenues coming in. This chapter reviews the response of successive governments in Ottawa to this matter.

Even before the Liberal's welfare state programs were finalized, some of the leading politicians had expressed doubts about Canada's ability to pay for its commitments in the future. Attempts were made to control expenditures by substituting block grants for open-ended grants in 1977, thus forcing the provinces to be more concerned about social program budgets.

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[4] Elsewhere, earlier, Tsalikis (1982) had reviewed the development of the welfare state: "the fiscal growth of the federal authority in wartime necessitated some kind of 'national purpose' in the field of social policy. This led the federal government to a medley of contradictory policies, the outcomes of which were hardly suitable to its 'Robin Hood' image. ... [However, the present] tendency in social policy is for more provincial autonomy" (p. 143). But the linkage mechanisms are not well developed, he said, after reviewing regionalization and community health services at the local level. He was doubtful even then (1982) about getting commitment from entrenched interests (e.g., the medical profession) to change.

At the federal level universal programs continued to be supported and, while social minimum developments were cut off, businesses began to get more concessions.

When the PCs attained power in 1984 they took some time to sort out their policies, but in due course they identified three priorities: reduce the national deficits, resolve the constitutional deadlock with Quebec, and sign a free trade treaty with the United States. Meanwhile, in the transition years there were a number of public inquiries into the best way to go to continue with collectivist commitments.

Many people were concerned about the value shift away from social programs to support of businesses and struggled to preserve a general concern about maintaining federal transfers to the provinces while these were being steadily cut back. Court challenges did not succeed in changing federal decisions. The provinces were told that they must accept greater responsibilities as partners in organizing services. Critics thought that retreat from centralized control over standards was likely to result in increased inequalities and an ending of welfare state policies.

CHAPTER 24

Provincial Inquiries into Health Care Organization

Reports of the Provincial Commissions of Inquiry[1]

As the federal cost constraints began to bite after the introduction of the Established Programs Financing Act (EPF) and subsequent revisions of federal transfer policies, particularly in the poorer provinces, some governments decided to consult the public about their ideas on how to ration services. This was more obvious in the Atlantic provinces than elsewhere (New Brunswick 1978). Newfoundland, for example, instituted three inquiries (e.g., Newfoundland 1984), one of which, called the *Green Paper on Our Health Care System: Expenditures and Funding* (Newfoundland 1986), expressed great concern about the province's ability to continue to provide the current level of health services. The government asked for the voters' views on the options — increase privatization, reduce expenditures, engage in deficit financing or change the tax system.

Nova Scotia addressed this cost control issue in a different way. A legislative committee (Nova Scotia 1984) examined how to cut down on hospital use in smaller communities (Doane 1990).

Some provinces preferred to use public inquiries, others decided to rely on their bureaucrats for advice. Manitoba seemed to believe in using consultants to prepare background papers for its policy discussions. In the mid 1980s the government commissioned studies of its medical plan (Roch and Evans 1985) and its mental health services (Manitoba Health 1984) before making a general health services review (Manitoba 1988a).

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[1] Angus (1991) summarized "the significant" provincial reports which had been published by that time. The reports and responses to them by the provincial governments are listed in Appendix B.

The reports, which were almost all concerned with cost control issues before 1986, began to change in content thereafter. Clearly they were strongly influenced by the federal document *Achieving Health for All: A Framework for Health Promotion* (Canada 1986c). The later recommendations reflect the shift in the paradigm from ensuring access to medical care to achieve health to the idea of promoting health through improving lifestyles and environment.

But how this shift to the new paradigm should be carried out is a matter of political ideology. The reports vary in their approach, showing that there was still a considerable difference in the provinces' acceptance of collectivism. The most reluctantly collectivist province was Alberta, although there was a general recognition of the need to improve *Caring and Responsibility* (Alberta 1988). In reviewing how the provincial government might improve its approach to health care, a royal commission made 21 recommendations in the *Rainbow Report* (Alberta 1990c).

At the other end of the scale is Quebec, whose government had become deeply committed to a model of collectivist care from the days of the Quiet Revolution (the 1960s). By the mid 1980s the province was ready to review what progress had been made in establishing the collectivist model (introduced in the 1970s after the publication of the Castonguay-Nepveu Committee report [Quebec 1970–72]) and whether it should be modified. A new Liberal government decided to examine the issue of privatization (Quebec 1986)[2] but also renewed the mandate of the Rochon commission (Québec 1988) appointed by its predecessor government (the Parti Québécois). The Rochon commission took public ownership as a given and made the following general recommendations:

1. There should be clear recognition of the importance of provincial decision making about social affairs
2. As far as possible the province should assume public ownership of the health care system
3. There should be an emphasis on community care rather than institutionalization
4. There was need for improved coordination of health and welfare services at all levels
5. There was need for greater control of professional behaviour, with the emphasis on protecting consumer interests
6. The basic principle of devolving management should be recognized

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[2] This investigation did not have any outcomes other than its report but in the 1990s, there seems to have been acceptance of a two-tier system of care (see below).

In order to end the confusion about Centres locaux de services communautaires (CLSC) objectives[3] it was proposed that social activism should be excluded from the centres. Government subsidies for voluntary organizations, which had been cut off when the CLSC model was implemented in the 1970s, should be reinstated. Quebec also commissioned a report on mental health policy (Quebec 1987b) and a separate report on CLSCs (Brunet 1987).

The reports of the commissions in the other provinces fell somewhere in between on the ideological spectrum. It may be more important to review them in terms of the response they elicited from the governments to which they were reporting than to review the reports themselves.

Government Responses to Reports of the Royal Commissions 1986–92

Neither the Newfoundland nor the Prince Edward Island governments or government-sponsored commissions produced reports on health or health care in the late 1980s, but they have moved toward regionalizing in the 1990s.[4]

A royal commission in Nova Scotia examined the financing and delivery of health services between 1987 and 1989 (Nova Scotia 1989a,b).[5] The government responded by publishing a review of its strategies (Nova Scotia 1990b). These focussed particularly on regionalization of services in three geographic areas. It has now decided to develop three health regions.

New Brunswick appointed two committees of inquiry — one to examine selected health care programs (New Brunswick 1989) the other, a nursing advisory committee set up to consider how to improve the quality of working life of nurses (New Brunswick 1988). The provincial government produced two responses — the vision and the plan (New Brunswick 1991, 1992). The plan was based on a continuum of care from wellness to illness and proposed that more attention be paid to health promotion and disease prevention. The strategies were to be:

1. consistent regional planning[6]

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[3] It will be recalled that Lésémann ([1981], 1984) had pointed out that there had been some confusion between epidemiological and community activist goals in the CLSCs.

[4] A new commission of inquiry proposed five regions for Prince Edward Island in 1995 (discussed in the Afterword).

[5] A legislative committee (Nova Scotia 1984) had examined how to cut down on hospital use in smaller communities.

[6] Reamy (1995) has reviewed the subsequent development of regionalization in New Brunswick.

2. better management of the hospital service sector, including development of more outpatient clinics and the extra mural hospital
3. improved ambulance services
4. reductions in the prescription drug program
5. reconsideration of ways to reduce the costs of Medicare
6. allocating more of the budget to public health departments for health promotion activities
7. developing family and community services
8. better planning for the use of professional services

In Quebec the response to the Rochon, Harnois and Brunet reports was hesitant at first. However, in 1989 the minister published a reply in *Improving Health and Well Being in Québec; Orientations* (Quebec 1989a). This was a pre-bill, a White Paper proposing new legislation. The paper emphasized:

1. four strategies for improving health promotion
2. the need for improved hospital emergency services
3. more solutions to the problems of the elderly
4. better distribution of medical specialties
5. pilot programs on service integration
6. development of medical technology
7. replacement of outdated buildings
8. health manpower planning
9. improved community consultation
10. selective service restructuring
11. improved manpower policies

Bill 120 which followed had its first reading, but then there was a provincial election and the minister was replaced. A new minister found that he had to deal with a crisis in the emergency services as well as responding to a parliamentary commission reviewing the bill. He published his response to the crisis in *Une réforme axée sur le citoyen* (Quebec 1990b) which proposed to give incentives to CLSCs and other clinics where primary care physicians work in order to relieve the emergency departments.

The bill had set out the current policy on health and well being and made a number of structural changes. It proposed the creation of a Council on Health and Well Being and set up seventeen regional authorities (but the regions were to have no elected officials, no taxation power and there was to be no regionalization of medical plan budgets). The minister was to report annually to the Parliamentary Commission on Social Affairs and triennially to the regions. Consumers' rights were to be enlarged. The lower level boards were to be re-elected, this time from community members only.

Renaud and Larivière[7] have traced the battles over Bill 120 which continued through 1991 and 1992. He saw the final version of the bill as a victory for the entrepreneurial doctors over the defenders of the Castonguay-Nepveu model of collectivism. The medical profession had successfully resisted attempts to accredit office practice, maintained freedom to open an office anywhere doctors wanted and fended off restricted entry to medical schools.[8]

Ontario's minority Liberal government commissioned three reports before an election in 1986: the first on health promotion (Ontario 1987b), the second on health goals (Ontario 1987a) and the third an overview of health policy directions (Ontario 1987c). The Evans committee thought that Ontario had a good health care system but suggested three ways in which it might be improved:

1. Strengthening the role of the individual consumer *vis-à-vis* providers and government
2. Improving linkages between different elements of the health care delivery system and increasing the emphasis on ambulatory and community-based care
3. Achieving a strategy for health in Ontario

The Liberals were returned to office and accepted the reports of these committees in a policy statement (Ontario 1989g) which focussed on enhancement of the role and responsibilities of consumers. The statement stressed:

1. Strengthening of community-based care
2. Maintaining the role of public hospitals
3. Integrating private sector strengths and resources
4. Improving quality assurance and treatment effectiveness
5. Strengthening the team of physicians, nurses and other professionals

The government set up a standing advisory committee — the Premier's Council on Health Strategy. This body was expected to clarify goals, establish strategic objectives and targets, develop operational plans and monitor progress. Within two years it had produced twelve major reports. However, it was a separate body from the operating ministry and the linkages were not clear. The ministry continued to pursue its own priorities such as putting in place a better coordinated service for the frail elderly, reconsidering and strengthening the role of the District Health Councils and so on.

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[7] Marc Renaud and Claude Larivière, personal communication, 1992.

[8] Although no other provincial report has dealt with organization and management of the medical profession, restricted entry is now being negotiated, elsewhere, following the Barer-Stoddart Report 1991.

The Liberals were replaced by the New Democratic Party (NDP) in 1990 and the Premiers' Council on Health Strategy became the Council on Health, Well Being and Social Justice. The thrust of policy was shifted to health promotion with an emphasis on identifying the determinants of health and directing the service towards improving outcomes.

Manitoba set up a Health Advisory Network Steering Committee in 1988, "to obtain advice through cooperative deliberation among representatives of various facets of the health community on [specified aspects of] organization, administration and financing of health services" (Manitoba 1988a). This advice, together with input from the Management Centre for Health Policy and Evaluation and the Urban Hospital Council was reviewed by the minister and published as *Quality Health for Manitobans: The Action Plan* (Manitoba 1992). The plan proposed a phased two-year shift from institutional to community care with more appropriate prevention, support and home care services to help people to avoid illness, to delay or reduce their need for institutional care. There were to be budget transfers, community development initiatives, review of professional service organization and examination of laboratory and pharmacy costs.

Although Saskatchewan's Conservative government commissioned and received a report from a Commission (Saskatchewan 1990a), this report made no impact then because the government had no money and was reaching the end of its term. A new NDP government elected in 1991 produced an alternative document: *A Saskatchewan Vision for Health* (Saskatchewan 1992). This pinpointed five wellness strategies:

1. Environmental policies which involve making partnerships outside government
2. Increasing understanding of health promotion and disease prevention activities
3. Integration and coordination of services by creating health districts
4. Developing community health centres and rethinking the role of rural hospitals in order to bring services closer to people
5. Developing health professionals as individuals and as teams, revitalizing regional hospitals and emphasizing evaluation

How this vision was implemented will be discussed in Chapter 29 which examines regionalization policies.

In Alberta the Rainbow Report (Alberta 1990c) made the following recommendations:

1. There should be a phased-in budgetary shift to prevention
2. A committee should be set up to review the better processing of health

data (this was basic to their idea of a Smart Card which would make individuals responsible for buying their own health care)
3. A provincial ethics committee should be set up to deal with such matters as living wills, power of attorney for the less competent, and environmental ethics
4. A committee should define what services should be insured. Budgets for health care should be protected
5. The province should be divided into health regions which would set up local priorities
6. Health technologies should be assessed for economic effectiveness and socio-psychological impact, and further research should be funded
7. Health human resources planning should be addressed

In response, a government office was set up to find answers to these recommendations but found it difficult to reconcile the strong emphasis on individual responsibilities with the recommendations for regionalism and community involvement. However, a government statement was produced in 1991 (Alberta 1991) and a series of public forums were set up to discuss the reform process and health goals. The minister then seemed to be more anxious to organize a policy of regionalization than to pursue the Smart Card idea. There was considerable resistance from traditional health care organizations and from some members of the cabinet to this policy, but it was pressed forward.

British Columbia was the last province to commission a report. The recommendations were to bring services *Closer to Home* (British Columbia 1991) and to focus on outcomes. In response the Minister of Health produced a document entitled *New Directions for a Healthy British Columbia* (British Columbia 1993c) and set up an advisory committee and six working groups to examine strategies for change in the following areas:

1. Better management
2. Regionalization
3. Governance and financing
4. People with special needs
5. Services and care delivery
6. Acute to community shift

Barriers to Change

The minister's advisory committee in British Columbia (1993c) asked the other provinces which had appointed royal commissions to identify the difficulties they had had in following through the recommendations of these commissions. These were the responses:

1. While some provinces focussed on building public commitment, very few had tried to build commitment amongst all sectors. The idea of "shared responsibility" had not got across
2. There were problems in determining/implementing reallocation of funds from institutional to community care
3. Some concessions were made when "equity" was redefined as fairness in service distribution across communities (but not necessarily similarity in programming)
4. There were challenges in managing empowerment of individuals and communities; how government can manage to let go; developing partnerships
5. Governments found difficulties in challenging the existing power groups — professionals, unions, hospitals, etc. (British Columbia 1992)

In Chapter 29 the way in which the provinces did respond to the public inquiries and how they restructured will be considered.

Clearly there were dissonances between different interested parties relating to choices of action. How should cost containment be addressed? Should the government negotiate with the medical associations regarding control of spending? How should the issue of drug benefits be tackled?

Fooks (1992) has argued that there is a shortage of information about factors in decision making. How would a cabinet assess health benefits? Would environmental clean-up take priority over services for street kids (even when services for children have been declared a priority)? How would cabinet members compare the benefits of paying more to doctors with the benefits of developing better programs for children? What evidence will the politicians use in making their decisions?

In spite of some hesitations British Columbia decided to embark on reform and restructuring.

Summary

In the mid 1980s provincial governments, particularly the Atlantic provinces and Manitoba, had begun to become anxious about the future of their health care services as federal cost constraints began to take hold. Committees of inquiry were set up all across Canada to see where reductions could be made or other reforms brought in.

After the federal government publication of *Achieving Health for All: A Framework for Health Promotion* (Canada 1986c), there was a marked change in the recommendations of the later provincial inquiries, which now focussed on health promotion as one basis of possible restructuring. Other issues which were raised were privatization, regionalization, improving data collection, use of technologies, improved coordination and management of services and greater consumer involvement.

Each province approached the issues of reform and restructuring somewhat differently but most sought to develop a broader base for policy making (e.g., Ontario's Premier's Council on Health Strategy, Manitoba's Health Advisory Network Steering Committee). Nevertheless there are bound to be some difficulties in following through with the recommendations because the idea of sharing responsibilities has to be worked out better with consumers and service providers, and there are major problems in moving funds from institutional to community care.

CHAPTER 25

The Challenge of Human Rights' Policies to Traditional Health Care Structures

In Chapters 3, 6 and 22 brief mention was made of Canada's commitment to new policies set out in the Charter of Rights and Freedoms appended to the patriated constitution in 1982. Pierre Elliott Trudeau, first as Minister of Justice and then as Prime Minister of Canada, had made the realization of the idea of equal citizenship for all Canadians one of his main aims.

The legislation relating to equality of citizenship is set down in the Human Rights Act, 1977, revised 1983. In 1983 four groups were designated as specially disadvantaged — women, native peoples, visible minorities and persons with disabilities. They were perceived to be groups whose needs for enhancement of citizenship should be given special consideration.

This chapter will follow through what these policies have meant for three groups in Canadian society — persons with disabilities, native peoples and visible minorities. There were, of course, other groups which Trudeau saw as disadvantaged (e.g., in the 1950s the Québécois and Canadian women), but these will not be discussed here as their problems of equality of citizenship are very complex and go far beyond health affairs.

Services for Persons with Disabilities

Hahn (1985), has described the transition in thinking about disability policy in the 1970s as: "The shift from the medical model of disability and from the economic (rehabilitation) model of disability to the sociopolitical (minority group) model which calls for public policy changes which shape the environment from a discriminatory one to one which is open to all people. This change calls for a restructuring and reconceptualization of [ideas about] disability and disabled persons" (Pfeiffer 1992, 55). This description would seem to fit what is going on in Canada.

The Challenge to the Experts and the Bureaucrats on Decision Making for Disabled Persons

By the end of the 1960s radical social movements were challenging the existing systems of service provision. The reformers were out to limit the power of "the disabling professions" (Illich 1974).

One professional group in the system which was particularly challenged were the psychiatrists in the mental health service (Czukar 1987). The interested public wanted more open government of mental hospitals (the establishment of boards), fewer technical procedures such as brain surgery and electric shock treatments, better review procedures for compulsory admissions, and review of the necessity for custodial care (particularly in the mental retardation hospitals). Although psychiatrists were active in promoting change in the way in which mental health services were structured, they came under attack. When the introduction of federal medical care insurance was under discussion the leading psychiatrists published their demands to be absorbed into the regular medical care system (Canadian Mental Health Association 1963). They wanted access to general hospital wards, acute hospital emergency department provision and payment from the medical plans for services given in their own offices.

Following this manifesto the psychiatrists worked with their American counterparts to develop a community psychiatry model of organization (Loeb 1966), but there was an angry response to the claims of community psychiatrists to be leaders of the team. Their model roused the anger of other professionals in the educational and social service field and several community groups concerned with children's welfare. *One Million Children* (Commission on Emotional and Learning Disorders in Children 1970) protested the limitations of the medical model for coping with the wide range of emotional problems of the many children who would need help at some point in their childhood.

Deinstitutionalization

Slower to start but more powerful in the long run, were the challenges of the parents of mentally handicapped children to the administrators of institutions and social workers (Simmons 1982). A consumer organization, the National Institute for Mental Retardation (NIMR), engaged Wolfensberger and Nirje (1972) to clarify the concept of "normalization" in the community. Some parents and other interested individuals had already tried out community resettlement programs and found they could be successful. Since then, the NIMR (later the G. Allen Roeher Institute) has been moving the governments beyond "normalization" to the next stage of policy development, that is, "finding the least restrictive alternative," and to demanding control over decision making and complete freedom from expert and bureaucratic dominance where the family or a circle of friends is willing to take responsibility for its own members.

There was great strength of feeling on the part of parents of institutionalized children about their disenfranchisement as parents. In the 1970s local community groups began to pressure governments to deinstitutionalize even the profoundly retarded — to transfer all the inmates of former mental retardation colonies to special care homes or group homes. Although provincial governments were committed to the general concept, the meaning of deinstitutionalization was not altogether clear. While, strictly interpreted, it implies return to the family or placement in a very small group home, in practice it may mean transfer to a more socially oriented institution.

In the late 1960s some of the traditional institutions were closed and their "less difficult" patients distributed to families or group homes (Canadian Council on Social Development 1985). Others were sent on to nursing homes or other traditional mental hospitals. McWhorter (1983) and the National Institute for Mental Retardation (1986) have described the closure of institutions in Ontario. Lord and Hearn (1987) studied the process of closure of one mental hospital in British Columbia and looked at what was happening to the ex-patients a few years later. Some were leading well-balanced lives in small group homes while others living in similar small homes in the community were still being treated in institutionalized ways. To try to deal with this matter, new guidelines for special care homes were established by parent groups (Vancouver Community Living Society 1985) or by government committees (Nova Scotia 1987b).

The International Year of Disabled Persons

The year 1981 was the International Year of Disabled Persons, a year in which Canada and other countries considered how persons with disabilities were being treated by the rest of society. In preparation for this year the World Health Organization (WHO 1980) had reconsidered its definitions of disability: "In the context of health experience a disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (p. 183).

The committee concerned with the definition separated out impairment, disability and handicap: "There is a distinct cleavage between disability and handicap, both conceptually and in the means for intervention [p. 41] … In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability that limits fulfillment of a role that is normal (depending on age, sex and social or cultural factors) for that individual" (p. 183).

Before 1981 only two groups of persons with disabilities were recognized as having special needs — persons with mental disorders and injured workers. Now attention was given to the rest of the group who had not been considered before, unless they were in need of long-term residential care or social assistance.

Following the report of a public inquiry by a special committee of Parliament (Canada 1981b,c), a new approach to policy development was adopted. Instead of expecting persons with disabilities to make all the adaptations to social conditions, it was recognized that society could work to remove barriers which made them dependent and unable to function optimally. Some of these barriers were social, others physical.

Throughout the 1980s great efforts were made to find out how many Canadians were impaired and what was their ability to function but as Greenwood (1985) pointed out, to know how many impaired people there are is only part of the story: "Certain dilemmas are evident in determining and providing for the needs of disabled persons: self-perceived and self-defined need versus bureaucratic standards and statistical definition: resource compensation versus resource enhancement: urban versus rural needs. Closely related to these perplexing problems are tensions in rehabilitation approaches: institutional and community approaches; individual functional improvement and environmental improvement" (p. 1241).

In 1988 a useful statement about the social model of health care for disabled Canadians was written to explain the needs of those with mental health problems (see Chart 8.2). This analysis can be used to explain any kind of chronic illness, impairment, degeneration into old age and so on equally well. This document (Canada 1988e) proposed that mental illness should be considered as posing two different sets of problems: first, coping with the disorder, and second, coping with the problems of living with the disorder. The viewpoint of that paper is summed up as follows:

> The process of achieving … health is the same for everyone — it involves removing or reducing obstacles that prevent the individual, the group and the environment from interacting in fruitful ways
>
> Apart from the disorder itself, the obstacles may include:
>
> - rejection by friends, family or workmates;
> - the stigma of mental illness [or other visible disorders];
> - inability to find or keep suitable employment;
> - lack of appropriate and affordable housing;
> - lack of social, recreational or educational opportunities;

- experiences of discrimination; and
- lack of needed information and coping skills. (p. 9)

Most persons with disabilities need medical help at some stage, but it is clear from this listing above that their rehabilitation will require much more from educational and employment services and housing and social welfare programs than medical care alone. And what is to be done needs to be worked out with the consumers as individuals and as a group. Advocates for persons with disabilities have made it clear that they are resentful of professionals and bureaucrats who do not respect their desire for independence and mutual support (D'Aubin 1986; Guay n.d.).

In Ottawa, under continuing pressure from Parliament, disability policy development was handed over to the secretary of state who endeavoured to coordinate the work of all ministries concerned with removing barriers and with meeting the needs of this group.[1] Some provincial governments set up premiers' councils to advise on policy and to work with government departments on special issues. Not all provinces have these councils; their governments may respond directly to advocacy groups or human rights' challenges. Some have interdepartmental coordinating committees within government, others do not. At the service level there are many problems of coordination between charitable, mutual aid and government organizations which provide supports.

If we accept that there has been a redefinition of health which requires that social supports as well as medical care be provided to those who need this assistance, this group of Canadians and their demands/needs for care in the community provide an example of the difficulties to be addressed in working towards a better model of care.

In discussing the shifting ideas about welfare state and welfare society we noted that in the 1980s there had been a move away from concern with the social minimum to concern with discrimination against minorities in society. But within the social minimum sector there have been major changes towards improving training for work, perceiving social assistance as being merely transitional to assist people between jobs and reducing the payments

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[1] Under the Progressive Conservative government 1988–93 a Standing Committee of Parliament on Human Rights and the Status of Disabled Persons was set up which was very active in suggesting policy changes, particularly in its second report *A Consensus for Action* (Canada 1990j). In 1990 Prime Minister Mulroney established a division within the Department of the Secretary of State to look into issues affecting the status of disabled persons. This division has now been cut back in the federal civil service reductions, but it achieved a considerable amount of change in legislation before this happened.

to welfare applicants. However, the withdrawal of funding for social assistance may greatly affect the group of persons with disabilities as well as other minorities in Canadian society. Torjman (1990) has argued that the needy group of Canadians with disabilities is unlikely to easily be able to respond to the new employment oriented policies. She explained that they would find it difficult to shift out of claiming social assistance and other benefits once such assistance had been granted for their rehabilitation and support. She said that analysis of social assistance found that it effectively locks recipients into that system through a variety of economic and psychological traps. Rates of assistance fall well below the poverty line.

This issue of social program restructuring will be discussed in Chapters 27 and 29.

Health Services for Native Peoples

Health Care on Reserves

The history of medical service provision by the federal government to sub-Arctic native peoples has been chronicled by T. Kue Young (1984, 1987, 1988).[2] He said:

> a high quality health care system is found in a region that rates very poorly in terms of its health status. ... On almost every indicator the Indians fare worse than the national population. The litany of health risks among Indians has become well known. Indices such as the birth rate, the perinatal and infant mortality rates and their components, the violent-death rate, tuberculosis incidence, and the prevalence of various nutritional inadequacies are all higher, sometimes several times so, among Indians. (1988, 125)

Young quoted Badgley (1973) who, after studying Indian health care in western Ontario, "concluded that the evolution of Indian health policy must be viewed in the broader context of the social and political development of Canada itself" (1988, 90).

The British North America Act, 1867, spelt out the constitutional powers of federal and provincial governments. While the provinces were designated as the regulating authorities for health and welfare services within their jurisdictions, the federal government took on the responsibility for Indian affairs (which included health matters).

The Medical Services Branch of Health and Welfare Canada set up nursing stations in Indian and Inuit settlements across the northern territories (O'Neil 1987). The nurse practitioners who staff these health centres are

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[2] See also O'Neil (1987).

backed up by doctors (who give advice by radio telephone), and by air ambulance services which take emergency cases into hospitals.[3]

As well, there are Indian reserves within provincial boundaries. Much depends on geography and population mix in sorting out which authorities will provide services to these. For example, in British Columbia, the federal government has agreed to take responsibility for non-natives in sparsely settled territories (such as the Chilcotin) while the provincial government has set up public health centres on southern reserves to provide health services to native peoples who are not good at accessing traditionally organized medical services in the area. And then there are the "mixed communities," like Alert Bay, where there are Indian settlements on one side of the bay and white settlements the other, gathered around what were originally mission hospitals and Indian residential schools. Speck (1987) has indicated that in such mixed race communities the hospitals are likely to be governed by boards which lack understanding of native cultural attitudes to sickness. She has discussed a scandal over Indian deaths in Alert Bay which forced the British Columbia Minister of Health to establish British Columbia's provincial health policies for natives more clearly (McClelland 1979).

Medical Care versus Community Development Policies

Until 1969 Indian policy was one of overt colonialization. In that year the government revised its policies (Canada 1969), and in the 1970s, Canadian consciences began to be stirred by books such as *How A People Die* (Fry 1970),[4] which demonstrated the failure of morale in many Indian bands when their traditional way of life was superseded. The lack of adequate economic and social development of native communities, in parallel with the strong economic development of communities of settlers in Canada, was compounded with the coming of the welfare state which established a social minimum for all. The government hand-outs to native peoples met needs for survival but not for the respect which comes through worthwhile occupation. Although (as Young pointed out) welfare state payments helped many bands to raise their marginal standards of living, these were no solution to their basic problems of adapting their cultures to the modern world.

As we have become more aware since the Meech Lake Agreement debacle, the native peoples do not think that they have had equitable treatment from Canadian governments (as compared with the immigrant peoples

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[3] The services for aboriginal peoples include non-insured health benefits above and beyond the Medicare system, that is, drugs, dental care, prosthetics, etc.

[4] See also Elliott (1971), Robertson (1970), Cardinal (1969) and Berger (1977).

and their descendants). However, there now seems to be more willingness on the part of governments to discuss the issues in dispute, to try to reach agreements on boundaries (land claims) and natives' autonomy within these boundaries.

It has begun to be recognized that providing medical care might not be very useful without doing something about community development, for medical care there is most needed after the violence or the disease strikes.

Restructuring in Cooperation with Native Peoples

Because of the constitutional arrangements, the main changes in Indian policies have to be introduced by the federal government. In 1979 the Minister of National Health and Welfare decided to move on health policy. By giving native peoples authority over their own health services, he thought they might gain greater self respect and some experience of self government. The federal government decided to fund a series of demonstration projects to determine whether natives could administer such projects effectively. By 1983–84, thirty-one projects were operational in seven areas across the country, fourteen of which were selected for evaluation.

In the meantime, apart from these demonstration projects, there were several other important pilot programs which were showing successful organization by native peoples: the Indian Health Centre in North Battleford, Saskatchewan; the Kateri Memorial Hospital in Kahnawahke, Quebec; the Alberta Indian Health Care Commission in Lethbridge, established in 1980;[5] and the Cree Board of Health and Social Services, established following the James Bay Agreement in 1979.

After the demonstration projects were evaluated (Indian Management Systems 1985) it was decided in 1986 to proceed to develop a transfer policy. Bands were invited to apply to the federal government to develop a plan to take over their own community health services,[6] environmental health services, prevention and counselling programs related to alcohol and drug abuse, the services of medical professionals presently employed on contract to the Ministry of Health, and (possibly) hospital services. The plan must

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[5] Associated with the Alberta project is the Four Worlds Development Project which has put out the following publications: (1) *Taking Time to Listen: Using Community Based Research to Build Programs*, (2) *Developing Healthy Communities: Fundamental Strategies for Health Promotion*; (3) *Towards the Year 2000: Overview of the Four Worlds Development Project*; (4) *Holistic Education Evaluation* (1988).

[6] Community health services may include: nursing (treatment and preventive care), community health representatives, health education, nutrition, mental health, dental services, medical and dental advice and assistance.

outline what health services are most needed, how those services will be provided and how health care money will be spent (Canada 1989a). The federal government is anxious to ensure that projects will be practical. A process of "working through" is going on.

The Assembly of the First Nations (AFN) has set up a health commission to review and report on transfer policies. And there are special issues sub-committees at work[7] (AFN 1988). D.E. Young (1988) has reviewed the integration of traditional and modern medicine and the prospects for the future.

Although the health transfer policies may be an attempt to empower Indian bands to take more responsibility for medical care services to Indians living on reserves, there are many social problems affecting health which need other solutions. It is generally agreed that medical care alone will not be enough to deal with the social dysfunctions of Indian bands. Drug and alcohol abuse, violence and sexual abuse are indications of deep disturbances among the native peoples.

Some would prefer to see government funds being allocated to community development before health services are transferred back to the bands.[8] However, a number of bands have taken up the transfer offer and are now responsible for health service development in their own jurisdictions.

Human Resources Development

In order to develop the human resources necessary to provide culturally appropriate health services to native peoples on reserves, new initiatives have been taken in the last few years. For example, the University of British Columbia has set up a First Nations' House of Learning with a Health Care Planning Division to find suitable candidates for training in established education programs. Bursaries are available from the provincial government (British Columbia 1990b). Athabasca University established a special program for native health administrators in 1990. All this is in addition to the existing educational programs for community health representatives (e.g., Alberta Vocational Centre Service).

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[7] In 1981 the International Year of Disabled Persons, the House of Commons investigated barriers to integration of disabled Canadians in society. A separate report, *Obstacles for Native People,* was published on disabled native peoples (Canada 1981c). This subcommittee continues to study the matter. Its most recent report, *Completing the Circle,* was published in 1993 (Canada 1993).

[8] Some bands and some friendship centres are concentrating on implementing community development programs such as improving women's self esteem (e.g., British Columbia Native Women's Society 1990), better parenting, alcohol and drug programs (Hodgson n.d.), suicide risk assessments.

Problems of Indians Living in Urban Cores

More difficult has been the development of a social policy for Indians who drift to the cities (Stanbury 1975). Brody (1971) provided an interpretation of their difficulties in becoming socially integrated into urban societies. These difficulties usually lead to excess alcohol consumption by natives in skid row areas.

Most service development for natives in urban areas is relatively recent. Friendship Centre projects have hardly begun or have not been written up (e.g., the Vancouver Pilot Friendship Project plans to open a seventy-two bed AIDS hospice and uses part of its building for a housing program). One which has been documented is the Boyle McAuley Centre in Edmonton, which has a fifty percent native Indian clientele. This centre functions as an inner city support service for a mixed local community (Edmonton Urban Core Support Network 1989). Toronto has opened a native community health centre (CHC), but Daly (1989) saw this as another blow to the CHC movement — yet further marginalization of the concept. She does not mention marginalization of the aboriginals.

The Métis Health

Another major concern for the prairie provinces is the health of the Métis population (Gresco 1987). Their problems are similar to those of native peoples who have left the reserves. They have no special rights to federally funded health care and they find access to the established provincial systems presents major barriers.

Health Problems of Multicultural Groups

Like the native Indians, Inuit and Métis, there are other minority groups in the Canadian culture who have health problems, and these health problems are only part of their cultural adjustment problems. It is recognized that they, too, have to be helped through community development approaches.

Yet while community development approaches may be important in the long run, in the short term it is recognized that individuals admitted to Canada with a background in other cultures will need to deal immediately with specific problems — that there is need to facilitate access to medical care, public health services and social support services.

Puzzled Immigrants who Need Health Care

Consequently, governments or voluntary agencies have produced handbooks to help some of the new immigrants to find the right kinds of medical and social services (e.g., Alberta 1984; Mercer and Murphy 1981), while recognizing that these will not help all of them to solve all their adjustment problems.

Alberta (Alberta 1986) undertook an immigrant and native women's health survey to identify the needs of members of special minority cultures.[9] The Canadian Council on Multicultural Health (1990) has also produced a list of translated pamphlets and additional materials in twenty-five languages and a bibliography about "reaching the multi-cultural community."

Waxler-Morrison, Anderson and Richardson (1990), in a guide book for health and social service professionals, presented information on the beliefs and attitudes of clients from non-European backgrounds, to assist health professionals with communication for the purposes of diagnosis and treatment.[10] Waxler-Morrison and her colleagues base their approach on the work of Kleinman (1980) (as do most other health policy makers working in the multicultural area). Kleinman stressed the need to understand intra-ethnic diversity and to avoid ethnic stereotypes, to appreciate the problems of resettlement in a new country, to be aware of general related issues and family adjustment problems, to accept the influence of the extended family on health care decisions, to recognize that these patients may have different expectations of health care professionals, and to give special attention to the adaptation of children and elders. Mathias (1991) has also written on the need for cultural sensitization of health workers.

The Social Integration Problems of Minority Ethnic Groups

Workers in the field (YWCA 1987) recognize that these approaches will not deal with some of the major difficulties of social integration (and thus health in its wider definition) for some members of minority ethnic groups. The meaning of social integration is considered in Appendix A which discusses definitions of terms.

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[9] The Alberta survey identified the following needs: learning the English language; availability of interpretation of languages in native tongue; need for services to be available where living; need for transportation; importance of contact persons; native women's issues; current access to care; immunization status, especially of children; number of children and ages (well baby implications); women in reproductive years — birth control counselling; low birth weight babies; coping with hospitalization; injuries; nutritional issues; health education resources; health practices — smoking, looking after dental caries, etc.; identifying agencies serving; relationship of health departments with these agencies; agencies' perception of health needs. Many of these are clearly health matters.

[10] *The Journal of Ethnicity and Disease* is concerned with identifying racial differences in disease rates, the impact of migration on health status, ethnic factors relating to health care access, and metabolic epidemiology.

Without taking a community development approach it is unlikely that the main problems of these minority groups will be solved. Bolaria and Lee (1983), Bolaria (1985) and Bolaria and Dickinson (1988) have examined some of the barriers to integration, identifying racism as the major difficulty. However, Doyle and Visano (1988) have said: "Multiculturalism continues to be addressed as an 'ethnic issue,' packaged and retailed as a commodity to benefit ethnic communities alone. The failure to involve all interests runs the risk of trivializing government commitments and fails to involve those who need to support diversity" (p. 14).

As well, the strategies need to be changed to take account of consumer inputs, they said. Wall (1990), writing from a base in Alberta, also supports the view that groups of consumers from visible minorities should be more involved in planning services.

There is some written material available on specific local initiatives such as the work of the Committee for Oriental Problem Youth in 1990, called together by a Calgary general practitioner; on the needs of Vietnamese immigrants to Calgary, researched by a public health nurse (Lentjes 1989); and on the mental health of Chinese Canadians in Vancouver (Vancouver 1990). But Perkins[11] said there is much going on elsewhere which is never written down, such as work being done in the Toronto public health service on moderating lifestyle or helping to cope with the environmental problems of visible minorities.

Restructuring Service Delivery to Meet the Challenge of Human Rights Legislation

This chapter has been concerned with three groups designated as disadvantaged — persons with disabilities, native peoples and visible minorities. While there is an obvious need for those wanting medical care in these groups to have access to medical services, this provision does not seem to touch the basic problems of social integration of these groups into Canadian society as a whole. Their struggles to be recognized as full citizens with equal rights are so complex that there are many evident dysfunctions within the groups themselves — dysfunctions which lead to the need for medical care but show greater basic needs of improved social organization which have to be resolved not only within the disadvantaged groups themselves but also with the rest of Canadian society.

It has become obvious that any restructuring of health and social services requires as much input as possible from these disadvantaged commu-

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[11] Fran Perkins, personal communication, 1990.

nities in order to find good solutions to the needs of these groups and to bring them into a satisfactory relationship with the wants of the middle class majority who are the main policy makers in Canadian society (Mahtre and Deber 1992).

Summary

The Human Rights Act, revised 1983, identified four specially disadvantaged groups in Canadian society. The discussion in this chapter is concerned with meeting the health needs of three of these groups — persons with disabilities, native peoples and visible minorities. The changed emphasis in Canadian society towards full acceptance of the equality of people in these groups since the early 1980s has led to reconsideration of social policies to facilitate this acceptance and to see how support should be given where necessary.

In the last fifteen years attitudes towards persons with disabilities have been changed. No longer are they expected to make all the adjustments to society. Real efforts have been made to remove physical barriers to their full involvement in working and social life as well as to reduce social stigma.

After trying out some pilot schemes it was decided to offer health transfer programs, that is, control over their own health services to Indians living on reserves. Whilst realizing that dealing only with medical care needs was not getting to the root of the social problems of Indian bands, transfers were thought to be one way to help the bands to take some independent action on one aspect of their social needs. Métis and Indians living in urban areas still have difficulties in adjusting to these cultures which are very different from their own, and as yet little has been done to assist them.

A new emphasis has been put upon multicultural health problems and efforts have been made to create an awareness of how to approach these and how to meet patients' needs more effectively, but it is recognized that it is not only better medical care but community development which is needed.

CHAPTER 26

A New Look at Community Inputs

At the provincial inquiries some members of the public had expressed concerns about lack of involvement of community members in policy development, other than as taxpayers providing revenues for social redistribution. These concerns had been there from the 1960s onwards. But as was pointed out earlier, power in organizations tends to be associated with formal authority or technical expertise. There are, of course, some community members who can use the informal and non-formal systems of power (i.e., knowing how to get the system to respond to their demands or getting their ideas across through social networking). The collectivist welfare state and its health care system are organizations where such power struggles go on.[1]

The focus of the Canadian federal welfare state in the 1940s was financial redistribution, and so community involvement was not a special issue for that government until after the Organization for Economic Cooperation and Development (OECD) conference in 1980 on *The Welfare State in Crisis* (1981), which suggested that the Westminster parliamentary countries could profit by broadening their discussions with economic policy makers. Concurrently Canada was working on its human rights policies (1968–83). These challenged the idea that income support and expert service delivery were all that was necessary for a satisfactory collectivist social organization. Acceptance of all other citizens as equals was as important as providing a social minimum and funding universal social programs. The concept of partnerships at a number of different levels became a new issue. And one issue in partnerships was community involvement.

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[1] As Alford (1975) demonstrated, the power of the health planners in New York was divided between professionals and administrators. They might from time to time co-opt consumers to their cause if they thought it to be useful.

The Response of Formal Authorities to the Concept of Consumer Involvement

The insecurities of politicians and bureaucrats who were learning how to set up and work the formal system were discussed in Chapter 16. Politicians were not anxious to have a third power group of consumers working alongside them (as the reception in Saskatchewan of the McLeod [Saskatchewan 1973] study of community participation showed clearly).

And in the early years of the collectivist system the bureaucrats were clerks without much power themselves, until the Established Programs Financing Act (EPF) legislation in 1977 forced the provincial governments to appoint professionally trained administrators. Then both politicians and bureaucrats had to learn how to cope more effectively with their jobs, and they did not want consumer interventions.

Writing about bureaucratic developments in Ontario, a more populous and advanced province, Vernon Lang said in 1974:

> Administrative evolution during the past three decades has built some monster-sized enterprises like OHIP (Ontario Health Insurance Plan) designed to relate to the citizen directly. It has also tried to work on more human scales. The province has enlarged the political size of communities, while simultaneously decentralizing the public service. These two trends, upward and downward, have for the most part not collided yet, but sooner or later they will. When that happens will they merge, coexist or back off? There has been a tendency to see the newer units — larger than before from the local viewpoint, smaller from the provincial — as being in some sense the citizen's future 'community'. The evolutionary process has led to some erratic shifting of the citizen's community, causing him bafflement. People in general have become more dependent on the state than they used to be. (p. 67)

Lang predicted that there would need to be more opportunities created for citizen involvement in social policy development, for people wanted more than work opportunities, and: "The kind of massive changes on which [social policy development depends] can be achieved only if we carry the citizens with us by organizing far more widespread citizen participation than we have today, in considering the options available and in reaching consensus on directions for social policy" (p. 69).

Lang's critique was published in the same year as the Mustard report (Ontario 1974) which presented a new plan for service development in the province. Ontario, responding to the pressures for change, had begun to set up new structures known as District Health Councils (DHC) in 1973 (Ontario 1975a). These were not management boards, as in Quebec, but advisory bodies reporting to the minister on local health priorities planning.[2] Nevertheless they were seen as a threat both by bureaucrats and professional experts and were not allowed much power. It was not until 1990 that Quigley and Kealey (1990) proposed a coordinating body so that they could work together to develop more effective planning. And it was in the 1990s that the DHCs were given some authority to comment on the operational budgets of hospitals.

A Democratic Socialist Plan for Consumer Involvement: British Columbia 1972–75

At about this time Canada's socialist governments were trying to involve consumers in policy making, and British Columbia endeavoured to set up a community participant social welfare program. Clague et al. (1984) have made a detailed examination of the establishment of community resource boards (CRBs) in the heady three years of the New Democratic Party (NDP) government in British Columbia from 1972 and have reviewed their rapid demise when the Socreds returned to office in 1975.

The analysis is detailed and provides a number of clues about the difficulties being encountered then and today in efforts to coordinate and integrate health and social services. Vancouver was chosen as the trial area — it was to be a region with a two-tier system of elected community boards.[3] This was a city in which the United Way had already done a good deal of preliminary work in planning the future development of voluntary social services (Canadian Council on Social Development 1972) and there were experiments involving community health centre development, multiservice centre activity, job training for women on assistance, development of the Greater Vancouver Mental Health Service, citizen involvement in economic development policy in the city council and regional district, and plans for decentralization of municipal service activity (p. 70).

Clague et al. (1984) identified many difficulties involved in setting up the Vancouver CRBs, one of which was hasty decision making. Focussing

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[2] British Columbia had set up regional hospital districts in 1966 for institutional facility planning but these advisory bodies, composed of appointed representatives of health boards, were buffer groups against back-bench pressures rather than true advisory bodies (Detwiller 1972).

[3] Local communities outside Vancouver were advised to form community resource societies as a preliminary to the establishment of CRBs in their areas. Guldemond (1977) has reviewed an experiment (funded as a federal demonstration project) in which the Social Planning and Research Council of British Columbia assisted eight non-metropolitan communities with health planning between 1973 and 1976.

more directly on the coordination and integration issues they identified the following problems:

1. There was no overall grand plan. The minister said he wanted to get community groups involved in the process of decentralizing and integrating services. "All action stemmed from this assumption" (p. 35).
2. The Community Resource Boards Act defined "social services" very broadly. In addition to the usual statutory and non-statutory services the term could mean "any services, either social action or preventive" that could help people "develop their full potential and well being." Also included were "services designed to encourage and assist residents of a community to participate in improving the social and economic conditions of their community." The government might delegate additional services to a CRB on recommendation from the Minister concerned, including public health services, mental retardation services, mental health services, correctional services and manpower and employment services of the provincial government" (p. 41).
3. The experiment brought the main private social welfare agencies under government control, a beginning attempt at provincial rationalization of the social welfare system.
4. "The two most contentious features of the act were control and accountability. … The funding process was intended to be the principal means by which the minister would retain control. Some community and consumer groups felt the bill did not go far enough in decentralizing authority. They saw the minister's desire to retain residual responsibility as a means of transferring heat from the government to the CRBs without relinquishing authority" (p. 45).
5. The relationship of the CRBs to existing municipalities had not been worked out. The municipalities saw them as the creation of another level of government (p. 78).
6. The relationship of the CRBs to the minister was advisory; they did not have the power to change provincial policies (p. 90).
7. The Vancouver Resources Board (VRB) used the mechanism of grant aiding local communities to redistribute resources to more needy areas (p. 111); and discretionary grants were used to help needy people (p. 195).
8. The composition of the boards was expected to vary but the top tier in Vancouver was to include representatives from the park and school boards and the city council as well as members appointed by the minister (p. 80).
9. The bottom tier was to be elected, but in the first election, voter partici-

pation was low[4] and the elected community representatives tended to be professionals and human care workers (p. 60).

10. At the ministry level, the Department of Human Resources was put under greater pressure by the changes going on below. Communication between the minister with his special project team and the regular civil servants was inadequate. The minister may have wanted to assure accountability but he did not have an adequate database on the costs of his projects, so they got out of control (p. 50).
11. There were no experienced staff at the CRBs. All had to learn on the job about the concept of community participation, about how the model should work, about team work and about basic procedural techniques (such as needs assessment) (pp. 54, 94).

In terms of structural issues Clague et al. identify these negatives in the CRB experiment:

1. The concept of elections to CRBs was a very unpopular issue.
2. CRBs were outside the traditional structuring of government (a legislative anomaly).
3. There was a lack of a command structure within the Department of Human Resources to coordinate the changes and a lack of consistency in informing staff about decisions coming down from headquarters.
4. The use of service contracts to voluntary agencies was very controversial (p. 15).

In fact the Minister of Human Resources was challenging the established social service structures in much the same way as the Saskatchewan government had challenged the established medical structures and with much the same results.

Why have we discussed this experiment within the Ministry of Human Resources? Because, as was indicated above, the intention was to set up community health (CHC) and human resources centres modelled on Quebec's Centres locaux des service communautaires (CLSCs) in which medical and social service resources were to be provided together under the governance of a local community board which bridged the present service divisions. But this experiment came long before the British Columbia voters were ready to move to this form of organization.

When the Socreds returned to power in 1975 their first targets were the CRB and CHCs' experiment.[5] The minister based his arguments for their

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[4] Only eight percent.

[5] British Columbia had set up a special division to develop CHCs under the guidance of Dr. Foulkes (see Chapter 11). Five centres were opened up. Four

demise on reinstating central accountability and control but, as Clague et al. (1984) have pointed out, there were other factors, many of them ideological (p. 15). Jones (1977) has also studied the short-lived existence of CRBs.

The Socreds were supported mainly by angry rural voters who pursued rural/urban rivalries. They had strongly resented the concept of providing better service levels in the cities and use of discretion by VRB employees to treat some clients better than the general guidelines suggested.

Quebec's Interest in Community Involvement

The plan proposed for Quebec in the Castonguay-Nepveu committee's recommendations (Quebec 1970–72) was to establish CLSCs, districts and regions under the provincial government of Quebec to deliver health and social services to the people of the province. The government, of course, would consist of elected representatives working with professional bureaucrats. Lower down, the subsectors of the organization would be governed jointly by consumer representatives and professionals working together on management issues. Brunet and Vinet (1979) showed how the service providers were able to dominate the discussions because of their inside knowledge but Godbout (1983) was less pessimistic about consumer inputs having an influence over practice.

There were a number of unresolved issues in addition to the governance questions (which were resolved in favour of total consumer control over policy making in 1990). The CLSCs employed community developers (animateurs sociaux) as well as professional service givers, and for many years it was uncertain whether their advocacy activities were useful and appropriate. The Rochon committee (Quebec 1988) recommended that their positions be eliminated. The government had stopped helping voluntary organizations. Rochon proposed this be reconsidered, thus ensuring that advocacy could continue but outside the CLSC service delivery structures.

It took twenty years for CLSCs to be set up all across the province because of medical resistance to the concept. The Brunet report (1987) recommended that when choices had to be made, CLSCs should be set up in high risk areas. And in 1990 it was at last accepted by the government that there was a parallel subsidized medical care organization.

The Issue of Medical Dominance

The issue of medical dominance has already been discussed in earlier chapters but it is necessary to restate the doctors' power position here. The first

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survived the scrutiny of an audit committee set up by the successor government (British Columbia 1977) and were retained. Otherwise the idea was killed.

confrontation on the matter of consumer involvement on boards of governance came in Saskatchewan in the early 1950s when the government proposed to set up more regional health boards after trying out pilot schemes in Swift Current and Weyburn. The government had built on the experience of the municipalities, which had developed boards to manage public hospitals, and the municipal doctor programs, which combined personal care and public health services in one salaried position.

Despite the pilot regions' evident success (Canada Hall 1964) in bringing together all the elements of medical care, public health and mental health under one authority, the government's plan to introduce further regionalization met with resistance from the medical profession. In 1951 two communities voted down proposals for introducing regionalization into their areas as a result of persuasion by the College of Physicians and Surgeons. This ended the Saskatchewan government's efforts to establish that model of organization.

Medical hostility to community boards was shown again later when the Saskatchewan doctors were unwilling to settle their strike over the introduction of provincial Medicare, 1962, until community clinic boards were reconstructed to a landlord-tenant relationship only (Badgley and Wolfe 1967).[6]

By the end of the 1960s some Canadians were becoming angry with the way in which they were being treated by doctors. Although the radical challenges to the professionals had begun in the United States (Illich 1974), both Ontario and Quebec decided to investigate whether professionals were sufficiently concerned with consumers' interests. (Ontario Krever 1970; Quebec Castonguay-Nepveu 1970–72). Both provinces set up new machinery for professional regulation.

Following the publication of the Krever committee's report, the Ontario Medical Association appointed its own investigating committee (OMA 1973) which recommended appointment of lay persons to its council. Other professional associations in that province followed. Quebec set up a new Office of the Professions in 1971 to look into the matter of protecting consumer interest, for the investigation of the Castonguay-Nepveu commission's subcommittee had shown that professional interests took precedence. To correct the worst abuses of power this Office of the Professions conducted consumer surveys and received complaints from dissatisfied clients (Quebec Office of the Professions Annual Reports). However, in a review conducted some years later, Slayton and Trebilcock (1978) thought that the changes introduced were

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[6] Nevertheless, although the government had to back off on this issue at this time, Coburn, Torrance and Kaufert (1983) thought that this strike negotiation signalled the beginning of the end of medical dominance.

not very effective in increasing professionals' concern because it soon became clear that it was not easy to change the attitudes of self regulating professionals whose licensing bodies held the monopoly position.

In 1990 Ontario passed a new act to regulate the professions, taking an entirely different approach. Under this act it is professional activities which are regulated, not professional persons. It remains to be seen whether this change will be effective.

Lower Level Boards in English-Speaking Provinces

There were, of course, some subsectors of the system of care where community members had been able to make their inputs — in municipalities, particularly in the prairie provinces, and on hospital boards, union boards of health, and voluntary organizations involved in social planning or service provision. Why were these regarded as insufficient for making community inputs into the collectivist model of care?

With the introduction of the Canada Assistance Plan some provinces removed much of the responsibility from the municipalities, though in other provinces they retained their powers. (Manga and Muckle [1987] have reviewed the situation as it was at that date.)

Hospital boards are long established foundations in which the roles of community representatives *vis-à-vis* medical staff and administrators have been clearly worked out (Perrow 1965). The community representatives most desired by these two other powers in the hospitals were local businessmen who could help to raise and decide on the use of funds. Board members were quickly made to realize that they must keep out of medical decision making territory.

Union boards of health which supervised public health services were made up of elected municipal politicians who were also well aware of the limits of the policy making role. Board members' interventions into medical health officers' professional decision making, common in the nineteenth century, were no longer possible.

So far as the voluntary organizations were concerned, Govan's study (1966) of developments up to that time have already been described. She discussed the changes brought about by the war (mutual aid organizations grew in numbers) and by the coming of the welfare state (charities got together to form United Ways to prioritize the allocation of contributions to their member agencies). Rekart (1994) and the Korbin report (British Columbia 1993b) have shown that in one province, British Columbia, there have continued to be large numbers of voluntary agencies that have been undertaking contract work for governments, but that this has been poorly administered and coordinated.

These last two investigators raised questions about the continued existence of these services. Should they be taken over, or at least better coordinated by government, or should they continue to be subsidized and allowed to "do their own thing"? There are arguments on both sides. Governments may be better at gap filling, particularly in rural areas, but voluntary organizations may see problems earlier and respond more quickly and flexibly to them. However, there seems to be the need to sort out the issues of gaps in service and overlapping provisions and who should be responsible.

The Impact of Three New Pressures

The health promotion and human rights movements made it clear that the welfare state approach to financial redistribution had its limitations. Unless there were attitude changes among individuals and changes in society's approaches to problem solving, Canada would not be able to deal with its social problems A third pressure was the necessity of reducing the cost of social programs. One way of tackling this matter was to involve consumers in taking more responsibility for making claims upon resources and in setting priorities on how to deploy these resources.

The Health Promotion Movement in English Speaking Provinces

As planners began to work on health promotion matters they could see that progress could not be made without involving both individuals and communities in improving their lifestyles and environment. The Canadian Public Health Association (CPHA) was active in educating its professional members in this new approach. It was not easy for public health nurses to shift from having been health educators, deploying their professional expertise on a one-to-one basis, to becoming community development specialists, but the CPHA worked hard on the matter and so did a number of the senior nursing administrators.

The CPHA also gave its support to the concept of setting up healthy community groups at the local level and developing provincial networks of these groups (e.g., British Columbia Healthy Communities 1989). Many provinces also support seniors' wellness groups.

The Institute of Health Promotion Research at the University of British Columbia and the British Columbia Consortium of Health Promotion Research have been developing projects in participatory action research (Green et al. 1995).

The Human Rights Movement

Even before the International Year of Disabled Persons (IYDP), 1981, advocates for change in disability policy had protested against medical and bureaucratic dominance and the assumption that the persons with disabilities must adapt to deal with the barriers in society. They had argued that some barriers could be eliminated and that the persons with disabilities could become much more independent (Hahn 1985). These arguments were accepted by the Special Committee of the House of Commons which investigated their problems for IYDP (Canada 1981b). Since then a number of steps have been taken to improve communications, open up work opportunities, restructure housing and transportation to enable those who wish, and who are able, to live independently in the community (d'Aubin 1986). This is one example of a disadvantaged group which has taken action to bring in major policy changes through community advocacy.

In Chapter 25 we have also described new policies which have been developed for transferring control over health services to native boards, and what has been done to help multicultural groups.

Networking

So far this discussion has been concerned with the establishment of formal structures for consumer/community involvement in health service policy making, planning and management, but in the last six years attention has turned to the combination of formal and informal participation. Particularly in the development of mental health services the idea of partnerships or networking has been pursued (Boudreau 1991; Gottlieb 1983; Gottlieb and Selby 1989). Gottlieb (1983) has proposed five levels of community networking involvement from one-to-one supportive relationships to working with the local media on community issues.

Regionalization

The financial inquiries into health services had begun to put forward regionalization as a solution to many structural problems of the Canadian health services. It was thought that by breaking the provincial structures down into smaller units it would be possible to solve a number of problems of coordination and integration of service provision and to bring consumer representatives into policy making. This will be discussed in Chapter 29.

Summary

This chapter has discussed two factors which led to the exclusion of consumers/community members from policy making for many years. The first of these was the emphasis in the welfare state on financial redistribution. However, in the 1980s the need for governments to work in partnership with others began to be recognized.

The second was insecurity on the part of politicians and bureaucrats and the traditional dominant stance of the doctors. Power is associated with formal authority and technical knowledge, and the power holders were not willing to let community members share this power except in the human resource boards experiment in British Columbia and in the limited number of CLSCs in Quebec. But in both of these, there were difficulties in getting consumer involvement established because of inadequate planning and/or unwillingness to let power go.

The medical profession was very resistant to consumer involvement and the provincial governments were unsuccessful in finding how to improve professional regulation when they tried to do so.

Traditional lower level boards in hospitals and public health services were usually permitted to continue after the introduction of welfare state legislation but these were very limited in what they could do.

However, times have changed under the influence of the health promotion movement and human rights movements and the need to find new ways to control the cost of services. Regionalization has been recommended as the best mechanism for addressing these issues, and it will be discussed in Chapter 29.

CHAPTER 27

The Health Care System in the Welfare Society

The previous chapters have reviewed the literature which was available on community health services up to 1993 and it is now important to consider what conclusions can be drawn from these documents. The project was funded to examine organizational models for community health services, but we decided that it was not only necessary to look at community services but at health services as a whole within the welfare state in order to tease out why community services were not better funded and more effective. We took a historical approach.

Organization theory indicated that we should look for three stages in the organizational development of a collectivist system of care:

1. The shift from an individualistic to a collectivist model of care delivery
2. The development of a collectivist model and, after a time, the questioning of this model (or first order change)
3. The proposed substitution of a new model after reviewing the mission (second order change)

Bartunek and Reis (1988) have first explained how new social organizations are formed. They have then discussed the first stages of a new organization's development. In the early stages of evolution of a new or merged organization, they said, the emphasis will be put upon gap filling and coordination. Then a second stage is likely to evolve. At this point the mission will be questioned and a new mission is likely to be substituted for the old. This revisitation of the mission will result in new objectives being set and will stir up the established patterns of doing things.

We found that there were three stages in the development of Canada's health care system which closely followed these ideas of the theorists despite the fact that there is little use made of research on organization theory in Canada. Reform and restructuring of the organization of administration and service provision, first in setting up the welfare state and then moving towards the welfare society, have not been based on research but on what seemed best at the time. There has been little attempt to see whether a good model of organization for providing collectivist care was chosen.

Identifying Criteria for Evaluating the Shift from Individualistic to Biomedical Collectivist Care and Then to Socially Oriented Collectivist Care

It is now proposed to use three concepts from organization theory against which to measure progress in establishing a collectivist health care system. These are:

1. Bartunek and Reis' (1988) idea of a *good organizational transition*. This idea may be summarized as follows: there are different orders of change in organizations which Bennett (1987) clarified as changes *within* the system and changes *of* the system. For example, changes within the system are the gap filling and streamlining which has been taking place. Changes of the system are the expansion of the boundaries and the restructuring of the mission

Good transitions require individuals and groups within the organization to identify with the culture and mission of the system. Good leadership is required for the reframing process.

2. Benson's (1982) ideas about *resistances to organizational transition* — defensive basic action orientations on the part of agency administrators

There are many inherited traditional structures which need to be reformed. Professionals and administrators may try to defend these traditional structures — their "turf" — and to hinder change. Benson (1982) identified the four basic action orientations of the administrators of sub-organizations. They expect to work towards: the fulfillment of program requirements; the maintenance of a clear domain of high social importance; the maintenance of orderly, reliable patterns of resource flow; and the extended application and defence of the agency's paradigm. Consequently, when asked to coordinate their work with other subgroups, they do not find it easy to do so.

"Organizations taking other approaches constitute an implicit threat to the security of resource flow. … Thus efforts are made to refute and discredit competing ideological claims and to establish the superiority of one's own technology" (Benson p. 75). Clearly these defensive behaviours in sub-units of the system do not advance the organizational transition of the whole.

We would argue that the overarching organizational model is the welfare state and below that the health care system, but for most professional service workers, the culture and mission of "the organization" is still the culture and mission of the subsection in which they work. These service subsections in the health care system have been grouped under hospital and medical care, public health, mental health and health care support services. This last group does not visualize itself as part of the traditional health care system but comes under various other departmental divisions which may or may not work in close relationship with medical care and public health services. But all are part of the publicly financed collectivist state society and most non-governmental organizations are largely dependent on government contracts.

3. Cummings' (1984) ideas about the *problems of identifying system boundaries and member organizations.*

One of the issues in defining health system boundaries has been what to do about the community context. One of the recurrent themes of this study has been the exclusion of the public by the experts. Some of the lags in understanding the total culture and proper mission of a socially oriented health service may be traced back to the lack of community participation in addressing the questions: What is a healthy society? What kind of services do we need to attain the goal of a healthy society? For presently a large number of members of the public gives *access* to medical care priority above all else, they do not understand the determinants of health and the community context as affecting outcomes.

The theme of community development, as Bennett (1987) has pointed out, is to achieve second order change in the local setting, for this second order change is required for promoting real collectivist health care. As much as the other service, administrative or policy making bodies, community organizations will need to develop their ideas in order to deal with the challenges of establishing healthy public policy at the local level.

1. A Good Organizational Transition?

So far as changes *within* the system were concerned, the first stage of development was to bring in publicly financed hospital and medical care insurance to add to public and mental health services already provided. But these services were brought in separately with much constitutional struggle. After moving from an individualistic model to a biomedical model, it was to be expected that the emphasis would be on gap filling and streamlining but it only focussed on the former. It seemed to be too difficult to integrate and coordinate sectors of the system.

A second stage of development followed the Canada Health Act, 1984, which legislated *access* to universal, comprehensive, portable, publicly administered and equal medical and hospital care. This second stage established health promotion as the way to achieve the new goal of better health status *outcomes*. It then seemed to be possible to move to reconsideration of the mission and resetting of goals — to shift from a biomedical to a social model of care.

But though the goals were restated, the organization did not seem to change greatly except within the public health departments which had room to bring in health promotion activities. Elsewhere there seemed to be resistance to all ideas about organizational development within the restated mission.

There were strong resistances to changes *of* the system from the medical profession which did not wish to move away from an individualistic entrepreneurial organization to a publicly financed collectivist organization.

Saskatchewan and Quebec wanted to establish rationally planned models of collectivist health care but they were not able to do so, in part because of professional unwillingness to make organizational changes. Saskatchewan was hindered by the constitutional challenges of other provinces at the Dominion-Provincial Conference on Social Reconstruction, 1945–46, and because delays in implementation led to medical resistance being built up. Quebec was unable to get enough support from the medical profession to develop its full range of Centres locaux des services communautaires (CLSCs) for about twenty years and is still meeting other resistances from the professional group. In both cases collectivist plans for organizational change were thwarted by the service deliverers with the technical power to deny the restructuring of their preferred form of organization.

After initial hesitations, the Canadian doctors agreed to become agents of collectivist redistributive policy relating the biomedical care. The medical profession was cajoled into providing access to medical services under the health insurance system, while the public was given assurances of a move towards providing universal and comprehensive medical care. As Daniel (1990), an Australian health policy analyst, has described it, there is a very "fragile consensus" between the medical profession and the governments on this issue of collectivist care. But Graycar and Jamrozik (1989) have pointed out that in *universal* service allocations of welfare states it is the professionals who are likely to benefit most. Tuohy (1986) has shown how the medical negotiators were able to strike good bargains at the time of entry into the health insurance schemes which left the doctors with considerable autonomy and good control over orderly resource flow using a biomedical model.

The history of the development of formal authority makes it clear that politicians have had much to learn about how to make policies and bureaucrats much to learn about how to manage their sectors of the welfare state/society organization. The task which Canada took on in setting up a welfare state was not well understood by the federal government or by the provinces (or by other nations). Struggling provincial politicians were unsophisticated and naive and more anxious to please their own local constituents than to look at provincial (or national) social organization as a whole.

The exceptions to this general statement were to be found in the provinces of Saskatchewan and Quebec where politicians and bureaucrats had a clear idea of the goals they wished to attain and were willing to work together to establish good formal organizations. But neither was successful in achieving their aims because of the conflict between formal and technical powers.

2. What Were the Reasons for Resistance to the First and Second Stages of Organizational Development?

Marmor and Thomas (1971) and others have noted the doctors' success in controlling payment systems, physician supply and distribution, and some have remarked on the increasing growth of medicalization (or attempts at medicalization) where doctors were not required before, because physician supply has increased and doctors want to keep their incomes up.

Many years ago Glaser (1969) explored the advantages and disadvantages of different medical payment systems. Fee-for-service, a symbol of entrepreneurial freedom (Blishen 1969), has frozen medical care in an earlier time frame and so far there are no very satisfactory incentives for getting doctors to accept a different system of payment have been devised. They like to feel they are subsidized entrepreneurs, not employees of government (Hunter 1981). And it is not only a matter of the doctors' own incomes which create concern among the provincial government negotiators, but the costs of the services which they generate. In trying to get control over costs, most of the action to change medical practice is presently taking place in the hospitals (the secondary and tertiary care sectors where the governments have greater powers of control), not in the community-based sectors, yet the costs of diagnosis and treatment in doctors' offices (volume of services, tests and drugs prescribed) are steadily rising.

The "regional hierarchies" of medical service organization identified by Fox (1987) are well entrenched. The medical schools perpetuate this model of organization which emphasizes individual clients' medical care, not the population oriented medical care required by a collectivist model. Efforts to overturn this model—to put primary care in a position of greater eminence—have been made since the 1920s, but have not yet succeeded. Family practice and public health practice remain low status occupations, despite efforts to bring about changes in perception among colleagues.

White and Connelly (1991) and others have attacked the medical schools' conservative influence, their failure to recognize the real needs in population health. Although the new medical schools started up in the 1960s have put more emphasis on family practice, there is still some concern about their lack of attention to health *system* goals.

Efforts to reform medical professional organization in order to make members more conscious of clients' interests, both as individuals and as a collectivity, and less concerned with their own needs, have not been very successful.[1] In fact the behaviour of most physicians fits well with the list of behaviours on the part of agency administrators who are not open to organizational transition. Coburn, Torrance and Kaufert (1983) examined medical dominance and the challenge by other groups wanting to make an organizational transformation (politicians, administrators, other health professionals and consumers). Despite minor losses of control over parts of the system, the doctors have had continuing success in keeping "a clear domain of high social importance" and "extended application and defence of their paradigm."

There have been no major changes in medical practice organization. There are still relatively few group practices. Community health centres (CHCs) have not been widely accepted as an alternative to the traditional practice model. There are a number of reasons for resistance to the development of CHCs. These organizational models came out of socialist traditions and have been resisted partly because of this. CHCs (and to some extent CLSCs) have by now been marginalized as belonging to the non-profit sector in inner cities and to rural areas where no real entrepreneur is keen to work. They exist, to a large extent, in high risk areas where the professionals are expected to deal, not only with clear-cut medical diagnosis and treatment, but with family violence, sexual abuse and other aspects of social maladjustment. Although there are other reasons for resistance to CHCs (such as payment systems or professional teamwork), the main objection has been

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[1] There have been some medical professional responses to public demonstration of concerns such as the Pickering committee of the Ontario Medical Association (1973) and the Watson committee of the Canadian Medical Association (1984), but a measure of self-interest is always visibly there.

to the existence of community boards. Medical professionals are not anxious to find themselves being told what to do by laymen. There is probably some confusion here about the distinction between policy making and management.

It is of interest that other alternative delivery modalities which might appeal to entrepreneurs — Health Service Organizations (HSOs) and Comprehensive Health Organizations (CHOs) — have been developed in Ontario, which was not wholeheartedly committed to collectivism between 1970 and 1990. Whether attempts to develop HSOs or CHOs will succeed is still unclear, but they may be successful, because the most open boundary of the medical profession is the referral system into the hospitals; the hospitals may want to cooperate in this matter, and attention has been paid to financial incentives. Other alternative forms of organization such as walk-in clinics do not appeal either to the traditional family doctors or to governments, only to the out and out entrepreneurs. Multiservice centres could improve horizontal coordination of support services, but apart from locating near diagnostic service centres and pharmacies, doctors do not seem much interested in becoming part of the multiservice concept.

Carrothers et al. (1991) have argued that professional resistances have affected the ability and willingness of governments to focus on organizational change. Instead of thinking about coordination and integration of services, they looked at "the regulation and remuneration of various types of health practitioners and the organization of the institutions of health care delivery" (p. 16) and not the system as a whole. They said: "The literature gives support to Tuohy's contention (1989) that debates related to health service reorganization and integration have remained 'peripheral' to the mainstream health care delivery system" (p. 16).

3. Identification of System Boundaries and Member Organizations

Despite the fact that Canada has shown commitment to a publicly financed health care system since the end of the Second World War, the medical profession seeks to maintain its separate bargaining position within the system and to look for advantages in private sector activities on the edge. Even after the passing of the Canada Health Act, 1984, it has never really been accepted by doctors that they are not subsidized entrepreneurs. There are strong feelings against community boards which may try to control their independent decision making. And as well, although the first step was to bring the medical profession to terms with a collectivist *medical* care system, the policies now are to bring the doctors into a collectivist *health* care system (for it is recognized that health care is broader than medical care alone), and this is very threatening to their technical authority.

One main theme in this book has been the inability of the groups involved in the development of a good organizational model for collectivist health care to see what are the boundaries around and within the system. We have argued that the health system cannot be understood without taking into consideration the concept of the welfare state and social programs as a whole because education, housing, income and support services all have an impact upon the health of citizens. But we have found that even within the health care system there is an almost complete lack of communication between hospitals and community care services and that the administrators and service providers cannot see beyond their own subsectors of the system.

We have spent some time considering the involvement of ordinary citizens. *Health Care: A Community Concern*? is the title of this book, and it has traced the ups and downs of consumer participation. There has now been a recognition that Canada cannot achieve optimal health for its citizens without ensuring their greater involvement in self care, neighbourly concern and policy development. It may take some time before all members of the public are willing to become involved in any of these activities, but many wish to be consulted and have a choice in actions taken to improve their personal health, to become less dependent upon experts and bureaucrats. Some would welcome opportunities to become involved in community networking. Perhaps only a few will be interested in taking full responsibility for policy making (Abelson et al. 1995), but there is a climate of change in this sector.

While all the western developed countries seem to be struggling with similar problems of trying to understand how to develop the optimal form of organization for their social organizations, Canada has a special problem with its shifting federal-provincial relationships. What are the boundaries of the welfare state(s) and the health care system(s)?

In 1945–46 the federal government was the strong force. It was able to offer grant aid to the provincial governments while balancing its budget. It had clear ideas about what it wanted to do. Although there are ten provinces with constitutional responsibility for social affairs, Saskatchewan was the only one among them which was planning its own program of collectivist care at that time. Today, however, the ten provincial governments have developed greater sophistication as legislators and have built up professional bureaucracies to support their activities.

Carrothers et al. (1991) said:

> A central and consistent feature of federal-provincial health policy debates since the 1940s is that they have involved conflicting ideas about the way in which accountability and responsibility for the management of health care services should be distributed between the federal, provincial and local levels of government ... health care

> policy debates have been pulled by two contradictory sets of ideas related to the centralization/decentralization of delivery system administration. The first set of ideas have been contained within the concept 'universal benefits' which ... depends for its success upon a strong central authority capable of establishing uniform terms or standards. The second set of ideas are related to 'regionalism' which supports decentralization of administrative authority as a mechanism for fostering programs designed to meet local needs. (p. 2)

Carrothers et al. (1991) discuss regionalization as having three dimensions — decentralization, geographic implications and rationalization. All Canadian provinces have been moving towards regionalizing their health services which will increase understanding of local issues and may help to bring costs under control.

Working Towards and Optimal Organization for Collectivist Care

There are at the present time questions about commitment to collectivism, but these are less urgent for most provincial governments than questions about how to improve the organization of social and health services. Most provinces seem to believe that regionalizing services would make them more comprehensible to the public, to service providers and to administrators and would enable them to be streamlined so that costs can be brought under control.

Summary

This chapter returns to the discussion of organization theory to consider the stages of development in the organization of collectivist health care. It was found that developments in the organization of collectivist health care have followed ideas present in the theory that there would be changes as there was a shift from individualistic to collectivist health care, that in time the model chosen would be questioned and a new model proposed.

Organization theorists have identified some problems in developing a new model of organization. How are good organizational transitions made? What resistances are likely to be encountered? There are likely to be problems in identifying system boundaries and memberships of the organization.

These issues were examined and it was found that there have always been difficulties in making a good organizational transition because of resistances by the technical power holders — the medical profession — who are not fully committed to collectivism. System boundaries have not been well defined and community members have been excluded until recently. As well, there has been a shift in power from federal to provincial authorities. Regionalization presently seems to offer the best prospects for making a good organizational change.

PART VIII

Afterword

This review of the literature on community health services organization was started in 1990 and finished in 1993, but much has happened since then. It is important to discuss these developments.

Should Canada continue to defend a welfare state or a modification of the original idea — a welfare society? Krauthammer, an American neo-conservative writer, has said that the welfare state has been "a primary cause of the decline of society's mediating institutions," especially the family (1995). While James Q. Wilson defends capitalism which "produces greater material abundance for more people than any other economic system ever invented ... [it does have costs but] for people worried about inequality or environmental degradation, the question is not whether capitalism has consequences but whether its consequences are better or worse than those of some feasible economic alternative ... [The costs of capitalism must be weighed against its benefits]" (Wilson 1996, 113–14).

The United States, Great Britain and some other western developed countries have moved away from their earlier welfare state commitments, much further than Canada. Canada is still quite strongly committed to collectivist sharing, but has been pulled away from its earlier concern with the social minimum towards the support of capitalist developments by its attempts to keep in harmony with its near neighbours.

Canada is still a country which seeks to make compromises, to find balances between contending interests, to take a centralist position. Although there were value shifts even under the Mulroney government, as Moscovitch and Albert (1987) and others have spelt out, they were not enormous swings to the right.

The Liberal party was reelected to office in 1993, and in its Red Book (its pre-election statement of purpose) it said that it wanted to protect Canada's social programs from further erosion. But Canada is not an independent entity, it is part of the global economy, and as such, it has not been free to follow its own course in the way it proposed to do.

This afterword will trace the continuing cutbacks in federal provincial transfers which the federal government has felt forced to make in order to address the continuing deficit/debt problem. Then it will consider the steps provincial governments have taken to reform and restructure their health care organizations (for these are the social programs which are of greatest concern to Canadians). Finally it will ask: Where do we go from here? What can we see as the possible future of the welfare state?

CHAPTER 28

Continuing Cutbacks: Implications for Health Services and Health

The Liberal government has had difficulty in keeping its election promises to maintain social programs at the same level of financing as before. The national debt continues to rise because of interest payments on earlier annual deficits. This has resulted in a move by the federal government to replace the Established Programs Financing Act (EPF) transfers and those of the Canada Assistance Plan with one Canada Health and Social Transfer (CHST) from October 1995, which puts the onus on the provincial governments to allocate the social redistribution across all the social programs. And Mendelson (1996) has said that:

> Without federally imposed national standards, the single payer medicare system will certainly erode. … Straightforward user fees could be initiated for some services. A private tier, either partially subsidized or unsubsidized, could be permitted … a special income tax surtax could be imposed on sick people for the value of services they receive from medicare. … Doctor's extra billing could be legalized again. … All these alternatives have one thing in common, Canadians end up paying more for health care, except they have the privilege of not paying it in taxes. … The dam will surely burst if the federal government pulls its finger out. The only question then will be where the system will restabilize. … If the federal government allows the CHST to dwindle or even diminish enough that it loses its moral authority, it is the end of universal single payer medicare. … For welfare and personal social services we don't even have to bother waiting for the CHST cash to disappear for national conditions to end. … The federal government having withdrawn from any protection of those most vulnerable in Canada, has paved the way for a merciless attack on all the programs developed over the last thirty years to provide at least some semblance of a social

> safety net. ... It certainly will have an impact on the health of the Canadian people. (pp. 5–7)

Many people (e.g., Schultz 1995; Valpy 1995) believe that social minimum programs rather than health care will be the main losers as a result of CHST cutbacks.

In order to offset reductions in social transfers, the federal Minister of Human Resources Development, Lloyd Axworthy, commissioned a series of reports (Canada 1994) which reviewed the possibilities of restructuring unemployment insurance and social assistance schemes. Now Axworthy has been moved to a new position while reductions to their social programs go on.

It has been suggested that the tax system which protects high income Canadians should be reviewed, interest rates should be lowered to prevent Canadian resources going to foreign investors, and all non-profit organizations should be encouraged. However, others, such as Courchene (a political analyst at Queen's University), think that Canada has overextended itself and must downsize. He believes that: "An 'active labour force strategy' can be pursued and social services rationalized so that health and welfare can be rolled into well being" (Schultz 1995, 14).

The National Forum on Health

The federal Liberals, returned to power in 1993, made an electoral promise that they would maintain the current health care system and that they would engage in discussions across the country in a National Forum on Health. Four subcommittees have been set up to deal with four themes which have been identified: (1) the determinants of health; (2) evidence-based decision making; (3) values that should guide health system renewal and policy development; (4) ethical dilemmas and the identification of strategies to improve the effciency of the health care system and to put resources where they have the greatest potential to improve the health of Canadians.

The forum asserts that public participation is essential and has arranged to hold a series of discussion groups across the country. While these seem to have been well attended in the east (where the provinces and their populations are anxious to have continuing national support), they have not attracted many participants in British Columbia, which is engaged in its own strategies for developing consumer involvement at the local level.

The forum has published a series of papers to stimulate debate on such topics as *The Public and Private Financing of Canada's Health Care System* (Canada 1995a) and a *Workbook* (Canada 1995b) for those attending (or unable to attend) discussion sessions. Its final report has just been published (Canada 1997).

Privatization as One Solution to Cutbacks

During the Liberals' earlier term of office (to 1984) there did not seem to be much support for the privatization of health services in Canada (Stoddart and Labelle 1985; Fried, Deber and Leatt 1987),[1] for Canada had distinguished itself from its American neighbor by instituting the publicly provided hospital and medical care upon which it prides itself.

However, when the Progressive Conservatives (PCs) took office in 1984, there was more discussion of such neo-conservative concepts. But it was left to the provincial governments to act on the privatization idea. In his attempts to balance the provincial budget in Alberta since taking office in 1993, Ralph Klein cut back a number of health care services that Canadians had begun to take for granted and he encouraged those who wanted to continue to access these services (or bypass waiting lists) to go to private providers or cross the border to get care in the United States. Klein's drastic cuts have resulted in strong opposition so that he has had to back off to some extent.[2]

Similarly Mike Harris, Premier of Ontario since 1995 and a supporter of privatization, has engaged in a series of major reductions in spending — closing hospitals and reducing doctors' remuneration as well as making cuts to other social programs. Again, this has resulted in major demonstrations in the province.

Elsewhere the provincial governments have come out against a two-tier system of care (e.g., British Columbia 1993c). In these provinces great efforts are being made to find out where savings can be made without changing Canada's ideological commitment to collectivist care — to sharing of resources.

The country is deeply divided on the privatization issue as shown by press reports in the summer of 1995. Coutts (1995), reporting on the Canadian Medical Association's annual meeting, described an emotional debate after which: "The doctors voted down a resolution supporting the idea of private insurance to cover all medical expenses — insurance which would, in effect, finance a private health care system."

The doctors went on to endorse a plan to start a national debate on whether private insurance for private medical services should be permitted. Coutts continued: "Calling for debate implies privatization may solve the problems of the health care system" (p. A5).

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[1] Kamerman and Kahn (1989) have drawn attention to Paul Starr's book, *The Social Transformation of American Medicine* (1982) for its insights into how the free market provided a variety of vehicles for use of the medical profession in organizing a privileged and prosperous monopoly against which consumers were and are helpless.

[2] The federal government reduced its transfer payments because Alberta's private clinics were charging basic rates plus additions for services.

But health systems analysts interviewed by her on this topic thought that useful economies could be achieved through better coordination of programs and program management.

Reduction in Bureaucracies

Meanwhile, the governments at the federal and provincial levels have felt it necessary to reduce their bureaucracies which have come under criticism as being too large and lacking in efficiency.

The reduction of government bureaucracies is not easy to achieve. In the last four years of his mandate Prime Minister Mulroney steadily reduced the federal public sector to a minor extent. The PC government then made some major reorganizations just before the election of 1993 which, it was hoped, would improve public sector coordination, but it was not until after the Liberal government was re-elected to power in 1993 that steps were taken to make greater reductions in the federal civil service. In 1995, 45,000 federal bureaucrats were offered early retirement.

The provinces have also been looking into this matter. So far as health services are concerned it has been hoped that devolving power to regional authorities would result in reductions to the provincial civil service. At the present time, however, the transfer of power has resulted in an increase rather than a decrease of appointments as the division of responsibilities has to be worked through. Provincial civil servants are strongly unionized and are likely to resist cut-backs, but considerable efforts are being made to transfer them to other positions in the health care system.

Reduction in Service Provider Positions

The closure of some hospitals and a large number of hospital wards has resulted in service providers' unions' concerns for their members. The British Columbia government agreed to a three-year accord when Shaughnessy Hospital was closed. This gave priority in applying for vacant posts which were advertised to those who had already been working in the system. Attempts are now being made to prepare applicants for moves from hospital to community through continuing education. Nevertheless there is great insecurity among all employees about these cuts which are likely to continue.

Hostile demonstrations by union members protesting the threats of job reductions have already occurred in Alberta and Ontario.

Improved Organization

The cost of health care has continued to rise despite the governments' concerns about debts and deficits. Evans, a renowned health economist, has said (Coutts 1995) that the health care system could be reformed and restructured effectively without having more resources put into it. The emphasis until now has been on gap filling rather than streamlining, and many improvements in organization could result in savings. This argument focusses on the way the health care system has been managed rather than on its financial supports. It is easy to see where management has been inefficient and where it needs to be reformed.

It has been clear from 1977 onward that the federal government wished to see the provinces put more of their resources into community care. The new EPF grants included a $20 per capita incentive to develop "home care" services — a clear signal to the provincial governments that there was need to reform and restructure the distribution of resources away from the hospitals. Though minor efforts were made to develop long-term and continuing care, there was no major shift in resource allocation. To take one example of the situation today, the Vancouver hospitals claim eighty percent of the budget of the Regional Health Board. (This budget does not include medical services plan or pharmaceutical costs but does include public and mental health, drug and alcohol services as well as continuing care.) One of the problems has been the lack of communication between hospital policy makers and community health care organizers and the separation of budgeting for each of these activities at the provincial level, so that efforts such as the British Columbia hospital-community partnership and the Saskatchewan scheme to shift money across to community services have failed to make more than a tiny dent in the traditional process of resource allocation.

The solution proposed for improving organization in most provinces is regionalization. By bringing services into smaller units closer to the people, better communication should be achieved, and by increasing public understanding of the problems of the system, it should be possible to make economies or impose rationing without upsetting consumers too much. This concept will be discussed in the next chapter.

Summary

The Liberal government elected in 1993 has had difficulties in maintaining its electoral promises to maintain funding for social programs. It has restructured its federal-provincial transfers into one Canada Health and Social Transfer which, from October 1995, put the responsibility on the provincial governments to decide how to allocate this grant between all its social programs.

Discussions have continued about the best way to raise revenues and allocate them.

A National Forum on Health considered the determinants of health, evidence-based decision making, values and organizational strategies.

It seems that the health care system has adequate resources to achieve its goals provided these resources can be better allocated. There has been lack of communication between different sectors of the system. Some provincial governments have preferred to consider partial privatization of health care services as a solution to cost control while others have set their faces against a two-tier system. The country seems to be deeply divided on this issue.

The governments at all levels have been under pressure to reduce their bureaucracies. The federal government has made large cuts, provincial governments have not yet done much to reduce their public service positions, but it is hoped that they may do so if regionalization continues. There have been considerable reductions in service provider positions in the hospitals.

Another perceived solution is to give the responsibility for resource allocation to a lower level of authority.

CHAPTER 29

Regionalization

Towards the end of the 1980s four strong pressures were forcing the provincial governments to think about organizational change in their health care systems: (1) the continuing reduction in transfer payments from federal government; (2) urgent questions about improving the efficiency and effectiveness of health service organization; (3) the shift in emphasis on goals from health care access to improving health status outcomes which has led to a reconsideration of the weight put on biomedical care (the need for a social model of care if outcomes are to be improved was accepted as a national policy in 1989); (4) the need to consider how best to increase community concern about individual and community health, so that lifestyle and environment issues could be addressed earlier and more continuously rather than waiting until disease struck. New human rights policies have also emphasized the need for attitude change towards greater individual responsibility and more concern for good community network supports.

It was thought that effective reform and restructuring could be achieved by bringing health services "closer to home," setting up regions which would be able to find savings by bringing together the traditional divisions in the system which had been kept separate in the provincial health departments; regions which would be able to develop health promotion ideas and would bring in community members as policy decision makers and partners in networking. But regionalization has taken many different forms across Canada so it may be useful first to consider what the provinces were changing from and changing to in developing this restructuring.

From Functional to Areal Decentralization

Mills and Vaughan (1987), who studied decentralization for the World Health Organization (WHO), distinguished between functional decentralization and areal decentralization. In functional decentralization, authority is transferred for performing particular functions in a particular service to a particular local office (e.g., mental health); in areal decentralization, health care is likely to be one social service among many, all of which are expected to work across limited geographical boundaries.

Until now most of Canada has had functional decentralization in its health care system.[1] Doctors negotiated with the medical plans, public health had separate budgets from continuing care and mental health, and hospitals made claims on their own divisions within the health departments. Drug and alcohol services might be funded through separate commissions. Each of these separate sections set up its own hierarchies in each province.

In the late 1980s and early 1990s provincial commissions of inquiry into health services identified a number of ways in which reforms could be brought about, and it was generally agreed that there should be a shift to areal decentralization of health services. This seemed to provide a mechanism for restructuring which:

1. Would cut across the existing divisions within the system
2. Would enable a shift of emphasis between acute care and community care to be more readily accomplished
3. Would permit local community representatives to become involved in policy making
4. Would increase the public's interest in sharing scarce resources by focussing on real health needs (clarifying what are the determinants of health and ways to improve health status)
5. Would encourage greater concern within communities for meeting the special needs of disadvantaged groups
6. Would enable regions to work towards setting up community networking to provide support above and beyond that given by professional experts and administrators of social programs

Regionalization and areal decentralization were seen to be similar concepts. But Carrothers et al. (1991) think that there are differences which have not been recognized because the research community has failed to deal with the issue, that is, to consider organizational models to assist in the identification and analysis of policy process variables.

Carrothers et al. provide a historical account of regionalization of health services in Canada (or ideas about regionalization) beginning with the discussion of a paper (Canada 1974b) in which the federal government first showed its interest in the topic. But regionalization was of greater concern to

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[1] Quebec's plan being the exception.

the provinces than the federal government because they had to decide whether to let some of their power go to lower level authorities.

Decentralization

Before going on to look at the delegation of power to regions, it may be useful to consider some ideas about decentralization. In connection with its restructuring, Quebec wanted to discuss what decentralization meant (e.g., McGill University 1979; Lemieux and Turgeon 1980; Contandriopoulos, Laurier and Trottier 1986).

Writing a WHO guide, Mills and Vaughan (1987) distinguished four types of areal decentralization: (1) deconcentration, (2) devolution, (3) delegation, and (4) privatization.[2] These are defined by legal frameworks. However, according to these authors, while the legal definition of decentralization will certainly affect the degree of local discretion which may be utilized, there are many other influencing factors: "These include the control over resources, ability to mobilize political support, the perceived legitimacy of [the local members' position] and the general climate of rules, regulations and expectations within which they operate" (p. 13).

In 1992 British Columbia commissioned Hollander (1992) to prepare a paper on the advantages and disadvantages of decentralization. He identified the advantages as:

1. The reduction of regional disparities
2. Greater local input into decision-making
3. Greater overall democratization
4. Increased accountability
5. Better coordination and planning of services

The disadvantages are likely to be:

1. Poor conceptualization of goals and objectives
2. Poor fit between the objectives and the system devised to meet the objectives
3. The problem of the capture of local boards by those opposed to the provincial government
4. Possible strains in the exercise of authority between the provincial government and local boards
5. The need to rationalize two separate systems of geographic boundaries (i.e., hospital regional districts for capital planning and public health divisions based on school districts)

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[2] See Appendix A for definitions.

Why Decentralize Now?

All provincial governments (other than Prince Edward Island[3]) had set up public inquiries into their health care systems during the 1980s (Angus 1991) and all of these, which had made earlier incremental changes, recommended reform and restructuring. (The Rochon report in Quebec [1988] encouraged the province to persist with its planned rational model brought in in the 1970s.) In most provinces the recommendations of the commissions or task forces had been to regionalize. The response of the governments to these recommendations was set out in Chapter 24, and most now began to move towards setting up regions.

Earlier Moves

Quebec's rational plan for structuring the health and welfare system of the province (Quebec 1970–72) proposed a four-tier system of Centres locaux des services communautaires (CLSCs), district hospital councils (DHCs), regions and a provincial government office. The emphasis was to be laid on consumer needs and consumer involvement in management at the point of entry to the system, the CLSCs. It has taken many years for the ideas to work themselves out because the technocrats in government were reluctant to delegate authority (Renaud 1984) and the service providers in CLSC management meetings dominated the consumers (Brunet and Vinet 1979). It is only in the last three years that the CLSCs have been governed by consumers alone and that the regions have been given any real authority.

Quebec has been settling down again after Bill 120 was passed. Recently, however, its regions have been given more authority over the district hospitals and community health centres (CHCs).

Elsewhere too, the provincial governments were not very willing to let power go.

Ontario

The Carrothers et al. (1991) study provided one explanation for these failures to address the issue of geographic decentralization. It said that governments had focussed on negotiations with existing service providers and had never looked at the system as a whole. But Ontario had set up a system of DHCs to advise the minister, following a public inquiry in 1974. Dixon (1981) has discussed these developments. At that time the government was not ready to delegate much authority to the DHCs, which were only expected to tender planning advice to the Minister of Health on priorities in their own

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[3] Prince Edward Island made a study of regionalization in 1995–6.

areas. The local members of DHCs are appointed by the provincial government. Each council is composed of forty percent providers, forty percent consumers and twenty percent local (municipal) elected officials. DHCs in Ontario are organized into six health planning regions across the province. Within each planning region, an informal, collaborative organization of the DHCs occurs, usually to address cross border service delivery issues.

Quebec and Ontario have compared notes on their progress in regionalizing from time to time, but progress was not rapid in either place as the central offices of provincial governments were not then ready to delegate much authority to these lower levels of decision making (Dixon 1981). Later studies of DHCs in Ontario (Sutherland and Fulton 1994; Quigley and Kealey 1990) have also shown the lack of good collective organization among DHCs at both the regional and provincial levels.

In 1991 the Ontario DHCs were given the task of annually viewing the operating plans of hospitals with respect to the service impacts for their communities. About this same time DHCs began to be involved in hospital restructuring plans. These events led to a heightened awareness of the DHC role in local planning. Concurrently the province set up pilot projects such as the Southwest Ontario Comprehensive Health System Planning Commission to explore regional planning and management functions. DHCs are being increasingly asked to take on regional planning initiatives. For example, mental health reform planning requires a regional planning component in addition to district or local level planning.

Are there too many authorities in Ontario which are confused about their roles and relationships? There is a planning department within the ministry which employs staff to delegate. The new government has not reappointed the Premiers' Advisory Council which worked alongside the provincial health ministry for years as a policy adviser on long-range health system issues. Neither seem to be able to communicate across the borders.

Regions exist but planning structures are informally organized and do not have formal legitimacy. The DHCs have no real control over the hospitals or the municipalities which provide a wide range of public health services, as their mandate is restricted to providing planning advice to the Minister of Health. The emphasis still seems to be on the biomedical rather than the social model of care in their planning process. Would it be better to set up a new structure (as Quebec did in 1971) or significantly restructure the existing one, rather than continue to introduce incremental modifications? Perhaps this is the wrong time to ask such a question when the whole social service system in the province is undergoing vast budget cuts and the unions are demonstrating fiercely against the neo-conservative policies of the government and any changes being made. The Omnibus Bill Legislation, 1995, provides significant powers to lever hospital restructuring and changes in physician practice. This signals a major deviation from Ontario's incremental approach but centralizes authority provincially.

Other Provinces

It would appear that the main reasons for restructuring today are the deficits and debts of the public authorities who have felt forced to find savings in the health care system. As well it has been clear for some time that there is a need to change the emphasis away from acute care to community care and that devolving responsibility to local authorities for setting priorities could be the means to that end. Another reason is to involve community participants.

The Atlantic Provinces

The relative poverty of the Atlantic provinces has made them much more anxious to maintain federal involvement in health service funding and they have strongly supported the National Forum on Health. They have also been trying to convince the Ottawa bureaucrats that Canada Health and Social Transfers (CHSTs) should be based on need not on per capita calculations.

Richard O'Brien has provided a review of the current situation:[4]

Prince Edward Island

The province has been divided into five regions governed by community-based health boards replacing individual hospital boards. A community-wide needs assessment was completed for all five regions from 1995 to 1996. The report *Comprehensive Health* (Prince Edward Island 1996) is a directional piece which developed a comprehensive health model and further describes comprehensive health services and primary care. A second community health centre has been launched in the province. The actual delivery of community health services has not yet been changed, however. The Department of Health has been downsized and restructured as well. The program and operations functions have been transferred to a newly established crown corporation known as the Central Health and Community Services Agency. The Department of Health maintains responsibility for policy, research and evaluation functions.

Newfoundland

Newfoundland has moved to five broad regions for community health and eight regions for institutional services including hospitals, health centres and

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[4] Richard O'Brien, personal communication, March 1996.

nursing homes. All community health services are administered by the community health boards, and community health is responsible for health promotion, health protection, continuing care, mental health, drug dependency and public health. Under the continuing care program, a single entry system has been implemented that is based on a multidisciplinary approach to assessing clients referred for long-term care services, that is, home support which includes home management, personal care, respite, and long-term care institutional services. Employees of the Department of Health have been deployed to the regions and remaining staff in the department function as consultants.

New Brunswick

Eight regional boards replaced the original fifty hospital boards in 1992 with district, community and regional hospitals in a region under one board. From 1993 to 1994 the twelve family and community services regions were rationalized into seven regions to match the health regions (i.e., includes hospital corporations, mental health, public health and now family and community social services). The following community health initiatives have been introduced: (1) two community health centre (CHC) pilots are underway; (2) an Early Childhood Initiatives Program has been implemented and there are seventeen early intervention programs in the province; (3) the Healthy Active Living Program for Seniors promotes wellness including the prudent use of prescription drugs, nutrition, active living, and stress management; (4) a provincial breast screening program, targeted at women between the ages of fifty and sixty-nine, has been developed; (5) Telecare, a pilot toll-free telephone line staffed by nurses using a structure/computerized assessment tool, was established to provide advice and information to residents unsure whether a trip to the emergency room is required; (6) the public health mandate has been redefined, based on policy direction outcome-driven, targeted services, and partnerships, all reflected in core public health functions.

Saskatchewan

The most dramatic development took place in Saskatchewan. When the province was faced with bankruptcy in 1992 it was decided almost overnight to close fifty-two rural hospitals and establish thirty regional districts to determine how best to reform services in local areas for "rural depopulation continues unabated" (Lewis 1995).[5] Key elements in the plan were that municipalities should decide their own alignments; the province should develop a needs-based funding formula; that home care, long-term care and

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[5] S. Lewis, talk given to conference of University of British Columbia Health Policy Research Unit, November 1995.

acute care should be integrated under district authority; and that funds should flow away from and not toward institutions (Saskatchewan 1993a,b,c).

The first boards were appointed by the Minister of Health, but by 1995 the province decided that board members should be elected. Whether or not this was a successful democratic change is uncertain because a number of people with vested interests (e.g., physicians and unionized health workers) were elected. The turnout in elections was fifteen percent in cities and thirty to fifty percent in rural areas.

In the meantime further steps to devolve authority had been taken. Mental health, addictions and public health were transferred to districts. The provincial Health Department reorganized to provide support and a new data system is in process of development as are new evaluation methods. A committee to supervise quality of care has been set up (Lewis 1995).

Manitoba

Manitoba has not yet taken steps to regionalize but it is looking over the border to its close neighbour Saskatchewan. Meanwhile it has been giving strong support to a provincial inventory of biomedical facts and has established a pilot nursing research centre in Winnipeg.

Alberta

Alberta decided to move towards regionalization soon after the Rainbow report (Alberta 1990c) was accepted by the government, but the decision of government was to keep tight control over this process of deconcentration by centralizing decisions about any appointment of board members and expecting them to follow through on the government's ideas for change. The purpose of the government in the last three years has been to set fiscal targets in the seventeen regional authorities. In 1994–95 $86.3 million was cut, and in 1995–96 $25.7 million was cut, although the cut of $16.2 million which was forecast for 1996–97 has now been put on hold. This drastic approach to health care reform has resulted in great dissatisfaction among physicians, 138 of whom plan to leave the province. Health service workers have also gone on strike in protest and 78,000 members of the public have enrolled as Friends of Medicare.

"The government policy still supports a two tier system where private clinics are available for those able to pay. … Since October 15, 1995 Mr. Klein's stubborn support of private clinics has cost the health system $420,000 a month in federal transfer payments." (Dier 1996, 4).

Dier is concerned that the community has been left out of the planning process. She has argued that: "There is an obligation for citizens, especially the better educated, to become informed and vocal about the direction and process of changes that are radically altering our community. ... The public generally only acts when their personal life has been affected by the changes" (p. 5). She said that although it is reported that patient satisfaction remains high, "the use of proxy" indicators rather than outcomes to determine the quality of care is suspect" (p. 4).

British Columbia

British Columbia has been interested in the possibilities of regionalization since it was investigated by Foulkes (1973). Regional hospital districts had been set up for capital planning in 1966, but they were based on economic development planning regions while public health services were based on school districts, mental health services on their own logic and social service regions on theirs. Foulkes found it difficult to try to sort this out as did many successors in the health department (Miller[6]; Ryan 1984) or the British Columbia Health Association (Ruault 1992).

However, in 1993, following the Seaton committee's report on provincial health services (British Columbia 1991) the government decided to set up twenty regions. The province decided that its policy should be to seek more input from community members. One third were to be appointed by the minister from recommendations of neighbourhood groups, one third to represent special concerns (e.g., mental ill health, physical disability) and one third were to be professional experts on legal or financial matters. It is hoped that, in due course, board members will be elected, but it is probably too early yet as the public has not had time to become aware and engaged in the process of planning. British Columbia has set itself against any privatization and is endeavouring to make the public more concerned about the determinants of health and the need to link health care with other social programs, though this is still a long way off.

Development of One Regional Board in British Columbia

It may be useful to look at the struggles of one health region to come to terms with meeting its objectives. The Vancouver Regional Health Board (VHB) has been in existence for fourteen months at the time of writing (though it had a preparatory interim regional planning committee in existence for eighteen months before that to assess the challenges).

Capital funding is administered separately, and the VHB doesn't have any jurisdiction over clinical medical services (which are still administered by the provincial medical plan) or over subsidized pharmacy services (administered by provincial Pharmacare).

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[6] James Miller, personal communication, 1981.

The VHB had to establish its own bylaws before the provincial government would consider making a budget available. Control over the budget is still to come. The VHB has reduced the number of hospital boards from ten to four and hopes this will make for administrative economies.

It is struggling with the fact that it has the main tertiary and quaternary care centres for the province, which are university medical school teaching centres, so it has to take a provincial as well as a local view. Some of these centres are taking in secondary level cases which should be treated locally (outside Vancouver), and so there is need to work out cross-border relationships with other regions.

The VHB is working on the development of a shared services corporation which will remove food, laundry, laboratory and other services from hospitals to a central service.

It is endeavouring to combine the work of the following community agencies: public health (which already includes continuing care), mental health, and drug and alcohol abuse services. It has inventoried the nongovernmental agencies with a view to eliminating overlaps and identifying gaps as and when possible, but it assumes NGOs (nongovernmental organizations) will continue to exist. Presently the provincial government is endeavouring to encourage amalgamations.

Six community health committees of up to fifteen members have been selected from the public resident in bounded geographical districts of the city. There are also subsidiary neighbourhood health committees. The community health committees have the responsibility for developing health plans for their areas and feeding these in to the VHB which will make a regional health plan. Seven population health committees have been set up to look at the special needs of seniors, persons with disabilities, multicultural groups and so on, and to feed this information into the VHB planning committee.

The VHB and the regional committees have been made well aware of the differences between richer and poorer geographic areas of the city and the special needs of less healthy people. They have been made very conscious of the determinants of health and are concerned about maximizing support services for those in need inside and outside their jurisdictions.

The board is working closely with a transition team of health service professionals recognizing that service providers will have to make the main adjustments to changes in the delivery process. This team has already identified many areas of savings.

A number of board and community health committee members have expressed interest in the idea of setting up community health or multiservice centres.

In the next four months it will be necessary to put together a health plan for the city so that budget adjustments can be made for the 1997–98 fiscal year. The community health representatives and members of population health advisory committees will identify issues which particularly concern them this year and will consider, as well, longer term plans for change.

Assessment of Regionalization

It was suggested at the beginning of this chapter that four strong pressures were forcing provincial governments to think about organizational change in their health care systems:

1. Reduction of transfer payments
2. Need to review efficiency and effectiveness of organization of services
3. Development of a social model of care
4. Greater concern about community participation

Regionalization may help to deal with the reduction in transfer payments by improving organizational efficiency.[7] It is clear that many provinces have not yet given regions the power to work right across the system to coordinate and integrate the whole range of services. They may advocate for a social model of care, but they have restricted mandates, restricted not only to health care but to some aspects of the health care system only. And as far as community participation is concerned, community members' inputs have been kept under tight control by the provincial governments, even in British Columbia which has been more committed to community involvement than many other provinces. The members can "advise and assist" in policy making but must steer clear of management activities. Researchers at McMaster University have been monitoring developments. Abelson et al. (1995) have raised questions about the willingness of community members to take total responsibility for making policy decisions and have found some hesitations in this commitment. However, Lomas, Woods and Veenstra (1995) surveyed board members in Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and British Columbia and found that most were working very hard and were satisfied with their ability to influence local policies.

Summary

In response to four pressures on provincial governments: (1) reduction of transfer payments, (2) questions about efficiency and effectiveness of health service organization, (3) the implementation of the social rather than the bio-

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[7] A report by the Canadian College of Health Service Executives focuses on rationalization and cost control (CCHSE 1995).

medical model of care, and (4) the need for greater consumer involvement, a number of provinces decided that restructuring into regions was the way to go. The next part of the chapter discusses areal decentralization and its advantages and disadvantages. Then the discussion moves on to look at the pioneering of Quebec and Ontario in seeking input from lower levels of the system — Quebec's rational plan which was not put into full effect until recently, and Ontario's reluctant form of delegation. Next the more recent restructuring by other provinces is described, including some details about the work of one board in Vancouver.

Finally there is a brief assessment of regionalization as it stands at the present time. It is still somewhat limited in its mandates but it has brought community members into policy making.

CHAPTER 30

Where Do We Go From Here?

It has taken a long time for Canadians to recognize that when they took on a commitment to collectivism in the 1940s it was a complicated and difficult move. They had a simplistic view of what sharing meant in those days and they had underestimated how difficult it would be to organize a collectivist society.

Commitment to Collectivism

In earlier chapters an attempt has been made to trace the way in which ideas about sharing resources changed from focussing only on financial redistribution, to considering how to enhance the citizenship rights of disadvantaged Canadians. Before that, however, in considering financial redistribution policies, the changes in the political salience of the different social divisions of welfare was also explored — how much weight to put on social minimum, universal or revenue foregone policies. And there was some discussion of Canada's attempts to adjust to changes in the global economic situation by shifting resources away from basic income support to job creation and job retraining programs.[1]

The increasing complexity of ideas about the purposes of a welfare state (or welfare society) has, it would appear, reduced commitment to sharing in some provincial jurisdictions though there have always been differences across provinces in that commitment. Alberta and Ontario are anxious to privatize a number of services in the previously accepted public areas of universal medical and hospital care and post-secondary education, and these two provinces have reduced income support programs as far as they possibly

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[1] However, as of March 16, 1996, Canada was ranked seventeenth only in its ability to compete in the global market today.

can. (However, they both have a history of conservatism compared with the other provinces.)

Marchak (1975) and others have pointed out democratic socialism was a counter-culture in Canada; its ideas about sharing were accepted in the postwar reconstruction years, but may no longer be so acceptable.

Should Canada continue to defend its modified welfare state? Or should it abandon it, as Krauthammer (1995) has suggested because "it has been a primary cause of the decline of society's mediating institutions" (such as the family)? It would seem that Canada is not likely to go so far to the right of the political spectrum as this, if it can only find a way to manage its deficit/debt problems. Canada is a centralist society, a nation which tries to make accommodations and find moderate solutions.

When the Liberals were elected to power in 1993 they found that the deficit was bigger than they had thought, and as this was the main concern of the public, they had to respond to it. Although they had campaigned for reconsideration of the financing of social programs during the election, they have been caught in the deficit web and forced to consider further cutbacks. Their more right-wing predecessors, the Progressive Conservatives, were not prepared to cut out social programs either. In 1991 Prime Minister Brian Mulroney himself opened up the division within the Department of the Secretary of State which was to be concerned with advancing the status of disabled persons.

What then is the likely future of collectivist sharing in Canada today?

As Djao (1983) pointed out, any analysis of social welfare programs is about values, and values continue to change. And as Boudreau (1987a,b,c) has said, there are conflicting ideologies at every level of the system. The social model of care varies from province to province and, within provinces, from one government to the next. While from 1940 to 1966 the importance of establishing a social minimum seemed to have equal weight with the establishing of universal programs, and helping businesses was less important, from 1975 onward the politicians began to emphasize the necessity for stimulating private enterprise to a much greater extent in order to make Canada a successful market competitor and to raise the revenues necessary to meet the costs of social programs. But then in the 1980s "harmonization" with other North American Free Trade Agreement (NAFTA) businessmen began to seem more important than Canadian social program funding.

The federal government backed off from its earlier commitments to financial redistribution because of the growth of Canada's national debt since 1981. During the 1980s the global trade situation changed dramatically. Canada's natural resources had been run down and the nation was finding it difficult to compete in world markets, so it reduced taxes on companies. It eagerly embraced the corporate model of decision making and the NAFTA model of free trade. But this has not brought in sufficient revenues to cope with the deficit and has resulted in increasing social differences between rich and poor.

On the other hand there is a major change in Canada's acceptance of minority groups. While it is recognized that this emphasis on attitude change establishes a new way of looking at social relationships, it may have detracted from concerns about poverty and the social minimum. Advocates for the "disabled community" have tried to keep both issues before the public, because persons with disabilities are often poor as well as handicapped, but the emphasis in "the welfare society" is less about money and more about acceptance of others. "Equality of consideration" seems to have taken over from "equality of condition" or concern about the social minimum.

Another shift in the perception of goals of the collectivist welfare state particularly affects health policies. The emphasis in the first stages of development was on access to medical and hospital care, but in the 1970s there was a move towards giving greater consideration to outcomes. Although it was made clear in the Lalonde report (Canada 1974a) and the Epp report (Canada 1986c) that biomedical care was likely to make a relatively minor difference to health outcomes and that good health was more dependent on good lifestyle and on good physical and supportive social environments, the Canadian public has had some difficulty in linking health goals to the broader goals of the welfare state. Thus, although a number of analyses have shown the relationship of health status differences to income (Manga 1981; Wilkins and Adams 1983; Schwartz 1987; Badgley and Charles 1987; Canada 1990m,n) and the *Active Health Survey* (Canada 1985c) identified the people in lower income groups as likely to be living less healthy lifestyles, it has not made the public willing to focus on minimum income support except in negative ways.

So what should be done to improve the living conditions of Canadians caught up in these complex situations? The public's emotions have been linked to the deficit, the difficulties of competing in global markets and in finding and keeping jobs. Most Canadians who have achieved the goal of access to medical and hospital care are not particularly interested in counteracting the bad determinants of health if it is going to cost them more. They do not want to engage in improving financial redistribution to an even wider group now that helping those with human rights needs have been recognized.

The early simplistic ways of seeing how to improve sharing in the welfare state are no longer viable and the Canadian governments are still struggling with the concept of collective security in a more complex world. The country is divided and confused.

Is the commitment to collectivism likely to continue in these circumstances? There is no doubt that the poorer provinces have found it important to have a financial redistribution even if this has now diminished and they would like to continue with collectivist sharing. Some of the richer provinces are less certain, but they are unlikely to want to separate from Canada as Quebec has threatened to do. The problem for the middle range and richer provinces is the complexity of the choices which they now have to make in supporting collectivism Perhaps one answer is better formal organization of the welfare state/society.

Organizational Restructuring

As we have seen in Chapter 27, Canada has a poor record in social program organization. It seems clear that this is the first place where changes should be brought in. By bringing service organization "closer to home" and focussing upon better communication between the present divisions of care in order to improve organizational efficiency, it may be possible to solve the country's problems without exposing poor or less competent citizens to the miseries of an out and out capitalist society.

It would appear that the Canadian provincial governments want to seek reasonable solutions, namely to involve local community members in reducing costs by finding better ways of organizing social programs — first by improving communication between service providers and the public; then by identifying the important local issues, setting priorities and working on streamlining the systems of care. An overview of the current system is provided in the Canadian College of Health Service Executives' latest report (1995).

It is clear that there was only one jurisdiction in Canada where the necessity for a planned restructuring of services was understood when the proposals for introducing a welfare state were first put forward, but Saskatchewan had no money of its own to implement such a program. Nor was it understood that there would be powerful resistances to the introduction of these new structures. For when Quebec later came up with a rational plan for reforming its health and welfare services, it was no more successful in achieving acceptance of the changes than the other provinces. This is not to say that other welfare states internationally have been much more successful in their organizational structuring. It would seem that the concept of collectivist sharing in Canada was too large to comprehend properly and the processes of decision making about the introduction of new legislation too incremental to deal with the whole situation.[2]

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[2] Tuohy (1994) has discussed the complexities of moving towards a new model of social *distribution* because of *constitutional* barriers and other resistances.

So where do we go from here?

It is clear that there has been a swing away from centralized decision making towards empowering people at local levels to make their own choices. This swing is being resisted by the poorer provinces, which are anxious to maintain financial redistribution across the nation. Elsewhere, however, there has been strong support for decentralization of power to regions by consumers excluded from policy discussions until now.

Will encouraging community members to become more involved in public decision making help? Canada still prides itself on its close-knit social organization, its acceptance of citizens of all colours and creeds. The annual report of the Canadian Policy Research Network (1995) said:

> Governments, corporations and citizens are all groping for new ways to enhance productivity and generate wealth.
>
> At the same time, we are beginning to understand that our capacity to generate wealth depends critically on the quality of social interaction — the trust and reciprocity that are woven into the social fabric. They are needed to sustain citizens' commitment to the rule of law and the legitimacy of democratic institutions in times of hardship. 'Social cohesion involves building shared values and communities of interpretation, reducing disparities in wealth and income and generally enabling people to have a sense that they are engaged in a common enterprise, and that they are members of the same community'. (p. 4)

As yet, however, regional structures and involvement of local communities are still in the process of development, and it is far from clear whether provincial governments are ready to devolve much of their power to these new authorities (except in Saskatchewan where the province was forced to take some action because of impending bankruptcy). The regions in Alberta and Nova Scotia are tightly controlled from the top down and limited in what they can do. And while British Columbia has said it wants to develop a consumer controlled system of health planning and management, the provincial Health Department has not been altogether willing to let go. (The board of the Capital Regional District was recently dismissed [Thomson 1995, 1995–96].)

It is still much too early to predict whether policy making at the regionalized level will become more successful than the centralized policy making of the federal government. There is no doubt that centralized welfare state programs of the last fifty years have helped to make Canada into a leading first world country with a healthy, well educated population.

Yet it seems that the unit of collectivist sharing — the nation as a whole — has been too big for most people to understand. Even the idea of sharing across a province is not easy to envision in such a vast country. It may be that by breaking the units of decision making down to the regional level, we can increase such understanding. In a city like Vancouver, the west side residents, who are comparatively well off people, have difficulties in visualizing what surviving means for others who live in the downtown east side of the city, on the streets, or in hotels with few facilities or in temporary shelters. Nor is there a great understanding by seniors of the pressures on adolescents who are concerned about finding jobs, relating to the other sex in contemporary ways and perhaps trying out drugs and alcohol. In addition, seniors have their own problems of degeneration into dependency and denial of the need for planning to meet it.

There is no doubt that allocating control over budgets to regional authorities will help to break down the divisions between service providers which have been allowed to grow up under federal and provincial jurisdictions, and should enable these authorities to move finances across to community services, underfunded in the past. It may even be possible, in time, to address issues of social inequities and their implications for health outcomes rather than continuing to stress access to health care, if health and social service agencies can be brought together under one authority.

Perhaps the emphasis on deficits and debts has its positive side, for it has forced Canadians to reconsider their basic values about sharing their resources. It has encouraged governments to go ahead with plans for reform and restructuring of their welfare state programs and to reconsider ways of letting community members have more say in decision making for their local areas. This may be the next way of getting renewed commitment to collectivist sharing.

APPENDIX A

Definitions

One of the problems in writing about community involvement in a collectivist society is that the meaning of the terms used is often unclear. There is an inconsistent definition and use of terms. Below are some of the definitions that were found. Since this book is concerned with reviewing the literature, it is likely that the terms used may vary from one person's writing to another, thus the readers must use their own judgement about the definition appropriate for a particular context.

The Biomedical Model of Care

Field (1973) has suggested that medical care has moved through four phases which he has called magical, religious, pastoral and scientific.

By the beginning of the twentieth century the western developed countries were putting their faith in scientific medical care (or the biomedical model) which proposed that the best health outcomes would result from consulting physicians for advice and treatment on the symptoms of disease. As a result of adopting this model, the number of medical specialists grew extensively and the medical profession developed "regional hierarchies" with quaternary and tertiary care specialists and university teachers at the top of the status ladder. Primary care was not so highly regarded.

McKeown (1971) and others have challenged this model as contributing only about ten per cent to the health of populations.

The principles underpinning health insurance in Canada are the provision of universal, comprehensive, portable, publicly administered and equitable medical and hospital care. At the time hospital insurance and diagnostic services, 1957, and medical care insurance, 1966, were brought in, Canadians wanted to have unlimited access to high quality biomedical services, and the guarantee of universal, comprehensive and portable care ensured this.

Collectivism

The *Concise Oxford Dictionary* defines a collective as "of [or] from many individuals, common."

"Collective ownership for land, means of production etc. [is] by all for the benefit of all."

Collectivism is used in the text to describe the shift from an individualistic form of social organization to a state in which resources are shared by all as equitably as the government can arrange to do so.

Community

There are many ways of defining this term. Robichaud and Quiviger (1990) base their definition on geography, interest and group membership. But if a definition from *Roget's Thesaurus*, is selected, community is linked to party and participation (the former defined as being concerned with alliances and the latter defined as being concerned with sharing). Both definitions seem to be used. In the past community-based health services were mainly defined by geography, although they could be organized by exclusive interest groups (such as paraplegics), or by membership groups (such as fitness clubs). However, these definitions seem to be changing, and we give more credence to *Roget's* emphasis on alliances and participation.

Community-Based and Community Oriented Services

The issue of public participation today raises another definitional question, the distinction between community-based and community-oriented health services. Hilton (n.d.) describes community-oriented health care as "health care in which plans are made by outsiders and community members are asked to participate. The program is centred around medical staff who dispense their knowledge to people. On the other hand ... community-based health care means that people begin to think about ways to solve their problems instead of just complaining ... they listen carefully and put into practice what they learn" (pp. 1–3). But "community-based" is not always defined in that way.

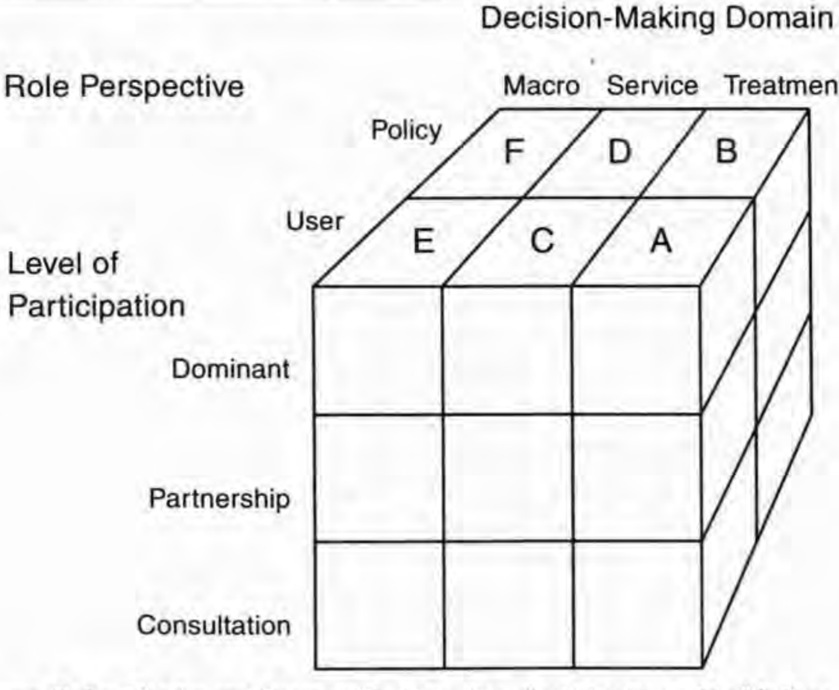
A Toronto document *Healthy Toronto 2000: A Strategy for a Healthier City* (1988a) defined "community-based" activity (which is not unlike the community-oriented system of Hilton) as "involving public health, community health centres and other forms of 'community-based' primary care, home care, community support services, day care/day hospital programs and free standing centres such as birth centres, abortion clinics and hospices." This strategy document distinguished between a "community-based" and a "community managed" system. "The community should play a much greater role than it does in managing its health services system. Such an approach, which would integrate institutional and community services into a comprehensive community managed system, would be a more rational approach rather than the current fragmented approach to health care system management. ... [It] would require, over time, the development of community boards, democratically elected, to manage the entire health care resources of a given community" (p. 19). These discussions raise two issues: (1) that of increasing personal responsibility for one's own and others' health care in the community and (2) that of how participation in policy making can best be organized.

Charles and De Maio (1993) have developed a chart (A.1) analysing community participation.

Community Development

The evolving health promotion movement is concerned with improving both the physical and the social environment. It has been suggested that in order to achieve success *vis-à-vis* the latter, it will be necessary to undertake com-

Chart A.1
Dimensions of Lay Participation in Health Care Decision Making



Source: Cathy Charles and Suzanne De Maio. "Lay Participation in Health Care Decision Making: A Conceptual Framework." *Journal of Health Politics, Policy and Law* 18, no. 4 (1993): 891. Reprinted with permission.

munity development so that citizens may become aware of their rights and responsibilities. One of the implications of becoming involved in health promotion is that the public health departments' nursing staff will need to change their approach from being health educators to being community development experts. This shift from a one-to-one relationship with their clients to a broader way of working will not be easy for many established health professionals.

Community Health Centres/Community Clinics/Centres locaux des services communautaires (CLSCs)

A form of group practice which relies on teamwork among professionals (who may be doctors, nurses, pharmacists, physiotherapists, occupational therapists, social workers and possibly others); it focusses on the prevention of illness and the promotion of health, and is guided by an elected community board.

Where the doctors are paid by fee-for-service, they will then have to pool their fees and accept salaries in order to fund support staff. Thus they have to be ideologically committed to this concept of organization. (In some provinces other forms of remuneration have been worked out, but ideological commitment is still necessary.)

Community Health Services

In the nineteenth century, community health services began to be seen as services delivered by experts outside institutions. Then the term was often used more specifically to describe the public health departments' services (particularly when these departments added health education to their sanitary engineering activities, employing public health nurses to work with special risk groups).

However, "community health services" today have often come to mean non-institutional services — services given in the home or in out-patient settings.

Decentralization/Devolution

The *Concise Oxford Dictionary* defines decentralization as "undo the centralization of; confer local government on."

Devolution has a number of meanings but the one most relevant to the discussions in this book is "deputing delegation of work or power."

To devolve is to "throw work upon a deputy or one who must act for want of others."

The confusions in using the words decentralization/devolution, deconcentration, delegation are discussed (to some extent) in Chapter 29 on regionalization.

A chart developed by Mills and Vaughan (1987) attempted to sort out some of the terms used in WHO documents (see Chart A.2).

In Chapter 22 Pleiger is quoted on decentralization. She was discussing corporate partnerships and used the words decentralization, informalism and sectoralization. The point being made was that the remote formal authority of central governments (particularly Westminster Parliamentary governments) was being reconsidered. Other interest groups were being brought into the process of policy development in discussions outside Parliaments — discussions which were more informally structured. These discussions were not restricted to top level politicians, bureaucrats and business leaders but were being opened up to community inputs at a number of different levels.

Disease Prevention and Health Promotion

Statchenko and Jelinek (1990) have explained the difference between traditional public health activities (prevention) and the new public health activities (promotion) in Chart A.3.

Chart A.2

The Decentralization of Functions in Different Types of Decentralized Systems

Functions	Deconcentration to ministry field office	Devolution to local government	Delegation	Privatization
Legislative	–	**	–	–
Revenue-raising	*	**	**	***
Policy-making	–	**	**	**
Regulation	–	**	*	–
Planning and resource allocation	**	**	***	***
Management				
• personnel	*	**	***	***
• budgeting and expenditure control	**	**	***	***
• procurement of supplies	*	**	***	***
• maintenance	*	**	***	***
Intersectoral collaboration	*	***	***	***
Interagency coordination	*	**	***	***
Training	*	**	***	***

Key *** Extensive responsibilities
** Some responsibilities
* Limited responsibilities

Source: Anne Mills and Patrick Vaughan, eds. *Decentralization and Health for All Strategy* (Geneva: WHO, 1987), 15. Reprinted with permission.

Home Care, Long Term Care, Continuing Care

"Home care" was developed in order to hasten hospital discharges and to prevent hospital admissions — a matter of short-term assistance by public health nurses.

As the demand for "long-term care" in institutions increased (either from those blocking acute care hospital beds or those becoming frailer and unable to cope in their own homes), the provincial governments recognized that they might be able to cut down on the demand by establishing improved assessment processes and a case management policy.

"Continuing care" describes the bridging of community and institutional care by these methods.

Crises may be dealt with through respite care or other temporary solutions. In British Columbia, quick response teams may avert crises leading to hospital admission by providing help in the home on a temporary basis (Finnie and Layton 1990).

Chart A.3
Health Promotion Versus Disease Prevention Approach: Prevalent Differences in Concept

Health Promotion	**Disease Prevention**
• Health = positive and multi-dimensional	• Health = absence of disease
• Participatory model of health	• Medical model
• Aimed at the population in its total environment	• Aimed mainly at high-risk group in the population
• Concerns a network of healthi ssues	• Concerns a specific pathology
• Diverse and complementary strategies	• One-shot strategy
• Facilitating and enabling approaches	• Directive and persuasive strategies
• Incentive measures are offered to the population	• Directive measures are enforced in target groups
• Changes in man's status and in his environment are sought by the program	• Programs focussing mostly on individuals and groups of subjecjts
• Non-professional organizations, civic groups, local, municipal, regional and national governments are necessary for achieving the goal of health promotion	• Preventive programs are the affair of professional groups from health disciplines

Source: Sylvie Statchenko and Milos Jelinek. "Conceptual Differences Between Prevention and Health Promotion: Research Implications for Community Health Programs." *Canadian Journal of Public of Health* 81 (1990): 53–59. Reprinted with permission.

Lay Participation

Charles and de Maio (1993) developed a chart (A.1) to show how lay participation can be increased from individual consultation with professionals about treatment to dominant policy making roles in formal organizations. This Canadian study builds on Arnstein's ladder of participation (1969) but simplifies it and extends the dimensions.

Multicultural Integration

The YWCA of Toronto has been active in promoting multicultural integration through group action: "Multicultural organizational change is a process of dismantling visible and invisible barriers to the full social participation of non-dominant groups, establishing an organizational response and responsibility to that larger community" (YWCA 1987, 30).

The Y's Program for Action makes an analysis of four models of relationship between established and new members of communities who are seeking integration, that is, the melting pot, separate ethno-specific activities, limited integration and fully integrated multicultural organization. In the last of these models (deemed to be what Canada is aiming to achieve), the guidelines say that the multicultural organization must reflect its client community in all aspects of its organizational culture. Long-term, ongoing monitoring is necessary to make an agency truly responsive. Equality of access must actively address the barriers to such access, a major one being racism in all its forms. Agency activities must go beyond meeting individual needs to advocating on behalf of community needs. The program approaches and emphasis should be developed to respond to the needs of the constituency and not vice versa.

The main difficulty, identified by Doyle and Visano (1988), was that multicultural policies were not community-based. Because the federal government's immigration policy has changed Canada from a predominantly English-French society to an extremely diversified cultural community, there has been concern to establish clear policies about the meaning of the concept "multiculturalism" at the federal level (Canada 1987c). But as Doyle and Visano said: "The multicultural policy in Canada was introduced on a top-down basis by the Prime Minister of Canada in 1971; it was not the result of any groundswell of consensus from the grass roots. As a result, it seems to have remained at the level of abstraction and been largely confined to the mandate of one Minister and one government department, rather than being the responsibility of every Minister and department" (p. 13).

At the provincial level there are differences in implementation of this policy across Canada. Writing about Ontario, Doyle and Visano said: "a Multicultural Strategy has been introduced that encourages this widespread responsibility, but it appears to be neither a 'policy' nor a 'strategy,' since it does not ensure a coordinated, coherent and interrelated set of activities" (p. 13).

They said that although they have consulted the public, politicians have not always listened to public views and top-down policies have not changed. The strategies need to be altered to take account of consumer inputs.

This was written some eight years ago. There seems to be more acceptance of multiculturalism today.

Multiservice Centres

Multiservice centres may provide all or some of the following services: medical care, pharmacy, physiotherapy, occupational therapy and social services. These are not quite the same as community health centres where the professionals work together under one managing authority. This term describes geographical continuity and an agreement to work on "team case management" between separate services agencies, not an ideological commitment to community identified needs.

Primary Care

Although primary care may be used to describe all kinds of care given outside institutions by health professionals and their support teams, it is often taken to be the first step on the ladder of medical care organization which may have three more levels of specialization above it.

Primary versus Community Care

While Hastings (1978a) distinguished between primary care and community care in Canada, attributing the latter to public health department activities, there now seems to be greater acceptance of the idea that all health professionals, whether in clinical or public health positions, should be concerned with promoting primary care in the community because good primary care focusses on the determinants of health (Evans, Barer and Marmor 1994). The Alma Ata Conference on Primary Health Care of WHO, 1978, stressed the importance of early interventions with respect to promoting health rather than the development of more and more specialist care for illness. This would seem to indicate that primary care should go far beyond any kind of biomedical care to give attention to such matters as nutrition, environment and so on.

Partnerships

Like many other terms used in discussing policy developments, "partnerships" has been used in a number of different ways.

When the idea was first adopted by the Mulroney government (1984–93) it was used to describe the promotion of improved linkages between the government and business and research leaders.

However, during the 1980s Gottlieb (1983) and Gottlieb and Selby (1989), working in the field of mental health, proposed a range of partnerships from improving relationships between those with mental health needs and other community members. Gottlieb's range is shown in Chart A.4.

Boudreau (1991), coming from the same stance, has also worked on defining this term. She proposed that partnership should be seen as a continuum, quoting Cawson (1982) who said: "This continuum has at one end 'the open competitive and fluid interplay of interests characteristic of pluralism' and at the other end 'the closed monopolistic and relatively stable structure of interests best captured by the concept of corporatism'" (p. 147).

She pointed out that partnership is still a theory waiting to be worked out in practice.

Guay (n.d.) has made out a case for partnerships to be developed among "survivors," consumers of mental health services who may know better how to give help to one another than other consumers or professionals.

To promote the development of partnerships there is need for community development to raise consciousness about social needs.

Resource Exchange Networks

Cummings (1984) said that *the interorganizational relations (IR) perspective*: "proposes that organizations enter into relations with other organizations in order to obtain needed resources. Moreover, because such resources are generally scarce, organizations tend to compete with one another, attempting to gain power and control over essential resources while trying to minimize dependencies threatening organizational autonomy" (pp. 370–71).

A Social Model of Health Care

Questions began to be raised about the effectiveness of the biomedical model of health care for a collectivist society in the early 1970s but, until the Canada Health Act was passed in 1984, access to medical and hospital care was a priority for Canadians. However, in 1986 an international conference on *Achieving Health for All* (Canada 1986c) drew attention to the social causes of ill health and the need for better health promotion activities. Following this conference some other nations (e.g., Australia) identified certain disease prevention activities which they could address. Canada recognized that while disease prevention was one aspect of health promotion there were, as well, other major social challenges which should be considered, for example, reduction of inequities and enhancement of coping. Since then there has been a growing interest in identifying the social determinants of health and adopting a social rather than a biomedical approach to health policy development.

Chart A.4
A Typology of Support Interventions

Level of Intervention	Examples
Individual	
Support provider	Promoting a network orientation to coping Promoting ways of coping that invite support
Support recipient	Controlling distress during supportive exchanges
Dyadic	
Support from key network member	Consultation to informal community caregivers Spouse-coach in the Lamaze method of childbirth Enlisting close associate in health habit change Lowering levels of expressed emotion (EE)
Introduction of new tie	Home visitor programs,including companions and friendly visitors Therapeutic partnerships between 'fellow sufferers' Lay helping alliances such as buddies, coaches, mentors, and preceptorships
Group	
Support from set of network members	Cultivation of natural helping networks Network therapy and its variants Network/support assessment and development
Grafting on a set of new ties	Creation of support groups Family support programs such as Extend-a-Family and Family Clusters Psychosocial rehabilitation programs such as Fountain House and Lodge society
Social System	
Role redefinitions	Expanded role for the primary nurse and high school homeroom teacher
Organizational policy/ structural changes	Workplace day-care programs Network members room-in and assume care responsibilities in hospital Students in first year of high school stay together for core courses
Community	
	California 'Friends Can be Good Medicine' campaign Radio talk/phone-in shows featuring self-help groups

Source: B.H. Gottlieb and Peter M. Selby, "A Typology of Support Interventions." (Adapted from Table 1, Gottlieb [1988]). "Support interventions: A typology and agenda for research." In *Handbook of Personal Relationships: Theory, Research and Intervention*, edited by S. Duck (Chichester, G.B.: John Wiley, n.d.). 512–542. Reprinted with permission.

APPENDIX B

A Chart of Important Dates in the Development of Canada's Community Health Care Organization

1867	Federation of colonies: British North America Act Provincial governments take responsibility for mental health Federal and municipal governments take responsibility for public health
1930–39	Great Depression
1932	Regina Manifesto published by Cooperative Commonwealth Federation
1939–45	World War II
1940	Report of the Royal Commission on Dominion-Provincial Relations (Rowell-Sirois)
1943	Federal Report on Social Security (Marsh) Federal Report on Health Insurance (Heagarty)
1944	CCF party elected to power in Saskatchewan. Reviews by Health Survey Commission
1945–46	Dominion-Provincial Conference on Social Reconstruction
1946	Saskatchewan introduces Hospital Insurance Act
1948	Federal offer of National Health Grants for planning, hospital construction and demonstrations in public and mental health
1951	Pilot projects on regionalization defeated in Saskatchewan
1957	Federal Hospital Insurance and Diagnostic Services Act
1959	Death of Premier Duplessis of Quebec thus freeing up the province to begin the Quiet Revolution
1962	Saskatchewan introduces medical care insurance legislation. Doctor's strike

1963	Fulton-Favreau agreement between Ottawa and Quebec on grant aid
1961–64	Royal Commission on Health Services
1965	Canada and Quebec pension plans introduced
1966	Canada Assistance Plan enacted
1966	Federal Medical Care Insurance Act passed
1968	Trudeau's proposal for a charter of rights
1970	Task Force on the Cost of Health Services Report
1968–71	Castonguay-Nepveu Committee Report on Quebec's health and welfare services
1971	Quebec introduces new health structures and programs
1972–73	Report of the National Community Health Centres Committee
1972	Science Council report on need for research on health care system
1973	Ontario sets up first District Health Council
1974	*A New Perspective on the Health of Canadians*
1974	Rejection of Orange Paper on guaranteed annual income by federal cabinet
1977	Established Programs Financing Act legislation
1977	Human Rights Act, revised 1983
1978	Alma Ata Conference on Primary Health Care
1980	OECD Conference on "Crisis in the Welfare State"
1981	International Year of Disabled Persons
1982	Constitution Act, Charter of Rights and Freedoms
1984	Canada Health Act
1984	Liberal government in Ottawa replaced by Progressive Conservatives
1984–91	Provincial Public Inquiries into Health Care Organization (see List of Provincial Commissions and Government Responses, Appendix B). Proposals for regionalization
1985	Canada job strategy introduced
1985	Report of Royal Commission on Economic Union and Development Prospects
1986	*Achieving Health for All: A Framework for Health Promotion*
1988	Canada–United States Free Trade Agreement, which agreed on a "harmonized" system of taxes
1993	PC government in Ottawa replaced by Liberals

Legislative Milestones in the Development of the Social Security System

Year	Act
1914	Ontario Workmen's Compensation Act
	Saskatchewan Municipal Medical Scheme introduced
1916	Manitoba Mothers' Pension Act
	Saskatchewan Union Hospital Act
1927	Federal Old Age Pensions Act
1930	Federal War Veterans' Allowances Act
1935	Federal Employment and Social Insurance Act (ruled *ultra vires* by courts)
1940	Federal Unemployment Insurance Act (major reforms in 1955 and 1971)
1944	Family Allowances Act
1946	Saskatchewan Hospital Insurance Act
1951	Federal Old Age Assistance Act and Old Age Security Act (replaced Old Age Pensions Act)
	Federal Blind Persons Act
1954	Federal Disabled Persons Act
1956	Federal Unemployment Assistance Act
1957	Federal Hospital Insurance and Diagnostic Services Act
1961	Quebec School Allowances Act
1962	Saskatchewan Medical Care Insurance Act
1964	Federal Youth Allowances Act
1965	Federal Canada Pension Plan Act/Quebec Pension Plan
1966	Federal Canada Assistance Plan Act (replaces earlier assistance legislation for the blind, disabled, elderly and unemployed which was repealed)
1966	Federal Medical Care Act – implemented by 1970
1967	Federal Guaranteed Income Supplement to Old Age Security Act
1973	New federal Family Allowances Act (replaced old act of same name and Youth Allowances Act)
1977	Federal Extended Health Care Services Program implemented in Federal-Provincial Arrangements and Established Programs Financing Act

1978	Federal Child Tax Credit introduced to Income Tax Act
1984	Federal Canada Health Act (replaced Hospital Insurance and Diagnostic Services Act and Medical Care Act)
1992	Federal Child Tax Benefit introduced to Income Tax Act (Child Tax Credit deleted and Family Allowances Act repealed)

Source: Canada Year Book 1994

List of Provincial Commissions of Inquiry and Government Responses 1984–92

Alberta

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About the Authors

Anne Crichton, PhD, taught health policy at the University of British Columbia from 1969 to 1985. Since retiring, she has been writing on the Canadian and Australian health care systems. She has served on the Vancouver Regional Health Board and is now doing research on this regional board's evolution.

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HEALTH CARE: A COMMUNITY CONCERN?

This book documents the causes and effects of changes made in this century to Canada's health care policy. Particular emphasis is placed on the decades following 1940, the years in which Canada moved away from an individualistic entrepreneurial medical care system, first toward a collectivist biomedical model and then to a social model for health care.

The changing roles of federal, provincial, and municipal government are explored, as are recent trends away from crisis-oriented health care toward an approach that stresses promotion of health. The authors argue that the original collectivist model restricted community members from participation in the decision-making process. Leaving health policy decisions in the hands of politicians and bureaucrats has led to a system that is poorly coordinated and often poorly managed. They propose a shift away from the "welfare state" model toward what has been called the "welfare society," in which there is greater participation of individuals and communities. They advocate partnership with business and research communities and reform and restructuring through regionalization.

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