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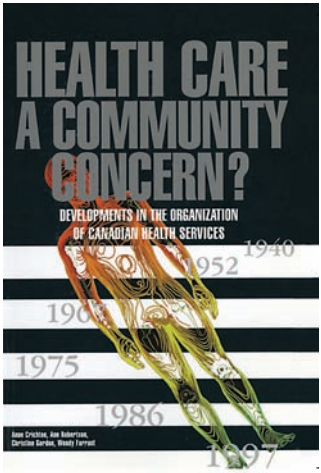

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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PART V

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]

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

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-

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

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-

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.

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.