



HEALTH CARE: A COMMUNITY CONCERN?

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

ISBN 978-1-55238-572-2

THIS BOOK IS AN OPEN ACCESS E-BOOK. It is an electronic version of a book that can be purchased in physical form through any bookseller or on-line retailer, or from our distributors. Please support this open access publication by requesting that your university purchase a print copy of this book, or by purchasing a copy yourself. If you have any questions, please contact us at ucpress@ucalgary.ca

Cover Art: The artwork on the cover of this book is not open access and falls under traditional copyright provisions; it cannot be reproduced in any way without written permission of the artists and their agents. The cover can be displayed as a complete cover image for the purposes of publicizing this work, but the artwork cannot be extracted from the context of the cover of this specific work without breaching the artist's copyright.

COPYRIGHT NOTICE: This open-access work is published under a Creative Commons licence.

This means that you are free to copy, distribute, display or perform the work as long as you clearly attribute the work to its authors and publisher, that you do not use this work for any commercial gain in any form, and that you in no way alter, transform, or build on the work outside of its use in normal academic scholarship without our express permission. If you want to reuse or distribute the work, you must inform its new audience of the licence terms of this work. For more information, see details of the Creative Commons licence at: <http://creativecommons.org/licenses/by-nc-nd/3.0/>

UNDER THE CREATIVE COMMONS LICENCE YOU **MAY**:

- read and store this document free of charge;
- distribute it for personal use free of charge;
- print sections of the work for personal use;
- read or perform parts of the work in a context where no financial transactions take place.

UNDER THE CREATIVE COMMONS LICENCE YOU **MAY NOT**:

- gain financially from the work in any way;
- sell the work or seek monies in relation to the distribution of the work;
- use the work in any commercial activity of any kind;
- profit a third party indirectly via use or distribution of the work;
- distribute in or through a commercial body (with the exception of academic usage within educational institutions such as schools and universities);
- reproduce, distribute, or store the cover image outside of its function as a cover of this work;
- alter or build on the work outside of normal academic scholarship.

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

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

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 se-

niors 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.

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.

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-

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

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.