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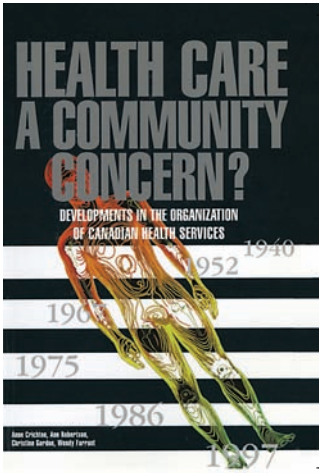

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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PART VI

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.