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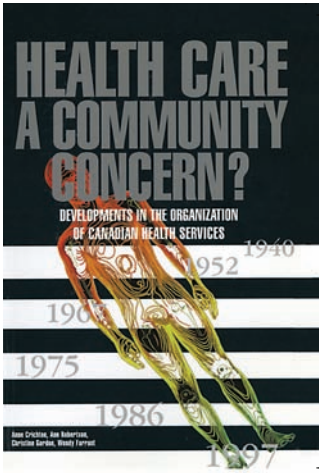

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 24

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).

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.