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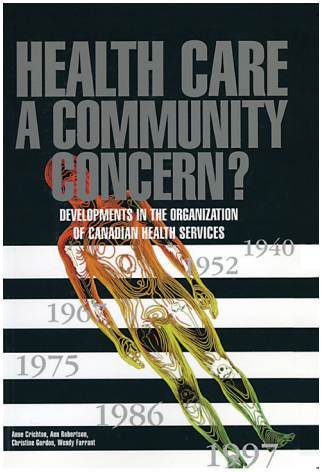

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 27

The Health Care System in the Welfare Society

The previous chapters have reviewed the literature which was available on community health services up to 1993 and it is now important to consider what conclusions can be drawn from these documents. The project was funded to examine organizational models for community health services, but we decided that it was not only necessary to look at community services but at health services as a whole within the welfare state in order to tease out why community services were not better funded and more effective. We took a historical approach.

Organization theory indicated that we should look for three stages in the organizational development of a collectivist system of care:

1. The shift from an individualistic to a collectivist model of care delivery
2. The development of a collectivist model and, after a time, the questioning of this model (or first order change)
3. The proposed substitution of a new model after reviewing the mission (second order change)

Bartunek and Reis (1988) have first explained how new social organizations are formed. They have then discussed the first stages of a new organization's development. In the early stages of evolution of a new or merged organization, they said, the emphasis will be put upon gap filling and coordination. Then a second stage is likely to evolve. At this point the mission will be questioned and a new mission is likely to be substituted for the old. This revisitation of the mission will result in new objectives being set and will stir up the established patterns of doing things.

We found that there were three stages in the development of Canada's health care system which closely followed these ideas of the theorists despite

the fact that there is little use made of research on organization theory in Canada. Reform and restructuring of the organization of administration and service provision, first in setting up the welfare state and then moving towards the welfare society, have not been based on research but on what seemed best at the time. There has been little attempt to see whether a good model of organization for providing collectivist care was chosen.

Identifying Criteria for Evaluating the Shift from Individualistic to Biomedical Collectivist Care and Then to Socially Oriented Collectivist Care

It is now proposed to use three concepts from organization theory against which to measure progress in establishing a collectivist health care system. These are:

1. Bartunek and Reis' (1988) idea of a *good organizational transition*. This idea may be summarized as follows: there are different orders of change in organizations which Bennett (1987) clarified as changes *within* the system and changes *of* the system. For example, changes within the system are the gap filling and streamlining which has been taking place. Changes of the system are the expansion of the boundaries and the restructuring of the mission

Good transitions require individuals and groups within the organization to identify with the culture and mission of the system. Good leadership is required for the reframing process.

2. Benson's (1982) ideas about *resistances to organizational transition* — defensive basic action orientations on the part of agency administrators

There are many inherited traditional structures which need to be reformed. Professionals and administrators may try to defend these traditional structures — their "turf" — and to hinder change. Benson (1982) identified the four basic action orientations of the administrators of sub-organizations. They expect to work towards: the fulfillment of program requirements; the maintenance of a clear domain of high social importance; the maintenance of orderly, reliable patterns of resource flow; and the extended application and defence of the agency's paradigm. Consequently, when asked to coordinate their work with other subgroups, they do not find it easy to do so.

"Organizations taking other approaches constitute an implicit threat to the security of resource flow. ... Thus efforts are made to refute and discredit competing ideological claims and to establish the superiority of one's own

technology" (Benson p. 75). Clearly these defensive behaviours in sub-units of the system do not advance the organizational transition of the whole.

We would argue that the overarching organizational model is the welfare state and below that the health care system, but for most professional service workers, the culture and mission of "the organization" is still the culture and mission of the subsection in which they work. These service subsections in the health care system have been grouped under hospital and medical care, public health, mental health and health care support services. This last group does not visualize itself as part of the traditional health care system but comes under various other departmental divisions which may or may not work in close relationship with medical care and public health services. But all are part of the publicly financed collectivist state society and most non-governmental organizations are largely dependent on government contracts.

3. Cummings' (1984) ideas about the *problems of identifying system boundaries and member organizations.*

One of the issues in defining health system boundaries has been what to do about the community context. One of the recurrent themes of this study has been the exclusion of the public by the experts. Some of the lags in understanding the total culture and proper mission of a socially oriented health service may be traced back to the lack of community participation in addressing the questions: What is a healthy society? What kind of services do we need to attain the goal of a healthy society? For presently a large number of members of the public gives *access* to medical care priority above all else, they do not understand the determinants of health and the community context as affecting outcomes.

The theme of community development, as Bennett (1987) has pointed out, is to achieve second order change in the local setting, for this second order change is required for promoting real collectivist health care. As much as the other service, administrative or policy making bodies, community organizations will need to develop their ideas in order to deal with the challenges of establishing healthy public policy at the local level.

1. A Good Organizational Transition?

So far as changes *within* the system were concerned, the first stage of development was to bring in publicly financed hospital and medical care insurance to add to public and mental health services already provided. But these services were brought in separately with much constitutional struggle. After moving from an individualistic model to a biomedical model, it was to be expected that the emphasis would be on gap filling and streamlining but

it only focussed on the former. It seemed to be too difficult to integrate and coordinate sectors of the system.

A second stage of development followed the Canada Health Act, 1984, which legislated *access* to universal, comprehensive, portable, publicly administered and equal medical and hospital care. This second stage established health promotion as the way to achieve the new goal of better health status *outcomes*. It then seemed to be possible to move to reconsideration of the mission and resetting of goals — to shift from a biomedical to a social model of care.

But though the goals were restated, the organization did not seem to change greatly except within the public health departments which had room to bring in health promotion activities. Elsewhere there seemed to be resistance to all ideas about organizational development within the restated mission.

There were strong resistances to changes *of* the system from the medical profession which did not wish to move away from an individualistic entrepreneurial organization to a publicly financed collectivist organization.

Saskatchewan and Quebec wanted to establish rationally planned models of collectivist health care but they were not able to do so, in part because of professional unwillingness to make organizational changes. Saskatchewan was hindered by the constitutional challenges of other provinces at the Dominion-Provincial Conference on Social Reconstruction, 1945–46, and because delays in implementation led to medical resistance being built up. Quebec was unable to get enough support from the medical profession to develop its full range of Centres locaux des services communautaires (CLSCs) for about twenty years and is still meeting other resistances from the professional group. In both cases collectivist plans for organizational change were thwarted by the service deliverers with the technical power to deny the restructuring of their preferred form of organization.

After initial hesitations, the Canadian doctors agreed to become agents of collectivist redistributive policy relating the biomedical care. The medical profession was cajoled into providing access to medical services under the health insurance system, while the public was given assurances of a move towards providing universal and comprehensive medical care. As Daniel (1990), an Australian health policy analyst, has described it, there is a very "fragile consensus" between the medical profession and the governments on this issue of collectivist care. But Graycar and Jamrozik (1989) have pointed out that in *universal* service allocations of welfare states it is the professionals who are likely to benefit most. Tuohy (1986) has shown how the medical negotiators were able to strike good bargains at the time of entry into the health insurance schemes which left the doctors with considerable

autonomy and good control over orderly resource flow using a biomedical model.

The history of the development of formal authority makes it clear that politicians have had much to learn about how to make policies and bureaucrats much to learn about how to manage their sectors of the welfare state/society organization. The task which Canada took on in setting up a welfare state was not well understood by the federal government or by the provinces (or by other nations). Struggling provincial politicians were unsophisticated and naive and more anxious to please their own local constituents than to look at provincial (or national) social organization as a whole.

The exceptions to this general statement were to be found in the provinces of Saskatchewan and Quebec where politicians and bureaucrats had a clear idea of the goals they wished to attain and were willing to work together to establish good formal organizations. But neither was successful in achieving their aims because of the conflict between formal and technical powers.

2. What Were the Reasons for Resistance to the First and Second Stages of Organizational Development?

Marmor and Thomas (1971) and others have noted the doctors' success in controlling payment systems, physician supply and distribution, and some have remarked on the increasing growth of medicalization (or attempts at medicalization) where doctors were not required before, because physician supply has increased and doctors want to keep their incomes up.

Many years ago Glaser (1969) explored the advantages and disadvantages of different medical payment systems. Fee-for-service, a symbol of entrepreneurial freedom (Blishen 1969), has frozen medical care in an earlier time frame and so far there are no very satisfactory incentives for getting doctors to accept a different system of payment have been devised. They like to feel they are subsidized entrepreneurs, not employees of government (Hunter 1981). And it is not only a matter of the doctors' own incomes which create concern among the provincial government negotiators, but the costs of the services which they generate. In trying to get control over costs, most of the action to change medical practice is presently taking place in the hospitals (the secondary and tertiary care sectors where the governments have greater powers of control), not in the community-based sectors, yet the costs of diagnosis and treatment in doctors' offices (volume of services, tests and drugs prescribed) are steadily rising.

The "regional hierarchies" of medical service organization identified by Fox (1987) are well entrenched. The medical schools perpetuate this model of organization which emphasizes individual clients' medical care, not the

population oriented medical care required by a collectivist model. Efforts to overturn this model—to put primary care in a position of greater eminence—have been made since the 1920s, but have not yet succeeded. Family practice and public health practice remain low status occupations, despite efforts to bring about changes in perception among colleagues.

White and Connelly (1991) and others have attacked the medical schools' conservative influence, their failure to recognize the real needs in population health. Although the new medical schools started up in the 1960s have put more emphasis on family practice, there is still some concern about their lack of attention to health *system* goals.

Efforts to reform medical professional organization in order to make members more conscious of clients' interests, both as individuals and as a collectivity, and less concerned with their own needs, have not been very successful.[1] In fact the behaviour of most physicians fits well with the list of behaviours on the part of agency administrators who are not open to organizational transition. Coburn, Torrance and Kaufert (1983) examined medical dominance and the challenge by other groups wanting to make an organizational transformation (politicians, administrators, other health professionals and consumers). Despite minor losses of control over parts of the system, the doctors have had continuing success in keeping "a clear domain of high social importance" and "extended application and defence of their paradigm."

There have been no major changes in medical practice organization. There are still relatively few group practices. Community health centres (CHCs) have not been widely accepted as an alternative to the traditional practice model. There are a number of reasons for resistance to the development of CHCs. These organizational models came out of socialist traditions and have been resisted partly because of this. CHCs (and to some extent CLSCs) have by now been marginalized as belonging to the non-profit sector in inner cities and to rural areas where no real entrepreneur is keen to work. They exist, to a large extent, in high risk areas where the professionals are expected to deal, not only with clear-cut medical diagnosis and treatment, but with family violence, sexual abuse and other aspects of social maladjustment. Although there are other reasons for resistance to CHCs (such as payment systems or professional teamwork), the main objection has been

1 There have been some medical professional responses to public demonstration of concerns such as the Pickering committee of the Ontario Medical Association (1973) and the Watson committee of the Canadian Medical Association (1984), but a measure of self-interest is always visibly there.

to the existence of community boards. Medical professionals are not anxious to find themselves being told what to do by laymen. There is probably some confusion here about the distinction between policy making and management.

It is of interest that other alternative delivery modalities which might appeal to entrepreneurs — Health Service Organizations (HSOs) and Comprehensive Health Organizations (CHOs) — have been developed in Ontario, which was not wholeheartedly committed to collectivism between 1970 and 1990. Whether attempts to develop HSOs or CHOs will succeed is still unclear, but they may be successful, because the most open boundary of the medical profession is the referral system into the hospitals; the hospitals may want to cooperate in this matter, and attention has been paid to financial incentives. Other alternative forms of organization such as walk-in clinics do not appeal either to the traditional family doctors or to governments, only to the out and out entrepreneurs. Multiservice centres could improve horizontal coordination of support services, but apart from locating near diagnostic service centres and pharmacies, doctors do not seem much interested in becoming part of the multiservice concept.

Carrothers et al. (1991) have argued that professional resistances have affected the ability and willingness of governments to focus on organizational change. Instead of thinking about coordination and integration of services, they looked at "the regulation and remuneration of various types of health practitioners and the organization of the institutions of health care delivery" (p. 16) and not the system as a whole. They said: "The literature gives support to Tuohy's contention (1989) that debates related to health service reorganization and integration have remained 'peripheral' to the mainstream health care delivery system" (p. 16).

3. Identification of System Boundaries and Member Organizations

Despite the fact that Canada has shown commitment to a publicly financed health care system since the end of the Second World War, the medical profession seeks to maintain its separate bargaining position within the system and to look for advantages in private sector activities on the edge. Even after the passing of the Canada Health Act, 1984, it has never really been accepted by doctors that they are not subsidized entrepreneurs. There are strong feelings against community boards which may try to control their independent decision making. And as well, although the first step was to bring the medical profession to terms with a collectivist *medical* care system, the policies now are to bring the doctors into a collectivist *health* care system (for it is recognized that health care is broader than medical care alone), and this is very threatening to their technical authority.

One main theme in this book has been the inability of the groups involved in the development of a good organizational model for collectivist health care to see what are the boundaries around and within the system. We have argued that the health system cannot be understood without taking into consideration the concept of the welfare state and social programs as a whole because education, housing, income and support services all have an impact upon the health of citizens. But we have found that even within the health care system there is an almost complete lack of communication between hospitals and community care services and that the administrators and service providers cannot see beyond their own subsectors of the system.

We have spent some time considering the involvement of ordinary citizens. *Health Care: A Community Concern*? is the title of this book, and it has traced the ups and downs of consumer participation. There has now been a recognition that Canada cannot achieve optimal health for its citizens without ensuring their greater involvement in self care, neighbourly concern and policy development. It may take some time before all members of the public are willing to become involved in any of these activities, but many wish to be consulted and have a choice in actions taken to improve their personal health, to become less dependent upon experts and bureaucrats. Some would welcome opportunities to become involved in community networking. Perhaps only a few will be interested in taking full responsibility for policy making (Abelson et al. 1995), but there is a climate of change in this sector.

While all the western developed countries seem to be struggling with similar problems of trying to understand how to develop the optimal form of organization for their social organizations, Canada has a special problem with its shifting federal-provincial relationships. What are the boundaries of the welfare state(s) and the health care system(s)?

In 1945–46 the federal government was the strong force. It was able to offer grant aid to the provincial governments while balancing its budget. It had clear ideas about what it wanted to do. Although there are ten provinces with constitutional responsibility for social affairs, Saskatchewan was the only one among them which was planning its own program of collectivist care at that time. Today, however, the ten provincial governments have developed greater sophistication as legislators and have built up professional bureaucracies to support their activities.

Carrothers et al. (1991) said:

> A central and consistent feature of federal-provincial health policy debates since the 1940s is that they have involved conflicting ideas about the way in which accountability and responsibility for the management of health care services should be distributed between the federal, provincial and local levels of government ... health care

> policy debates have been pulled by two contradictory sets of ideas related to the centralization/decentralization of delivery system administration. The first set of ideas have been contained within the concept 'universal benefits' which ... depends for its success upon a strong central authority capable of establishing uniform terms or standards. The second set of ideas are related to 'regionalism' which supports decentralization of administrative authority as a mechanism for fostering programs designed to meet local needs. (p. 2)

Carrothers et al. (1991) discuss regionalization as having three dimensions — decentralization, geographic implications and rationalization. All Canadian provinces have been moving towards regionalizing their health services which will increase understanding of local issues and may help to bring costs under control.

Working Towards and Optimal Organization for Collectivist Care

There are at the present time questions about commitment to collectivism, but these are less urgent for most provincial governments than questions about how to improve the organization of social and health services. Most provinces seem to believe that regionalizing services would make them more comprehensible to the public, to service providers and to administrators and would enable them to be streamlined so that costs can be brought under control.

Summary

This chapter returns to the discussion of organization theory to consider the stages of development in the organization of collectivist health care. It was found that developments in the organization of collectivist health care have followed ideas present in the theory that there would be changes as there was a shift from individualistic to collectivist health care, that in time the model chosen would be questioned and a new model proposed.

Organization theorists have identified some problems in developing a new model of organization. How are good organizational transitions made? What resistances are likely to be encountered? There are likely to be problems in identifying system boundaries and memberships of the organization.

These issues were examined and it was found that there have always been difficulties in making a good organizational transition because of resistances by the technical power holders — the medical profession — who are not fully committed to collectivism. System boundaries have not been well defined and community members have been excluded until recently. As well, there has been a shift in power from federal to provincial authorities. Regionalization presently seems to offer the best prospects for making a good organizational change.

This review of the literature on community health services organization was started in 1990 and finished in 1993, but much has happened since then. It is important to discuss these developments.

Should Canada continue to defend a welfare state or a modification of the original idea — a welfare society? Krauthammer, an American neo-conservative writer, has said that the welfare state has been "a primary cause of the decline of society's mediating institutions," especially the family (1995). While James Q. Wilson defends capitalism which "produces greater material abundance for more people than any other economic system ever invented ... [it does have costs but] for people worried about inequality or environmental degradation, the question is not whether capitalism has consequences but whether its consequences are better or worse than those of some feasible economic alternative ... [The costs of capitalism must be weighed against its benefits]" (Wilson 1996, 113–14).

The United States, Great Britain and some other western developed countries have moved away from their earlier welfare state commitments, much further than Canada. Canada is still quite strongly committed to collectivist sharing, but has been pulled away from its earlier concern with the social minimum towards the support of capitalist developments by its attempts to keep in harmony with its near neighbours.

Canada is still a country which seeks to make compromises, to find balances between contending interests, to take a centralist position. Although there were value shifts even under the Mulroney government, as Moscovitch and Albert (1987) and others have spelt out, they were not enormous swings to the right.

The Liberal party was reelected to office in 1993, and in its Red Book (its pre-election statement of purpose) it said that it wanted to protect Canada's social programs from further erosion. But Canada is not an independent entity, it is part of the global economy, and as such, it has not been free to follow its own course in the way it proposed to do.

This afterword will trace the continuing cutbacks in federal provincial transfers which the federal government has felt forced to make in order to address the continuing deficit/debt problem. Then it will consider the steps provincial governments have taken to reform and restructure their health care organizations (for these are the social programs which are of greatest concern to Canadians). Finally it will ask: Where do we go from here? What can we see as the possible future of the welfare state?