ALTERNATIVE CARE DELIVERY SYSTEMS:
AN EMPIRICAL STUDY AND COMMENTARY

by

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ABSTRACT

The rising costs of health care and the lack of integration between parts of the delivery system has led to discussion and experiments on new forms of delivering care. Governments have included the development of ambulatory care in new statements of objectives and goals in the hope that expenditures might be reduced through the reduced use of acute care hospital beds.

This is a study of the experience surrounding an acute care hospital's attempts to have a Medical Day Care Program accepted by the government as an adjunct to the existing Ambulatory Care Services of the hospital.

As Director of Nursing at the hospital it was possible to follow the sequence of events, concept development, proposal design, ministry involvement, implementation and evaluation. A diary was kept for one year following implementation of the program as a pilot project and project documents have contributed to the analysis of events. What was not readily apparent were the many forces outside the hospital which were impacting on the likelihood of the proposal's acceptance.

Since Ambulatory Care was the health policy of the 1970's it was puzzling to find the Ministry of Health unresponsive to a proposal which seemed most appropriate.

In attempts to resolve the puzzle regarding the lack of interest in ambulatory care at the hospital level, other developments in the province were reviewed. Planning models were explored seeking explanation for inconsistencies observed between stated government objectives and government behavior in relation to the development of hospital ambulatory care. More satisfactory explanations were found in a political model than in planning models, in the light of actual developments.

Some conclusions are drawn about the impact of political realities on management functions in health care institutions.

CONTENTS

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CHAPTER I

INTRODUCTION

This is the study of the development of a Medical Day Care Program at St. Paul's Hospital, Vancouver, BC, especially as the development relates to the Ministry of Health's involvement. As Director of Nursing at the hospital, and member of the Executive Committee, it was possible to follow the decisions taken about introduction, development, and implementation of the program on the part of the hospital. A diary was kept for one year following the initiation of what finally was to be a pilot project, and supporting documents have been brought together to form a basis for analysis of events. What was not immediately visible to a Director of Nursing were the shifts in power and the changes in government policy which were necessary to explore to answer the question of this thesis: Since ambulatory care was the desired health policy of the 1970's in Canada, why has an apparently successful program failed to receive continuing government support?

The Context

Chapter II sets the scene. The Canadian Health Insurance program was developed between the mid 1940's and the late 1960's. The federal government offered a series of matching grants to the provinces to develop

publicly funded health care programs. British Columbia responded, accepting the federal offers. By the mid-sixties, however, concerns had begun to be expressed about the extent of the commitment to provide services and the methods for doing so. The extensive use of inpatient care in acute care hospitals began to be questioned and alternative methods of funding care and delivery of services were suggested. How the province of British Columbia has responded to its health care responsibilities in the area of ambulatory care is the content of Chapter III.

The Ambulatory Care Program

Once Ambulatory Care had been declared a 'good thing' several groups picked up the initiative to develop a variety of services which fit under the umbrella of ambulatory care. Some of the groups implemented programs, other groups attempted to facilitate development. At that time, the main provincial activity in this field seemed to be oriented toward hospital-based programs. The short-lived British Columbia Medical Centre and the Greater Vancouver Regional Hospital District were two bodies in B.C. which have played the role of facilitators of hospital ambulatory care programs. As individual institutions were motivated to develop programs, the field expanded. Government funding/support was, and remains restricted to a short list of procedural items and, more recently, block funding was provided for a

limited number of programs at one hospital.

However, the provincial Public Health Service had developed a Home Care Program over many years and in 1971 resources were directed into a hospital replacement program. It was aimed at direct substitution of expensive acute care hospital time with care provided in the patient's own home instead.

Five Community Human Resources and Health Centres were established during the NDP government of 1972-76 but further action in this area of development was abandoned when a Social Credit government was re-elected in 1976. The four centres which continue to exist have met initial expectations for less hospital usage, better accessibility and less costs. (See Chapter III) Reasons for not pursuing this successful option remain a matter of speculation.

One manpower substitution project demonstrating the effectiveness of the nurse practitioner was the only provincial activity in this area of potential cost reduction. Findings were similar to those of other projects, (See Chapter II), conducted across the country. Despite positive results, this development has died for reasons which probably relate to the medical control of health care delivery.

Arriving on the scene at a much later date, but having a strong influence on further Ambulatory Care developments including hospital based programs, was the Long Term Care Program (LTC) introduced January, 1978. Introduction of the program recognized the need for chronic care in the province. It was expected to relieve the problem of families caring for their elderly members and to place people requiring institutional care into more appropriate, i.e., not acute care, environments. The program was expected to consume 15% of the health care budget.

Even so, it has not met the demonstrated need. Presumably the expense of this program, as well as maintaining other services, has brought about the government's intense concern about fiscal control. Most ministry activity is now focussed on tighter control; with cutbacks in inpatient and ambulatory care, 1981 allocations to hospitals are less than the inflation rate. Investigations of financial management of the larger hospitals are ongoing. The LTC program has oriented the public toward institutional care although the stated prime purpose of the program was to assist people in their homes.

The Pilot Program at St. Paul's Described

Chapter IV is an account of the evolution of the Medical Day Care Program at St. Paul's Hospital.

In response to an internal need and a British Columbia Medical Centre commitment, the hospital sought government support of a new ambulatory care program in 1976. The program was designed to alleviate the hospital's high occupancy problem as well as to contribute a less expensive care delivery option to the community. The proposal was accepted as a one year pilot project only, but three years later no government evaluation has occurred.

The Question

Chapter V raises the question of the inconsistencies between stated government objectives and actual behavior, in relation to ambulatory care generally. Why did the government appear to support the development of ambulatory care programs and then withhold support for two years from St. Paul's proposal, accepting, in the end, only a pilot project?

Analysis

Planning models are considered in Chapter VI. They proved inadequate to explain the St. Paul's situation. Decisions are constantly made on the basis of misinformation, false images of the world and, in the absence of crucial information which may or may not exist. Options studied are not all those possible but a selected few that decision-makers choose on political

grounds. Planning is a process used to control development in the manner desired by those with power.

Ad hoc and inconsistent purposes in government encourage 'game playing' and competition between institutions and agencies which rely on government for funding. Tracing the progress of issues through the political system provides more satisfactory explanations for the circumstances observed in British Columbia. This process is described in Chapter VII using the Hall et al model which organizes the process into the areas of legitimacy, feasibility, and support. Although each issue travels an idiosyncratic route, the characteristics described do apply to each issue in a lesser or greater degree.

Chapter VIII provides a summary of the conclusions which have been drawn from personal experiences as a health care administrator in B.C.,at the hospital level, exploration of events related to the development of ambulatory care in B.C. and, from attempts to apply planning and political models to explain the situation.

This partly entrepreneurial, partly government controlled health care business demands that a successful manager understand and learn how to negotiate the maze resulting from conflicting ideologies, fiscal constraints, and power brokering.

CHAPTER II

THE HISTORICAL CONTEXT OF AMBULATORY CARE IN CANADA

The British North America Act of 1867 makes little specific reference to health care, which is understandable, since the Act was written in a time when government involvement was restricted to responses to emergencies. For the most part, individuals relied on their own resources or those of their family. Hospitals of the day were administered and financed by charities, voluntary and religious organizations, to carry out their philanthropic objectives.

The Act is very unspecific about jurisdiction but through tradition and court decisions the provinces have been given the responsibility for health care. At the beginning this was a matter of regulating standards. However, the Canadian National Health Insurance program was developed between the mid 1940's and the late 1960's. Through this, the federal government offered a series of matching grants to the provinces to develop publicly funded health care programs.

Government intervention into the provision of sickness care[1] has brought with it a peculiar set of

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[1]The phrase 'sickness care' is used because it is more correctly descriptive of the services supported through early federal funding.

problems. Policies instituted have had some positive results but have also proven to have some unforeseen negative consequences. By the mid-sixties, concerns had begun to be expressed about the extent of commitment to provide services and the methods for doing so.

In Canada, as in the United States,[2] acute care hospital beds were overbuilt and this generous availability of beds has led to usage which would not have been necessary except that the beds were available. The Hospital Insurance and Diagnostic Services Act of 1958 focussed on incentives which promoted the use of hospital beds. This legislation provided federal funds on a matching basis with the provinces to cover almost all operating costs of acute care hospitals which had been constructed across the country with federal funds granted through earlier legislation.

The extensive use of inpatient care in acute care hospitals began to be questioned and alternative methods of funding care and delivery of services were suggested. Several reports and commissions, federal and provincial, proposed means by which the health care system could reduce expenditures without endangering the public health and well-being. The 1964 Royal Commission on Health

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[2] Robin E. McStravic, "A Case For A Hospital Census Variation and Bed Needs Formula," American Journal of Health Planning, (April, 1978), 51.

Services stated that an unnecessarily large volume of care was being provided to inpatients which could equally well be provided at lower cost to outpatients.[3] The Commission recommended that hospitals become involved with development of home care programs to free beds and reduce costs, and to encourage this development the Commission recommended the Act be amended to require outpatient services as a condition for further payment of inpatient services. In Volume II the Commission expresses the expectation that outpatient and home care services will be hospital associated.[4]

The federally appointed Task Forces of 1969[5] were to determine means by which health care would remain of high quality and access with improved availability but with reduced expenditures. The recommendations of the Task Forces can be summarized as;

1. change federal-provincial cost sharing mechanisms
2. increase outpatient (ambulatory care) activities in order to reduce dependency on hospital inpatient services
3. use less expensive manpower wherever possible

It was not until 1977 that the cost sharing mechanisms were changed and replaced with the Established Program Financing Act.

The Task Force on Operational Efficiency described

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[3]Canada. Royal Commission on Health Services, Ottawa, 2 vols. (1964), p.13.

[4]Royal Commission (1964), 65

[5]Canada. Task Forces Reports on the Cost of Health Services in Canada, 3 vols., Ottawa, 1969.

the hospital of the future as an ambulatory care centre with inpatient beds attached. The hospital's major service should be ambulatory care including multiphasic screening, preventive services, diagnostic and treatment services, and a network of relationships with other health care programs. It was suggested that the hospitals would operate satellite units of various types.[6]

The Task Force on Beds and Facilities[7] recommended the development of a 'broad range' of ambulatory services in order to reduce the actual treatment bed ratios. This task force also suggested the possibility of satellite arrangements. It is the only task force that referred to the possibility of a community health centre when it suggested that needs of an area should be reviewed and consideration given to erecting a Community Health Centre rather than a hospital.[8]

Several competing possibilities evolved from these recommendations. Federally financed investigations of ambulatory care (The Community Health Centre Project 1971-72) and manpower substitution (Report on Nurse Practitioners 1971-72 and Physicians' Assistants 1971) followed.

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[6]Task Force on Operational Efficiency (Vol. II,1969), 136.

[7]Task Force on Beds and Facilities, 275

[8]Task Force on Beds and Facilities, Recommendation 19.

Federally Funded Experiments

Community Health Centres

The concept of one establishment combining primary medical care and organized preventive services was first formulated in the report of the Consultative Council on Medical and Allied Services meeting held in England in 1920.

In Canada, some more recent major reports have specifically recommended the establishment of Community Health Centres (CHC). At the federal level, the Hastings Report[9] at the provincial level, the Castonguay-Nepveu Report (Quebec),1970,[10] the Manitoba White Paper,1972,[11] the Foulkes Report (B.C.),1973,[12]. The Mustard Report in the Province of Ontario,1974. agreed that CHCs were a goal but that they were not the immediate solution.[13] The report stressed more control and planning in the proposed reorganization but not necessarily the CHC concept of bringing all services together.

Despite the recommendations and federal incentives to

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[9]Canada. Department of National Health and Welfare. The Community Health Centre in Canada, Ottawa, Information Canada, 1972 and 1973.

[10]Quebec. Commission of Inquiry on Health and Social Welfare. 1970-71.

[11]Manitoba. White Paper on Health Policy. July,1972.

[12]British Columbia. Health Security for British Columbians, Report of Richard G. Foulkes to the Minister of Health, December 1973.

[13]Ontario. Report of the Health Planning Task Force, January 1974, p.15.

change pilot projects in many provinces continue to be pilot projects.[14] The experience with CHCs in Quebec and B.C. (which is better documented than that of the other provinces) is described further in the next chapter and in Appendix I.

Nurse Practitioners

In response to the Boudreau Report[15] federal funding for demonstration projects of nurse practitioners' work was made available through National Health Research and Development Programs to determine the validity of substituting prepared nurses for family physicians in some portions of the delivery of primary care. A number of such studies were conducted across the country, in Ontario, in British Columbia, and later, in Newfoundland.

Projects in Ontario were conducted by McMaster[16] and Queen's[17] Universities. The two universities prepared the

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[14] Suggestions by the Federal Government to provide incentives for development of alternative modes of health care delivery (Thrust Funds) were not accepted.

[15] Canada. Report of the Committee on Nurse Practitioners, Department of National Health and Welfare, Ottawa, 1972.

[16] W.O. Spitzer, et al. "The Burlington Randomized Trial of the Nurse Practitioner." New England Journal of Medicine, (January 31, 1974), 251-56.

[17] R.E.M. Lees, "Physician Time Saving by Employment of Expanded-Role Nurses in Family Practice." Canadian Medical Association Journal, (April 1973), 871-75.

nurses and then conducted a number of different studies during the project's lifetime. In British Columbia, UBC developed a continuing education program for nurses and funding was provided to the Victorian Order of Nurses to carry out a study.[18,19] Memorial University in Newfoundland conducted the most recent studies.[20]

General findings were similar, - more primary care services were provided; doctor time was saved; nurses were able to take over between 60-70% of the doctor's responsibility; a shift occurred from the hospital to the community for location of services; there was no measurable change in quality of care; the care was acceptable to patients; doctors and nurses were satisfied with the arrangement. But, most importantly, the arrangement was not financially profitable for the doctors and therefore gained little support from that quarter. In isolated instances the project doctors and nurses continued working together but, generally, the concept of a prepared nurse substituting for a family physician is not functioning excepting, of course, in those areas where doctors choose not to practise, namely, the outposts of the country.

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[18]Canada. (Grasset), Department of National Health and Welfare, Attaching a Visiting Nurse to a Group Medical Practice to Change Hospital Stay Patterns, NHG 610-20-6, June, 1975.

[19]Programs for the preparation of outpost nurses have long existed at the University of Alberta (Advanced Obstetrics) and Dalhousie (Outpost Nursing). See Appendix II for University of British Columbia course outline.

[20]L.W.Chambers and A.E.West, "The St.John's Randomized Trial of the Family Practice Nurse:Health Outcomes of Patients," International Journal of Epidemiology (1978) 7:153-161.

Outcomes of the Pilot Projects

The goals of manpower substitution and increased use of ambulatory (primary) care through CHC to control health care expenditures have essentially died in this country. The prime cause for this outcome has been the indifference or active hostility of the medical profession. There was simply insufficient advantage to the profession in either possibility and both caused too much change in established modes of practice.

Hospital Ambulatory Care Programs

Hospital-based ambulatory care programs have had a greater degree of success probably because the hospital is an established and familiar health care resource both to the public and doctors. Power has lain with hospitals rather than with other components of the health care system and so hospital needs (this includes medical practice needs) are addressed first within the system.

Federal-Provincial Funding Changes

These experiments were conducted in the period 1969-1977 when negotiations were on-going between federal and provincial governments regarding changes in the cost sharing formula for health, education and welfare services.

When the new agreements were reached, the provincial governments were freed from having to observe the tightly

written rules of the Hospital Insurance and Diagnostic Services Act,1957. The block grants made available by the Established Programs Financing Act, 1977, permitted the provincial governments to develop programs outside the system of care which had been developed up to then. By this time most provinces had become aware of the gaps between the separately funded programs, particularly relating to the care provided for the elderly, the handicapped and the chronic sick. Introduction of the new funding formula, it was hoped, would redress the balance in the existing system of provision a) towards ambulatory care, b) towards gap filling, but power had passed from the federal government to the provincial governments who were now responsible for taking initiatives in the development of programs.

The redesigned federal provincial funding arrangements of 1977 have included the Extended Health Care Services Program which provides block funding contributions to the provinces in order to provide them with greater flexibility in the identification, implementation and development of health services such as nursing homes, intermediate care, adult residential care, converted mental hospitals, home care (health aspects) and ambulatory care which are complementary to existing funded services.

CHAPTER III

PROVINCIAL ACTIVITY IN AMBULATORY CARE

British Columbians, until recently, were reluctant supporters of government intervention in the provision of health care. The governments maintained only public health, mental health, and public assistance programs with the provincial funds. Until 1973, public assistance programs were funded by municipal governments. Between 1920 and 1948 successive Liberal governments had tried to introduce one version or another of prepaid health insurance schemes without success. In fact, the Liberal government of 1952 was defeated over a proposed compulsory hospitalization insurance scheme.

The inadequacy of this provincial, municipal, and private sector activity and the timely arrival of the federal government cost-sharing programs of 1948 finally involved the provincial government in funding more services but there was still a reluctance to take direct control.

Succeeding Social Credit governments primarily delegated responsibilities for health and welfare to municipalities, voluntary organizations and professional associations. Hospitals and doctors were still expected to manage their own activities. In consequence new services which were developed were usually initiated by institutions or doctors. Under the revised Hospital Act of 1960 hospitals

continued to be voluntary organizations subsidized by government responding to local need.[1]

British Columbia accepted the hospital construction support (1948) of the federal government and then, in 1958, accepted also the support offered through the Hospital Insurance and Diagnostic Services Act. Emphasis was placed on hospitalization as the primary means for care delivery. Also, the late development of the BC Medical School in 1951, on a 'specialist' teaching model, seriously deferred the absorption of ambulatory care into provincial models of health care delivery. Physicians found the specialist hospital model of care favorable to themselves and the public has come to equate good care with medical advice and hospitalization.

In the sixties, even before the introduction of the Medical Care Program of 1967, the last of the federal-provincial matched grant programs, there was concern about the rising costs of health care. At the provincial level, the Social Credit government introduced Regional Hospital Districts in 1967. The regional districts were to be responsible for hospital facility construction (acute and extended care). They were given limited budgets.

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[1]It is only in 1980 that a government financial discussion paper has proposed that hospitals should become 'public bodies' under more direct control of the province. Whilst this concept has been set aside, it may well resurface in the next few years.

This arrangement enabled the provincial government to limit capital developments - construction and equipment - through a buffer group which managed 40% of the local expenditures and which would presumably apply priorities. However, limiting operational expenditure was much more difficult. The government continued to negotiate directly with each of its 120 hospitals through the Rate Review Board and other mechanisms.

Planning as part of a political ideology has been identified most strongly with socialism.[2] During the single term of the New Democratic Party government in BC (1972-76) centralized planning was introduced in the health care field and system-wide changes which demonstrated this policy were initiated.

Dr. R. G. Foulkes, a staunch party member, was engaged as a consultant to work with the Minister of Health to develop a master plan of health care for the province. Before this was published, however, certain steps had already been taken to change directions. A consortium of teaching hospitals was set up as the British Columbia Medical Centre and a Development Group was formed to review the potential of community health centres.

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[2]Maurice Spiers, Techniques and Public Administration, (Fontana, 1975) p. 155.

British Columbia Medical Centre

The BCMC was established as a corporation in 1973 to operate a medical and health sciences centre for the province, in Vancouver. Facilities affiliated with the centre included the Vancouver General Hospital, St. Paul's Hospital, Shaughnessy Hospital, Children's Hospital, the BC Cancer Institute, the G. F. Strong Rehabilitation Centre, and the University of British Columbia Health Sciences Centre Hospital.

The corporation comprised a Board of Directors of twelve persons appointed by the Lieutenant-Governor in Council and included professional and business people from the community. The Board was responsible for the co-ordination of planning for the hospitals but had direct operating resonsibility for the Shaughnessy Hospital which was transferred from the Federal to the Provincial Government in July, 1974.

Institutions affiliated with the Centre were to have integrated services with a total of 2,850 acute, activation, and rehabilitation beds. Each institution had a special role to fill in the integration of services, e.g. St. Paul's Hospital was to be a 600-bed facility and was to become the major ambulatory care centre. The VGH was to have been a 970-bed institution providing the major trauma, emergency, and surgical services, the surgical role being heavily emphasized.

All the hospitals named would have to submit changes in program and future proposals to the Board. The Board also had the authority to coordinate and integrate educational programs in the health field and to establish policies and directions for educational programs after consultation with the hospital or educational institution but only with prior approval of the Lieutenant-Governor in Council.

A number of committees were struck to facilitate the work. One of these was the Ambulatory Care Committee formed in March, 1975. The committee's purpose was to "look into the problems of ambulatory care and to offer some recommendations regarding future changes."[3] The committee's recommendations included a plea for a "basic framework of overall direction and policy."[4]

By this time there was a strong pressure to change the direction of the medical school towards the Health Sciences Centre model[5] (the emphasis being on teamwork) and community centred medical care (not hospital centred care). It should be noted, however, that in BCMC

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[3]Ambulatory Care Services in the BCMC Progress Report, June 10, 1975.

[4]Ibid. p. 10

[5]The Health Sciences Centre model has since been introduced at the University of British Columbia.

discussions of ambulatory care were based entirely upon the medical model of care delivery, completely omitting any recommendations about involvement of other health professionals in new roles.

With the change in government in 1976 the BCMC was disbanded and the health care system returned to the operational design which existed during the previous Social Credit governments. Many health systems managers supported the concept of BCMC because of its potential for reducing competition between hospitals and improved co-ordination of services to the immediate community and the province. The medical profession was less supportive.

Hospital Based Ambulatory Care: The Arguments For and Against

Resulting from the discussions of need and the positive contribution that alternative care can bring to the health care delivery system, hospitals began to see a role for themselves[6] in this form of care delivery in the early 1970's. American hospitals with low occupancy and threatened resources began turning to a variety of alternative care programs.[7]

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[6]Convention Reports, Hospitals, Oct. 1, 1978, pp. 128-129.

[7]Mark Tager and Charles Jennings, "Hospitals now are discovering wellness", Seattle Times, February 10, 1980.

Some U.S. authors promote the idea of the hospital becoming the community health centre or the control for satellite centres. It is suggested that the hospital should be the vehicle for reorganizing the health system. They view the hospital as the centre of total health care for the community, coordinating a variety of care programs for patients, education programs for health professions, service programs for the community, with affiliations to medical schools and clinical research. A number of Canadian hospital administrators reacted to the Community Health Centre project report arguing that such service should be provided through hospital outreach.

These authors[8,9] predict that the hospitals will and should expand services and will be viewed as responsible for total health care delivery rather than as providers of acute and emergency care. Foulkes thought the community health centre could be part of an acute care hospital allowing close relationships and shared services.[10]

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[8]J. D. Wallace, M.D. "Hospitals and New Perspectives in Health Care", Hospital Administration in Canada, March 1976, p. 18.

[9]Peter F. Hart, M.D. "Primary Care: the Hospital Perspective", Hospital Adminstration in Canada, February 1976, p. 16.

[10]British Columbia. Health Security for British Columbians, Report of R. G. Foulkes to the Minister of Health, December 1973, II:1-3.

It seems the public has already accepted this role for the hospital by the extensive use of Emergency Departments for primary care instead of a doctor's office. Emergency is one service the public has available without the use of a professional "gatekeeper." Cugliani adds that the scarcity of physicians in undesirable locations contribute to the use of emergency departments for primary care.[11]

Interviews[12] with several Chief Executive Officers of hospitals in Canada indicated that the use of Emergency Departments for primary care was not seen as an abuse. Those hospitals with less business than capacity were agreeable to this use of their facilities; those with busier departments thought public expectations must be met, and the remainder were so busy few patients sought primary care in the Emergency Department. The C.E.O.'s thought that availability and accessibility of physicians affected usage and in some cases patient preference explained the usage.

In 1975, M. Lalonde, Federal Health Minister, encouraged the Canadian Hospital Association membership to undertake education in family planning, safety on the road, at home,

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[11]Anne Cugliani, "Patterns of Hospital Based on Ambulatory Care", Social Science and Medicine, (Vol 12), 55-8.

[12]"Is Emergency Abuse a Problem?" Health Care, January 1981, p. 13.

at work, and on nutrition.[13] In other words, to become a CHC and to emphasize preventive measures.

The Canadian Council on Hospital Accreditation has also recently legitimized the development of hospital based alternative care with the survey guidelines for ambulatory care centres.[14] One of the six criteria which must be met is that the centre must have a functional association with a hospital or other structured health care agency such as a government service or a health care organization. As of October 1980, ten centres in Canada have been accredited by the council.

There can be some advantages to such developments. Expanding already recognized care centres will improve the possibility that both the public and the medical profession will make the necessary adjustments and use the services. There would be no need for a complete change of long standing habits. In fact, new concepts may be more easily accepted in familiar surroundings, e.g. health promotion programs.

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[13] "Ottawa to promote improved lifestyle - Lalonde tells CHA." Hospital Administration in Canada, July 1975, p. 6.

[14] Dr. A. L. Swanson, "Report from the Canadian Council on Hospital Accreditation." Dimensions in Health Service, November 1980, p. 36.

Initial capital costs may be less if new facilities are unnecessary and existing facilities may contribute to the specific characteristics of the services offered, for example, Emergency Department services might emphasize primary care, becoming Ambulatory Care Departments. The hospital's technical and organizational skills are available to the developing ambulatory care programs resulting in lower start-up costs.

Not everyone feels hospital based development is advantageous. The University of Ottawa, School of Hospital Administration, puts forward these major disadvantages:

1. perpetuation of inpatient primacy
2. difficulty dividing cities into hospital service areas
3. failure to recognize that ambulatory care relationships ought to be primarily with the community and with other social services.[15]

The developments in Quebec demonstrate interesting differences of opinion between the community workers and the government about the purposes of the CLSC and the resultant difficulties of the centres attached to hospitals.

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[15]School of Health Administration, "Community Health Centres", University of Ottawa, January 1972. (mimeographed)

The hospital centre (HC) - local community service centre (CLSC) has been developed in those regions where low population density and distance from major centres requires such a development. Since implementation of this organization, there has been conflict between the centres and the hospitals and the community about purpose so that the CLSC are calling for complete separation. In the fall of 1976 the Ministry of Social Affairs commissioned Clermont Bégin to study the situation.[16] Findings led to the conclusion that there were many basic differences between the values, technologies and the structure of social organization of the two components and that the capacity for integration was not present if the CLSC was determined to maintain its community action role as foremost.

Home Care: A Public Health Initiative

From the beginning of the twentieth century, the Victorian Order of Nurses has provided a district nursing service in most of the larger cities of Canada. When this type of care began to be demanded outside these cities, the public health service assumed more responsibility in the area of home nursing.

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[16]Clermont Bégin, "Can the HC's and the LCSC's Co-exist?" Canada's Mental Health, Vol. 25, December 1977, p. 11.

The federal government has been interested in home care since 1949 when demonstration grants were made available to the provinces for program development.

British Columbia home care services were developed by the provincial Public Health Service from 1940 onward. In B.C. fifty percent of the clientele of the Home Care Program come directly from the community with the goal of preventing admission to hospital. In 1971 this type of service was extended into a hospital substitution program in order to facilitate earlier discharge of inpatients and to promote the use of day care surgery.

The first category of care, Non-hospital Replacement, provides professional nursing care and some physiotherapy service at no direct charge. Other support services, e.g. physiotherapy, are coordinated by program staff but payment is the responsibility of the patient. The second category, Hospital Replacement, comprises services provided at no direct charge to the patient and includes visiting nurse service, physiotherapy, visiting homemaker, Meals-on-Wheels, transportation, medications, medical supplies, equipment and other services as indicated. The patient's eligibility for this range of services is limited to the number of hospital days replaced as determined by the liaison nurse. The services provided in either category are not intended to relieve persons and families of any functions which they can or should provide.

Requests for service may originate with the patient, the patient's family or physician, Long Term Care Program, local hospitals, or other community agencies. The attending physician must be aware and must continue his/her responsibility for the direction of the medical care of the patient while on the Home Care Program. Patients are selected for admission to the Home Care Program on the basis of individual assessment. If the patient does not meet admission criteria for either category they may be referred to the Long Term Care Program for placement. According to the Ministry, the program is available to 80-90% of the population, i.e. those who live within reasonable distance of a public health office although each location may not have a comprehensive range of services available.

Governments have viewed home care programs as cost effective in the use of public funds, disregarding the added costs to individuals and families, and as a means to reduce acute care bed usage. Evaluations of cost effectiveness are usually made on a cost-substitution basis. Direct comparison of home care and hospital costs is difficult. Home care costs can be determined relatively easily since the care received is made up of distinct services which have been costed previously. Hospital costs are presumably reflected in the per diem allocation and the average cost per day multiplied by the number of days equals hospital costs but home care does not replace the intensive and

expensive days of hospital care. It would apply only to the convalescent, much less expensive days near the end of the hospital stay.

The Greater Vancouver Regional Hospital District Report on Home Care, 1973, proposes, firstly, that Home Care offers substantial savings in operating costs over hospital costs for the end period of hospitalization, i.e. the 'housekeeping' aspects of the hospital costs which are borne by the family at home. Secondly, the report also states that the shortened hospital stay resulting from the Home Care Program will reduce the need for acute beds and therefore will result in reduced capital costs. Thirdly, the shorter stay and higher turnover of patients will result in greater per diem costs of operation of acute care beds because of the greater cost involved in the early days of hospitalization.

The Home Care Program has had some major limitations from the view of the hospital staff; for example, the notification of discharge is expected to be received by the liaison nurse 48 hours prior and no referrals are accepted on the weekends. These restrictions force either a lengthened hospital stay or a situation where no assistance is available to the discharged patient.

The 1981 funding allocations to the Home Care Program will result in a significant cutback in the number of hours of care available to patients already on the program and waiting lists will expand for those not yet on the program. One would suspect that the result of this

situation will be an increased use of acute care hospital beds for patients previously maintained in their homes, when families become unwilling to absorb the reduction in service.[17]

The expanding capability of medical technology is assuring that the need for acute care beds will remain high. The hospital with high occupancy problems is also the sophisticated hospital which offers high technology and the accompanying expertise. This hospital is very unlikely to experience a lessening in bed usage through the existence of a home care program although a high user of the service.

Long Term Care Program

Varieties of long term care have been provided over the years through many programs and services ranging from the Workers' Compensation Boards aimed at rehabilitating workers following illness or injury, the acute services of Renal Dialysis to the Home Maker services available to the elderly or otherwise disabled and could include the numerous voluntary organizations providing services to groups of people with specific health problems.

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[17]Sixty percent of the Home Care Program patients are over sixty years of age.

Following the changes in federal-provincial funding arrangements in 1977, Mr. J. Bainbridge, Deputy Minister, was commissioned to initiate a major new government policy, Long Term Care. Effective January 1, 1978, residents of British Columbia became eligible for a government sponsored Long-Term Care Program. The definition of the program as presented by the Ministry of Health is:

1. Long-Term Care is a continuum of care services for those people who are unable to live independently without help, because of health related problems, which do not warrant admission to an acute hospital.
2. Long-Term Care Program will range from home support services and personal care to the more intensive care services provided at the intermediate and extended care levels.[18]

Administration of a number of separate Acts have been pulled together under the Provincial Adult Care Facilities Licensing Board. The Administrative Services Division of Hospital Programs was charged with the review of the existing legislation with a view to developing new legislation specific to long-term care.

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[18]British Columbia Ministry of Health, Introduction to the Program for Long-Term Care, January 1, 1978.

The point of entry into the Long-Term Care Program (LTC) is through the Long-Term Care Adminstrator in the Public Health Unit servicing the community in which the applicant resides. Applications for placement may be initiated by physicians, public health nurses, social workers, and others who may have knowledge of a need.

The primary aim of the Long-Term Care Program is to permit that segment of the population who qualify for benefits to remain in their own homes amongst their own families when desirable and practical. When the former is not possible, the individual will be placed in an approved community care facility, or admitted to an extended care hospital, whichever is appropriate. Where possible this accommodation will be in the individual's own community.

The types of services and facilities available through the program are:

1. care in mental health boarding home
2. home support service
3. care in a personal care facility
4. care in an intermediate care facility
5. care in an extended care hospital[19]

There is a charge of $10.50 per day for any institutional care and home support services are paid for on a graduated scale in accordance with the recipients' means.

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[19]These categories of care were defined in a classification document published by the British Columbia government in September, 1973.

Initiatives for developing facilities and an appropriate range of services is expected to stem from the community, but the Community Care Facilities Licensing (Adult) Board is responsible for total coordination of the program. The GVRHD is responsible for construction of acute and extended care institutions in Vancouver Metropolitan area. The autonomous provincial Long Term Care Program is responsible for developing personal and intermediate care facilities. This separation of control is of concern to the GVRHD because of the resulting coordination difficulties. Recommendations to consolidate all facility planning under one body will be forwarded to the Ministry of Health from the GVRHD Hospitals Committee in the near future.

Response to introduction of the LTC program was overwhelming. Home support services and institutional care were taxed beyond possibility almost immediately, and hundreds of names were placed on waiting lists. Media announcements of the new program were quickly withdrawn. It seems likely that planners had not adequately assessed the need or resources required.

The most severe repercussions of these developments was the impact on acute care facilities because inadequate facilities for personal, intermediate and extended care existed to meet the sudden and overwhelming demand which surfaced. Distinctions between long term care facilities and acute care facilities faded or perhaps were never established in the

minds of those who heeded the promise of the politicians that care would be available to all. Elderly people admitted to acute care facilities are simply never discharged. Many of these patients require care that some families are unable to provide but many others come from families which are unwilling to keep elderly family members in their homes despite home support services.

The proportion of 'placement patients'[20] in the patient population of the two tertiary care, referral hospitals in Vancouver has grown to a constant 20%. Both hospitals have had severe problems meeting their acute care mandate under these conditions as well as having grave concerns about the ability of nursing staff to cope with these very time-consuming but not acutely ill patients. Expensive registered nurse time is not usually required for these 'placement patients' so acute care hospitals have, in some cases, reorganized nursing units to consolidate these patients in a single area where appropriate staffing can be introduced and attempts made to provide more appropriate environments. The hospitals are concerned about the costs of these unit changes and about their permanency since most acute care hospitals wish to restrict their activity to acute care.

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[20]Patients requiring placement in a long term care facility.

Some principles under which the LTC Program operates have exacerbated the situation in acute care hospitals. People in the community, i.e. outside acute care institutions, are given priority for placement over patients in the hospitals which leads to situations in which patients remain in acute care hospitals from 3-9 months before placement or death intervenes. Also, the program promises placement of choice. Therefore, when a bed becomes available it can be refused as undesirable. Abuses of the system abound and are particularly evident in the use of the acute hospitals to get "granny" into the institutional system and out of the home.[21]

In June 1981, the Ministry of Health's allocations to the home support services in the province were inadequate to maintain current services. Reductions in the hours available to individuals will, without doubt, place even more people into the acute care hospital system.

Long Term Care facilities are under construction throughout the province but in the face of a waiting list of approximately 1200 names in the Lower Mainland, the 400 additional beds to be available by fall, 1981, will not make any significant reduction in the acute care

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[21]Stories of abuses are not uncommon among physicians, assessment, liaison and hospital nurses.

hospitals' involvement with long term care. The government's costs for maintaining the LTC Program are probably considerably more than projections and would help to explain the recent activity of the Treasury Board within the Ministry of Health.

There are some presumably serendipitous results which have developed since introduction of the LTC Program (1978). Acute care hospitals are required to notify the Ministry of each patient who no longer requires acute care but remains a patient in an acute care facility. Reduction of bed usage by acutely ill patients and increased use by long term care patients, along with the required notification of BCHP[22] of the long term care patients leads to significant downward per diem funding readjustments. The annual operating allocations received by acute care hospitals have recently included a specific number of long term care patient days which are remunerated at a lower per diem rate.[23]

The compromised admission possibilities for acute and elective patients and the concern about diminishing 'teaching

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[22]British Columbia Ministry of Health, Circular letter 79/10, March 2, 1979.

[23]The acute care per diem at St. Paul's Hospital in 1980 was $232.40; the long term care per diem was $37.80.

material' for the medical student's clinical learning is contributing to physicians leaving the staffs of the severely affected hospitals. With the large number of additional acute care beds opened recently, or opening soon, such realignment is in the Ministry of Health's and the new hospital's favor. The new hospital can become fully functional more quickly. Unfortunately, it may also undermine the quality of care in the older hospitals.

Experiments in Hospital Ambulatory Care in B.C.

Ambulatory care services as provided by hospitals in British Columbia usually mean a service provided without admission to a hospital bed, within one day and controlled by the attending physician. These services are simply an extension of the traditional core model, not incorporating any of the innovative features suggested in the studies and reports described previously.

Work done in Ambulatory Care in the Vancouver area has focussed on hospital-based programs, too. St. Paul's and Vancouver General Hospital have developed similar programs; Lion's Gate Hospital has introduced a slightly different approach, but all remain medically controlled. The Greater Vancouver Regional Hospital District has, through several attempts, continually promoted hospital-based ambulatory care programs. More recently, the University Council of Teaching Hospitals has shown interest in controlling development of ambulatory care.

The Greater Vancouver Regional Hospital District:

Activity in the Early '70's

The Greater Vancouver Regional Hospital District (GVRHD) has sponsored several attempts to explore and encourage the provision of care on an ambulatory care basis. In March, 1973, a Day Care Facilities Study Group was formed to study and examine all existing and potential Day Care Services in terms of service components, space requirements, and to develop standards and specifications. The Group's recommendations can be summarized as:

1. Day Care should be renamed Ambulatory Care and Treatment Services (ACTS)

2. Facilities for ACTS should receive urgent priority at all levels of health care administration in the province.

3. All new construction and reconstruction should include facilities to provide ambulatory services in keeping with the defined role of the hospital.

Lions' Gate and St. Paul's Hospitals' ambulatory care developments were, presumably impacted by the positive nature of the 1973 study group's recommendations.

Lions' Gate Hospital

The Lions' Gate Hospital in North Vancouver, B.C. has been active in attempting to develop a specific Ambulatory Care Centre.[24] From 1969 to 1973 members of the

[24]Valerie Young and Lorna Romilly, New Models in Ambulatory Care, Dimensions in Health Service, June 1981, p. 17-19.

medical staff pressed the Ministry of Health to support the establishment of ambulatory programs on the basis of a lowered length of stay for inpatients and of inpatient replacement days, i.e. direct substitution.

Within the expansion and redevelopment of the hospital an Ambulatory Care Centre was completed in December, 1979. The programs are typical of hospital-based ambulatory care, i.e. medically controlled. All patients are referred by their attending physician and the programs are restricted to a specific diagnosis, problem or procedure. To overcome some sensitivity and hesitancy towards the use of the services, since some physicians, especially general practitioners view them as competition, the voluntary/elected directors of each program are sometimes general practitioners.

Funding to the hospital is restricted to the established list, $2.00 for the unlisted services such as Chemotherapy, is paid by the patient. There is block funding for the Rehabilitation, Chronic Obstructive Lung Disease, Asthma, Back Problems, Stroke and Parkinson's Disease Programs. Lions' Gate Hospital does not maintain large indigent primary care clinics as do Vancouver General and St. Paul's Hospitals.

Lions' Gate Hospital has initiated program evaluations using the criteria of patient benefit and cost effectiveness. Ironically, funding for the evaluation is being sought from sources other than the Ministry of Health.

St. Paul's Hospital involvement with ambulatory care services will be discussed in the next chapter.

Greater Vancouver Regional Hospital District: Activity in the Late '70's

In February 1976 the GVRHD struck the Ambulatory Services Study Committee. The committee went over ground similar to the 1973 study group, with some new directions added. The terms of reference were to

1. determine and catalogue which ambulatory services are provided in each hospital at present,

2. determine which hospitals are planning new or expanded programs and to document these programs

3. explore which other diseases or conditions may benefit from specific new programs

4. identify all services which could be provided in an ambulatory setting and develop models (appropriate to each, i.e. community, regional, referral and tertiary referral hospitals) of how best to provide ambulatory care thereby encouraging new programs to develop,

5. develop guidelines for physical facilities (space, relationships, utilization) required to carry out identified ambulatory care programs,

6. report regularly to the Professional Practices Sub-Committee.

The task proved too large for the committee and no report was ever finalized although an enormous amount of information was accumulated and some preliminary models were developed. In 1979 the GVRHD tried to establish

future directions again. Based on the experience of the 1976 committee, they approached the problem in a more specific manner than committee work.

In September, 1980, in a joint venture with the Ministry of Health, a position was developed in GVRHD to study and encourage the development of ambulatory care services. It is entitled "Medical Planning and Liaison Officer, Ambulatory Care Programs." A Steering Committee composed of representatives from the Ministry and GVRHD will prepare and assign tasks; evaluate progress and reports of the officer; make recommendations to BCHP Planning Group and GVRHD Hospital Advisory Committee regarding development; an expansion of ambulatory care services; identify potential areas for new ambulatory care services, and develop guidelines for their study.

The job description of the Medical Planning and Liaison Officer is summarized as follows:

1. will help establish the criteria and in the development of program policy of Ambulatory Care in liaison with BCHP and GVRHD making use of the conceptual models as prepared by the GVRHD Ambulatory Services Study Committee (of 1976).

2. will promote the expansion of Ambulatory Care Services and Programs which have prior approval of the Ministry of Health in the hospitals of the GVRHD through educational efforts directed towards patients, administration, and medical staff.

3. will evaluate the various kinds of service which can be included in the Ambulatory Care

Programs. As part of this evaluation the economics, changes in medical practice, ability of hospitals to participate, and specific needs will be covered.

4. will report regularly to the Professional Practices Sub-committee of GVRHD and through the Planning Group of the BCHP to the Minister of Health.

The first completed task of the Medical Planning and Liaison Officer is before the GVRHD Hospital Advisory Committee at the time of writing. The report deals with Surgical Day Care and provides a historical perspective as well as recommendations aimed at promoting this service.[25]

Council of University Teaching Hospitals

Yet another group showing interest in the development of Ambulatory Care Services appears to be the Council of University Teaching Hospitals. A position paper dated September, 1980, is presently in circulation for discussion among the four university affiliated (medical) teaching hospitals. The paper promotes hospital-based ambulatory care programs as the best type of outpatient care and recommends the establishment of an inter-hospital planning committee to develop a comprehensive health care

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[25]The writer of this thesis was a member of the 1976 Ambulatory Care Study Committee and is presently a member of the GVRHD Hospital Advisory Committee.

planning base for ambulatory care programs. At this writing no public action has been taken. This interest in the promotion and control of ambulatory care programs and facilities is probably related to the difficulties which the medical school is having in seeking student placements for clinical learning opportunities; a situation which will become increasingly problematic as the student numbers are increased.[26]

Funding of Hospital-Based Ambulatory Care:

Provincial Involvement: Hospital Programs

Methods of hospital funding in B.C. have been under attack by hospital administrators for many years. Funding for inpatient care is through a per diem allocation applied annually to a pre-determined number of patient days. Seldom, if ever, does the allocation approach projected need in the tertiary care referral and teaching hospitals of the province. This arrangement leads to cash flow problems and to a deficit at year's end. Occasionally a program will be funded separately, for example, the Open Heart Surgery Programs.

Ambulatory services are funded quite differently. The government has developed a very short list of

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[26]Government permission has been received to double the enrolment of the UBC Medical School.

recognized services for which the hospital is paid a specific amount of money for each service. The list has not changed over several years despite new possibilities for care to be delivered in this manner. It includes Surgical Day Care, Psychiatric Day/Night Care, Physiotherapy, Deitetic Counselling and Renal Dialysis. Any other procedure, no matter how complex, is paid for by the recipient of the service at $2.00 per visit.

Revised Approaches to Hospital Funding

A hospital funding study, jointly sponsored by the Ministry of Health and the B.C. Health Association, was instituted in May, 1978, in order to develop a more rational and equitable approach to funding hospitals in the province and which would aim for optimum use of available funds in a manner which is clearly understood by all parties.

In 1979, as an essential part of the initial study, a jointly sponsored (B.C. Hospital Programs, division of the Ministry of Health and BCHA) hospital role study began. Hospitals would be defined and categorized on the basis of the characteristics of the individual hospital and funding would reflect each hospital's mandate. Draft I was circulated to all hospitals for critique and comment. Several respondents requested more explicit reference to the ambulatory care role of the hospitals.

As a result of these requests, a study group was formed in the Ministry's Department of Planning and Development. The group found the area of hospital-based ambulatory care fraught with lack of data, definitions and standards. It is anticipated some general development principles and planning guidelines for future hospital-based programs will be available in 1981 as a conclusion to this study.[27]

Community Human Resources and Health Centres

Another action which had begun before the Foulkes Report was published was the formation of the Development Group which was charged with the task of implementing and evaluating the validity of introducing a new entry point into the health care system through the Community Health Centres. The CHC would place emphasis on care delivered outside hospitals providing better first contact (primary) medical care, health promotion activities and preventive services all through an integrated service contributed to by all health and social workers.

Simultaneously, the Ministry of Human Resources was developing the idea of Community Resource Boards.

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[27]Personal Communication from Diane Layton, Planning and Development.

The two Ministries, Health, and Human Resources, joined forces to present legislation for the institution of Community Human Resource and Health Centres (CHRHC). The proposed legislation came from the Ministry of Human Resources with the possibility of including health services because provision of health services through the centres held much more heated controversy than the social services.

The NDP government's short term denied the completion of the organizational changes it began. The succeeding Social Credit government cancelled all new activity and withdrew the enabling legislation. Those CHRHC which continue to exist have proven their acceptability and effectiveness in cost reductions.[28]

As can be deduced from this brief summary, British Columbia has not advanced far in the direction of new alternative care delivery systems. The CHRHC were aborted, the Long Term Care Program is developing a need for other types of institutions and Home Care's potential has been cut back. There has been some advancement in hospital-based programs but these are restricted to the traditional mode of care delivery on an ambulatory basis.

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[28]See Appendix I for a more complete description of the CHRHC developed during this period.

CHAPTER IV

MEDICAL DAY CARE PROGRAM AT ST. PAUL'S HOSPITAL

History of Ambulatory Care Services at St. Paul's Hospital

St. Paul's Hospital has long maintained an outpatient service for indigents and skid road inhabitants. Such service was frequently found in the teaching hospitals and in the hospitals operated by religious orders. Even today, despite comprehensive medical coverage since 1968, approximately 1900 individuals still use the department for episodic and continuing care.

These outpatient services are provided through clinics of various medical specialties conducted by medical clinical supervisors with medical learners providing the care. A general clinic conducted by the Department of Family Practice provides primary care and a triage function to redirect patients to the specialty clinics.[1] Generally, the medical staff's attitude toward the service has been negative. The clinics conducted for medical teaching purposes are inconsistently attended by medical staff and are conducted by different doctors on rota which affects the availability and quality of care. An aura of poverty and disillusionment permeates the service. There have been periods where the

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[1]The Vancouver General Hospital is the only other hospital in the province maintaining a similar service. Seen as the municipal hospital, the VGH, until recently, received a funding allocation from the City of Vancouver to maintain the service.

general clinic was seen to be in competition with the general practitioners on staff, especially after a full time physician was employed in 1976.[2]

During the late 1960's and early 1970's several other ambulatory services were initiated throughout the hospital where services were rendered primarily to private patients with few indigent patients except as they were referred. Some of these clinics were the Diabetic Clinic, the Eye Clinic, the Gastrointestinal Clinic, the Enterostomal Clinic. These services were, and are today, available to inpatients as well as outpatients. These clinics provide diagnostic, treatment, and patient education services.

In 1974, when the BCMC was functioning as the coordinator of health care delivery organization in the Lower Mainland, St. Paul's Hospital was allocated the task of developing a major ambulatory care service for Vancouver.[3] The hospital accepted the challenge and henceforth planned actively toward this goal. Ambulatory services were seen to be a means to provide health care to more patients. It was viewed as an actively functioning and growing service which would alleviate the inpatient occupancy pressure. In some instances,

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[2]In 1981 the general practice clinic reverted to a rotation of practicing family physicians.

[3]British Columbia Medical Centre document dated February 25, 1975, outlined the Ambulatory Services which were to be available at St. Paul's Hospital.

this commitment on the part of the hospital administration led to the establishment of some outpatient programs without formal funding.

A renovation of the former indigent outpatient department has included considerably more space and incorporated several services for private patients as well (e.g. minor surgery, which had previously been scheduled in the Emergency Department, was now set up in the newly named Ambulatory Care Department). Space was prepared in the same area to receive a Medical Day Care service but remained unused until September 6, 1978. Established clinics situated around the hospital could not be consolidated in one location because of insufficient space but plans for the future reconstructed hospital include such a consolidation in Phase III. Replacement of the existing hospital has been planned in three phases. Completion dates are dependent upon government funding.

Development Plan for a Medical Day Care Program

Development of a Medical Day Care Program was based on a rational decision made by interested parties within the hospital structure to answer some recognized internal needs as well as to respond to BCMC commitments.

The consistently high occupancy, the number of elective patients cancelled each day, and the medical staff's concerns about physician's inability to admit patients despite one of the lowest length of stay (LOS) in the country, were the immediate motivations in developing the Medical Day Care

Program. A commitment to ambulatory care generally, and to improvements in patient use of beds, were underlying considerations.

Program Planning

The Medical Day Care Program was conceived as a complement to Medicine as the Surgical Day Care Program functions for Surgery. The concept was first formally recommended in the Ambulatory Care Committee[4] 1974-75 Annual Report.

The first proposal to government went forward in the fall of 1976. On April 18,1977 and again on December 6, 1977 (See Appendix III and IV) after no response and some verbal exchanges, a proposal for a pilot project was submitted. In May 1978 approval to proceed with a one-year pilot project was received.

The proposed program was to function seven hours daily, within which time certain more complicated diagnostic and treatment procedures, which then required hospitalization, would be carried out, with the patient returning home following each session.

Use of program services was restricted, initially, to members of the Department of Medicine, thereby reducing the number of physicians involved. Also, the number of patients was restricted, initially. Both these measures allowed the

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[4]The committee, with medical and nursing membership, acts as a problem-solving and advisory group.

Department of Nursing time to become competent in specific procedures and to work out organizational 'bugs'. Later, the service was opened to all members of the medical staff. Patient numbers are restricted by time requirements and the number of beds available.

Each procedure has to meet safety, knowledge, and legal criteria, before being accepted. For example, the Director of Ambulatory Care must be satisfied the patient can experience the test or treatment and recover sufficiently to be discharged in seven hours. The Nursing Department has to accept the responsibility and liability of safe nursing, since most procedures are carried out by nursing staff. (See Appendix V) The Pharmacy and Therapeutics Committee sanctioned the use of certain drugs, and agreed to their use by nurses independent of medical supervision.

A protocol was established to consider a proposal for any added procedure so that the criteria for acceptance can be reviewed before its inclusion. As time passes, new procedures are added. Extensive inservice education and orientation programs to prepare the nursing staff were designed, implemented, and are on-going any time a new procedure is accepted or when new nursing staff are employed.

In March 1980, as pressure on inpatient beds increased even more than previously, the hours of service were extended to allow for the implementation of either medical or

surgical procedures requiring an overnight stay. Patients leave at 0700 and that day's patients arrive at 0730. This arrangement also allows a single stretcher bed to be used by two, and sometimes three, patients in one 12-hour period.[5] Program usage grew slowly but today, as the doctors become more adapted, the ten stretcher beds accommodate a range of 7-14 patients in 24 hours.

Since house-staff are not available to the program, considerably more planning input is required of the attending physician for the MDC patient than for an inpatient. The patient's history and orders precede the patient by 24 hours. Also, the orders for the day have to take into account sequencing and incompatibilities of tests, although the Ambulatory Care Department does undertake to make the necessary appointments in various hospital departments.

Despite these additional demands on the physicians and the inevitable problems experienced in institution of the new procedure, there was no resistance to the establishment of the program. Its initiation had support through the Ambulatory Care Committee membership but most importantly, the program was seen by some medical staff members as a means to

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[5]The extension of time is not funded in any aspect.

treat more patients at a time when elective patients must wait extended periods of time before admission. Problems that did occur were primarily related to the changes in established modes of practice required of the doctors and having to meet program requirements before the patient could be treated.

Recording the activity of the program and recording the patient's experience were established in a manner which fitted into the standardized medical records and admitting procedures of the hospital. Management Engineering Unit 13.1 was requested to design a daily statistics sheet which would serve as a daily worksheet as well as a statistical record.

This accumulation of data became very significant when the program was accepted as a pilot project. At no time did the BCHP indicate what evaluation criteria would be required. The writer made the decision about what items of data would be maintained.

Resource Planning

After February, 1975, attention within the hospital was focussed on existing programs and facilities for ambulatory services. A renovation and updating of the Outpatient Department and its program was undertaken and space was added to the department for the introduction of a Medical Day Care Program. The cost of the renovation was $69, 490.00, and was completed in 1976; additional equipment coasts were $7, 395.00.

The MDC program was to be part of the administrative organization of the Ambulatory Care (Outpatient) Department and therefore would share in the established resources available in the department, but by its nature, it required special resource planning. Since the Outpatient Department had been only a basic primary care facility, additional supplies, manpower, and equipment were required to provide an MDC service at secondary and tertiary levels.

By October, 1977, in-house planning for an MDC service had progressed to the point where a memo, dated October 28, 1977, gave instructions to prepare submissions for equipment to BCHP and to process necessary tendering and purchase documents. This equipment was purchased at a cost of $9,225.28. In June, 1978, an additional sum of $1,225.00 was spent for more equipment, which was related to the finalized nature of the specific procedures to be offered.

More recently, the reclining chairs originally purchased have proved to be less acceptable to patients than expected and were replaced with stretcher beds through the annual Capital Budget Process.

Expenditures necessary in the Central Supply Department for additional procedure trays and equipment was estimated initially at $452.50 but when the procedure list was completed, costs rose to $905.00. It was well understood that the MDC service would be an add-on service in this department.

Some manpower resources were to be shared with the larger department. Porter, aide, and clerk services were shared.

Requested additional staffing was:

1.6 R.N. positions
1.0 Unit Clerk
.5 Pharmacist
.2 Medical Records Clerk
.4 Admitting Department Clerk

With acceptance of the pilot project, a portion of the manpower request was granted by BCHP:

1.1 R.N. positions
.6 Unit Clerk
.5 Admitting Clerk

The inadequacy of the manpower resources granted became apparent within a short time and additional Registered Nurse services were added.

The operational costs of equipment, supplies, and manpower, were absorbed into the existing and on-going costs of operating existing services which contributed to the cash flow difficulties, the need for cash advances, and finally, the year-end deficit position of the hospital. No monies ear-marked for MDC were received.

Financial Planning

Much of the written and verbal discussion with government was about substitution, i.e., what would the hospital exchange in existing expenditures if a Medical Day Care Program was introduced?

Specific requests[6] were made for the "...percentage days which the hospital hopes to save ... out of existing patient statistics ... 'and' ... detailed projections of work volume ..." Attempts were made to provide this information but it was based on the best judgment of hospital personnel since there were no previous MDC programs in the province.

Using an estimate of direct replacement days, i.e., how many days would the patient occupy a hospital bed for the same service, with no accounting for the lesser efficiency of hospitalization; the response was a reduction of ten acute care beds and a commensurate reduction in supplies and drugs. Estimated operating costs of the new service would result in a net saving of approximately $20,000.00 per year at 1977 rates.[7]

The response to the information submitted was the suggestion of Ministry officials that the CEO of the hospital approach the Mr. and Mrs. P. A. Woodward Foundation for funding to promote organization and development of

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[6]May 16, 1977. Letter from the Associate Deputy Minister Hospital Programs. See Appendix VI.

[7]December 6, 1977. Letter from Chief Executive Officer to BCHP. Verbal exchange preceded this formal letter.

Ambulatory Care at St. Paul's Hospital.[8] The request was rejected "... until some concept of government policy on supporting such a programme is available."[9]

Eventually,monies were made available to purchase equipment and some personnel positions required were granted by BCHP. The program was to have been a pilot project of one year duration when, presumably, it would be evaluated and funded or perhaps rejected. At this writing, the program is approaching three years of functioning without any government evaluation having taken place.

In the past, the hospital, using discretionary funds, had introduced new programs without formal acceptance of BCHP, if the programs complemented patient care. In 1977 the pressures on all acute care hospitals regarding 'deficits' and bed reductions, while maintaining all services, led to an adminstrative decision not to implement the MDC until a specific payment scale was received in writing from BCHP. This decision, of course, was changed when the suggestion of a pilot project was put before BCHP.

No actual reduction of beds or personnel, supplies,

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[8]Letter to Foundation dated November 7, 1977. (See Appendix VII)

[9]Letter from Foundation dated December 8, 1977. (See Appendix VIII)

or drugs, resulted from the introduction of the MDC program. The original need for the release valve due to occupancy pressure and patient cancellations was exacerbated by the introduction of the Long Term Care Program and none of the anticipated savings were realized although the MDC patient is being provided service in a less costly way. Remuneration from BCHP for the service has never been established. At present, the hospital collects a $2.00 outpatient fee directly from the patient for each visit to the Medical Day Care service, no matter how complex or costly the care provided.

Patient Benefit

The Medical Day Care Program continues in the mode of sickness care. The population served are patients with chronic illness (hemophilia, cancer) who require regular treatment interventions such as chemotherapy, and people with symptomology who have consulted doctors. The physicians control the availability of the service. The diagnostic workups are extensive and often include tests which cannot be done well, or done at all, outside the hospital.

A similar population, without doubt, became inpatient admissions prior to the establishment of the MDC. Ambulatory care patients may still have inpatient admissions, periodically or terminally, in the chronic illnesses, or after diagnosis is established. The MDC

services, however, reduces the number of inpatient admissions these people would require.

Testimonial evidence, received from patients, family, and physicians, indicates high patient acceptance, with many patients (especially the chronically ill) preferring day care admission over inpatient admission. The special abilities of the nursing staff have contributed greatly to this high level of patient acceptance.

Methodology of Data Collection

Once the decision to examine the process involved with the introduction of the Medical Day Care pilot project was taken, all related documentation available through hospital sources was collected. This documentation included minutes of the meetings of the Ambulatory Care Management, the Ad Hoc Ambulatory Care Planning and the Executive Committees, in-house memos, correspondence between the Chief Executive Officer and senior officials of British Columbia Hospital Programs, Ministry of Health, the written proposal, the report after one year of operation, St. Paul's Development Plan Functional Program, annual reports of the Ambulatory Care Committee, BCMC document, Study of St. Paul's Ambulatory Care Services, correspondence with the Woodward Foundation, Management Engineering Unit 131, and personal communications. Also, a diary of events of the first year of operation was

kept by the writer who at that time held the position of Coordinator of Specialty Services at St. Paul's Hospital and was responsible for planning and implementation of the Medical Day Care Program as part of Ambulatory Care Services.

Summary of the Development of Ambulatory Care at St. Paul's Hospital (SPH)

1875 - 1960	- Free food and health care to those who presented themselves at the hospital. (One of the duties of the student nurses as late as 1960 was to distribute free food to those who lined up at the kitchen door each mealtime.)
1958	- Establishment of an Outpatient Department
1960 onward	- Establishment of ambulatory services for private patients as well as the indigent, e.g. Diabetic Enterostomal Therapy, Gastrointestinal
July 1974	- BCMC challenge to develop St. Paul's Hospital as the major ambulatory care centre in the Lower Mainland
1974	- Ambulatory Care Committee proposal for a Medical Day Care program (MDC)
February 1975	- Document prepared by BCMC outlining services to be accommodated in the large ambulatory care complex to be incorporated into new construction
June 1975	- Medical Advisory Committee St. Paul's Hospital struck and Ad Hoc Ambulatory Committee to review requirements. An expanded version became the planning committee for redevelopment.
January 1976	- Submissions received from all hospital departments, medical departments, regarding services and programs which should be developed
March 1976	- Chairman, Ambulatory Care Committee submitted outline of proposed services to SPH Director of Planning
April 1976	- Proposed Ambulatory Care Centre incorporated into Functional Program for redevelopment

August 1976 - Proposed MDC Program submitted for approval to BCHP

Full-time salaried general practitioner employed to provide primary care

September 1976 - Study of St. Paul's Hospital Outpatient services and remuneration commissioned

March 1977 - Senior administrative officers seeking a way to gain BCHP approval for an MDC decided to re-submit the proposal as a pilot project since all indications were the first proposal would not be acceptable

April 1977 - Letter to BCHP requesting a cooperative endeavour. Identical proposal as previously submitted but called a pilot project

May 1977 - BCHP requiring detailed projections of work volume, specialized equipment and personnel, and inpatient day savings

August 1977 - Response to May 1977 letter, with estimates, required

Circulation of in-house planning document

Renovation and expansion of Outpatient Department completed - renamed Ambulatory Care Department

October 1977 - Second draft of planning document circulated

CEO authorized submission for equipment to BCHP

November 1977 - Requests to Woodward Foundation seeking funding to support a director of ambulatory care services

December 1977 - Second attempt to satisfy a verbal request for more detail about inpatient days to be saved, number of beds to be reduced, staff reductions

December 1977 - Request to Woodward Foundation rejected " ... until some concept of government policy on supporting such a programme is available."

January 1978 - Implementation of LTC Program

May 1978 - BCHP approval to proceed with implementation of a pilot MDC Program

June 1978 - Specific planning began with Ambulatory Care Committee

July 1978 - Finalized implementation document

September 1978 - Additional expenditures for equipment with finalizing services to be provided

Opening of the MDC Program

March 1980 - Expansion of the program to allow an over-night stay from MDC and SDC program

1981 - General practice clinic reverted to a rotation of practising family physicians

CHAPTER V

INCONSISTENCIES IN BEHAVIOR ON THE PART OF GOVERNMENT

When a hospital initiative does arise, delays, requests for more information, and rerouting through a variety of officials and sections of the Ministry defer the need to make a decision. This vagueness and lack of leadership leads to confusion and disillusion at the institutional level. Hospital administrators continually wonder what is acceptable, what is the goal, who makes the decision?

In the case of the Medical Day Care Program initiative from St. Paul's Hospital, the institution was trying to find a way the proposal would become acceptable, because it had become clear after two years of deferment that introduction of such a program was not going to happen, although there had been no rejection.

Why, if the government is interested in determining the effectiveness of ambulatory care programs and concerned about financial commitment before proven, did the suggestion of a pilot project have to be initiated by hospital personnel rather than by the government? The pilot project was acceptable for reasons known only to government officials, since nothing but the inclusion

of those two words had changed in the proposal,[1] but St. Paul's Hospital's experience would indicate that ambulatory care is not a priority among alternatives.[2] Despite what seems sufficient reason to pursue the development of alternative care delivery modes, little has actually happened on a scale which could be adequately evaluated. Having established the encouragement of ambulatory care development as an objective of the Ministry, actual commitment to action seems indecisive and confusing.

There is no significant promotion or planning effort on the part of government directly in regard to ambulatory care. Activity which does exist, demonstrates a desire to maintain an 'arm's length' relationship to any actual commitment. Several examples of this stance can be given. Planning and Development Group of the Ministry documented existing ambulatory care services in B.C., once the need for such documentation was initiated by hospital administrators as a result of the first circulated draft of the Hospital Role Study (1979).

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[1] See Chapter IV for specific dates of submissions, requests for more information, deferments, etc.

[2] Ambulatory care approaches were favored by the Minister as stated by the Senior Director, Hospital Programs, in a letter to St. Paul's Hospital and dated May 16, 1977, but the Ministry's behavior does not support the statement.

Construction plans for redevelopment or new development of hospitals may include ambulatory care facilities and programs in functional programs if requested by the hospital, but not as a suggestion or requirement of the Ministry. Funded ambulatory services have not changed over several years despite many new possibilities which have been demonstrated effective. The Ministry has accepted joint sponsorship with GVRHD of attempts to expand the use of ambulatory care services and the introduction of new services, but also has applied a potentially severe constraint with efforts having to be limited to " ... programs which have prior approval of the Ministry of Health.[3]

Initiatives appear to rest with bodies other than the Ministry. The Ministry's role appears to be one of acceptance or rejection but most often it appears to be one of delay and deferment. As Warham writes, no decision " ... may constitute policy ..."[4], a policy to avoid proaction, to react but not to create.

Current Government Objectives

Finally, in 1977, the 1969 Task Force's recommendations to redesign federal funding of health care was

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[3]Taken from the job description of the Medical Planning and Liaison Officer employed to promote ambulatory care programs. See page 41.

[4]Joyce Warham,"Notes on Planning in the Context of Social Policy." University of British Columbia, 1974, p.1.

effected in the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act. This legislation is now the basis of federal assistance to provincial health care programs. It is designed to change the incentives away from inpatient care, to cause careful monitoring of resources by removing open-ended cost sharing and introducing per capita allocations. The province's costs increase with usage of services, the federal government's do not. The provinces are no longer monitored by the federal government and there is no legal obligation to increase spending for alternative care modes but it is expected that inevitable cost containment attempts would steer a course in that direction. Concern has been expressed that the provincial government will simply not provide the required funding to maintain the system as it is known, now that its share of expenditures has significantly increased.[5]

The first written objectives for the Ministry of Health in B.C. are dated December, 1978, and were prepared by the then Deputy Minister, Dr. Chapin Key.

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[5]Frances Russell, Consider B.C. Without Medicare, Vancouver Sun, July, 1976.

They read as follows:

I To promote programs of a preventive nature as well as other alternatives in order to contain rising costs of health care and provide an optimum state of health.

II To foster a responsive organization of the Ministry of Health which facilitates effective communication, co-operation and co-ordination and achieves a planning and evaluation capability supported by an integrated health information system.

III To provide an effective delivery system throughout the province which provides equitable access to preventive and treatment programs.

IV To implement a province-wide Public Education program directed at the Public dealing with their:

(a) financial responsibility and utilization of services

(b) lifestyle and attitudes

(c) personal, family, and community involvement

V To identify and reduce environmental hazards to health in co-operation with other minstries and agencies.

Dr. Key has since been replaced by a new Deputy who has emphasized cost control rather than standards. However, the general statement of objectives has been accepted, with some modifications.

If objectives mean intent, it seems the government of B.C. has at last (reluctantly?) accepted its role in the provision of health care to the citizens of the province. This commitment was further demonstrated during the recent fee schedule negotiations with the provincial medical

association. (Objective III). When the association threatened added billing, legislation to prohibit it was formulated and remains pending.

The government's commitment to increasing personal responsibility for health care costs has also been demonstrated as a result of these negotiations (Objective IV). Beginning July, 1981, health insurance premiums will rise and the direct cost to users of hospital care was also raised.[6]

There is inconsistency between Objective III and Objective IV. "Equitable access" is inconsistent with rising personal costs of care, since those who do not have access are also those who cannot afford added costs. The new regime in Victoria has said that this objective is being reconsidered in line with Socred ideology.

These inconsistencies in government behavior may reflect internal struggles between rival factions within the Ministry, or perhaps the continuing reluctance of the government to accept the leadership/management role in health care, or, perhaps reflect the rival proposals initiated from many sources (GVRHD, BCHP, Public Health, Federal demonstration grants) and which all deal with

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[6]Acute care co-insurance rose from $5.50 to $6.50 per day. Extended care rose from $6.50 to $10.50 per day, and Surgical Day Care rose from $5.00 to $6.00 per visit.

different sections of the Ministry leading to a lack of coordination within the Ministry.

The Minister of Health, commenting on the introduction of the 1978 reorganization of the Ministry, indicated the existence of such a difficulty when he told reporters:

> "We have to remember that in recent years the Ministry of Health has been functioning as an amalgam of operations which were once more or less independent, and this required considerable effort in coordination."[7]

This ad hoc manner of administration by the government eliminates the possibility of a health care system and usually reduces any incentives senior executives may have to contribute toward integration of services in an area. In this kind of environment each institution is isolated, open, and probably receptive to the needs and leadership of members of the medical profession attached to the institution and in competition with other institutions. An inconsistent approach must result in unnecessary expenditures through uncoordinated action.

After acceptance of the pilot project, there was no input from the Ministry regarding information required and no evaluation criteria provided. If a pilot project

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[7]British Columbia. Ministry of Health Newsletter No. 1, November 30, 1978.

was appropriate, one would expect some interest in gaining data to prove or disprove the validity of the project for future applications. The hospital staff felt very positive about the projected program outcomes, but without any Ministry involvement they did not know what the government expectations were. If expectations are unknown, how could they be met? Even if the program were a great success, there was no assurance that the program would be maintained and funded. The Ministry maintained an 'arm's length' stance as though officials could dissociate themselves from the experiment if that proved to be useful.

CHAPTER VI

Planning: A Political Process

With the use of public monies for the provision of health services to the populace there follows an expectation that these funds will be well spent and that services provided will be assessed for effectiveness and quality. In attempting to fulfil these expectations, governments have established vast bureaucracies which are monitoring agencies, especially of expenditures. One might also expect that policy formation/decision-making/planning would be aimed at fulfilling the ideology of high quality care, accessible to all for the least possible expenditure, as described in the Health Charter for Canadians. In the mundane day-to-day we find the system insufficiently funded, controlled in a piecemeal fashion, divided by diverse interests but, highly regarded by most consumers of the existing services who have little awareness of true cost and who are generally unaware of the gaps in service.

Since the costs of health care are substantial, establishing means to monitor expenditures is a reasonable undertaking, as are attempts to discover less expensive means to provide services; to plan and to evaluate these attempts. Nationally, cheaper alternatives have been sought and researched. A consensus had developed in the country that ambulatory care could contribute to a

reduction in expenditures.

If ambulatory care is a 'good thing', one would expect that provincial resources would be made available for the development of applications. Despite this rational consensus resources did not flow or, more correctly, some money was spent in a seemingly unplanned manner in B.C. In order to understand this contradiction it was necessary to explore the area of planning seeking explanations for this government behavior.

In the search for an understanding of the role of planning in the government's responsibility for the delivery of health care, this writer has been confronted with widespread differences of opinion about the purpose of planning. Is planning policy formulation, policy analysis, goal-setting, decision-making, implementation, a means of controlling or merely crystal-ball gazing?

Rational Planning

Michael defines planning as all of these activities and more. He is careful to call it the planning process, presumably meaning that a number of different sources of input might be involved.

> " ... the planning process includes: systematic conjecture about future settings for which developing of plans over time is relevant and desirable; goal stating (... regulative as well as target setting); estimating costs and benefits (including non-monetory ones) attached to alternative means for moving toward stated goals; attending to circumstances outside the directly relevant environment to understand their implications for the

> operation of the plan; of the specifying sequenced actions necessary for realization of the plan; continuing to evaluate estimated futures, stated goals, and programs instituted in response to them; all accomplished in ways that result in appropriate revisions."[1]

Michael's description of the planning process is essentially a definition of rational planning. A definition by Harris holds the same sequenced series of steps, the setting of goals, the formulation of alternatives, the prediction of outcomes and the evaluation of the alternatives in relation to the goals and the outcomes.[2]

Michael insists that we must learn to plan in this systematic manner because plannning schemes rejecting this approach have, for the most part, been failures. He views future conditions such as scarcity of resources, the increasing demand for equitable shares, appreciation of secondary and tertiary consequences of technological inputs, and technology used to cope with shortages which will constrain related social and economic systems as requiring systematic rational planning. Michael believes that present day planning could be better if we would

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[1]Donald N. Michael, 'Speculations on Future Planning Process Theory," in Planning in America: Learning From Turbulence, ed. by David R. Godchalk (Washington, D.C. American Institute of Planners Publication, 1974) p.40.

[2]Britton Harris in the Foreward of Decision-Making in Urban Planning ed. by Ira M. Robinson, Beverly Hills, California: Sage Publications, 1972.

maximize our available abilities rather than 'satisficing'.[3] Eckstein supports this when he says that planners substitute routine responses for rational calculation in difficult decision-making situations.[4]

Michael brands the present planning process as unacceptable because when information is inadequate, or not credible, resolution and risk-taking are turned over to the political process, " ... to the workings of mutual partisan adjustment and pluralistic contest and accommodation."[5]

Harris presents a conflicting view when he writes that value systems that must be satisfied are becoming more complex and conflicting and subject to change.[6,7]

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[3]Herbert Simon's term to express man's tendency to seize upon the first acceptable alternative rather than seeking the best.

[4]Harry Eckstein, "Planning: The National Health Service", in Policy-Making in Britain, ed. by Richard Rose, (London, MacMillan & Co., 1969), p. 230.

[5]Michael, p. 43.

[6]Britton Harris, "Planning Method: The State of the Art" in Planning In America: Learning From Turbulence, ed. by David R. Godschalk. (Washington, D.C., A.I.P. 1974), p. 65.

[7]Rein goes as far as to say that in a democratic society there are no commonly shared goals which can give direction to the planning process.

If this is so, and bears some importance in the planning process, how can there ever be a 'correct' or rational answer. Even a 'best' answer would have time limitations unless control is inherent in the process.

Boulding thinks decisions are constantly being made on the basis of misinformation, false images of the world, absence of crucial information which may or may not exist.[8]

Mott is realistic when he says that the selection of planning goals is primarily a political act and although analysis plays a role in weighing alternative courses of action, there is an important and crucial political aspect here as well. To underline this view, Mott refers to planning as a 'political process'[9] and Mechanic writes that "policies designed simply on rational assumptions are likely to miss their mark in successfully altering behavior."[10]

In a particular situation, if power rests with the planners, then the technical analytic process may be applied,

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[8]Kenneth E. Boulding, "The Boundaries of Social Policy," Social Work, (January 1967), p. 10.

[9]Basil J. F. Mott, "Politics and International Planning, "Social Science and Medicine, Vol. 8, (1974), p. 271.

[10]David Mechanic, Future Issues in Health Care, Social Policy and the Rationing of Medical Services, New York: The Free Press, 1979, p. 3.

but no plan works of itself. The incentives to behavior change must be recognized and assimilated by the implementors of the plan. This concept would explain developments in the area of Community Health Centres and manpower substitutes. The rationality of these means to reduce health care costs has been shown, nonetheless, they have not been applied. For the change to succeed, the medical profession would have to cooperate, but there are no incentives to do so. To give up control and the leadership role of the doctor, which would reflect on social standing, without even financial benefit, does not promote willingness to absorb such a change.

According to Tannen, control has been the major impetus in the development of the federal National Health Planning and Resource Development Act of 1973 in the United States.

> "Portrayed as an objective and rational mechanism of determining the future, planning is a socially acceptable means of exerting third-party control over a sector of the economy long able to escape meaningful controls on its growth and development."[11]

Klarman sees the American planning incentive as an attempt to dilute the medical profession's control of the health industry.[12]

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[11]Louis Tannen, "Health Planning as a Regulatory Strategy: A Discussion of Its History and Current Uses," International Journal of Health Services, Vol. 10, No. 1, (1980) p. 115.

[12]Herbert E. Klarman, "National Policies and Local Planning for Health Services." MMFQ/Health and Society (Winter 1976), p. 1-28.

From this brief exploration it would appear to this writer that the application of rationalist planning requires a high degree of control; clearly stated objectives accepted by interested parties and limited numbers of variables to allow the development of clear alternatives of choice, the ramifications, of which, are understood. In British Columbia, to date, there has been very little centralized control of health care and even less province-wide planning of health care. In fact there appeared to have been a resistance to centralization. Since there has been no provincial plan for health care and objectives of the Ministry of Health hold inconsistencies, it is probably fair to say rationalist planning does not function in B.C. Perhaps rationalist planning as described by its proponents could not function anywhere.

Incrementalism: Political or Bureaucratic Planning

If rationalist planning is unlikely to function effectively where objectives hold inconsistencies and control is slight or focussed elsewhere than program planning what is actually happening in most systems?

Lindblom represents the school of 'Muddling Through", the mutual partisan adjustment approach to policy-making rejected by rationalist planners such as Michael and Harris. Most political interventions involve add-ons or tinkering at the margins of existing programs to avoid

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[12]Herbert E. Klarman, "National Policies and Local Planning for Health Services," MMFQ/Health and Society, (Winter 1976), p.1-28.

large scale conflict.[13] So, despite the dissenters and the attempts to develop rational approaches, the incremental approach to policy formulation and planning appears to be the most common approach used.[14] Klein supports the use of this method for the British National Health Service primarily because of the absence of objectives for the service.[15] Eckstein echoes this view when he writes that people who plan and control in bureaucracies cannot use rationalist approaches to decision-making because of the inconsistencies within objectives. He says it is the impossible task of planners to translate values with all their ambiguities and inconsistencies into consistent, rational, politically defensible programs in an environment of great psychological pressure and with lack of control over a multitude of factors crucial to adequate calculation.[16]

Eckstein's and Klein's views on the difficulties with the implementation of a rationalist approach to planning within bureaucracies apply in B.C. as well.

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[13]Charles E. Lindblom, "The Science of 'Muddling Through'", Reprinted from Public Administration Review (Spring 1959) p.86.

[14]One could argue, as Klein has done, that a policy may be politically rational or administratively rational and not both.

[15]Rudolf Klein, "Policy Problems and Policy Perceptions in the National Health Service", Policy and Politics, Vol.2, No.3, p.224.

[16]Eckstein p.226

The inconsistencies in objectives and the the lack of central control make incremental change the most likely to occur.

Health Planning in Canada

There are some who view the Canadian health care system positively specifically because of the use of incremental (political) planning. Hatcher states Canadian health care policies have been pragmatic and incremental rather than based on a broad ideological or systems approach. Policies were adopted because they worked to the satisfaction of the population and without too much grumbling from special interests.[17] Development of a health care system in Canada was controlled to some degree because practical men responded to financial incentives but this is not to say that the system developed in a comprehensive way.

There is no legislated health care planning requirement but in recent years the need for the control implicit in planning has come forward. Government intervention has always been suspect and government controlled planning more suspect still but the pressures of costs are forcing governments to take steps toward increased control. This control may be expressed as fiscal control or as program and systems control.

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[17]Gordon H. Hatcher, "Canadian Approaches To Health Policy Decisions - National Health Insurance", American Journal of Public Health, (September, 1978) p.888.

Two journalists, Bennett and Krasny, responding to federal government concerns about the rising expenditure for health care, carried out an assessment of the Canadian system and have devised in general terms a grand plan to meet the overall objective of containing expenditure growth while maintaining or upgrading the quality of care. These men point out that it is the ten provincial governments which are most able to determine the direction of the Canadian health system. They control funding and most of the planning and decision-making mechanisms that affect the basic configuration of care delivery and therefore each should develop a long term plan; a health care strategy.[18]

In fact, several provinces have developed grand plans which for the most part are gathering dust on library shelves.[19] In British Columbia, the Foulkes Report would have been the master plan had the vagaries of politics not intervened. It would remain to be seen what a government could accomplish in the face of strong opposition from powerful groups. As described previously, the governments are now beginning to assert the necessity to place controls on the growth and costs of the health care

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[18]James E. Bennett, Jacques Krasny, "Time to Face Up To The Health Care Crunch", Financial Post, (May 7,1977) p.39.

[19]John Browne, Summary of Recent Major Studies of Health Care in Canada, Department of Health Administration, University of Toronto for the Canadian College of Health Service Executives.

system. Planning must, of necessity, follow.

Health Planning in British Columbia

McQueen suggests a master plan for the Canadian system is impossible, but supports a combined effort of interested parties to work together especially for systems and program planning through a provincial government planning office.[20] In British Columbia the Planning and Development Group of the Ministry of Health was developed for the specific task of planning, implementing and evaluating the community health care centres which came into existence during the tenure of the socialist NDP government. In the reorganization of 1978, the group became responsible for the general planning, development, evaluation and research function of the Ministry though the major subsections of the Ministry continued to maintain their own planning sections. Perhaps this reorganization, including a general planning section, signals a recognition of the necessity that the government analyse proposals for their effectiveness and the range of application in the system. The much more disruptive 1981 reorganization retained the so-called planning department. Little has been heard from or about them as yet but change may be on the horizon.

Each subsection of the Ministry, such as institutional

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[20]Ronald J.C. McQueen, "Governments and Long-Range Planning", Hospital Administration in Canada, (September 1976), p.34.

services, community health, and the special Long Term Care Program, develop plans in isolation. Hospital-based ambulatory care was, therefore, isolated from the planning of other forms of ambulatory care or from any assessment by other sections for wider effects. The general planning section may take over and coordinate planning activities of the Ministry in the future but at the time St. Paul's Hospital Medical Day Care Program proposal broached the Ministry it assessment would have been confined to BCHP. There is no evidence that the MDC proposal was submitted to any analysis of a rational planning nature. Nor is there any evidence to show more than cursory interest in other applications of the program as part of some provincial plan.

The implication in Michael's description of rational planning is that there will always be one best answer. Unfortunately the 'best' answer may vary dependent upon whose rationality is applied. What is rational to the consumer whose expectations are those of high quality care, easily accessible for as little personal cost as possible may not be rational to the government bureaucrat who must function within budgetary restrictions, or the politician who must be seen as fiscally responsible as well as improving services, or the hospital administrator whose mandate is to meet consumer expectations and professional demands within restrictive funding allocations. Obviously this variety of viewpoints causes problems

which affect outcomes.

The medical profession has controlled health care delivery through the control of the individual patient's access to health care and in the introduction and utilization of very expensive, highly specialized technology used for diagnosis and treatment. While costs of health care appeared reasonable and while the health status of the population was improving little concern was heard. Now that costs continue to increase and the health status of the population has reached a plateau politicians and bureaucrats are becoming more vocal about the need to control cost. Ultimately this intention to control costs means a transfer of power from the medical entrepreneurs to the government. How easily this can be accomplished remains to be seen. The control implied in this transfer of power requires continuity which places the bureaucrat in a stronger position than the short term politician. Power finally resides with the bureaucrats. The means of control is planning. Whatever the planning model "...far from being the neutral science which it is heralded to be, the planning process serves the interests that are able to control its use." [21]

So far, the B.C. government has played at planning. Planning methods have been used with individual projects but there were no system-wide criteria against which proposals were analysed.

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[21] Tannen. p.115

Objectives for the Ministry of Health were written in 1978 but ad hoc planning continued, probably because there was no administrative set-up to include planning and coordination of Ministry activities. The machinery must be present and supported before planning and coordination can exist. The introduction of strong public administrators instead of medical professionals into deputy and assistant deputy ministerial positions probably indicates the government intention to take a 'hard line', to establish controls.

Practicality must prevail and the system planning function will gain importance in the Ministry when it is recognized as the major tool of control and as cost containment measures and fiscal management applied to hospitals fall short of objectives in the face of demand.

The planning model most applicable to the B.C. situation is the incremental. No planning theory has been applied with intent. Developments in the B.C. health care system have depended upon ad hoc initiatives from a variety of sources with personal and/or local motivations. No doubt past decisions taken would be defended as rational although isolated from other components of the system and without any coordinated plan for health care in this province.

Planning as an activity is fraught with contradictions and human inability. There is no straight line to a conclusion but the planning exercise does offer a

better chance of success if there is an attempt to consider variables influencing the outcome. The planning process is a political process in which various actors exercise influence to varying degrees dependent upon their power resources, according to their interests and preferences and those with the greatest influence control the outcome.

CHAPTER VII

PROPOSALS AND THE POLITICAL SYSTEM

The exploration of planning models offered some explanations for government bureaucratic behavior in relation to ambulatory care but also opened the avenue of political considerations. It was decided to review some different models which might provide other ways of looking at the difficulties encountered in the development of the Medical Day Care Program. One model which traces the movement of an issue through the political system is applied below.

The model developed by Hall et al may explain the lack of action. The model deals with the reasons why a proposal gains the attention of policy makers and what criteria affect the possibility of the proposal's acceptance and implementations. The criteria help to simplify, organize and understand the evidence. These criteria are Legitimacy, Feasibility and Support. Interpretation of these criteria is affected by a government's ideology.[1]

Legitimacy/Underlying Ideologies

Ideologies are defined as patterns of attitudes and aspirations leading to programs of action and sustained by reasonably coherent sets of assumptions and prognoses about the workings of society. Ideologies are the basis

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[1]P.Hall et al. Change, Choice and Conflict in Social Policy (London : Heinemann) 1975, Chapter 15.

upon which political parties loosely rest.[2] The concept of legitimacy revolves around assumptions held about the proper role and sphere of government action. The legitimacy of a contemplated intervention by government depends upon the ideology of the party in power and with its suppositions about private and public support for intervention.

Donnison writes that clarification of goals can be counterproductive to the maintenance of ideologies.[3] Sometimes political ideologies are related to political behavior but usually a great deal happens between the ideological pronouncements and the applications as they finally take form, if they take form.[4] Nevertheless Donnison argues that governments need social ideologies to guide and coordinate their work, to secure the support of the voters and to make the behavior of citizens orderly and predictable.

Canadian Ideologies

Which ideologies are in favor is dependent upon the social values of the day. One of the accepted ideologies in Canada is the idea of collective action to solve individual's problems. Translated into action this

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[2]David Donnison, "Ideologies and Policies", Journal of Social Policy (Vol. 1, No.2) p. 100

[3]Donnison p. 100

[4]Daniel S. Greenberg, "Washington Report, The Frustrated Reformers", The New England Journal of Medicine (January 25, 1979) p. 211

ideology provides a basis for the welfare programs of many different governments and political parties. An example of this commitment in Canada is the 40% of Gross National Product spent on welfare programs in 1977.[5] But Canada is not monolithic. Ideologies held by different sections of the society may conflict.

One ideological commitment which is ambiguous is toward redistribution and the role of government in this process. Man has developed a boundless sense of his capacity to control his world. This view increasingly focuses on government as the force for solving social problems[6] and engineering society.[7] This view is not without conflict since the concept of equality has implications for the limitation of some individuals' privileges in favour of the increased good of other individuals.[8] There is a growing public recognition of the government's powers to regulate and distribute wealth and opportunities through social policy formulation.

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[5]Walter Stewart, " The God That Failed ", Macleans, January 24, 1977, pp. 30-34.

[6]Martin A. Levin, "Political Dilemmas of Social Policy-Making", JHHRA, (May 1979) p. 464.

[7]Donald N. Michael, "Speculations on Future Planning Process Theory", in Planning in America: Learning From Turbulence, ed. by David R. Godschalk (Washington, D.C.: American Institute of Planners Publication, 1974) p. 54-6.

[8]Joyce Warham, The Concept of Equality in Social Policy, Department of Health Care and Epidemiology, University of British Columbia (mimeograph)

There is a distinction between the amount of commitment of different Canadian governments to this policy of redistribution. The federal government is more deeply involved in redistribution policies because of the inequalities of resources existing in different parts of Canada and the necessity for a central government to be concerned about the country's strengths and weaknesses. In B.C. the dominant ideology is much more that of individualism, self help and let the best man win.

Government intervention in assisting citizens procure health care has had a long incremental history in Canada. The longevity of the federal Liberal government has allowed a continuing development of health and welfare services through the use of federal financial resources to stimulate provincial governments to exercise their constitutional responsibilities.

There is an element of timeliness in legitimizing government intervention. Wars, particularly, alter assumptions about legitimate spheres of government function. This was true in Canada as development of a national health service was viewed by the federal government as an important reconstruction measure following the Second World War. To define the scope of federal intervention two reports were commissioned, the Heagarty, dealing with health issues[9] and the Marsh, dealing with social

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[9]Canada. (Heagarty) Health Insurance Report of the Advisory Committee on Health Insurance. Ottawa : King's Printer, 1943.

services.[10] These reports provided the background for an overall health and welfare policy statement presented at the Dominion-Provincial Conference of 1946. That the overall policy was never implemented comes as no surprise but its presentation did allow the federal government to assess the general acceptability of the idea of government intervention in health care and social services. This generalized acceptance reassures government that proposals should proceed toward implementation and legitimizes its actions.

The federal government was not always the first to move in introducing new programs. The socialist ideology of the C.C.F. Party in Saskatchewan provided leadership in the area of government involvement in providing health care to all citizens. The absence of philanthropy and the sparse settlement made government the most efficacious vehicle for solving sickness care problems on the Canadian Prairies. Other programs were begun by a variety of institutions across the country, for example, medical care insurance was established by insurance companies and by the doctors themselves who sought a means to establish regular payment for their services.

Provincial commitment to the health care system is not as well documented as federal commitment except in

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[10]Canada. (Marsh) Social Security for Canada, Report of the Advisory Committee on Reconstruction. Ottawa : King's Printer, 1943.

Saskatchewan. Before federal involvement the Social Credit Party and its supporters in B.C. resisted any efforts to introduce government sponsored public welfare programs.

After 1945 a continuing adjustment between the two levels of government began. Ottawa's control of financial resources allowed its involvement in matters which were traditionally provincial responsibilities. By 1957, operating funds were badly needed for the hospitals which had been constructed through the stimulus of the National Health Grants Program of 1948. A cost-sharing arrangement was then developed and implemented through the Health Insurance and Diagnostic Services Act of 1957. In 1966 the Health Resources Fund provided monies for the development of facilities for teaching health professionals and in 1967 the Medical Care Act was passed to match payments of doctors' fees.

In 1962 a Royal Commission was set up by Order-in-Council of the Liberal Government to make recommendations which would ensure the best possible health care was available to all Canadians.[11] The Commission legitimized past government action in the provision of health care and recommended even more intervention (in the form of

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[11]Canada. Royal Commission on Health Services, Ottawa, 1964.

medical care payments). The Commission developed the Health Charter for Canadians which embodies the ideology of optimal health care for every citizen. The Charter has become the normative expectation.

Sometimes an ideology transcends political party boundaries, such an example is the Canadian Health Care System. During its short life the Conservative Government commissioned a review of the health care system (1979) to assure itself that the initial charge was being met.[12] The question of government intervention in health care is beyond political platforms on the federal level. Regulation and administrative arguments continue between the parties but the ideology remains intact.

However, there are dissenting voices. The Fraser Institute of Vancouver views health care as a personal responsibility i.e. an individual can have as much health care as he can afford to purchase.[13] Ironically, the earliest motivation for government intervention in the public health was as a support to the market economy ideology. Healthy workers meant higher and more consistent productivity.

Another ideology, about which there is conflict, is the extent of technological development. Illich thinks

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[12]Canada. Canada's National-Provincial Health Program for the 1980's, Ottawa. 1980.

[13]Ake Blomqvist, The Health Care Business, The Fraser Institute, 1979.

the commitment to medical technological development has gone too far.[14] He represents the ideology of more realistic expectations about life and death. He desires a return to an acceptance of personal responsibility for health and an acceptance that life holds pain and death. Illich and Laframboise[15] both make the point that the North American tends to place his faith in the restorative powers of doctors, hospitals and medical technology rather than assume responsibility for maintaining health through personal behavior.

In 1977 the federal government removed itself from the open-ended financial arrangements with the provinces. This readjustment of financial responsibility is testing the Canadians' commitment to one ideology over another because the provinces will now be the single decision-making authorities for financial resource allocation. British Columbia, with its history of resistance to government intervention and the current Social Credit Government's espousal of increased personal responsibility for health care costs , is one of the most likely testing grounds for legitimacy.[16] The financial largesse of the federal government in supporting health care could be

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[14]Ivan Illich, Medical Nemesis : The Expropriation of Health, New York : Pantheon, 1976.

[15]H.L. Laframboise, "Health Policy:Breaking the Problem Down Into More Manageable Segments", C.M.A Journal (February 3, 1973) p. 393.

[16]See Appendix IX for a statement of Social Credit ideology.

ignored only with severe repercussions, despite some province's dominant ideology of personal responsibility.

Since it would be politically unwise to discontinue a provincial health care system, the alternative is to limit and reduce involvement as much as the electorate will tolerate. If a government's ideology is one of personal responsibility the evolving financial pressures and the ideology combine to support such actions. The question of legitimacy has seemed settled but remains tenuous in the face of these two pressures in B.C. Being one's brother's keeper depends on his beliefs as well as how deep he has to dig into his own pocket.

This general attitude of limitation would permeate the Health Ministry's staff and be demonstrated in the nature of the response to any new proposals if there were no obvious savings or government involvement is seen to be increased. Any added service proposal, including ambulatory care proposals, submitted into this atmosphere would probably not fare well.

Feasibility

Feasibility is the second criteria of the Hall et al model which attempts to explain the acceptance or rejection of proposals by bureaucratic policy makers. It is the determination of the ease of assimilation into the existing system, the amount of negative impact on the government if implementation occured and the resources required.

Broadly speaking, feasibility is limited by the prevailing structure and distribution of theoretical and technical knowledge. The concept of alternative care delivery systems places no unusual demands upon existing theory or technology[17] but the matter particular ideologies, interests, prejudices and information does affect conclusions drawn about feasibility. Hall et al explain that actors in the policy-making process are likely to assess feasibility differently because they are aware of and are influenced by different sets of constraints.[18] These constraints have become known as inputs and withinputs. Pross writes that governments not only process 'inputs' i.e. demands external to the system (Ministry) but also 'withinputs' which are demands generated within the system. Withinputs may be products of bureaucrats perceptions of short-comings in existing policy; representations for outside interests; logical consequences of existing structures and policies; or may grow out of innumerable rivalries which exist within complex organizations.[19]

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[17] Improved technology has allowed certain treatment and diagnostic interventions to be provided on an ambulatory basis.

[18] Royal Commission 1964, p. 479.

[19] A.Paul Pross, Input Versus Withinput : Pressure Group Demands and Administrative Survival, in Pressure Group Behavior in Canadian Politics, ed. by A.Paul Pross, McGraw-Hill Ryerson Series in Canadian Politics, p. 161.

Of all the options developed from inputs and withinputs only a few are examined since it is impossible to closely analyse all possible choices as recommended by the rationalist planners. To simplify a complex concept Hall et al have organized their discussion of feasibility under three headings, namely, resources, collaboration and administrative capacity. These elements will be employed to demonstrate some of the considerations affecting the feasibility of alternative care delivery systems.

Resources

Resource feasibility includes financial and manpower resources and is concerned with resources available now, in the future and those released by the proposed change.

Substitution [20] is a concept widely used in the discipline of economics to describe a situation in which one commodity that satisfies similar needs or desires replaces the original commodity, usually at a lower price.

Freiberg [21] lists four sources of substitution in health care

1. technological invention and innovation
2. changed organizational arrangements
3. increased capital accumulation
4. increased medical knowledge

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[20] Richard G. Lipsey, Gordon R. Sparks, and Peter O. Steiner, Economics (San Francisco : Harper and Row, Publishers, 1979) p. 898.

[21] Lewis Freiberg,Jr., "Substitution of Outpatient Care for Inpatient Care:Problems and Experience", Journal of Health Politics, Policy and Law. (Winter 1979), p. 479

The source of substitution applicable in the context of alternative care delivery systems is changed organizational arrangements, i.e. the way in which the use of manpower and technology are organized to deliver care.

In the context of sickness care, it is said that many episodes of care could be provided as effectively for less cost in settings other than inpatient settings, and in some cases appropriate care could be provided by health workers less costly than physicians. Both expected outcomes of ambulatory care would release resources; some inpatient bed usage and some physician time, thereby reducing the number of necessary acute care beds and allowing physicians to work more effectively in the areas of care for which they have been prepared or perhaps even reducing the number of physicians required in the health care system.

As more empirical research is carried out, the direct substitution of ambulatory care for inpatient care becomes less clear.[22,23,24] The concept of complementarity is now a part of the discussion. A complement is defined as 'a commodity that tends to be used jointly with the original commodity.[25] Over time, a single patient may use both

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[22]Freiberg p.480

[23]A. Elnicki, "Substitution of Outpatient for Inpatient Hospital Care : A Cost Analysis", Inquiry. (September 1976) p. 248

[24]Wm. G. Weissert, "Costs of Adult Day Care:A Comparison to Nursing Homes", Inquiry. (March 1978) p. 12

[25]Lipsey/Sparks/Steiner p.884

ambulatory and inpatient care modalities for one or more episodes of illness. It is likely that if no alternate services were available even more inpatient bed usage would occur.

Direct substitution exists in some applications of ambulatory care but with constantly changing needs, especially toward maintenance programs, the real situation is not static. Government appears to be clinging to the direct substitution requirement when approving ambulatory program proposals. Certainly this was true in the communications between St. Paul's Hospital administration and BCHP regarding the implementation of the Medical Day Care Program. (See Appendix VI)

The concern about 'add on' services is understandable and realistic but the resistance to ambulatory services is in conflict with the ideology of optimal health care at least cost for all Canadians.

Hospital-based programs require manpower which is already available and functioning in the health care system but programs such as community health centres which require health professionals to practice in an expanded role would cause manpower difficulties and impact feasibility. There would be need to prepare these workers in sufficient numbers, to have them accepted by the medical profession and to change existing legislation to allow expanded practice. (See Chapter II)

Collaboration

Patterns of collaboration on the part of those individuals and organizations upon whom successful implementation depends are another element of feasibility. Unless the providers of the care services agree upon the goals and methods of goal achievement the enterprise will fail. Teitz writes that professional identification depends upon possession of certain methods which become the insignia of acceptance by clients and colleagues. A profession is made up of three elements, besides maintenance of the traditional problem area, knowledge and organizational integrity, the second element, content innovation, extends the area of control and enhances both self-image and status. The third element, role innovation, is difficult to confront. New methods appropriate to a new context are often too difficult to assimilate and may be rejected in the name of professionalism.[26,27,28,29,30]

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[26]Michael B. Teitz,"Toward a Responsive Planning Methodology", in Planning in America:Learning From Turbulence, ed. by David R. Godschalk, (Washington D.C., American Institute of Planners Publication 1974) p. 89.

[27]James O. Hepner, Donna M. Hepner, The Health Strategy Game. St. Louis : C.V. Mosby Company, 1973.

[28]Michele Vigeoz-Souchon, "Thoughts on Certain Aspects of the 'Mission' on the LCSC's", Canada's Mental Health, (December 1977) p. 8.

[29]"Ideology and Change", Doctors and Doctrines - The Ideology of Medical Care In Canada, (Toronto : University of Toronto Press 1969)

[30]Canada. Task Force Reports on the Cost of Health Services in Canada, Vol. 3, 1969, p. 276.

Despite demonstrations of nurse practitioners providing acceptable and adequate substitution for physicians the role innovation required of the powerful medical profession has killed this effective and less expensive mode of care delivery. Success of this manpower change requires medical cooperation to function unless the medical and nursing acts are rewritten. At this point in time no government is willing to take on the conflict inherent in such a move.

Klein has written that the decision-makers will assess the likelihood of resistance on the part of some important interest group and may decide that a proposal is not feasible. They would consider that pursuing the proposal has less merit than maintaining good relations with the interest group as a form of investment for the future.[31] This would seem to have been partly the case in the discontinuation of further Community Human Resource and Health Centres in B.C. since of five pilot projects the only one that failed did so due to medical resistance. The medical profession perpetuates the myth that appropriate health services are already provided within the existing system and lobbies against services which would

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[31]Rudolf Klein, "Policy Problems and Policy Perceptions in the National Health Service", Policy and Politics. Vol.2, No. 3, p. 227.

be provided outside the traditional medical model.[32]

In Vancouver a proposal is presently circulating which recommends development of ambulatory care programs in the four university affiliated teaching hospitals.[33] This document gives credence to Mitchell's idea that groups re-evaluate their activities and change their behavior but not necessarily their goals.[34]The point of the proposal is that the ambulatory programs in these hospitals would be controlled by medicine/university, demand no role innovation and thereby maintain the gate-keeper function of the physician.

At St. Paul's Hospital, resistance by medical staff has been absent or muted. Concern has been expressed about ambulatory care services competing with the family physicians in the community and the new program did have difficulty with some physicians' resistance to accepting more responsibility for planning the patients' care (which was necessary because time was limited to a 7-hr. period). There has been no serious test, however, for example, no attempt has been made to introduce the nurse practitioner, which would have been a role innovation.

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[32]Anne Crichton, Community Health Centres : Health Care Organizations of the Future? Information Canada, 1973

[33]Hospital Based Ambulatory Care, A Position Paper, September, 1980.

[34]Fred H. Mitchell Jr., "Anticipation Versus Results: An Approach to Improved Forecasting", American Journal of Health Planning (April 1978) pp. 7-14.

Traditional medical practice has not been challenged.

Administrative Capacity

Tests of administrative feasibility involve questions such as - Can the scheme be implemented? Are related policies enforceable? Does an administrative structure exist? Can one be adapted?

The term ambulatory care has a variety of descriptive meanings, dependent upon its application. Services as varied as a visit to a physician's office, visits to indigent clinics, to assessment clinics, home care visits by a nurse and care provided in free standing centres in the United States have been termed ambulatory care. Ambulatory care may be provided as a single episode or numerous episodes for health maintenance or chronic illness treatment. It is described as not requiring an inpatient hospital stay. Yet some services termed ambulatory provide overnight care or a limited stay in a hospital bed.

An additional difficulty with definition is related to the fact that much of what is or could be offered in alternative care delivery falls outside the medical model. The roles of the providers are less differentiated and the role of the patient is much more active than within the hospital structure. It is difficult to categorize activities which do not fit existing administrative norms.[35]

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[35]H.L. Laframboise p. 393.

Governments hesitate to fund, users hesitate to use and traditional providers hesitate to provide services.

Not only do the services rendered vary but the term ambulatory care itself has a variety of disguises. Some of these disguises are public health services, alternative care, outpatient care, ambulatory medicine,[36] partial hospitalization[37] day care and day hospital.[38] Each of these terms has a coloration specific to the user and/or the specific nature of the service.

The lack of administrative organization has troubled planners, both professional and governmental, and is reflected in the paucity of results from several attempts to develop models or outline boundaries for ambulatory care within the health care system.

The lack of explicit standards of care, of standardized record keeping, audit methods and coding systems[39] compounds the administrative difficulties.

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[36]Task Force Reports p. 359 and p.118

[37]Raymond F. Luber. The Scope and Growth of Partial Hospitalization ed. by Raymond F. Luber, New York, Plenum Press, 1978.

[38]M. Farquhar, V.E.R. Earle, "Day Hospitals : a Program Development Perspective", Dimensions in Health Service (January 1981) p. 16 - 18.

[39]Ellen A. O'Neal, "A Framework for Ambulatory Care Evaluation", Journal of Nursing Administration (July 1978) p. 15 - 20.

It is possible that part of the hesitation to accept the MDC proposal was related to the difficulty of funding. Other ambulatory, day care type services have been recognized but expanding into medical as opposed to surgical procedures may have appeared a 'bottomless pit' for funding. It may be, too, that the administrative energy necessary to define acceptable procedures was thought excessive.

Laframboise explains that general classifications allow easier communication and defines the allocation of resources.

> "...organized thinking permits a more rapid identification of inter-relationships and simplifies the assessment of their importance."[40]

He was writing of the entire health care system but the principle applies equally well within one sector of the system. The establishment of a common understanding through language and organization such as attempted by the 1976 GVRHD Ambulatory Services Study Committee would to a long way toward the recognition, planning and funding of alternative care delivery modes within the health care system provincially and nationally.[41]

Authorities assess feasibility within a restricted time span, say between now and the next election, or within accustomed planning periods. This element is well

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[40] H.L. Laframboise, 394

[41] See Chapters II and III

demonstrated by the current 5-year capital construction projection and the recent requirement of hospitals to project work volumes, revenues and costs for the period 1981 - 1986.

There was no established administrative capability in the Ministry to allow easy assimilation of the Medical Day Care Program. There were no previous programs for precedent, there was no established financial recognition of the procedures and services included in MDC and there probably was concern about the extent of this 'add-on' service if it were introduced in many other hospitals. It is probably for these reasons that a pilot project was more acceptable than a permanent commitment.

Support

Hall and associates speak of the 'stock' or 'credit' of a government to make new commitments without losing electoral support. Since policy change alters some features of an existing distribution of power, influence, benefits, status or values it will, inevitably, create satisfaction in some sectors, discontent in others. Whose satisfactions, whose discontents and the general state of the government's public support will be considered in estimating the value of supporting a proposal[42] i. e. how negatively or positively will it affect the party at

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[42]Hall et al p. 483

the next election. In general the discontent of groups which control key resources, for example, medical care, will be avoided as much as possible.

Supporters of a proposal seek further support from what Marmor terms the 'substantial majority'.[43] Through polls, public discussion, White Papers, Royal Commission Reports and locating of supportive groups the government determines with what degree of surety it can proceed to place the proposal in the political arena. The history of Canadian health care legislation amply demonstrates this type of activity.

Klein introduces a very interesting application of the psychological theory of cognitive dissonance. He says this theory suggests that

> "....information inconsistent with existing attitudes will tend to be ignored; there may be an attempt to discredit its sources, there will certainly be a readiness to exploit any ambiguities which justify holding on to one's present views." 44

According to Klein policy-making will remain incremental, based on agreed consensus, but occasionally the incongruity between the model and the experience will prove too great and lead to a change in perception and to a search for new models.[45]

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[43] T.R. Marmor, The Politics of Medicare, Aldine Publishing Co., 1973, p. 95 - 132.

[44] Rudolf Klein, p.229

[45] Rudolf Klein, p.229

Hospital-based ambulatory care services have grown incrementally, program by program and bring no significant reduction in expenditures. There is no challenge to the medical model of health care. The programs assist patients in an undramatic manner; they support the physician because more work can be processed; they allow certain physicians an outlet for individual expertise and may assist hospitals with high occupancy problems. To ignore a hospital-based program proposal would cause no significant repercussions. On the other hand government could create enough dissonance to allow wider implementation of alternative care delivery systems if it chose to do so.

Until recently, government emphasis has been upon cost containment through a cutback program in 1976-77 and, subsequently, by the inadequacy of allocations (especially in the face of inflation and union contract increases). Now in 1981, perhaps, indicating a change in policy, the government has confronted the medical profession over medical services payment schedules. The government's estimation of its 'credit' must be high to confront a group which is usually avoided, if not courted - a group which embodies the government's own entrepreneurial ideology. A crisis of cost has been manufactured over these negotiation results. Government and ministerial statements made clear that the increase demanded by the doctors would jeopardize the system and could not be met out of general revenues but had to be met through higher

premiums and co-insurance. The corrective action undertaken by the government was not directed toward development of less costly ambulatory care but toward a shifting of increasing financial responsibility from government to the individual (government's version of balance billing) for payment of services.

It is interesting to conjecture about the government's choice of action. Was the fee negotiation issue one in which government felt sufficient public support that a confrontation with the medical profession was likely to make political gains in the public eye through a demonstration of fiscal responsibility. In contrast, was the role innovation necessary to develop and operate alternative care systems (such as the community health centres) viewed as a situation in which the public would support the medical profession and thus has been avoided despite proven cost effectiveness?

As Klein and others have written, government usually avoids convrontation with powerful groups. Lukes describes the most persuasive exercise of power as that which is maintained through the willing cooperation of those to be controlled, preventing people from having grievances by shaping their perceptions, cognitions and perferences in such a way that they accept their role in existing order of things.[46] In this society the medical

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[46]Stephen Lukes, Power : A Radical View, Toronto : Macmillan 1974, p. 21-5.

profession has gained this type of power. The general public believes that it is receiving the best possible health care through a medically controlled system. It would take a situation of crisis proportion (extreme dissonance) before government would confront such power if it is assessed that the public would support the medical profession.

As a consequence of these realities, the government will continue to attempt control of the medical function through fiscal control of fees and hospitals. Laframboise writes that only politicians and civil servants are concerned about health care costs.[47] This concern is gaining a great deal of high powered attention currently. Van Loon predicted that, as health care expenditures became more significant, health care decisions would be taken over by public finance specialists, provincial treasurers, premiers and prime ministers.[48] A shake-up in the B.C. Ministry of Health has replaced incumbent clinically trained officials with individuals of administrative and regulatory backgrounds and there are examples of direct intervention by the Treasury Board in Ministry

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[47] H.L. Laframboise p.390.

[48] R.J. Van Loon, "From Shared Cost to Block Funding and Beyond, The Politics of Health Insurance in Canada", Journal of Health Politics, Policy and Law, Vol. 2, Part 4, 1978, p. 454-478.

operations.[49,50,51] It is even rumored that one Minister of Health resigned over Treasury Board intrusion into Health Ministry matters.

Laframboise[52] has suggested that a proposal which solves more than one problem has a much greater chance for acceptance and implementation. The Medical Day Care Program was a partial solution to St. Paul's Hospital occupancy problems but held little or no recognized possibilities for contributing toward the cost containment goals of the Ministry. As a pilot project, the program was simply too small to cause immediate action and was probably finally accepted because of its insignificant effect on expenditures and the possibility that hospital revenues would rise slightly reducing the next annual allocation.

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[49] Six Lower Mainland hospitals' financial methods are being assessed by a consulting firm retained by the Treasury Board.

[50] Interest has been expressed in using a nursing care management toolas a means to fund hospitals. A committee considering this possibility submitted a report in June 1981

[51] The Financial Administration Act is proposed to improve financial control by naming hospitals public bodies and thus subject to direct Finance Ministry intervention.

[52] H.L. Laframboise, Moving a Proposal to a Positive Decision : A Case History of the Invisible Process, Reprinted from Optimum, Vol.4, No.3, 1973.

In contrast, the preferred Long Term Care Program did not offend the medical profession (it took some weight off the doctors) and it seemed to have potential for solving some of the cost problems. At the time of its implementation it was clearly considered to be a vote getter.

CHAPTER VIII

CONCLUSIONS

The question posed at the beginning of this study was why an apparently successful program failed to receive continuing government support when ambulatory care was the health policy of the 1970's in Canada?

This investigation has attempted to set out answers to the question. The rising costs of health care and the lack of integration between parts of the delivery system has led to discussion of new forms of care delivery. Several demonstration projects have shown the effectiveness of a variety of approaches under the umbrella of ambulatory care. Health care could be provided by others as well as by doctors and much more care could be provided on an outpatient basis without any decrease in the quality of the care received and for less cost. Across Canada a consensus developed that ambulatory care was a 'good thing'. Governments included the development of ambulatory care in statements of objectives and goals. The establishment of alternative care delivery systems became the policy of the 1970's.

Ambulatory Care at St. Paul's Hospital

The process of trying to gain government acceptance of the Medical Day Care ambulatory care program was puzzling to the hospital managers. The Ministry of Health

seemed unenthusiastic and did not respond to the submission for ten months and finally responded only after a second submission proposed a pilot project.

By the time the hospital's MDC component of the Ambulatory Care Services was proposed (1976) the administration was aware of the limitations of direct substitution. The major motivation for the proposal was as a solution to occupancy problems although the validity of ambulatory care as a less expensive option had already been proven by the hospital.

There followed requests from the Ministry for more information all of which was financially oriented. The major consideration of these requests remained substitution, even though its limitations were presumably common knowledge, and despite the hospital's stated motivation for implementation. Acceptance of a "pilot" project seemed to allow Ministry officials an opportunity to dissociate themselves and the Ministry from the program should that prove useful.

The MDC Program has been very successful contributing some substitution of inpatient care, and providing some less expensive care and is extremely well received by patients. There was no attempt to change the physicians 'gatekeeper' role, therefore there has been no unwillingness to use the service.

Rival Programs

The program did not even partially resolve the problem of high occupancy due to other events which were happening concurrently and which actually worsened the hospital's situation. Government resources had allowed Home Care to expand to include a hospital day replacement program (1971) which presumably would reduce acute care costs since the length of stay would be shortened. The actual result was that acute care beds were turning over more rapidly and therefore hospitals were dealing with even more patients in the initial very expensive portion of a hospital stay. The anticipated empty beds never occurred.

When it became known that the Ministry was developing a Long Term Care (LTC) Program (1977) it was obvious that other program proposals submitted, including the MDC program would be in competition for resources with a program to which a very large commitment had already been made. Once the LTC program began, January 1978, the numbers of patients occupying acute care beds but not requiring acute care steadily grew from approximately 20 to 100 in St. Paul's Hospital alone. A program which was supposed to assist the elderly to remain with their families actually provided incentives to institutionalize the elderly. The problem of insufficient beds was magnified 5-fold.

As time passed the types of ambulatory care which

actually developed and, more important, those which did not develop, demonstrated where power lay in the health care system at different times. Hospital-based programs developed more quickly and in a manner which supported the traditional, medically controlled health system but they did not go far because the power of hospitals declined during the '70's. Other alternatives to inpatient care suffered from indifference, outright hostility and from the fact these alternatives, for example, community health centres and nurse practitioners required enormous governmental resource input and commitment to effect these changes. Governments, Quebec excluded, after trying out pilot projects, decided against the inevitable confrontations such commitments entailed. Home Care and LTC have had set backs after initial enthusiasm but they seem likely to be more lasting programs.

The initial expectations for the substitution of these outpatient (ambulatory care) services for inpatient services proved overenthusiastic. As the health care system was more and more required to respond to chronic illnesses as well as to acute episodic illnesses the use of outpatient services became primarily an option rather than a direct substitute for inpatient care.

These clouds on the horizon were not visible to a Director of Nursing in a hospital which had accepted the

challenge to develop ambulatory services and was planning in that direction.

Several possible explanations or combinations of explanations for the inconsistencies between stated government objectives and behavior in the development of ambulatory care in B.C. have been set out in this paper. The Ministry of Health objectives would lead one to believe that ambulatory care would be a planning priority but there is no evidence to indicate so. The GVRHD and the hospitals are dabbling in hospital-based programs but government is not exploring the other more significant and conflict filled alternative delivery systems.

Planning literature reviewed indicated that the planning process should be a rational process but in fact is not. Planning appears to be primarily planning implementation of alternatives chosen through a political process in reaction to a number of constantly shifting considerations. Various actors exercise influence on choices to varying degrees dependent upon their power resources, according to their interests and preferences.

There appears to be no overall health care plan for services and programs. The current major effort is focussed on fiscal control of existing services.

The political model of Hall et al elucidated government's behavior as being primarily related to

continuity in the bureaucracy and re-election of the politicians. Government's mandate is so short that it is extremely difficult to make long term commitments or to implement what are seen to be necessary or unpopular measures.

Decisions taken are based upon alternatives chosen for consideration because they reflect ideology, are feasible and will increase the 'credit' of the government with the electorate. These alternatives will usually not include any which involve confrontation with power groups in the society e.g. the medical profession.

With government apparently losing enthusiasm for outpatient as well as inpatient care the alternative remaining is a move toward personal responsibility both in financing health care used and in preventive health behavior. First steps in personal financial responsibility have already been taken. Preventive programs are one of the objectives of the Ministry which have not yet been implemented but the future promises vigorous action.[53]

From Policy Formulation to Management Practice

The process of government acceptance of the MDC program was clearly a fluctuating political process rather than a rationalist planning one. The process a proposal

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[53]The Senior Deputy Minister, in a speech to the Canadian College of Health Service Executives September 17, 1981, stated preventive programs will become a priority of the Ministry directly after fiscal control.

undergoes is dependent upon the specifics of the proposal, the timeliness of presentation, the characteristics of the government and the pressures being experienced by the government and the civil service at a particular time.

It is appropriate that the health care manager assess the forces which will influence any proposal he might formulate and submit for approval in order to design appropriate strategies for presentation and to decide if it is worthwhile undertaking the project since future negotiation might be affected. Laframboise has offered lighthearted and concise means to analyse a proposal for its likelihood of acceptance and suggests means to make a proposal more acceptable.[54]

Implications of Conflicting Ideologies

The federal government commitment to maintaining a health care system is now without question, no matter which of the federal political parties is in power. This commitment is not so clear in the case of some provincial governments. Recent changes in the financial arrangements between the federal and provincial governments has made the provincial jurisdiction in health care explicit. Those provincial governments with conservative ideologies, such as in B.C., are confronted as never before with the dilemma of public expectation of government for the pro-

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[54]H.L. Laframboise, Moving a Proposal to a Positive Decision : A Case History of the Invisible Process, Reprinted from Optimum, Vol.4, No.3, 1973.

vision of health care versus their personal responsibility ideology. Despite Socred ideology it is very difficult to maintain an 'arms length' stance when a growing portion of the government budget is being spent by health care entrepreneurs. Pressures are gathering, demanding a more pervasive government presence in the management of the health care system. The public expectation that government will assure optimal health care be available and easily accessible,[55] the unremitting demand for more and broader services, the entrepreneurial aspects of health care which assume little responsibility for expenditures and, finally, the increasing proportion of public monies expended on health care are major developments which will force a larger government presence. At the same time the public's general lack of dissatisfaction with the present medically controlled model of health care delivery makes politicians very careful about making changes which might disaffect the voter. Every government response to these pressures impacts the health care manager.

The scenario surrounding the hospital is constantly shifting. The hospital has little if any controls to apply. It has no resources other than those allocated by government. Its range of decision-making is severely

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[55]The government does nothing to dissuade people of this expectation hoping to control costs through pressures on administrators of hospitals.

limited and, in a fundamental way, control of health care has been given to the medical profession. The hospital is buffeted by the political requirements of the government which change without warning and the final ignominy is that managements are publicly scolded for poor management practices.

The Social Credit ideology is contrary to government control, and problem-solving techniques applied are those developed in the private sector but lacking the market-place incentives. Concerns about health care expenditures are the prime motivator of government actions since introduction of the new financial arrangements. For several years cost containment programs were expected in each institution but these programs have had no significant results. Now stronger measures have been introduced.[56] REcent allocations are much below even the inflation rate and are presumably incentives to more productive.

The Problems of Delegated Authority

Managers of institutions have already been given warning that performance considered inadequate will suffer the introduction of public administrators. Also a threat to define hospitals as public bodies exists. Despite

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[56]Recently placed advertisements seeking three deputy ministers contain future policy '...to plan, develop and monitor the policies of the ministry to turn it into the most cost efficient government health care organization in the country.' Taken from the Vancouver Sun, July 17, 1981

these incentives it is difficult to see how this pressure on health care managers can possibly succeed if at the same time the government upholds the entrepreneurial rights of the primary cost generators. Continued pressure in this vein will inevitably bring government and the medical profession into confrontation. The government does not wish to control directly or to manage hospitals (although there are those who believe this should occur) and it does not wish confrontation or to exercise control over the medical profession but these two results seem inevitable given the circumstances described.

It can be expected that in the near future government will continue to promise optimal health care, will maintain the health system with "as little government as possible", will use every opportunity to place more financial responsibility on individuals within the political reality, will cut back on services perceived to be less politically problematic, will support private medical practice and care delivery, will avoid add-on services unless politically advantageous and will continue to pressure hospital managers to reduce spending which is essentially an attempt to control medical practice.

True stewardship of the health care system rests with no one. The administrative and regulatory nature of the health care system is affected by these variables. Reaction to specific situations instead of long term

planning, leads to fragmented attempts to control which finally become a contradictory and confusing maze for the goal oriented health care manager to negotiate. Because of the ambiguities, the contradictions and the double messages in objectives and behaviors managers can never be sure of the 'mission' of the exercise.

Suggestions for Improvements

Theoretical models of the health care system would enhance understandings and provide means which would allow quicker responses to innovative proposals. A model does imply previously established objectives as well as a stable environment which allows continuing development and implementation. In reverse a model would give direction to the health care manager developing an initiative.

A model is not the complete answer because models inevitably depict ideologies and therefore would probably be redesigned or at least readjusted with changes in government.

Alford has suggested that little has been written of the political processes which are part of health care systems.[57] Much more must be written if theoreticians as well as practitioners are to build a useful body of knowledge for management. Managers of health care

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[57]Robert R. Alford, Health Care Politics, The University of Chicago Press : Chicago, 1975, p. 15.

institutions have a wealth of case study experience which should be committed to paper and used in the development of theory and models. For the present it is not likely that anything but incremental reaction will occur.

APPENDIX I

COMMUNITY HEALTH CENTRES

Over the past several years considerable attention has been given to the community health centre as a new entry point to the delivery system which would reduce the need for sickness care through providing better first contact (primary) medical care, by providing health promotion activities and by providing preventive services, all through an integrated service contributed to by all health and social workers.

There are problems to overcome before CHC can contribute optimally to the health care of Canadians. Legislative steps would be necessary to allow fully integrated practice among the disciplines, payment systems must be developed, the CHC must be integrated into the overall health system and finally, the public would be required to adjust current perceptions about the doctor being the single purveyor of health care.

Crichton describes the CHC as the centre of a system of communications which sorts out problems and channels them. She sees the CHC as an attempt to find a different balance in health care away from the excesses of biomedical technology.[1]

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[1]Anne Crichton, Community Health Centres : Health Care Organizations of the Future? (1973) p. 19.

A spin-off of a reduction in the use of 'bio-medical technology' would be reduced use of acute care hospitals and an eventual readjustment of the number of acute care beds available.

The concept of one establishment combining primary medical care and organized preventive services was first formulated in the report of the Consultative Council on Medical and Allied Services meeting held in 1920 in England.

In Canada, some more recent major reports have specifically recommended the establishment CHC. The Castonguay-Nepveu Report 1970,[2] the Manitoba White Paper 1972,[3] the Foulkes Report 1973,[4] and the Hastings Report.[5] The Mustard Report in the Province of Ontario 1974 agreed that CHC were a goal but that they were not the immediate solution.[6] The report stressed more control and planning in the proposed reorganization but not necessarily the CHC

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[2]Quebec. Commission of Inquiry on Health and Social Welfare. 1970 - 71.

[3]Manitoba. White Paper on Health Policy. July, 1972.

[4]British Columbia. Health Security for British Columbians, Report of Richard G. Foulkes to the Minister of Health, December 1973.

[5]Canada. Department of National Health and Welfare. The Community Health Centre in Canada, 1972.

[6]Ontario. Report of the Health Planning Task Force, January 1974, p.15.

Foulkes thought the CHC could be part of an acute hospital operation which would allow close relationships and sharing services.[7] Only two provinces have actually developed versions of the CHC separate from the hospital.

The Quebec government, acting upon the recommendations of the Castonguay-Nepveu Report, is the only government which has undertaken to restructure the province's health care delivery system. There are three operational levels in this restructuring, the local health centre, the community health centre (the general hospital) and the university health centre, all to be found operating within a single health region.

The new component of this stepped delivery system is the local health centre which offers primary care and ambulatory medical services and basic social services. The centres are responsible for the health of the entire population in the community (10 - 15,000) and for continuity of care.

M. Vigeoz-Suchon, a Montreal CLSC Administrator, believes the 'raison d'etre' of the CLSC (Centre Local de Service Communautaire) is preventive action; that the major mandate is not to assume general curative care.[8]

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[7]Foulkes II, 1-3

[8]Michele Vigeoz-Suchon, "Thoughts on Certain Aspects of the 'Mission' of the LCSC's", Canada's Mental Health, Vol. 25 (December 1977) p.8.

Begin writes that CLSC refuse to be local health centres defining for themselves a political role that is aimed at 'consciousness-raising' regarding ecological, social and economic conditions as the first step to health promotion.[9] The responsible Ministry seems to differ with this interpretation of the CLSC's mission. Diagnosis and primary medical and social treatment, screening and education programs are the intended major mission. Community action is seen as a support activity only.

At present, in British Columbia, there are four functioning Community Human Resource and Health Centres (CHRHC) which began as pilot projects during the NDP government of 1972-76.[10]

Two ministries, Health and Human Resources, agreed to develop the concept of a community centre together. The enabling legislation was brought forward by the Ministry of Human Resources rather than the Ministry of Health because health services offered in a community health centre were much more controversial than social services.

A Development Group was established including people from the Foulkes staff and from the Ministry of Health.[11]

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[9]Clermont Begin, "Can the HC's and the LCSC's Co-exist?", Canada's Mental Health, Vol. 25 (December 1977) p. 11.

[10]History of the Development Group was by personal communication from Paul Pallan.

[11]Implementation of recommendations found in the Foulkes Report began before the report's publication.

It was to develop the principles of operation for a number of centres around the province which would be established as pilot projects. The Ministry of Health received requests from many communities wishing to be the site for a pilot project. Only five were chosen due to cost implications They were chosen because of particular characteristics which would lend themselves to evaluating the concept of CHRHC in a variety of settings. Queen Charlottes had a defined population, James Bay was the urban setting, Houston and Gran Isle were newly developing industrial towns and Grand Forks where the doctors had shown interest in establishing a new delivery system.

Informal advisory groups were formed in each community and acted to determine community needs and to develop a submission to the Ministry until enabling legislation was passed in 1975. Thereupon formal Boards were elected by the community in municipal elections. Once the community's submission had come forward the Development Group developed the ramifications of the implementation. When accepted, the Group worked with the community.

A major problem was the hiring of staff. The health disciplines already functioning in the community were to be integrated into the CHRHC through seconding arrangements. Other necessary staff would be employed directly by the Centre. The seconding arrangement placed into question

the lines of responsibility to be followed. There was outright disagreement with the philosophy of the concept and there was fear of losing control on the part of the existing agencies.

Due to the hostility which finally developed among the doctors and the short tenure of the NDP government the centre in Grand Forks never began.

Once the Social Credit party returned to government the Development Group was required to give reason why the CHRHC project should proceed. The government argued it was duplication of services. The group argued that the investment had already been sizeable, that services in the community had improved significantly and that the government could expect a public outcry if the centres were discontinued.

The Development Group was given 12-18 months to conduct an evaluation of the centres. An independent audit committee composed of representatives of the RNABC, BCMA, BCASW, Ministry of Health, Ministry of Human Resources, the Chairman was a member of the Faculty of Commerce at the University of British Columbia, was struck and the report submitted to the Deputy Ministers of Health and Human Resources, February 28, 1977.

The audit committee was to evaluate the degree to which the goals of CHRHC had been met. These goals were

to

1. foster coordinated and integrated services
2. be preventive in focus
3. have community involvement in operation and planning
4. be cost effective

The audit committee's task was difficult because of the very short history of the centres. The committee's report could not be definitive but did state that all centres were making good progress, that the existing four should be made a permanent part of the delivery system, that others should be started and that medical, social services and public health facilities in urban areas should be similarly coordinated.

In investigating the cost effectiveness goal the committee found that the communities with centres were spending more for primary care than other similar communities. The increase was approximately 8-10% per capita. On the other hand the committee found a 20-30% decrease in hospital utilization. The committee recommended continued establishment of community health centres.[12]

It would appear these results were unexpected and unwelcomed by the government. As a consequence the evaluation period continues with no termination date and no activity. No more centres have been developed and

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[12]British Columbia. Report of the Audit on Community Human Resources and Health Centres in British Columbia, February 28, 1977.

the established centres are well able to manage their own affairs through the elected Boards. The Development Group was given different activities and the centres were transferred to the Special Care Services Division in 1979. The remaining four centres are funded through grants, one from Human Resources and one from Health. These grants pay for doctors salaries as well rather than the usual arrangement of payment to doctors from Medical Services directly.

Other communities, e.g. Pender Harbor, Lumby, Courtnay have evolved Community Health and Human Resource Centres under the Community Resources Board legislation. These centres are controlled and organized as societies, staff of the centres cooperate with existing community health and social workers. The committee stated that these attempts to integrate services were laudable but they did not achieve the same quality as the pilot CHRHC and that government support of the nature of the Development Group was essential to start up.

APPENDIX II

THE UNIVERSITY OF BRITISH COLUMBIA
CONTINUING EDUCATION IN THE HEALTH SCIENCES
CONTINUING NURSING EDUCATION

An Educational Programme for Expanded Nursing Roles in Primary Health Care

University of British Columbia
School of Nursing

PROGRAMME OBJECTIVES

The first objective of this programme is to prepare nurses to function in expanded roles in primary health care in British Columbia. Through the programme, efforts will be made to evaluate the effects of nurses functioning in expanded roles in the delivery of primary health care and to evaluate patient attitudes toward care received from nurses in this role.

A second objective is to teach physician and nurse associates to work together effectively in the delivery of primary health care.

PROGRAMME SPONSORSHIP

The Provincial Government of British Columbia has funded The University of British Columbia School of Nursing for two years to implement and evaluate this programme. The Millbank Foundation has also provided support for interprofessional workshops. Programme implementation will be through the Division of Continuing Education in the Health Sciences, University of British Columbia.

The programme is endorsed by the Registered Nurses Association of British Columbia and by the College of Physicians and Surgeons of British Columbia.

PROGRAMME STRUCTURE

Three types of educational offerings are planned: (1) supplementary programmes of 2 to 5 days duration for nurses already in expanded roles or those having had equivalent experience and needing to fill gaps in their background; (2) a preparatory programme of approximately 12 weeks for nurses wishing to work in the field of primary health care and needing a general introduction to community practice; and (3) interprofessional programmes of approximately 3 to 5 days duration for physicians and nurse associates already working together or for those wishing to enter this type of practice and focussing on team work

St. Paul's Hospital

VANCOUVER 1, B.C.

APPENDIX III

April 18, 1977

Mr. J.G. Glenwright,
Associate Deputy Minister,
Hospital Programs,
Department of Health,
Parliament Buildings,
Victoria, B.C.,
V8V 1X4

Dear Mr. Glenwright,

re: Ambulatory Care Services

We have witnessed in the past ten years an enormous upswing of surgical day care in British Columbia making it possible to treat an ever increasing number of patients on a day care basis. Through this system it is now possible to keep numerous patients out of in-patient beds which results in significant savings and benefits.

At St. Paul's Hospital the number of surgical day care cases during 1976 increased to 2,247.

BCHP has promoted greatly the development of ambulatory care programmes not only in surgical day care but also in psychiatric and diabetic day care, and in the treatment of patients requiring renal dialysis etc.

In our opinion a number of medical patients who are presently admitted to in-patient beds could be cared for on a day care basis. Ambulatory care allows an intermediate level of care between office practices and hospital admissions.

Already during the BCMC era St. Paul's Hospital was assigned a very significant role in offering ambulatory care in the Greater Vancouver area. With this in mind the Out Patient Department was renovated allowing a separate area for medical day care patients which would make it possible to introduce a programme for investigation and treatment of these kinds of patients, which are either - now admitted as an in-patient or treated in other areas scattered all over the hospital. The area is now called the "Ambulatory Care Department" and the renovations have just been completed but the area reserved for medical day care is still empty.

Medical day care patients would differ from surgical day care in that they would not be requiring a general anaesthesia for the certain procedures carried out.

St. Paul's Hospital is most anxious to explore and develop ambulatory care methods of treating patients, not with the prime goal of attracting more patients, but to provide a more efficient type of care at a lower cost and, at the same time, develop a system of coping effectively with the continually increasing workload demand over which we have little or no control.

As there is, at present, no budgetry provision for funding of additional ambulatory care services which we believe are feasible, and as we have a facility capable of accommodating such progracs, with minimal additional operating costs to our existing services, we wish to propose the following to you:

1) That St. Paul's, jointly with BCHP and GVRDH develop a pilot ambulatory care project at St. Paul's Hospital to:

   (a) determine the feasibility of the various types of services we visualize for day care and the impact of such a service on current in-patient services and related programmes;

   (b) identify costs and benefits;

   (c) identify an appropriate method for funding of approved and feasible services;

   (d) establish criteria for the planning of the ambulatory care facility as proposed in the Phase I redevelopment project.

2) That officials from BCHP and GVRDH work with the staff at St. Paul's Hospital to determine:

   (a) objectives of the pilot project;

   (b) specific services, or procedures, to be provided within the facilities available;

   (c) the operating costs and the method of funding;

   (d) policies for operating the programmes;

   (e) implementation and evaluation.

A great deal of thought has been given to ambulatory care programmes by the members of our medical and hospital staff. A synopsis of existing ambulatory care services and an indication of what kinds of services could be provided is attached as Appendix "A".

It is rather unlikely that even with the reduction of beds the patient demands will change, though through this approach to medical care we will be able to take care of those patients who do not need acute in-patient care. We do not visualize a so-called "added on service". We just want to maximize the opportunity for diagnostic and treatment services on an Ambulatory Care basis as an alternate to an in-patient mode of delivery and will offer a high level of clinical skills, often of an inter-disciplinary nature, to a multitude of patients who must be investigated and/or treated.

The Staff at St. Paul's Hospital has spent a great deal of time in planning a viable programme for this type of service.

In your letter you ask for more information about the number of admissions, the projected number of patient days and the anticipated savings that could be the result of such a Medical Day Care Programme.

The impact on in-patient load is estimated as follows:

We anticipate that we will be able to replace 10 acute beds after we have introduced the service based on (1) 93% occupancy which has been our experience for the year 1976 and (2) our length-of-stay for medical patients of 11 days. We feel that this service can obviate the admission of 300 or more patients with the savings of approximately 3400 patient days.

With the loss of 10 acute beds we can visualize a staff reduction of:

R.N.	3.5	$52,780.
P.N.	1.5	19,296.
Unit Clerk	1.0	11,160.
Aide	1.0	10,740.

20% for fringe benefits should be added to this amount which brings it to a total of $112,771.

The estimation of cost reduction in medical supplies and drugs amounts to $26,220.

These cost figures are based on the 1977 salary rate. The total cost reduction for salaries, medical supplies and drugs is $138.991. These are our estimates of cost reduction in the direct component of care at the bedside of the patient. It is impossible to calculate the indirect cost reduction with the decreased number of beds. We estimate, for instance, the cost of portering a patient from the Ambulatory Care Unit to Radiology, and Laboratories and other departments, will be off-set in portering the patient

who otherwise would have been admitted in one of the in-patient beds prior to the reduction in bed numbers.

Statistical Workload Projection

This programme is anticipated to commence on January 2, 1978. We expect to start with 3 to 4 patients per day which will gradually increase to 10 patients or more a day. An estimated 1500 patients will be admitted to the Medical Day Care Unit in 1978.

Projected Operating Cost of New Service

This can be divided thus - (a) Operating Cost and (b) Capital Cost.

Operating Cost:

Nursing	1.6 RN	
Unit Clerk	1.0	
Pharmacist	0.5	
Clerical Staff	0.4	(Admitting Dept.)
Clerical Staff	0.2	(Med. Records Dept.)

Total salaries = $61,238.

Added to this will be the cost of perquisites amounting to 20% which amounts to $73,485.

Trays and supplies at $10.00 each	=	$15,000.
Drugs at $5.00 per patient	=	7,500.
Dietary services 10 meals/day at $2.50	=	6,250.
Forms and Stationary	=	1,000.

This amounts to $29,750.

Total operating costs are estimated at $103.235. based on 1977 salary rates.

Capital Cost

The cost of equipment necessary for the opening of the Medical Day Care Unit totals $12,030. (see Appendix III).

Please find enclosed the functional program developed for the department and the policy for the operation of the Clinic (see Appendix IV).

A system to assess the quality of care and to evaluate the effectiveness of the programme will be introduced when the program

is initiated. We will provide you with a report of this evaluation as well as the statistics at the end of the year and we sincerely hope that it will be a successful project.

We would request your comments and early approval for the Medical Day Care Services so that we may proceed with the hiring of the Staff prior to introduction of this programme on January 2, 1978.

Yours sincerely,

H.D. McDonald, M.D.
Executive Director.

encls.

cc.: Dr. C. Ballam
Medical Director
Finance Director
Director of Nursing.

/CJM

aged person can function independently following discharge. This requires health maintenance instruction in hospital, as well as health maintenance amublatory care facilities to prevent or minimize acute episodic illness so that they can function in the community and enjoy life to the maximum degree possible. Such programs are diabetic clinics, pacemaker clinics, high blood pressure clinics, arthritic clinics and geriatric clinics.

3. The socio-economic population - the area served by St. Paul's Hospital has a large number of unemployed, drug addicts, alcoholics and a high incidence of psychiatric illness. Programs and facilities must be provided within the hospital not only to manage the illnesses of these individuals but to attempt to return them to a more productive life.

The primary method of providing for these types of community needs will be through the ambulatory care program, particularly in the general practice clinic and the multi-disciplinary clinics where much of the care can best be provided by nurses and other health workers supervised by a physician.

If the objectives of ambulatory care services are to be achieved - i.e., emphasis on health maintenance and prevention of illness; provision of alternate diagnostic and treatment services for patients not requiring in-hospital admission - then such services must be carefully organized and directed. Of equal importance, results must be evaluated in an on-going manner to ensure that objectives are being reached and that we are not simply adding "another tail to the health delivery system dog."

St. Paul's was therefore delighted to read in the Mr. and Mrs. P. A. Woodward's Foundation Annual Report that the Foundation Funds would be "directed to very special activities which cannot and should not be financed from government or other public funds." It is our belief that the new cost sharing formulas between federal and provincial governments will remove the constraints which have previously prevented either the establishment or evaluation of this type of program. However, as in the past, the early realisation is only achieved through the stimulus of private funding, e.g., intensive care and coronary care units, and the G.I. lab.

St. Paul's hopes that the development of a major Ambulatory Care Centre lies within the Terms of Reference for grant support outlined by the Foundation.

We therefore request that the Mr. and Mrs. P. A. Woodward's Foundation give approval in principle to a grant of $30,000 per annum for a period of three years to support a qualified director of ambulatory care services whose functions shall be to "organize, direct and evaluate the development of exemplary ambulatory care services at St. Paul's Hospital." - such approval in principle being contingent upon -

1. the hospital's ability to attract the right person to carry out these duties,

2. written assurance to the Foundation from B. C. Hospital Programs that it concurs in the development of a major Ambulatory Care Centre at St. Paul's Hospital.

The program thus developed will serve as a model ambulatory care service and teaching unit for development in other centres in the province.

Your consideration of this request is most appreciated.

Yours sincerely,

H. D. McDonald, M.D.
Executive Director

HDMcD/bws

British Columbia Social Credit Party

THE FOUR PRINCIPLES

Social Credit is based on four basic principles. These principles are our political guidelines. These principles show how and where we stand as a political party, and how we believe as members of the party.

For your information, they are as follows:

1. The individual is the most important factor in organized society and as a divinely-created being with both spiritual and physical potentials and needs, has certain inalienable rights which must be respected and preserved.

2. The major function of democratic government in organized society is to secure for the people the results they want from the management of their public affairs as far as such results are physically and morally right.

3. Security with freedom. Material security alone is not enough.

4. Whatever is physically possible and desirable and morally right can and should be made financially possible.

Social Credit is unalterably opposed to communism, fascism, and all other forms of socialism which make the individual citizen subservient to the State. Social Credit recognizes the family as the basic unit of society and regards the sanctity of the home as fundamental.

Social Credit means the credit of our society to have and to use the goods and services that we as a nation are able to produce under a competitive free enterprise supply and demand economy.

Social Credit believes in the principle of helping people to help themselves.

We believe that a free economy, based on good moral principles can provide a better way of life for those in need. We believe that one cannot have freedom without responsibility.

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