QUALITATIVE STANDARDS-SETTING FOR CANADIAN HEALTH CARE SERVICES

by

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Abstract

The purpose of this study was to examine the process of standards-setting in the Canadian health care system to determine how quality health services are assured and maintained for the elderly population who require care. The interrelatedness of all aspects affecting the provision of quality services was examined: the professional, organizational and administrative aspects governing care delivery.

The historical development of health care standards-setting revealed the unsatisfactory nature of regulatory activity in Canada. A shift from a focus on structural standards to a preference for peer-review mechanisms established the professional mechanisms as the preferred means of control; essentially, quality health care services were equated with meeting the normative standards of practice. These professional aspects of care delivery, however, increasingly have led to the medicalization of needs and the fragmentation of services.

Standards-setting, from government legislative standards to quality assurance programs, supported and promoted normative practices that tended to escalate costs and provided the wrong incentives for acute and long term care services. The evolution of the long term care services in British Columbia was identified to illustrate the deficiencies in the current approaches to health care standards-setting.

Gaps existed in the provision of services for the elderly who required long term care. The nature of long term care services was
examined and discussed. Long term care services were not so much based on outcomes, as in the acute care system, but on the processes of care -- the aspects of care provision that would enhance the quality of life for the elderly who require health care services. Current standards-setting practices did not address or provide for these services.

The administrative aspects governing care provision were explored as a means to assure quality service delivery. Canadian health care developments were compared to those in the United Kingdom and the United States. Regardless of the approach -- in the United Kingdom with its national Health Service, or in the United States with the proliferation of regulatory activity -- costs continued to increase and conflicts arose between the professional and administrative aspects governing services. It becomes apparent, however, that as cost constraints increase micro-level decisions will become more dependent on macro-level decision making.

Current standards-setting practices do not address or provide for services that require expanded models of care provision. Appropriate standards-setting for care processes, therefore, must include not only the professional aspects but take into account the administrative and organizational aspects when developing services.

Based on the findings of the study, recommendations are made for standards-setting for long term care services.
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DEDICATION

To my children, Andrew Tovey and Christine Tovey

and

my parents, Phyllis and George Greenwood.
SECTION I  Introduction
CHAPTER I

INTRODUCTION

The purpose of this study is to examine the process of standards-setting in the Canadian health care system to determine how quality health services are assured and maintained for the elderly population who require care. Qualitative standards-setting is examined in detail to answer the question "are the current standards-setting mechanisms appropriate for assuring the quality of long term care service developments for the elderly in B.C.?" To accomplish this, the study will:

1. identify the development in qualitative standards-setting in Canada to determine the nature of the process for assuring quality health care services;¹

2. identify the developments in long term care services to determine the nature of the process for comprehensive service delivery;

3. determine appropriateness of current standards-setting practices for assuring quality services for the elderly;

1. See Appendix A for the approaches to evaluating quality of care in the Provincial reports listed.
examine how government involvement in redistributive policies changes the context in which standards-setting occurs; so that the study will recommend how standards-setting can occur for the provision of quality (comprehensive services) and for long term care services, in particular.

DEFINITIONS

In developing its argument, the study employs certain terms that require definition. For the purpose of this study, Slee's (1982) definition of quality as:

... the degree of conformity with generally accepted principles and practices, and the degree of attainment of achievable outcomes, consonant with appropriate allocation of resources ... (p. 1)

is challenged. The term standard, defined as

... an authoritative or recognized example of correctness, perfection or some definite degree or any quality or something set up as a rule for measuring, or a model to be followed (Webster, 1971:2223)

Normative standards are those relating to or dealing with norms, their nature or mode of discovery and existence (discipline) (Webster, 1971:1540)
whereas

Empirical findings are those based on factual information and capable of being confirmed, verified or disproved by observation or experiment (Webster, 1971:743).

Regulation is broadly defined as "principles, rules or laws imposed by external authority for controlling or government behaviour" (A.H.A., 1977:1). The term regulation takes on varying shades of meaning and its interpretation has become highly controversial. While direct control is "having the power or authority to direct, to regulate or to keep within limits", indirect control "occurs when an agency exercising authority attempts to establish limits on their behaviour" (1962:208). The Economic Council of Canada (1978) defined regulation in an interim report as:

... a political-administrative process specifically designed to replace or modify the operation of economic markets, or, in some cases, to fill gaps where no markets exist. Both the decision to regulate and the decision to change regulatory processes significantly are made in the political arena. For these reasons, the Council has found it necessary to examine both administrative and, to a lesser extent, political processes (p. XI).

Regulatory mechanisms, therefore, are intended to modify or constrain the behaviour of health care providers or health care insurers, including the training of such providers and the entry of such providers (or insurers) into the health care system.
FORMAT OF THE STUDY

The scope of the research is substantive in nature, leading to the identification and examination of the historical developments of normative and empirical standards set for health care and their effect on long term care institutions. The method of data collection is through examination of relevant documents, agreements and regulations, review of the literature related to standards, and the collection of expert opinions.

The study is organized to accomplish the list of objectives set out above. The nature of standards-setting in the Canadian health care system is determined. Chapter II identifies the historical development of Canadian health care standards-setting. Chapter III identifies Canadian government involvement in the funding of health services. Chapter IV, then, examines the specific standards-setting mechanisms that are available for standards-setting.

The next section examines the nature of standards-setting for comprehensive health care programs. Chapter V identifies the evolution of long term care in British Columbia as a separate service within the context of the general health care developments. Then, Chapter VI examines standards-setting for long term care services. Chapter VII examines the comparative development in standards-setting to determine how to proceed with standards-setting for comprehensive services (long term care).

The conclusions and recommendations in Chapter VIII reflect the developing argument of the previous chapters.
SECTION II Standards-Setting for Canadian Health Care Services

Section II determines the nature of the standards-setting processes in the Canadian Health care system for assuring quality health services delivery. The historical development of qualitative standards-setting is followed by government involvement in the funding of health services. The specific standards-setting mechanisms are then examined, to provide further insights into the standards-setting process.
CHAPTER II

HISTORICAL DEVELOPMENT OF HEALTH CARE STANDARDS SETTING

This chapter explores the historical development of legislated, educational, professional and institutional standards. As these evolve, mechanisms are created that ensure the standards are maintained.

The pre-Confederation period in Canada was characterized by limited government involvement in social service provision. Religious organizations, families and voluntary lay groups managed matters of health within local communities. Hospitals and personal social services were organized by religious orders as charities or by citizens' groups, sometimes working with municipal authorities. These institutions were devoted to the care of people whose needs were largely social rather than medical.

The first hospitals in Canada were in settlements along the St. Lawrence Valley. These institutions were mainly refuge centres for orphans, the aged poor, the infirm without resources and the sick poor. Buildings were built for the insane as early as 1714 (Hastings & Mosley, 1966:1). Provision was made for the care of lepers in 1844 (Cameron, 1972:1). It was not until after the American Revolution that Canada began to receive any great volume of immigrants, but when boatloads bringing cargoes of sick people began to arrive in the St. Lawrence Valley the problem of infection control started to create demands for government action.
LEGISLATED STANDARDS

Government action was basically reactive. After 1832, colonial departments of health, concerned primarily with public hygiene, established local boards of health. These were intended to control epidemics and were often disbanded when the immediate threat of disease subsided. Standards were set for reporting infectious diseases and for certification of those in danger to themselves and others in the community. For example, an act in 1707 controlled the sale of meat; in 1821 quarantine stations were established (Heagerty, 1934:54); an ordinance in 1748 dealt with foundlings (Gregoire, 1972:65) and an Act in 1820 made provision for sick and disabled seamen (Gelber, 1973:3). Programs and legislation were limited, specific and quite localized. It was not until the second half of the 19th century that legislated standards were generalized and clearly spelled out. This became necessary when the four existing provinces decided to federate, and had to decide what were federal and what were provincial responsibilities.

The British North America Act (BNA) 1867, joined the British Colonies in North America into a Federal Union. The provinces were to retain certain powers and authority: Sections 91 and 92 of the BNA Act outline the distribution of powers to parliament and the provincial legislatures. The Act allocated the powers of "quarantine control, the establishment and maintenance of marine hospitals, and health services

1See Appendix B for BNA Act.
required by immigrants, the military and convicts" to the federal government. These services were to be administered by related departments with no specific reference to health care issues.

Regulation of health care institutions was essentially retained by the provinces. The exclusive powers of provincial legislatures were described in Section 92:7 of the 1867 Act, and included

the establishment and maintenance and management of Hospitals, Asylums, Charities and Eleemosynary Institutions in and for the province, other than marine hospitals (Bryden, 1974:20-22; Canada, 1970:16-20).

Any jurisdiction that was not specifically assigned to federal responsibility necessarily fell within the provincial domain. The mechanisms used to control institutions was a Societies' Act which required the bodies named above to report on their accounts to a Registrar once yearly.

As noted above, hospitals were originally refuges or asylums for orphans, the aged poor, the infirm without resources and the sick poor. Physicians rarely visited these institutions. Although anaesthetics were introduced between 1840 and 1950, they were used in offices and homes. With the advent of microbiology, the growing knowledge of asepsis after 1860 allowed patients to be treated with a greater degree of safety in institutions.

There was reluctance, however, to enter hospitals due to the fear of infection and it was not until the 1920's that this reluctance decreased in Canada (Agnew, 1974).
In Britain, with the growth of a scientific approach to medicine in the early 19th century, voluntary hospitals began to be used as training centres for doctors. When the germ theory was developed and infections began to be controlled, a battle for authority over the hospitals was joined. The original purpose of these institutions had been to relieve poverty through charitable contributions of money or services, but after the introduction of aseptic medicine they were becoming centres for the treatment of the sick.

Canada did not have many charity hospitals in the mid 19th century. There was less struggle for control here since most institutions were opened after the new medical function of general hospitals had been established. By the late 19th century they were seen to be workshops for doctors treating sick people who were admitted on grounds of illness, not poverty. This change in objectives was important; until the goals were clear, standard setting could not begin.

In due course, provincial governments removed hospitals from the Societies Act. They were recognized to be different - to have large professional staffs who were not employees but who needed to be regulated by some method or other. Thus the Hospital Acts have two main functions: regulation of accountability for funds, and regulation of accountability for quality of care given by the medical staff.

Responsibility for the day-to-day management of hospitals rests with a Board of Trustees, which delegates to the Medical Staff the duty of providing quality care. The mechanism of "hospital privileges" determines access to the institution and provides the potential for strong control over the quality of service (Kessel, 1958:25). The Board
grants hospital privileges on recommendation of the senior medical staff, who make the actual decisions. In 1971 the Ontario Minister of Health, Lawrence, established a Commission of Inquiry into a denial of hospital privileges. The Grange Report (Ontario, 1970-71) suggested rationalizing the process - a recommendation opposed by the Medical College. It was ruled that the Ontario Cabinet actually had the power to overrule Medical College Council decisions. A provincial Hospital Appeal Board was established in 1971 to hear appeals from doctors denied hospital privileges by Boards. This provided an example for other provinces.

PROFESSIONAL STANDARDS

As outlined above, most institutions were religious charitable organizations in the early days of the colonies. Physicians acted as consultants to these charitable institutions, and in settled areas they managed health matters and policies within their local communities.

Canada inherited both British and French traditions in the practice of medicine as, at first, all physicians were immigrants. From the early 19th century an entrepreneurial system existed. Medical power was based on a free-enterprise system regulated in a minor way by British common law precedents. Canada inherited the traditions of Stratton v. Swanlord (1374) which established a concept of malpractice based on normal standards (Hilary, 1374), and a ruling by Bonham (1609) that established the right of the judiciary to overrule the legislature (Sharpe & Sawyer, 1978:13). As well there was a tradition developed in
the exclusive Royal College of Physicians that it should be a self-regulating body with sharp punitive powers, accountable to no public authority. These British precedents had influence on the attitudes of Canadian governments to the medical profession.

There was little definite control of the profession until 1788, when an act governing conditions of practice by Medical Boards was passed in Lower Canada. Similar boards were established in Upper Canada in 1795 and Nova Scotia in 1828, but there was little control over large numbers of unlicensed practitioners until the late 18th and early 19th centuries. Some early practitioners in Canada had diplomas from recognized European Universities; some had no credentials at all. The borders were open and medical entrepreneurs from the U.S. moved from one side to another at will. This led to some very 'fly-by-night' practices, especially in the frontier areas.

Practitioners who felt this situation was not in the best interest of the profession, petitioned governments to empower them to set standards and license practitioners (Canadiana, 1963:8). The College of Physicians and Surgeons of Upper Canada was formed in 1843 for this purpose. However, the first real Medical Act was passed in 1865 in Ontario with the formation of the Royal College of Physicians and Surgeons. Medical Acts provided a rational basis to registration and the movement towards a system of self-government for the medical profession.

In keeping with the BNA Act, responsibility for personal health care was exercised by the provinces, who delegated the authority to physicians, regulated through Medical Acts that brought the medical profession into direct negotiation with governments.
Collegial associations evolved. The standards for medical practice, however, remained dubious for a long time in North America. Unlike collegiality in Britain, this system in Canada did not, at first, have the effect of ensuring adequate educational standards among registered practitioners.

EDUCATIONAL STANDARDS

Patterns of medical practice grew from two closely related factors, medical teaching and the regulation of practice. At first, and for many years, medical schools were self-governing and independent of the universities. The relationship was affiliation for the granting of degrees. Medical schools evolved where the need was apparent. Montreal Medical Institution was opened in 1873, later to become the medical faculty of McGill University. In Ontario, various medical schools became part of the University of Toronto in 1887. In Newfoundland there were no medical schools; medical practitioners were graduates of English and Scottish Universities and were scattered in small settlements. Western Canadian medical schools were established later and developed in similar ways, in response to the needs of the community.

The Medical Council of Canada, established under the Canada Medical Act (1865), was empowered to examine candidates for medical registration on behalf of provincial medical licensing bodies. Although the Medical Council was able to set a uniform standard for graduates from universities across the country, numbers of immigrant physicians who
arrived would go straight to the province of their choice and take the provincial College's exams. Gradually, the provincial Colleges developed restrictive entry criteria, being unwilling to admit candidates who had not received training in recognized University programs. And it was not until 1929 that a Canadian Royal College of Physicians and Surgeons for specialists was established with restricted entry requirements.

In Britain, empirical standards had come to be seen as important and hospitals used for scientific research became more prestigious. In North America the whole question of medical practice standards and their relation to empirical research was raised by the Flexner Report (1910), which began the first serious effort at qualitative manpower planning. This study of medical education in the United States and Canada focused attention upon the need for adequately trained physicians. It was particularly critical of many of the medical schools on the continent at the time. Of the schools in Canada, only McGill University and the University of Toronto were rated as excellent. Upgrading came through closure of many marginal schools and revision of admission criteria, standards of curricula, qualification of faculty, and a firmer basis of financing in those that survived. This was consistent with a realignment of the method of North American medical education from apprenticeship to formal scholarly training by scientists and physicians devoted to research. The Flexner Report set the basic development plan for scientific medicine. It accelerated the pace of educational and service changes, and received substantial backing from wealthy corporations and the government.
After 1910, North American educational standards for practice began to be addressed. Research was promoted and studies such as those by Codman (1914) pointed out the real need to improve the quality of surgical care and surgical education in hospitals, for new surgical treatment methods required facilities that were available only at hospitals. Technological discoveries in medical science, in turn, necessitated specialization in the services provided in the diagnostic and treatment centres which hospitals had become.

Medical teaching changed chiefly in the direction of adding more instruction as more knowledge was accumulated. The difficulty of developing satisfactory curricula became apparent. As specializations grew, the inability of an individual practitioner to have comprehensive knowledge of medical advances became a concern. Rekindled concern for quality of care as the increasing costs of health care were increasing led to the Federal grants for hospital construction (1949) and health resources facilities (1965). Concern for educational standards extended this second aspect of federal funding for hospitals that were educational facilities until 1980. In 1976, Crichton wrote of the medical schools:

The position of the Medical schools in Canada is very ambiguous. They do not seem to be regarded as arbiters of quality medical care nor as the apex of the referral system in Canada. Yet they have these functions in other countries. In Canada they are seen only as a very expensive part of the post secondary education system (1976:63).

As the Medical Schools developed, students were subjected to a prolonged period of socialization and training in which they were
expected to internalize standards, acquire a repertoire of skills and master a general set of theoretical principles that would enable them to make decisions and act autonomously in a responsible and expert fashion. Internal controls were developed that guided the profession and controlled the practice of medicine in Canada (Clark, 1964).

Different groups have been successful in lobbying for recognition and improving educational standards. The nursing profession in British Columbia, from 1923, for example, worked towards raising educational standards that were achieved with the revision of the Act in 1946. National academic standards are now set for the health disciplines in Canada. Medical schools are accredited by the Liaison Committee on Medical Education of the Canadian Association of Medical Colleges and the Association of American Medical Colleges. Allied provincial health personnel professional associations have accredited other programs through the assistance of the Canadian Medical Association (Roemer and Roemer, 1981).

PROFESSIONAL CONDUCT

The Code of Ethics of the Canadian Medical Association enunciates seven principles of conduct:

I Consider first the well-being of the patient.

II Honour your profession and its traditions.

III Recognize your limitations and the special skills of others in the prevention and treatment of disease.
IV Protect the patient's secrets.

V Teach and be taught.

VI Remember that integrity and professional ability should be your only advertisement.

VII Be responsible in setting a value on your services.

(leaflet: Canadian Medical Association, 1979)

Regulation and the educational developments of the various health disciplines follow similar patterns. Licensure is the process by which government agencies grant permission to engage in a given profession and excludes those who do not hold a license to practice. A license certifies that the holder has attained a minimal degree of competence, whereas registration recognizes an individual's professional identity through association with an occupational group. Since that group has authority, through a practice act, to limit entry to the profession, registration -- even when it is not mandatory, as with nursing -- does take on the character of licensure.

Regulation of health personnel has been made more effective by enactment of new registration laws in a number of provinces. The most innovative is the Professional Code of Quebec (1973), and the Health Disciplines Act (Ontario, 1974) give joint lay professional boards responsibility for coordination and monitoring of regulatory activities of the health professionals, including physicians, dentists, registered nurses, optometrists and pharmacists.
Legal standards governing professional conduct are also set by common law. Although recent precedent has established that Hospital Boards are indeed responsible for care delivered (in Ypremian v. Scarborough Hospital) it has been held that a hospital is not accountable for any negligence of employees, such as nurses or doctors, carrying out their professional duties, as contrasted with their administrative ones. The rationale for the limitation was that the hospital did not and could not order, direct or control the exercise of professional knowledge or judgment (Picard, 1979). In 1942, however, the principle of Respondant superior was upheld and hospitals have, increasingly, been found liable for the actions of their employees; however, self-employed professionals remain accountable to their professional bodies and are judged by normative standards.

CONTINUING EDUCATION PROGRAMS

The literature on educational accreditation refers to basic or professional education (JAMA, 1972). Aspects of education that make one think about the nature of clinical practice, ways in which we can improve quality now, and standards of professional competence on entry to general practice have not been addressed adequately, said McLachlan in 1971 from a British perspective.

Continuing education of Canadian physicians became an issue in 1963 when Kenneth Clute and associates conducted a study of practitioners in Ontario and Nova Scotia. They reported that 40% of Ontario's general practitioners and 60% of Nova Scotia's general practitioners did not
meet their criteria of effectiveness and efficiency. This study led to the formation of the College of Family Practice and the encouragement of continuing education for general practitioners.

The Universities and Community Colleges profiting from federal-provincial post secondary education grants and the new facilities built from the Health Resources Fund (1966) began to establish continuing education divisions, as did the health professional associations. Indeed, it is now quite a competitive area.

DEVELOPMENT OF STANDARDS AT THE INSTITUTIONAL LEVEL

With the development of Hospital Acts, Codman's recommendations were taken up by the American College of Surgeons. This body recruited the administrator of the Vancouver General Hospital, Malcolm McEachearn, who became the chief advocate of accreditation of hospitals across North America.

Accrediting procedures were developed by pooling the interests of medical and hospital organizations leading to a joint American-Canadian standardization program (1923). It was not until 1958 that a distinct Canadian program was begun after formation of the Canadian Council on Hospital Accreditation (CCHA)(1952) -- a voluntary commission under the Companies Act. The CCHA then provided its members with a connecting link to federal and provincial departments of health and hospital services, many professional and scientific colleges, associations and societies, and developments internationally.
Accreditation provided overall direction towards a specific standard of care in hospitals by requiring adherence to provincial health acts, medical bylaws, peer review, medical audit committees, quality assurance programs, continuing educational programs and the like. Accreditation is a mechanism that has improved the standards of health care and encouraged uniformity across Canada.

QUALITY ASSURANCE DEVELOPMENTS

Accreditation mechanisms promoted the development of quality of care mechanisms for the personal medical care system. Nembcke (1956) rekindled Flexner's concern for improving patient services through medical audit procedures. The focus was on micro-issues with less concern for the overall direction of the system (De Miguel, 1975; Warner et al., 1980).

The formal quality assurance programs in the form of medical audits and peer-review became requirements for accreditation in the 1950's. This development was prompted by the fear of regulation from outside the profession and the need for cost-containment. Research became the means to establishing quality standards (Mather, 1971; Widdell, 1972). The implicit assumption in quality assurance mechanisms at that time was that it is more productive to review practices of individual physicians in hospitals than to review the organization and administrative structures of hospital relationships involved in the delivery of medical services (macro-issues). Concurrent review and (medical) peer-review
techniques became established as the best methods for evaluating medical quality of care (Campbell, 1974).

Quality assurance programs were developed by nurses in the 1950's in response to the concern for quality of medical care issues. Soon efforts were coordinated and national and provincial standards projects developed. As leaders in this area, these professionals soon recognized the need for a voice on accreditation committees and indeed were successful by the late 1950's. Concern over minimal standards of care and practice has led to a series of studies which addressed the need for education standards for practice (RNABC, 1980) to ensure quality health care delivery.

Until recently the American Joint Council on Hospital Accreditation introduced the principles and standards for quality assurance as an addition to the former accreditation requirement:

There must be integration, coordination and synthesis of existing information so problems can be clearly identified, solutions specifically developed and carried out, and essential follow-up performed so that all concerned can be assured that acceptable quality is maintained (Williams & Donnelly, 1982:189).
CHAPTER III

GOVERNMENT FUNDING OF THE CANADIAN HEALTH CARE SYSTEM

The historical development of health care standards and the emergence of institutions to house the "indigent" and poor were examined in Chapter II. Thus the foundation of the Canadian system was laid. As precedent accumulated, these standards ensured the maintenance of the structures that promoted their development. The Federal Constitution left health care decisions to the provinces and provincial legislation supported the professional health care developments. It was not until the foundations of the health system were firmly established that the Federal government set policy to shape the direction of health care developments.

DEVELOPMENT OF FEDERAL SOCIAL SECURITY PROGRAMS

A Royal Commission was formed in the 1930's when provincial governments found they could not raise enough money to support basic health and welfare services. Almost one half of the hospital beds in British Columbia were occupied by the "indigent" who became the financial responsibility of the province (Cassidy, 1945). Thus, Federal social security programs were needed to ease the plight of the local and provincial governments' responsibilities for the poor. Legislation was enacted at the national level in 1935 to provide a nation-wide program of social insurance to include medical care costs. As outlined under
the BNA Act (1867), this was seen as an invasion of provincial prerogatives by the Supreme Court. A number of voluntary insurance plans then emerged, sponsored by medical societies and by hospital associations. Meanwhile a Royal Commission considered how the Canadian Constitution was working and whether major changes in the distribution of Federal/Provincial power ought to be made (Rowell-Sirois Report:1940).

Attitudes towards national health funding were finally changed by the Rowell-Sirois recommendations and by the war. National services were needed for veterans and reconstruction reports from the United States (Burns, 1942) and the United Kingdom (Beveridge, 1942) influenced Canadian developments. The Canadian Federal government commissioned reports on Social Security (Marsh, 1943) and on Health Insurance (Heagerty, 1943) and produced an overall policy statement for the Dominion-Provincial conferences in 1945/46. The Federal Department of National Health and Welfare was established in 1945; it was to have:

... control over all matters relating to the promotion or preservation of the health, social security and social welfare of the people of Canada but not to cover any health authority operating under provincial laws (National Health and Welfare Act, 1944; Bryden, 1974:83)

The Federal and Provincial governments also agreed to introduce national health insurance, but the order in which programs were introduced reflects political rather than health care planning logic.

This commitment by the Federal government to national health insurance in 1943 and the subsequent legislation beginning in 1948 took
the form of financial incentives for hospital construction and professional training for employees in health services in the provinces. This made good political sense — to develop a plan for hospital construction first — as the medical profession was supportive of the development of better "workshops" for themselves. The introduction of the National Health Grants Program (1948) was the beginning of a process of continuing and piecemeal adjustment between the two levels of government. Hospital construction was given priority and costs increased, and in the mid 1950's the provinces became aware of the need for federal support to meet hospital costs as well as construction costs. The Hospital Insurance and Diagnostic Services Act (1957) provided matching grants for the provincial acute care hospitals.

Meanwhile physicians, at first supportive of Heagerty, had become strongly opposed to the Federal involvement. They wanted to stave off government intervention but were having difficulty collecting fees at the time of service, so had decided to set up their own Trans-Canada Medical Plans. Physicians appealed to trade unions who sought to have such plans included in their collective agreements. With the support of the medical profession and unions, insurance plans spread across Canada in the late 1940's and early 1950's.

The next step proposed for national health insurance legislation, namely payment of physicians' fees by government, was likely to run into opposition from the medical profession. This was realized in the Saskatchewan "strike" of 1962. Canadian governments became aware of the political attitudes of physicians and the extent of the efforts they
would take towards self-regulation. Another Royal Commission (1961-64) investigated the health needs of Canadians at that time.

As late as 1961 only 59% of Canadians had any form of medical insurance. Those who needed it most - the poor and elderly - did not have it. The Commission considered whether medical care should become one of the Federal/Provincial cost-shared programs and, following the Commission's recommendations and extensive Federal/Provincial bargaining about administrative mechanisms for financing the scheme, the Medical Care Act was passed in 1966. This universal health insurance plan was to improve some of the inequalities in health services to Canadians.

In 1969, even before the Medical Care Act (1966) was accepted by all provinces, a task force was set up to enquire into expenditures. The Report of the Task Force on the Costs of Health Services (1969) recommended a change from an open ended matching grant to a block grant system. Criticisms of current policy included over-use of hospitals, uneven development of hospitals, prominence of the medical model, lack of health care research, and a lack of linkage between different parts of the system. Other equalities arose out of the emphasis on acute care.

Inequalities continued, medical facilities and services increased, yet programs in public health, mental health and for care of the elderly were not addressed directly by the Federal government. In addition to health insurance, Canada's social security system involved other complex issues around the care of these groups.
Health Services in post war years were paralleled by the development of a complex Federal social security program financed from taxation and (contributory) social insurance payments, with benefits payable mainly to individuals (Canada Pension Plan, 1965). Social assistance programs became cost-shared under the Canada Assistance Plan (1966) so that provincial welfare programs did not need any longer to reflect Elizabethan poor-law attitudes (Crichton, 1976:59-67).

The Federal Health Care programs were shown to have contributed to the escalation of health care costs, yet those with long term problems were denied services especially designed for their needs. The "blocked bed" phenomenon became a focus of concern and provided a strong impetus for development of community care alternatives for the chronically disabled.

The Federal Task Force of 1969 addressed the issue of increasing costs of health services. The Federal Government stopped cost-shared programs for construction of Acute Care Institutions in 1969, but those hospitals connected with educational institutions continued to receive funding for teaching and research facilities for an additional decade under the Health Resources Fund provisions (1966). These facilities

1. A "blocked bed" is most commonly seen as the use of an acute care bed by the elderly who are waiting for transfer to nursing homes.
used new technologies and required further specialization by the professions. This enormous technological expansion raised ethical problems about equitable distribution, the interdependency of health specialists and their relationship to the consumer. After years of negotiation, Federal/Provincial fiscal arrangements were finally moved from a cost-sharing basis to block funding of programs with the Established Programs Financing Act (EPF) 1977. This gave the provinces strong impetus for monitoring accountability of health programs instead of just collecting matching funds from Ottawa.

Additionally, the Task Force had sparked a number of studies of possible restructuring of health service organizations. The Castonguay Report (Quebec:1970-71) prompted planning reports from other provinces. The Nutrition Survey (1971) stressed ways of improving fitness for Canadians; the Hastings Report (1972) proposed an alternate model of health care delivery in the Community Health Centre concept. A New Perspective on the Health of Canadians, (Lalonde, 1974) proposed emphasizing preventive medicine concepts and consumer responsibility.

It was concluded that the current system was limited in its capability to meet new goals. An appeal was made for a broader focus on health care and research, rather than attention to medical issues. But, despite the undeniable logic of developing a health care system emphasizing prevention and health promotion, it was hospitals that were wanted, by people living in local communities, by the doctors, by the businessmen and by the politicians (Crichton, 1980:12).
None of these studies had a major impact on changing the health care system. The provinces were waiting for Established Programs Funding and the renegotiation of the Canada Assistance plan of 1966. When the Established Program Financing Act (EPF) (1977) came, it included Federal support for extended health care services and provided financial incentives for the provinces to establish long term care programs.

Many people were concerned about the new arrangements however, particularly the medical profession. A mini-Royal Commission was set up to examine the effects of the EPF Act. In the Report of the Health Services Review (1980), Mr. Justice Emmett Hall encouraged the federal government to continue with its policies of equitable distribution. A Senate Committee on Federal/Provincial Fiscal Arrangements (1982) reported that this policy should be pursued. Consequently, in 1984 we have witnessing a new Canada Health Act proceeding through Parliament. The Canada Health Act (1984) restates the Federal role in support of universal health insurance. The fact that this Act deals only with some narrow issues of financing has led to some criticism. Mr. Herb Breau, Chairman of the Senate Investigating Committee, has stated that the Act was not intended to enlarge the sphere of federal government involvement but solely to reinforce the principles established in the 1940's, namely:

- universality
- comprehensiveness
- reasonable access
- portability
- non-profit administration
Criticism continues. The Canadian Medical Association has set up a Task Force on Resources going into health care to review whether the amount of Gross National Product allocated is adequate.
CHAPTER IV

SPECIFIC STANDARDS-SETTING MECHANISMS

The historical developments in the previous chapters outlined the evolution of a number of mechanisms that set qualitative standards in the Canadian Health Care system. Formal legislated, professional and educational mechanisms directed institutional standards setting. The following chapter examines the specific mechanisms that set these standards for health care developments. The information helps determine the nature of the process for assessing quality services in Canada, and provides data for the recommendations in the concluding chapters.

STANDARDS-SETTING MECHANISMS

Political, economic and social factors provide the context in which health care developments occur. These factors act on the external mechanisms that direct health policy developments in Canada. The form of control for these mechanisms is of a mandatory or voluntary nature.

MANDATORY MECHANISMS

The External Mandatory Mechanisms are listed below.
Legal Mechanisms: Case law/Common law

Under common law, health care institutions need only achieve compliance, that is, meet standards set by governments, the professions and the institutions. Therefore,

... hospitals could be found liable for failure to meet standards established by legislation, by bylaws of the hospital and by the Joint Council on accreditation of hospitals (Schroeder, 1972:55-57).

Legal standards force compliance through their compulsory status. The American health care system has used rulings in malpractice suits and negligence law to set accepted standards for regulation of quality of care provided in U.S. hospitals. These legal interventions as regulatory measures are steadily increasing in the U.S., resulting in defensive medical practices and great health administrative costs (PSRO, 1978). They have not improved efficiency and effectiveness of health care institutions (Mechanic, 1976).

Health Law stresses the need for accountability of the medical profession and hospitals, yet promotes the conservative ideology of individualism and free-enterprise. Federal health insurance schemes, such as the Canada National Health Insurance program, are viewed as contrary to the objective of free-enterprise.

Statutory Legislation

Government participation in the delivery of health care can take several forms:

i) services and benefits may be provided directly through government departments - for example, quarantine services by
Federal government, and school immunization through local health boards.

ii) funding payments may be made to another government for provision of health care services or facilities by that government.

iii) government may appoint members to a statutory body where management is by government employees and the staff are not public servants.

iv) funding may be provided to non-governmental agencies.

Federal Legislation

Funding by government is contingent on meeting some form of requirement, either as general principles, or in the form of very specific regulations. The latter model is used with U.S. Federal funding of Medicare - Medicaid for services for the elderly. In Canada, the BNA Act delegates most of the decisions regarding health care developments to the Provinces. Maintaining the principles of the National Health Insurance scheme, the funding body, the Federal government has a considerable amount of indirect power.

Provincial Legislation

Direct Provincial control has until recently been minimal, with the development of standards delegated to the professions. Provincial governments were seen as funding bodies interested in quality questions only in relation to claiming National Health Insurance payments from Ottawa.

There are various methods of participation that Provincial governments can employ:
i) **Fiscal controls:**

Fiscal controls may or may not be tied to some other form of regulatory requirement, but reimbursement could determine the level of quality government will support. The elements of control can include: budget approval, rate setting, control of referrals or placement, incentive reimbursement, outcome reimbursement, or use of some competitive market force. These controls can be legislated or set by program policy. These mandatory control mechanisms may lead to resistance to the controls as "bureaucratic rules" by the public and the providers of services.

ii) **Licensure:**

This form of regulation requires an Act and Regulations, which define the minimum regulatory standards to be met and the process and sanctions of enforcement of these standards. There is much concern in the U.S. over lack of ability to enforce the many licensing Acts in their health care system.

iii) **Program Standards:**

Standards of care or training which establish program expectations may be part of licensure or established by a separate Program, Act or policy. It is more common in Canada to amend existing Acts than to introduce new legislation for program developments.

iv) **Contracts:**

Contracts imply a competitive market with a time limited agreement and public commitment and/or disclosure. They may
be established by legislation or as a program policy with the ability to negotiate specific standards or requirements. Governments usually use highly standardized contracts, and the time spent in negotiation is usually minimal. Contracts put the onus on boards of institutions to assure quality services through competent administration. These contracts are subject to sanctions through the civil law process.

Professional Licensure/Registration/Certification

Government sets the requirements for the education or training of care givers, and maintenance of professional standards is delegated to professional associations. This method assures that provision of qualified staff will result in quality services. Governments usually assume some responsibility to see that appropriate education and training programs are available.

The Medical Acts

The historical developments reflect the desire on the part of the public, as expressed by legislation, to give licensing authorities power to regulate more and more aspects of the medical practitioner's practice. However, the reason government has been willing to give the medical profession such statutory power was outlined in a judgement by the British Columbia Court of Appeal in these words:

The provisions of the statute show that the powers are given not primarily for the benefit of the medical profession but for the primary purpose or protecting public health and safety (Sawyer and Sharpe, p. 165).
The public has benefitted from the setting of normative standards as they are not in a position to evaluate the expertise of the professional group.

In B.C., as in the other provinces, a separation of control exists between the B.C. Medical Association, a voluntary group which concerns itself with the economic interests of its members, and the College of Physicians and Surgeons, a licensing authority which concerns itself with quality control and the protection of the public interest. The College, established by legislation, is entrusted with the regulation and discipline of the medical profession. It maintains a register containing the names of all those who are licensed to practice, and regulates those so registered to maintain standards of conduct and competence acceptable to the professional body.

Licensing and educational standards are set by medical professional groups. Internal professional standards control the socialization process and the educational progress of students. This leads to extreme compliance with existing standards, set by the dominant medical profession (Scott, 1982).

**Institutional Legislation**

**Hospital Act**

The Hospital Act was passed in British Columbia in 1948 for the licensing of institutions which had been regulated under the Societies Act for many years. This change required the organization of a "definite medical staff" to determine which doctors would be admitted to a hospital as staff and to define the members' (Roemer & Friedman,
In 1961, revision of the Hospital Act stipulated that the "governing boards of hospitals were responsible for the standard of quality of care provided".

**VOLUNTARY MECHANISMS: FORMAL**

The mechanisms listed below are considered voluntary mechanisms. These methods of regulation are delegated by government to involve the professional groups.

**Registration**

With registration, the onus is on the provider to supply proof of compliance with government standards. Registration is similar to licensure requirement and enforcement, but does not require pre-inspection, and a copy of the regulatory requirements is provided to consumers. In simple registration, there is no supervision or enforcement of promulgated requirements, standards may be part of an education package given to institutions, and reliance is placed on non-regulatory supervision and public education. This is often used where there is less technical care and consumers have knowledge of the services required.

**Industry Regulation**

Industry Associations could have responsibility for assurance of quality delegated through provincial legislation or programs to institutions. This would include membership requirements and surveillance of the membership. Institutions could then be denied membership if they did not maintain a certain level of service. Associations exist provincially for hospitals and long term care facilities that could fulfill this role.
Accreditation

Accreditation is a voluntary, peer review process of evaluation based on broad principles and supporting standards that go beyond the minimum standards required by government for licensure.

The Canadian Council of Hospital Accreditation (CCHA) is a voluntary organization for setting standards for Canadian hospitals and is composed of five national associations represented as follows:

- The Canadian Hospital Association (5 chairs)
- The Canadian Nursing Association (2 chairs)
- The Canadian Long Term Care Association (1 chair - 1981)
- The Canadian Medical Association (4 chairs)
- The Royal College of Physicians and Surgeons of Canada (2 chairs)

Accreditation is the process of assessment of all the circumstances in a health care facility. Buildings, equipment, environment, safety factors, qualification of personnel, and their organization into a well functioning and integrated whole are all considered. While accreditation is a measuring device establishing and quantifying (as far as possible) the standards of institutional operation, it is also a mutually educational, consultative process to foster knowledge and wise judgement for all concerned.

One of the most important aspects of accreditation is that it provides for an intense study, an intense review of your operation, far more in depth than any legislative standards and/or process which can be provided by
government. It points out obvious weaknesses, inherent strengths, analyzes the facility on a department by department basis, on a program operational basis, giving management, the Board and the public served, a springboard for improvement (Long Term Care Association pamphlet, 1984).

The CCHA accreditation mechanism interfaces with national hospital associations in both Canada and the United States and has been the most accepted mechanism in British Columbia (B.C.) for setting standards for health care. It is a major voluntary mechanism for achieving compliance with the existing medical-professional framework for the health care system and for assuming that it is maintained. Preparing for Accreditation ensures that the internal mechanisms for setting traditional standards are in place. Each accreditation, in turn, has the effect of strengthening the nature of that control.

The acceptance of a hospital for accreditation by the CCHA is assumed to be a sufficient guarantee of quality (Bradley, 1972). Because of this assumption and general attitudes in government self-help rather than regulation, there have been no provisions in the B.C. Health Acts for quality assurance.

Referral Agency to Facilities as a Control Agent

In this method it is expected that the referral agency has a "professional and moral" responsibility to insure the adequacy of the institutions used or recommended. The referral agent is seen by the provider as a source of business, and can often penetrate the institution where others may not, particularly where the agency is responsible for assessment of patient care levels to facilitate reimbursement. Referral agencies can maintain data on the
characteristics of the facilities; these may be referenced by consumers or families when they require placement.

**Labour Unions**

Labour Unions are considered as voluntary mechanisms that set standards in health care. They add further constraints to the system. Economic issues are less important in standards-setting, however, than the accompanying agreements regarding conditions of service. The restrictions set by agreements have enormous implications for the performance of work and, in addition to simple union agreements, inter-union jurisdictional boundaries lead to other restrictions affecting performance. Unions seek to assure clear role definition and general mechanization of the system and that works against comprehensive models of health care delivery. Professional registration restrictions, for example, may not allow tasks to be shifted or personnel redeployed to enhance the effectiveness and efficiency of care delivery (Teans et Comers, 1969; Hershey, 1969). As Scott said,

> Occupational registration is a constraint imposed on the Health care system and another concrete manifestation of the enduring power of the occupations and professions in determining the arrangements under which health care will be dispensed (1983:3).

**Continuing Education**

Basic professional education is regulated by Universities and Colleges, which are themselves accredited or inspected. Continuing education is less highly organized. Because professional and educational activity in continuing education has often been less than satisfactory,
hospitals have had to fill gaps when technology has outrun educational provision (Somers, 1974). For example, critical care nursing courses have often been offered to meet individuals' needs for further training. Less formally peer review, career performance assessment, or self-evaluation programs may be considered as continuing educational mechanisms employed by institutions. Continuing education in Canada is a voluntary mechanism; where continuing education programs have been compulsory these have been evaluated as being ineffective in improving standards (Somers, 1974).

VOLUNTARY MECHANISMS: INFORMAL

The voluntary mechanisms listed below are usually seen as an adjunct to mandatory standards and not as sole methods of control. Other than the continuing education mechanism which advances or updates the professionals' training, the following mechanisms can be used in areas where health services are less technical and more understandable to the general public.

**Public Education**

This method aims at educating the public in order to raise general awareness of what should be expected of facility care; encouraging communities to take responsibility for surveillance; enabling communities to support other efforts to achieve quality care and make use of regulations as a consumer protection.
Consultation and Education for Institutions

This may be offered by government in two forms: as consultation by the regulator regarding the requirements of regulation; or as advice not specific to regulatory requirements. For the latter, some governments have referred facilities to external agencies; or government may pay for consultative service where a simpler regulatory system makes available funds to be redirected in this way.

Volunteers

Knowledgeable volunteers provide some surveillance over care, and community health and social services may play a significant role in initiating, coordinating, and operating volunteer groups.

Surveillance by Family, Friends, or Others

This is an important source of surveillance, as consumers are often unable or afraid to raise concerns due to the dependent relationship with the provider. Surveillance is exercised in two ways: personal observation of the condition of the institution and patient; and listening to the concerns of the patient.

Community Advisory Groups

With this method, interdisciplinary groups composed of professionals and laymen form to provide surveillance and a voice for the consumer.

Consumer Representation on Committees/Boards

Resident committees are one way to encourage consumer participation in the surveillance of facilities, and are encouraged in Canadian Mortgage & Housing Corporation funded housing. Residents can also be represented on monitoring or inspection teams.
Advisory Group to Program or Licensing Bodies

Advisory groups of providers, consumers, or community members are often established by government to provide input to the regulatory process. This may be on a regular or ad hoc basis. Sometimes an advisory group is formalized as a council or individuals may be invited to become members of a regulatory body.

INTERNAL MECHANISMS

The external mechanisms act on the internal mechanisms that regulate institutions. The latter tend to correspond to their external counterparts. For example, under statute law, the B.C. Hospital Act (1961) delegated ultimate responsibility for operating institutions and providing quality patient care to the hospital governing boards which, in turn, delegated operations to the administrator and surveillance of quality care to the medical staff. Legal protective mechanisms of institutions are not discussed in any detail except that this process mainly consists of ensuring proper record keeping and seeking legal help as necessary for advice or representation in court. Hospital Risk management programs that arose in the United States over concern for increase of litigation were investigated by Canadian hospitals, but neither the Hospital Associations nor the insurance companies promoted this activity (Mysak, 1982). Internal legislation takes the form of bylaws that direct the operation of the organization and provide the structural and procedural apparatus by which objectives under incorporation are achieved. In passing bylaws, the hospital acts as a
legislative body and makes what, in effect, becomes law (Rozovsky, 1979).

These internal mechanisms are directed by the Hospital Act (1961), which ensures that a medical-professional system is in place.

Quality Assurance Programs

As concerns increased for quality of care in the Canadian health care system, additions to the structural macro-approaches to standards-setting were undertaken by the Canada Council for Hospital Accreditation (for example). Concerns led to the need for setting up a micro-mechanism to focus on clinical aspects of care by the professions. Quality Assurance programs were developed with a strong focus on peer-review. The medical focus was on outcome measures while the Nursing profession sought process standards of care. The following discussion on quality assurance helps illustrate the focus of qualitative standards-setting in Canada.

Quality Assurance in the Canadian Health Services Systems

Legislative standards that established the position of the professions encouraged development of empirical (research based) standards that become equated with quality assurance. Provincial governments had no reason to oppose the delivery of "quality" services when they had no financial input into the system; Canada accepted the American ideology of voluntary control of service providers within very broad frameworks, and the mechanisms regulating the professions and institutions were voluntary peer-review mechanisms.

The growth of institutional bureaucracies and the development of stresses within the voluntary accreditation model resulted in the
emergence of quality assurance programs to address micro-aspects of health care. This structural change took place before the development of financial concern about costs of technological development was addressed by governments.

The micro-macro distinction needs further definition. Conflicts between administrative and professional models in institutions are legitimate when you consider that macro care focuses on the characteristics of populations or patients and is governed by principles applicable to that aggregate -- for example, the overall shape of the distribution of services or outcomes, the specification of minimum or model levels of service (Brickman et al., 1980). By contrast, micro care is focused on the needs and interests of individual patients and is governed by a principle that assesses the needs of an individual as a basis for determining appropriate action. The emphasis is on individual need, its assessment and satisfaction (Freidson, 1970).

DISCUSSION

The regulatory mechanisms that set standards seek to modify institutional performance. Certain mechanisms are more effective than others in achieving compliance to a specific model of service delivery. Mandatory standards meet with resistance while voluntary mechanisms are more accepted as regulatory measures in the Canadian health care system. Those mechanisms of a formal-voluntary nature which combine elements of the two methods have been particularly effective in achieving compliance to the standards set (see Chart, page 45). They all, however, ensure
## CHART I

**ALTERNATIVE METHODS OF STANDARDS SETTING**

<table>
<thead>
<tr>
<th>Mandatory Mechanisms</th>
<th>Voluntary Mechanisms (Formal)</th>
<th>Voluntary Mechanisms (Informal)</th>
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<tr>
<td>Legal Structures (case-law)</td>
<td>Professional registration</td>
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<td>(common law)</td>
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<td>Federal Legislation (funding)</td>
<td>Education for Providers</td>
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<td>Provincial Legislation (licensing)</td>
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<td>(program)</td>
<td>Accreditation (Peer Review)</td>
<td>Volunteers</td>
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<td>Professional Legislation</td>
<td>Labour Unions</td>
<td>Surveillance by Family, Friends</td>
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<td>Institutional Legislation</td>
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<td>Community Advisory Groups</td>
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</table>

Consumer Representation on Committees/Boards
Advisory Group to Program or Licensing Bodies
the maintenance of the medical-professional institutions that created them.

Political, economic and social environmental forces (including developments in health care in other countries) act on the external mechanisms that direct the internal developments that in turn feed back to the external forces that direct health care developments.

EMPIRICAL STANDARDS

The following sections discuss micro-research and the measurements of quality of care that aid in determining the nature of the standards-setting process.

Research by Nightingale in 1858, Groves in 1908, and Codman in 1913 led to the setting of standards for institutional care, as proposed by Flexner in 1910. For the next 30 years, however, very little work was done on quality of care. "Expert opinion" set normative standards; since this opinion was "expert", measurement of the results of care was thought to be unnecessary.

In the early days, expert opinion also took into consideration the matter of costs. If the patient could pay, well and good; if not, the practitioner and the institution had to decide whether to provide free service. Quality of care was closely related to ability to pay. As third party payment systems became entrenched, the matter of payment no longer troubled practitioners. This problem was handed over to governments and insurers.
Accreditation processes, like the legal standards established earlier, set up a framework which was later adjudged insufficient to deal with micro-matters. The accreditation mechanism implicitly and explicitly states that quality of care is assured through attainment of normative macro-standards set out by the Council. However, accreditation officials agreed that "the observation and the experience had been that standards were not used widely enough nor well enough in the pursuit of a definite level of excellence" (Bradley, 1972).

Physicians began to give their full attention to the development of empirical micro-standards in the 1950's. The rationale underlying the development of these standards came from a perceived need for two separate and distinct elements to determine quality of care: first the creation of universal absolute standards; second a monitoring process through which standards are enforced. Quality of care research further legitimated accreditation standards that were already equated with excellence. The incremental adjustments in the accreditation system led to short-range planning with no apparent recognition of the consequences of these actions. Quality assurance was simply layered onto the regulatory system. The pressure to develop quality assurance programs came from the United States. Great Britain stayed with "expert opinion", but has had to acknowledge the advances made by United States academics in this area (McLachlan, 1976).

Discussion

The focus of research has been on micro-medical issues, with some debate over how to establish a system to examine the process and outcome of care. Donabedian (1967) described a systems approach which, though
unable to encompass quality of care, is an influential conceptualization of evaluation in the health care system and helps illustrate why accreditation mechanisms do not achieve the desired objective of quality control.

The nature and influences to which quality assurance is subjected are analyzed in three areas: Structure, Process, and Outcome.

**Structure:** The level of quality measurable by norms or standards, or through comparisons of facilities and equipment, organizational structure, professional qualifications, etc.

**Process:** Professionally accepted standards of practice and procedures and their governance.

**Outcome:** Indices of effect of therapies.

The Donabedian adaptation of the systems model is limited in measuring quality of care issues. There has been increasing sophistication in the debate about what is necessary and sufficient to assure quality service. In 1967, Donabedian saw Outcome as a criterion of quality in medical care, and validity of Outcome as a dimension is rarely questioned (p. 168). He asked whether Outcome measures could be used with discrimination, partly because these measures are concrete and seemingly amenable to precise measurement.

In much of the literature, Process and Outcome are in contention for recognition as the method which best assesses quality of care
(Donabedian, 1966:168-69; Brook et al., 1973; McAuliffe, 1979; Glass, 1980). Outcome reflects both the power of medical science to achieve certain results under any given set of conditions and the degree to which "scientific medicine" has been applied in the instances under study. Research is really just beginning to examine the linkages of these dimensions, with the assumption that there is some relationship (Phaneuf, 1973).

An interesting expansion of the Donabedian model was suggested by the British researcher, Sir Richard Doll (1974:5), who added another dimension to Structure, Process, and Outcome, that of "Social Acceptability". Social Acceptability was based on the idea that Outcome has implications other than recovery. He described two facets of social acceptability. One was the level of quality and standards accepted by the community -- it was possible to indicate such levels by comparisons with other areas within a nation or other countries. The second facet was not as easily indexed -- the interpersonal, supportive, and psychological aspects of the physician/patient relationship. This factor gives rise to satisfaction on the part of the doctor and the patient, accompanying and sometimes replacing the cure. From the patient's point of view, it is certainly the most visible, easily perceived, and greatly appreciated of the quality components. So far, this has not been measured by traditional mechanisms, although social and clinical research in this area are beginning to converge (Killilea, 1982). The information on aggregate models for assessing quality have the most promise (Kane & Kane, 1982).
Donabedian recently defined the assessment of quality:

Assessment of quality is a judgment concerning the process of care, based on the extent to which the care contributes to valued outcomes (1982:3).

Ultimately, Structure and Process have to be judged, with reference to each policy decision, by observing the Outcome. This raises the question, "What are desired Outcomes?" and brings the discussion back to the problem of achieving the highest possible quality of care within the constraints of administration.
SECTION III Standards-Setting for Long Term Care Service

This section examines the evolution of long term care as a separate service. The nature of long term care services is determined and current standards-setting practices discussed. A discussion of administrative aspects of care provides insight into how to proceed with qualitative standards-setting in the Canadian health care system.
CHAPTER V

EVOLUTION OF LONG TERM CARE AS A SEPARATE SERVICE

IN BRITISH COLUMBIA

Long Term Institutional care in British Columbia is one aspect of the Ministry of Health's Long Term Care (LTC) Program, now known as the Continuing Care Division: Institutional Services. The following sections describe the evolution of Long Term Institutional Care in British Columbia as a separate service.

BACKGROUND

In the 19th century, Canadian governments provided only basic public and mental health services to the community. Families were expected to look after themselves and their friends. When necessary they could seek help from doctors, whom they were expected to pay, or from hospitals financed from charitable or municipal funds and patients' fees. For the few elderly people who had no families there was charity or social assistance (based on Elizabethan Poor Law) or sometimes institutional care provided by charitable organizations. In the last resort they were placed, by provincial government authorities, in mental or public hospitals. Titmuss (1972) has called this residual welfare.
As Canada became more urbanized and as the numbers of elderly increased, traditional social networks began to fail. Families and neighbours could no longer look after all their elderly, particularly the chronically ill. Public responsibility for the elderly came in the form of grants for hospitals. Often the indigent were provided with care but there was no separate provision for the elderly as a group. Acute care hospitals were intolerant of long stay patients who "blocked beds" that were needed by very sick people; costs were estimated at 40% to 50% of the total hospital operating costs in B.C. (Cassidy, 1945). Many elderly were sent to mental hospitals. There, no separate provision was made for this group of people until treatment became a focus and the laws for compulsory treatment changed in 1961 (D'Arcy, 1975). Legislation such as the Provincial Infirmity Act (1948) did respond to the need for chronic care housing which dealt with the "maintenance and care of the incurable".

Gradually some groups began to address the issue of services for the elderly. This led to the emergence of proprietary chronic care hospitals. Proprietary owners supplied two types of service -- one for those who could pay privately and a separate service for "welfare recipients". Pressures began to develop for government intervention to provide more equitable services.

The federal government had become concerned about health and social security provision in the 1940's, as outlined in the previous chapter. When the National Health Grants of 1948 made funds for construction of hospitals contingent on submission of provincial plans, British Columbia undertook two studies. The Hamilton Report, "A Hospital Plan and
Professional Education Program for the Province of British Columbia" (1949), focussed on hospital bed requirements. It also estimated health manpower needs and the education establishments required to meet them. The Elliot Report, "Survey of Health Services and Facilities in British Columbia" (1952), described the federal, provincial and local public health and mental health services, hospital facilities and other health services.

The National Health Insurance programs dealt with public health, mental health, and acute care but there were large gaps in provision. Chronic care was not addressed in these programs. This oversight became more apparent as the numbers of elderly grew, social supports weakened and the acute care industry became less tolerant of those requiring chronic care.

Most of the elderly in British Columbia were concentrated in Victoria and Greater Vancouver (B.C. Research, 1974). The United Way of Vancouver, a body responsible for coordinating charitable efforts and planning concerns, set up a research department in 1959 to streamline its activities. One of the concerns was for the care of the elderly. In 1969 a new provincial advocacy group was formed. It assumed some of the activities of the Committees on Aging and Health which were formerly carried by the Social Planning & Research divisions of the United Way. This Social Planning and Review Council of B.C. (SPARC) was concerned specifically with health issues for the elderly. Their report on Community Care for Seniors (1972) provided an identification and analysis of the existing services and needs for service in all levels of institutional and community care for the elderly in British Columbia.
It identified a strong need for community support services which would enable the elderly to remain in their homes or communities. An analysis of the network of existing services observed that,

... as the elderly move through the system, service to them suffers because of the division in jurisdictions, financing formulas, legislative regulations, and sanctions (SPARC, 1972).

This report concluded that the system of care should be "integrated, humane, community oriented, and research based."

The provincial government had been building acute care hospitals quite rapidly during the period 1949 to 1966, though more in the interior than in the cities. In 1965, a Regional Districts Act was passed and in 1966 the Regional Hospital Districts were enacted and were responsible for planning for future hospitals. Only three districts were active in planning: Kitimat-Stikine in the north (which had few elderly people), the Capital Regional District of Victoria, and the Greater Vancouver Regional Hospital District (GVRHD). The last body had to sort out a confused situation in the Lower Mainland.

Institutional planning was undertaken by the GVRHD and a number of reports were written. The provincial report, Health Security for

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British Columbians (1974), known as the "Foulkes' Report"\textsuperscript{2} addressed the need for the provision by government of a continuum of services for the elderly.

**LONG TERM CARE IN BRITISH COLUMBIA**

By 1969, the inadequacy of federal/provincial fiscal agreements with respect to the handicapped and the elderly was widely acknowledged. Steps began to be taken to change the system of funding so that the matching grants were not, in future, so closely tied to acute care. Prior to this, incentives had been given to develop programs that treated illness. Extended care programs were cost-shared, but no such help was available for intermediate care and nursing homes. By 1977, agreement had been reached between the federal government and the provinces on Established Program Financing (EPF). Under the terms of the Extended Health Care Services Program, some provinces expanded the health system and made possible a continuum of services administered and funded as insured services for the elderly by provincial governments (Government of Canada, 1982; Walker, 1982).

Government interest in B.C. in the development of a Long Term Care program (including institutional care) followed a pattern similar to many other North American jurisdictions -- it began as a social welfare service and subsequently took on more of a health orientation. As early

\textsuperscript{2} See Appendix C for outline of Foulkes' Report.
as 1938 under the Welfare Institutions Act, government regulations ensured the protection and safety of dependent residents in adult and child care facilities, with responsibility shifting over the years between the social service and health ministries. In 1969, with the passage of the Community Care Facilities Licensing Act, jurisdiction was allocated to the Ministry of Health. This Act regulates physical, economic, and social welfare conditions in both profit and non-profit institutions. By 1970, it was felt that the regulatory authority should be with public health under the direction of an interministerial licensing board. By 1975 growing public concern over facility care resulted in the addition of community representation and the development of separate boards (and Regulations) for adult and child care facilities. Concern for quality of care issues was addressed through revisions and amendments to the Act and regulations; for example, the focus shifted in long term care from a custodial to a care-training orientation for mental retardation and mental health clients and from personal care services to include intermediate care services for the elderly.

The Adult Care Board was given responsibility to develop a proposal for a Long Term Care Program (LTC), which was implemented January 1, 1978 under an order-in-council. This program was to meet standards established by various Provincial Acts. Under the terms of reference

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3. See Appendix D for the Philosophy and Objectives of the Long Term Care program.

4. See Appendix E for legislation directly affecting Long Term Care Institutions.
of the program, non-institutional care was legitimated; it included such services as homemakers, home-care nursing and physiotherapy, meals-on-wheels, and day care programs. Institutional services were to include those given in private hospitals and in personal, intermediate, and extended care facilities. The program also was given responsibility for the government Mental Health Institutions.

The idea was to

... assist those who have ongoing health-related problems by providing services in the individual's home or in an institution ... (LTC Manual, 1978).

Based on the commitment to the provision of a continuum of services for the elderly in British Columbia, preventive and supportive services meeting health, personal, social and shelter needs -- comprehensive services -- for the elderly were to range from independent living through five levels of institutional care: personal care, intermediate care levels one, two and three, and extended care.

The concept of a "single point of entry" to the system provided a gatekeeping function -- the prescreening and channelling of potential clients for home care or long term facility care -- administered by government and delegated to public health or social service staff who determined the need for services. This assessment would be monitored on an ongoing basis through a centralized information system. This concept allowed for accessibility either through the acute care system or
through community services making it possible for alternate care services to develop.

Such a system, if developed to its potential, would be a unique concept in Canada for provision of services for the elderly.

DISCUSSION

The Long Term Care Program in B.C. was the result of a long historical development. This publicly funded program was the logical result of the efforts undertaken to provide needed services. The movement in long term care towards publicly administered, universal access and a distinct model of Long Term Care service provision moved Canada away from some of the more complex problems experienced in other countries. Movement is also towards integration of services and investigation of improved methods of providing effectiveness (and cost control). Standards-setting, however, is not well developed to maintain and assure continuation of these developments.

Government funding as a means to assuring quality services is criticized by Ruchlin (1982) who takes the view that public funding creates an environment in which quality is not deemed a priority. In contrast, Somers (1982) believes that programs not directly addressed through the regular fiscal arrangements of the health care system, such as long term care, must be publicly funded.

The latter position is realized in B.C. However, the government funding in B.C. tends to provide basic minimum standards rather than quality standards. Since the program is government financed, the main
pressures on it at the present time are for accountability. But accountability for what?

The problem of the balance between cost and quality arises, quality services at what price? Ways to obtain a balance between the cost and the quality of long term care services in institutions are being investigated. How can this be accomplished? Who can provide quality care and how can this be regulated? Why are the concerns not dealt with by current regulatory measures? These are questions asked by most North American jurisdictions as the numbers of elderly people and health and welfare costs increase.
CHAPTER VI

STANDARDS-SETTING FOR LONG TERM CARE INSTITUTIONAL SERVICES

As cost-containment became the major issue in health services planning in the 1980's, concern for the provision of quality health services became increasingly apparent. Over the past century many public health concerns -- such as the control of infectious diseases and the introduction of medical cures -- had been dealt with successfully. Standards-setting activities encouraged acute medical-care and institutional developments. However, as was apparent in Chapter VI, the areas of chronic disease and long term care services were not addressed in the Federal/Provincial fiscal agreements and, compared to acute care services, had received relatively little attention. The technological advances in the medical care outcomes, in fact, tended to aggravate the processes of long term care services leading to extreme problems of a social, moral and ethical nature.

The 1970's were noted as a decade of health regulation with increasing concern and intensity of activity in the development of regulatory control of costly institutional services. The Canada Health Survey (1978-79) showed the elderly as using significantly greater numbers of health and welfare services than younger people. A search for alternative approaches to the traditional provision of health services occurred in the belief that community programs would not only improve the quality of life but also save money (Baum, 1972). This explanation of possible alternate services led to the need to address
the complex issues around the definition of "quality of life" (and therefore quality services) for the elderly.

What was clarified in examining the evaluation of long term care services was the need for more comprehensive services which include the provision of "shelter, financial security, health, recreational, cultural/spiritual and social needs" (GVRHD, 1979) for the elderly population who require these services.\(^1\) It has been determined, however, that current health standards-setting developments promote acute care medical developments to the exclusion of alternate services that would allow more comprehensive services to evolve.

**COMPREHENSIVE LONG TERM CARE SERVICES**

Provincial long term care programs developed rapidly across Canada since the EPF (1977). These programs varied from province to province in the differences in population served, extent of the program, eligibility patterns and provincial patterns of standards development.\(^2\) Provincial efforts and the subsequent sharing of information led to the identification of the major issues affecting provision of long term care services across Canada.

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1. The elderly have increased in both number and proportion in Canada's population (Stone, 1980). More than 12% of the population in British Columbia is over 65 years of age (Hall, 1984). Of the 15% of the elderly who require long term care services, 7% at present are institutionalized in B.C.

2. See Appendix F for outline of Canadian provincial Long Term Care Programs from the Canadian Report on Aging, 1982.
This section examines the nature of long term care services. What makes these services distinct from those provided for acute care medical services? Fundamental to understanding the differences is the need to establish clear objectives for the long term care programs and to define conceptual models for long term care planning and administration.

The initial philosophy and objectives of the B.C. Long Term Care Program (1978) outlined in Appendix D, reflected the uncertainty by governments as to the direction of the program. Provincial Long Term Care Associations (1979) evolved to address institutional needs and began to clarify long term care services as distinct from acute care services. Basic principles were presented, but the lack of knowledge about appropriate services for the elderly and the lack of planning expertise was apparent. In the attempt to gather information, various provincial efforts at dealing with services for the elderly were shared in 1983 leading to the formation of the Continuing Care Programs of Canada (1983).

CONCEPTUAL MODELS

Understanding the nature of Long Term Care services begins with defining "quality of life" for the elderly. Research into what constitutes "quality of life" is minimal, however, it is related to meeting the physical, economic and social needs of this group of people.

3. See Appendix G.
(Penning & Chappell, 1980). Research linking "quality of life" to needed institutional services is beginning to be investigated (Kane & Kane, 1981; Killilea, 1982).

The factors that influence the definition of "quality of life" for the elderly in institutions are explored leading to a possible model of care. Ascertaining the health status of the elderly as a basis for planning services is a complex and complicated task. First, health must be defined. The World Health Organization (WHO) defined health as:

... a state of complete physical, mental and social well-being, not merely the absence of disease or disability (World Health Organization, 1958).

This concept considerably expands the traditional medical viewpoint. Its purpose was presumably to encourage people to take a wider view of health than medical care, and therefore of the factors which contributed to it. In fact, it is widely accepted that various environmental and life-style factors may have more effect on health than medical services. This perception has resulted in an expansion of the medical system into the realm of advising on human behaviour which has taken medicine beyond its proven technical competence (Friedson, 1970).

As models for care of the elderly were proposed, more and more attention was given to the social aspects of their environment. Lynch

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(1979) linked social aspects of caring with morbidity data and showed a correlation between social stability and the incidence of heart disease. Cassel (1975) showed that strengthening social supports effectively reduced illness -- acting as a "buffer" to life stresses. Social Support is defined as

... that set of personal contacts through which the individual maintains his (or her) social identity and receives emotional support, material aid, services, information and new social contacts (Syme, 1975:17).

During the past decade social support has been linked to a variety of mental and physical pathologies (see Pilisuk and Froland, 1978; Cobb, 1979; McKinlay, 1980). Perhaps most influential, because of its large population and longitudinal design, the Alameda County study of Berkman and Syme (1979) is regarded as the most general indication of the impact of social contacts on health (Hammer, 1983). These researchers demonstrated an inverse relationship between social support and morbidity and mortality.

Wan and Weissert (1981) have shown that social support plays an important role in mitigating the effects of deteriorative health status, thus reducing the risk of institutionalization, and that those who were most likely to improve in physical and mental functioning had stronger social support networks.

It has been determined that factors other than physical influence admission to institutions, and that institutional living correlates highly with "living alone" without social supports, resulting in mental
and physical deterioration (Wan & Weissert, 1981). These writers appeal for research directed toward identifying societal (macro) and individual (micro) determinants of institutionalization of the chronically ill.

Myles (1980), in support of institutions suggests that the image of dependency and loss of self in institutions identified by Goffman (1961) may only be a reflection of wider societal attitudes. Whether or not these needs can be addressed through provision of a continuum of services in the long term care program remains an empirical question. A basic premise of the study is that institutional services are an integral part of the comprehensive services needed for the elderly in British Columbia.

Jesion and Rudin (1983) proposed the social model for Long Term Care Institutional services as distinct from the medical model (see Chart II on page 67). A combination of the elements from social and medical approaches in varying proportions -- based on the level of resident independence -- will likely evolve.

ORGANIZATIONAL ASPECTS WITHIN LONG TERM CARE INSTITUTIONS

Professional Organization

While it has been recognized that gerontological studies cross disciplinary lines, there are no institutions which bring together applications of this research in the way that hospitals bring together medical peers engaged in clinical work to review what they are doing. There is no structuring of standards-setting in long term care as there is in acute care settings. Scott (1982), however, has presented an
<table>
<thead>
<tr>
<th>Characteristics of Institutional Care in the Social Model vs. the Medical Model</th>
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<tbody>
<tr>
<td><strong>Social Model</strong></td>
</tr>
<tr>
<td>Primary social needs</td>
</tr>
<tr>
<td>More generalized care</td>
</tr>
<tr>
<td>Resident's overall needs primary</td>
</tr>
<tr>
<td>Quality of life priorities</td>
</tr>
<tr>
<td>Focus on quality of life for quality assurance</td>
</tr>
<tr>
<td>Admission for social factors by self, family, doctors,</td>
</tr>
<tr>
<td>Negotiate for consent</td>
</tr>
<tr>
<td>Various organizational arrangements - simpler</td>
</tr>
<tr>
<td>Less expensive</td>
</tr>
<tr>
<td>Hospital administrator's role more pivotal and central agent</td>
</tr>
<tr>
<td>Accreditation standards - should be increased &quot;emphasis on quality of life,&quot; (e.g., resident councils)</td>
</tr>
<tr>
<td>Future: Resident contracts for all activities, including medical activities; resident has access to medical care as he/she would at home</td>
</tr>
</tbody>
</table>

interesting conceptualization of a professional organization within long term care institutions. He describes the "conjoint professional organization" as a possible rather than an existing model of professional organization that fits with a matrix organizational structure. It supports a focus on care and decentralization of decision-making. It is possible to visualize the conjoint professional model as a series of concentric circles with settings for care and professional interests at the centre. Managers and support systems form the next layer, with general administrators facing out to the environment more than into the institution -- responding as a "buffer" to environmental influences and building bridges to the care level from the policies developed (Pfeffer & Salancik, 1978). This conjoint professional organization represents an approach that recognizes an autonomy of the professionals as well as the increasing interdependence of the work they perform.

Organizational Structures

The matrix structure\(^5\) is the most functional organizational framework for long term care settings (Steward, 1963; Beckhard, 1977). The traditional hierarchical structure in place in acute care institutions focuses on specialization (differentiation of tasks) (Neuhauser, 1972) with integration of services occurring on a project

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5. See Appendix I for analysis of the matrix organizational structure in health care.
basis. In long term care institutions the focus is on integration of services with specialized tasks having minor significance. Integration and differentiation of tasks are needed by both long term care and acute care institutions but the proportions are different. Rotate the acute model shown below and the long term care organizational structure results (see Chart III on page 69). Basic organizational contrasts listed in Chart IV on page 70.

The conceptual models presented focused on both the aspects of care and organization of long term care institutional services. They reflect the nature of long term care services providing what Margulies & Adams (1982) described as,

... a consistency of design of the organizations with the appropriate models of care reflected at all levels of the institutions (p. 369).

CHART III
ORGANIZATIONAL MODEL OF ACUTE CARE

DISCIPLINARY FUNCTIONS for DIFFERENTIATION of TASKS

Hierarchical structure

MULTI-DISCIPLINARY PROJECT FUNCTIONS for INTEGRATION of TASKS

Matrix Structure
CHART IV
ORGANIZATIONAL MODEL FOR LONG TERM CARE

MULTI-DISCIPLINARY
FUNCTIONS for
INTEGRATION of TASKS

Matrix Structure

DISCIPLINARY PROJECT FUNCTIONS
for DIFFERENTIATION of TASKS

Hierarchical Structure

CHART V
BASIC ORGANIZATIONAL CONTRASTS

<table>
<thead>
<tr>
<th>ORGANIZATIONAL DIMENSION</th>
<th>(DISCIPLINARY) BUREAUCRACY</th>
<th>(MULTIDISCIPLINARY) MATRIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority</td>
<td>Hierarchical</td>
<td>Participative</td>
</tr>
<tr>
<td>Command</td>
<td>Unitary</td>
<td>Multiple</td>
</tr>
<tr>
<td>Integration</td>
<td>Vertical</td>
<td>Vertical/Horizontal</td>
</tr>
<tr>
<td>Change</td>
<td>Rigid</td>
<td>Flexible</td>
</tr>
<tr>
<td>Power</td>
<td>Administrative</td>
<td>Expert</td>
</tr>
<tr>
<td>Tasks</td>
<td>Routine</td>
<td>Non-routine</td>
</tr>
<tr>
<td>Loyalty</td>
<td>Organization</td>
<td>Team</td>
</tr>
<tr>
<td>Organization</td>
<td>Functional</td>
<td>Project</td>
</tr>
<tr>
<td>Rules</td>
<td>Strict</td>
<td>Loose</td>
</tr>
<tr>
<td>Orientation</td>
<td>Maintenance</td>
<td>Change</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Controlled</td>
<td>Discretionary</td>
</tr>
</tbody>
</table>

Adapted from Theodore Walden, 1981.
IMPLICATIONS FOR STANDARDS-SETTING

... curing disease is not the same as promoting health and well-being. If health is seen, as it once was, as successful adaptation to one's situation or overall environment, we can help the elderly achieve this by different types of services and different methods of delivery from what we now offer them (Dubos, 1979:11).

The difference between acute care and long term care services is that the latter is not so much about outcomes as about processes. Since the outcome of long term care is likely to be death, the appropriate standards for long term care must address processes of care. Chart VI on page 72 begins to clarify these differences.

Reliance on the medical-professional aspects of care and the mechanisms that maintain this focus is incomplete particularly for the elderly. This approach results in the medicalization of needs (McPhee, 1977), with old age often seen in this society as synonymous with sickness (Shanas, 1968). This is inappropriate for the provision of comprehensive services that include the approaches to health care outlined in this chapter.

The appropriate standards-setting for long term care must address processes of care -- not only the medical-professional aspects but also the administrative (governmental) and organizational aspects of service delivery.
<table>
<thead>
<tr>
<th></th>
<th>SOCIAL MODEL</th>
<th>MEDICAL MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial services</td>
<td>Psychosocial services such as educational, creative, sensory awareness,</td>
<td>Organic/physical problems with physical methods, rehabilitation</td>
</tr>
<tr>
<td></td>
<td>religious activities provided by social workers, chaplains, recreationists,</td>
<td>and treatment using doctors, nurses, and rehabilitation staff</td>
</tr>
<tr>
<td></td>
<td>community volunteers, and others.</td>
<td></td>
</tr>
<tr>
<td>Psycho-social -</td>
<td>Psycho-social - capability orientation - finding solutions to problems</td>
<td>Medical-disease orientation</td>
</tr>
<tr>
<td>capability</td>
<td>which interfere with social functioning</td>
<td></td>
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<tr>
<td>orientation</td>
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<tr>
<td>to problems which</td>
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<tr>
<td>interfere with</td>
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<tr>
<td>social functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric/behavioural</td>
<td>Psychiatric/behavioural characteristics</td>
<td>Physical, physiological, and rehabilitative characteristics</td>
</tr>
<tr>
<td>characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on social</td>
<td>Focus on social relationships and purpose/meaning to life</td>
<td>Focus on institution</td>
</tr>
<tr>
<td>relationships and</td>
<td></td>
<td></td>
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<tr>
<td>purpose/meaning to</td>
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<tr>
<td>life</td>
<td></td>
<td></td>
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<tr>
<td>More generalized</td>
<td>More generalized</td>
<td></td>
</tr>
<tr>
<td>Focus on overall needs</td>
<td>Focus on limited needs (medical)</td>
<td>Cure emphasis (outcomes)</td>
</tr>
<tr>
<td>Care emphasis (process)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term - chronicity</td>
<td></td>
<td>Short-term - acute care</td>
</tr>
<tr>
<td>More community-based</td>
<td></td>
<td>Institution-based</td>
</tr>
<tr>
<td>Medical problems are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>multiple and complex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team</td>
<td></td>
<td>Doctor-patient (Key for decision making)</td>
</tr>
<tr>
<td></td>
<td>From Jesion and Rudin, Health Management Forum, Summer 1983.</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER VII

ADMINISTRATIVE ASPECTS IN HEALTH CARE STANDARDS SETTING

COMPARATIVE DEVELOPMENTS

Government intervention into health care systems in the form of reimbursement policies varies from country to country. The historical developments outlined in previous chapters support a view of trends, identified by Roemer & Roemer (1981) across five countries that developments are towards increased organization of services, both in terms of economic support and control over patterns of delivery. In addition, as the demand for accountability by governments increases, there is increasing tension between federal and provincial governments, between professionals and government and between the professionals themselves. This chapter explores where Canada stands in health care standards-setting compared with the two countries that have most influenced Canadian developments -- the United Kingdom and the United States. This provides a continuum on which Canadian developments find an intermediate position.

The British influence has affected Canadian administrative and funding structures. By the end of the 19th century, the United Kingdom had laid the groundwork for a national health insurance system. The emphasis of government had been on funding problems. When the Second
World War led to the need for reconstruction policies, among these were the development, not only of a social insurance system, but also a tax supported health care delivery system. The Beveridge Report (1942) proposed policies and programs that resulted inter alia in the formation of the National Health Service (1946) in Britain. As Crichton (1976) explained, this welfare state philosophy had some appeal in Canada.

The organization of Canadian society was very different from that of Britain. By virtue of the Canadian Constitution, standards for health care were set by the provinces. In the 1930's, when Federal/Provincial involvement was examined generally, it was considered unconstitutional for the Federal government to become involved in health care matters. As a result of the Rowell-Sirois (1940) investigation, it was decided to amend the constitution in order to enable the Federal government to develop a social security and health insurance system. A national health service was not initiated in Canada.

Canada was not a homogeneous, industrial country. It was characterized by a federal system of government, heterogeneity of population, pluralism of culture and widespread rural populations. It had not suffered from the rigours of war at first hand in such a way that all its citizens had become convinced of the need for a comprehensive social security program and State intervention in social planning (Crichton, 1976:60).

The health insurance plan was introduced very gradually through federal-provincial negotiation, as described by Taylor (1976), and with many glances across the U.S. border.
In the United States, attempts by Roosevelt to establish a "national health bill" as part of the New Deal - to give grants to the States for health insurance plans -- were interrupted by World War II. The Wagner-Murray-Dingell bills failed, but they had much the same effect as Canada's post war proposed program of enacting comprehensive national health insurance - they stimulated the further rapid growth of voluntary insurance. National Health insurance never did arrive in the U.S., although the passage of Medicare and Medicaid (1965) are seen as moves in that direction. The Canadian proposals took twenty years to complete.

The U.S. Congress attempted to produce hospital and medical treatment appropriate to an industrial nation. The Hill-Burton Act of 1946 facilitated long-range planning and hospital construction in the less populated states, and the Hill-Harris Act of 1964 directed hospital construction away from rural areas to urban areas that had been neglected. Short term developments in Canada followed closely upon the American legislation with respect to hospital construction under the National Health Grant Program, 1948.

The American influence was transmitted through communication between the various international professional associations and accrediting bodies. Neither system however - Canada with its Federal Insurance plan or the U.S. with numerous planning acts - improved the coordination of construction plans or services among hospitals and other health services. Changes occurred in an incremental, disjointed fashion.
In Great Britain government became directly involved not only in funding but also in the delivery of health services. In Canada, governments gradually got more and more involved in funding but, on the whole, were not much involved in service delivery. This was delegated to subsidized, entrepreneurial professionals and "voluntary" institutions.

Although in due course Canadian institutions became almost totally funded by governments, they retained their delegated powers. Accountability has not been tight, although improving this has recently become a focus. In the U.S., both funding and service provision remained outside government control, except for some planning activities related to construction, and the funding of the two programs for the elderly and for poor people - Medicare and Medicaid.

MODELS TO COMPARE DEVELOPMENTS

Four models have been identified which help to conceptualize the relationship of Canada to the United States and United Kingdom regarding their national health systems -- the models proposed by Lowi (1964), Spiers (1975), Illich (1975), and Johnson (1972).

Lowi (1964)

The government activities model proposed by Lowi (1964) is useful in examining developments across countries. The distribution of prerogatives, regulatory activities, and redistribution of rights by government are placed on a continuum.
Sabatier (1981) wrote of the U.S. system that:

Distributive and redistributive policies are less likely to meet with opposition as they focus on benefits to people, whereas regulatory policies focus on modifying behaviour and are more likely to have functional rivals.

Spiers (1975)

The second model, proposed by Spiers (1975), provides a continuum of four major kinds of planning along a scale of control, ranging from free enterprise at one extreme to near complete planning at the other.

Government Activities:

<table>
<thead>
<tr>
<th>Limited Free Enterprise</th>
<th>Indicative Planning</th>
<th>Limited Dirigism</th>
<th>Pure Dirigism</th>
</tr>
</thead>
</table>

The position of planning by countries is identified by:

a. The degree of control sought.

b. The quantity and kind of information required by the planning authority to make the plan effective.

c. The type of sanction used by the planning authority to make the plan effective.

d. The focus of the control.
Illich (1975)

The third model, proposed by Illich (1975), arose out of a questioning of the efficacy of the traditional role of the doctor. He described medical care as having become "perverse" - its objective being not to further the health of the general population, but to promote the well-being of those who provide care. He went as far as to describe it as promoting "clinical, social, and technical iatrogenesis" (1975:27).

Johnson (1972)

Illich's model is best understood in conjunction with Johnson's model (1972). He focuses on categories that describe the relationships of the medical profession to the rest of society - stage of patronage, collegiality, and mediation. Tensions develop as health care policy evolves through these stages. As the producer-consumer relationship was changed by the increasing use of technology and changes in funding to third-party payment schemes, the common area of shared experience and knowledge was reduced.

Illich's interpretation leads to a more radical view of what Johnson proposed.

Mediative System

Patronage  Collegiality  or

Perverse System

Illich's model of the control of health services by the professionals supports the findings in this chapter. The fact remains that the medical professional strives to maintain a self-regulating position (Illich, 1975), while the trend appears to be towards mediative
measures by third-party payers in all countries. The following chart illustrates the chronological development of these stages:

CHART VII
MODELS FOR HEALTH CARE DEVELOPMENTS

<table>
<thead>
<tr>
<th>Government (Lowi Model)</th>
<th>Dates</th>
<th>Profession (Johnson model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distributive</td>
<td>1800</td>
<td>Patronage</td>
</tr>
<tr>
<td></td>
<td>1867</td>
<td>Collegiality</td>
</tr>
<tr>
<td>Regulative</td>
<td>1940</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1977</td>
<td>Mediation/Collegiality</td>
</tr>
<tr>
<td>Redistributive</td>
<td>1980</td>
<td></td>
</tr>
</tbody>
</table>

At first, government involvement in prepayment schemes introduced more money into health care systems, which enabled more to be spent on patients, on technological developments, and on health workers' pay. The system displays a continuing demand for increased payments, and at a time of economic restraint this has led to increased tensions between government and the health care system. The dominant professional groups have challenged the distribution of resources and the total amount devoted to health care, which they argue is insufficient to maintain good standards. The self-regulated medical profession receives substantial public support when it speaks out on quality assurance issues, yet the elected officials have to find the money to support the system. This is the classic situation of responsibility without authority, hardly a stable mechanism.
THE PATTERN OF HEALTH INSURANCE DEVELOPMENT (CANADA)

Governments in Britain, Canada and the United States are drawn more and more into redistribution and regulation and, as they react to increased costs, they became concerned to improve quantitative and qualitative controls. This leads to increased politicization of the health care system.

Weller (1976) discussed the progression from a narrow to a broad conception of the range of forces that operate in health policy formation - the movement from micro-issues relating to physicians and legislation to macro-issues of organizational control of expenditures. He took the many suggestions of the 1970's and identified points where government could intervene. As with various other analyses at this time -- provincial reports, and the like -- he appealed for acceptance of more comprehensive models of care. The financial consequences of introducing these broad ideas were not considered.

The evolution of health insurance financing follows a pattern. This can be established from the examination of historical developments. Mandatory health insurance programs are first introduced in response to political pressures to achieve greater equity in health services, while patterns of health care delivery are left untouched in the face of conservative opposition to change. The subsequent rise in expenditures and their social visibility then generate a whole new series of regulatory controls, among which are deliberate strategies to restrict the growth of health care resources, and the introduction of new patterns of health care delivery. The 1977 E.P.F. Act in Canada was
designed to intensify the force of this second stage. The third stage overlaps with the second; in response to continued cost-control pressures, sweeping changes are made in the structure of the health care delivery system to achieve greater efficiency and effectiveness within acceptable cost limits.

Depending on the health insurance system the amount of regulation and need for accountability varies, but the trend is towards accountability by all funding bodies. This movement, however, leads to opposition by professionals who have profited by leaving things ambiguous.

CONTROL OF THE MEDICAL PROFESSION BY GOVERNMENTS

The consequences of introducing increased accountability for health services delivered must be considered. A number of writers have examined the political, economic and legal powers of the medical profession. Political power has helped doctors to shape relevant legislation, licensure, and regulatory activities (Krause, 1977). Economic power derives from the medical profession's monopoly status (Reinhardt, 1975). Legal power gives dominance to medical activity by statute (Dolen, 1980).

Parsons (1952) considered how the 'gatekeeping' functions of the profession were social control mechanisms. Watkins (1975) described how personal service professions have always emphasized skills and underplayed other professional activities (economic/political) to keep them indeterminate. McKinlay (1981) and a number of others have
discussed the usefulness of neo-Marxist explanations to the development of the capitalist state. Because of the gatekeeping power of the medical profession in rationing and allocation of services (Parker, 1967), attempts to control medical/technological developments met with resistance. As Marchak (1975) stated, doctors tolerate government only as a regulatory organization permitting the professionals to provide the services they consider appropriate. Friedson (1982) recently remarked, however, that the position of the medical profession is changing and that the trend is for government to gain more control of doctors' activities. To accomplish this it is advisable to employ cooptation rather than confrontation, as confrontation (or perceived threat to professional autonomy) has historically provoked strong resistance to change.

RESISTANCE TO CHANGE

The British Columbia government has a traditional policy of non-intervention in most health matters. It has deemed itself a funding body, delegating service decisions to regulated professional associations and institutions. The legal and administrative process established by government sets the framework for the health care system, but has interfered very little in the day-to-day conduct of service associations and institutions. The system is essentially medically dominated, supported by government financing.

Canadian governments, however, have moved towards the third stage outlined above: accountable redistributive policies. Such policies
pose a threat to established "regulated entrepreneurialism", so adherents of this ideology resist change (Crichton, 1980). Two accounts of resistance to government control are explored by Thompson (1962) and Badgley and Wolfe (1967). The Thompson Report (1962) showed that doctors were not sufficiently involved in the planning process when health insurance was introduced in Saskatchewan and this led to strong political repercussions. Badgley and Wolfe (1967) discovered that provincial governments, even with a clear political mandate, could not make unilateral decisions to systematize health care.

In both situations, the legitimacy question was assumed to have been settled. As Crichton explains,

Unless all groups who have veto power are involved in the legitimation process, they may decide to undermine the feasibility of a project (1976).

Canadian governments have found that increased regulation of the medical profession has not been advisable (Bennett and Krasny, 1977). Blishen (1969:14) reported a situation which remains apparent today: "efforts at regulation lead to inactivity and strong attempts by both parties to maintain the status quo."

Professional associations and health service institutions were regulated by public statute and by established accrediting bodies which pre-dated public insurance and were, at first, not significantly challenged to be accountable. Since the E.P.F. Act (1977) this has changed. Federally, government moved into block funding, seeking more accountability within the provinces. Political resistance from the
provinces resulted in the Canada Health Act (1984) which returns total responsibility for health expenditures to the provinces as long as they meet the criteria of the Medical Insurance Act (1966).

WHAT IS APPROPRIATE STANDARD SETTING FOR CANADA?

Given these briefly outlined but salient concerns that arise as accountability for health funding increases, standard setting becomes an art. Experiences from other countries may help us to understand what decisions are appropriate for the Canadian health care system. The study of health manpower policies across five countries by Roemer and Roemer (1981) provided a comparison of the general effects of national health systems on shaping health care developments. Weller (1974), and more recently Evans (1983), have examined Canadian Federal/Provincial arrangements in more detail and described the potential for conflict over increased regulation. The Economic Council of Canada presented a special report on Reforming Regulation (1981) concerned with the use of monopoly power by the professions. These discussions revolve around the issue of relating quality to costs and the need for rationing and priority setting, issues which have not been considered properly by the peer-review groups which have focussed on individual cases.

THEORIES ON REGULATION

Theories that establish patterns relevant to regulation of a health care system fall into two categories, dominant interest group theories
and participatory interest group theories. The dominant interest group theory states that: "the regulated desire regulation for the benefits they expect it to bestow upon them and demand it as it is in their best self-interest" (Bernstein, 1955:155). Posner (1974), another American writer, accepts this hypothesis but views regulation somewhat differently: "the regulated and the regulator jointly dominate the regulatory process at the expense of the public" (p. 135).

In a later work, Bernstein (1970) discussed participatory group theories that describe the nature of regulation as a process -- as experienced in the U.S. specifically by the long term care industry. He described the cycle that participatory groups go through when they desire to introduce mandatory regulation. The initial phase involves public pressure for action with regard to specific social programs. This continues until an agency of regulation is introduced to take control of attempts to refine regulatory goals and policies. Instead of pursuing a plan, this agency reacts to the issues. Resistance is shown by the providers of care and public support decreases. In the third phase, the agency adjusts to the conflict atmosphere and functions more as a manager than a regulator, which begins the process explained under dominant interest group theory. The fourth phase includes abandonment of the agency by the public, who opt for safety in policy decisions and for funding through legislation. This pattern of development in the U.S. provides insight into the public scrutiny of the health care industry (p. 476).

The arguments about Canadian regulation are different. Evans (1983) believes government intervention is required and that a mediative
role is necessary because the subsidized entrepreneurial professionals in a monopoly position have "lost sight of reality" (p. 4). Their emphasis on quality care for each individual who comes under their charge misses the main point - that there are limits to the country's ability to pay. Challenged by this, physicians fall back on their legal position, saying that they will be sued if negligent. Like many others, Baldwin (1974) disagrees with self-interest theories and feels that the process of decision making is not controlled by regulations. Blishen (1949) sees much of the Canadian medical professionals' behaviour as a response to stress, not self-interest. What, then, is likely to happen? McLachlan (1976), a British writer, indicated that with greater financial involvement requiring more accountability, less government regulatory involvement in determining standards is necessary.

A NEW CONCEPT OF QUALITY ASSURANCE

In order to be effective a quality assurance program must focus on the professional, administrative and organizational aspects of care (Australian Council on Hospital Standards, 1977).

An expanded conceptualization of a quality assurance program that included other than the professional aspects of care was not considered in North America. The idea that quality assurance is about expanded models, such as aggregate models (Kane and Kane, 1981) was discussed in Chapter IV and quality management certainly has been introduced as necessary (Slee, 1982). The result, however, is still a focus on
(micro) clinical aspects of care and aggregates of this. As determined in the previous section, the professional aspects of care influenced standards-setting to focus on the medical outcomes of treatments or curative aspects of health care. Essentially the micro-clinical aspects -- concern about delivery of quality service to individual patients -- often neglected the macro concerns about equity and distributional aspects.

Certainly the need for alternate systems of health care delivery and quality of care standards was addressed in the 1970's in the various Provincial Reports; however, attempts to introduce multi-service programs were short lived. Why was this?

Lowi's (1964) discussion of the administrative aspects in health care showed how government involvement in redistributive policies changed the context in which standard-setting occurred. Is it possible that government must be involved with health care standards-setting (with all the inherent difficulties) if multi-service health care delivery is the objective?
SECTION IV Conclusions and Recommendations
CHAPTER VIII

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to examine the process of standards-setting in the Canadian health care system to determine how quality health services are assured and maintained for the elderly population who require care. The question may not be "what are the appropriate mechanisms for setting standards for Long Term Care developments?" but, rather, "what is the most feasible and appropriate mix of mandatory and voluntary mechanisms which is likely to eliminate unnecessary quantity and stimulate high quality long term care services?"

This study set out to examine qualitative standards-setting in the Canadian health care system. It was concluded that standards-setting in Canada moved from a focus on structure to a preference for peer-review mechanisms as the means of control -- the movement from macro- to micro-concerns. However, the focus on professional aspects of care emphasized the outcomes of acute care treatments. Since the outcome of long term care is likely to be death, the appropriate standards-setting for long term care must address the processes of care (quality of life processes) which include not only the professional aspects (peer-review), but also takes into account the administrative and organizational aspects of service delivery.

The general development of qualitative standards-setting revealed the unsatisfactory nature of regulatory activity in Canada. When resources were unlimited and the population overwhelmingly young in age,
the professional (micro-) aspects of care were less likely to impinge on the macro-aspects relating to distribution and equity. But the situation changed in the sixties as technology advanced and population structures changed. Concern for the rising costs of health services led to increased regulation in the seventies. Standards-setting, however, promoted normative practices that tended to escalate costs and provide the wrong incentives for acute and long term care services.

The study investigated the interrelatedness of all aspects affecting the provision of quality health care services: the professional, administrative, and organizational aspects. The debate ranged from the belief that administrative-government involvement was essential for the provision of quality services for groups such as the elderly (Somers, 1982) to the belief that government involvement decreased professional incentives for the provision of quality services (Ruchlin, 1978). Regardless of the approach to regulation -- the United Kingdom with the National Health Service to the United States with the proliferation of regulatory activity -- costs continued to increase and conflicts arose between the professional and administrative aspects governing care. The recognition in this study of the presence and legitimacy of this conflict led to the need for identifying a political-bureaucratic model for introducing change (Marmor, 1973).

Alternatives to the traditional medical system were suggested as a means of improving the quality of life for Canadians in the 1970s. The alternatives, such as preventive programs, focussed on the processes of care rather than on the outcomes of medical treatments, yet developments were not maintained. The existing standards-setting mechanisms ensured
the maintenance of the medical institutions which created them. From legislative standards to quality assurance program standards, the focus was on medical outcomes that led to the medicalization of needs and the increasing fragmentation of services.

The difference between acute care services and long term care services is that the latter is not so much based on outcomes of treatment as on the processes of care. Programs that require process care were not addressed through existing standards-setting mechanisms. Attempts to modify and redesign existing mechanisms have been poorly directed efforts. This is in part due to the lack of clarity and definition of objectives, conceptual models and appropriate organizational structures for long term care services. Based on the provision of process care, standards appropriate for guiding long term care developments must reflect the nature of these services at all levels of standards-setting.

The examination of long term care services in British Columbia has revealed gaps in the provision of services for the elderly. Long term care developments have illustrated how the existing mechanisms for setting qualitative standards did not directly address the health needs of this group of people. In fact, the standards developed to assure quality in acute care institutions were perverse in long term care settings. They encouraged the medicalization of the needs of the elderly thus promoting the "sick role" and dependency on institutionalized services. The elderly require a continuum of services that would enhance the quality of life in later years. For this development to occur, it became evident that in the Canadian health care
system, government involvement was necessary for assuring comprehensive services to the elderly.

Government became directly involved with program development for long term care services in 1978. Movement toward a mixed provider system avoided many of the concerns for quality long term care services experienced in other jurisdiction; however, government has only addressed efficiency issues. The assurance of quality services to meet the health needs of the elderly who require services has not been addressed. As Somers (1982) suggests, what is needed is a policy that takes change in total health needs and family structure into account, and acknowledges that the quality of life in later years is at least as important as the quantity.

What is needed is a mixture of mandatory and voluntary mechanisms which are likely to eliminate unnecessary quantity and stimulate high quality long term care services. Long term care services are less technical than acute care services and understandable to the general public; therefore, the Canadian system, with its political-bureaucratic model for assuring health care changes, must move toward mobilizing the informal voluntary mechanisms. The plan for this is essentially an educational one. Once the process standards are set, the more formal voluntary mechanisms that are effective in achieving compliance, namely accreditation and continuing education, can be used to ensure that the changes are instituted.

Based on the findings of the study, the recommendations on qualitative standards-setting for Canadian process (long term care) services are summarized as follows:
- that assessment of professional, administrative and organizational aspects governing care delivery are necessary for assuring quality process (long term care) services;

- that a multidisciplinary task force (including consumers) be formed to define and clarify the direction of process (long term care) services; then,

- that appropriate standards be developed that reflect a consistency of design at all levels of health care delivery;

- that educational programs be developed for professionals and consumers;

- that mandatory professional standards should reflect the distinct nature of process (long term care) services as compared to acute care services;

- that mandatory administrative standards, both Federal and Provincial, should provide financial incentives for the development of process services;

- that formal voluntary mechanisms (Accreditation and Continuing Education) should be modified and adapted to reflect process standards; and used to achieve compliance to the health care standards developed; and
that informal voluntary mechanisms be used to monitor and develop the quality of process services.


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Commission of Inquiry on Health and Social Welfare ("Castonguay Report")
A broad inquiry into an income, health and social security system for the Province of Quebec. (1970)

White Paper on Health Policy (Manitoba "White Paper")
A "White Paper" proposing broad policies for Manitoba health and social services for discussion with public and professionals. (1972)

A plan for organizing, within available fiscal resources, a comprehensive health plan for Ontario. (1974)

Health Security for British Columbians ("Foulkes Report")
Proposals for the rationalization of health care services in British Columbia. Two volumes and 13 commissioned studies. (1973)

A New Perspective on the Health of Canadians ("Lalonde Report")
A working paper outlining future health programs, particularly in the preventive area. (1974)

The Community Health Centre in Canada ("Hastings Report")
A discussion of Community Health Centres and their possible social and economic impact on the Canadian Health Care System.

EVALUATION OF QUALITY

Information system required. Based on census, regular surveys, health records, specific surveys and special registers. Evaluation to measure state of health, operation of system, output of health plan.

Province supplies technical back-up for districts and retains overall responsibility. Precise mechanisms not spelled out.

(a) On-going matching outcomes to objectives; monitoring resources used.
(b) Audit: extension of medical audit of patient records to primary care groups and secondary care programs.
(c) Review: external peer review by teams including laymen; use of audit and OHIP data; internal peer review mechanisms to be established for groups and programs.

Evaluation carried out by Regional Boards along provincial guidelines; more funds needed for evaluation and long range planning.

Urges development and use of new measures of effectiveness (e.g. causes of illness) to determine what programs are most effective. Need for better and more accurate information. Calls for a way to discover ill health in the population treated outside hospitals, the numbers of chronically disabled, the amount of self-limiting or self-treated disease, etc.

Ongoing evaluation a critical element of system; existing methods of delivery must be appraised and alternative methods designed and assessed. Sufficient funds must be allocated for this task both in provincial and district budgets. A record and communications system must be designed for and employed throughout all levels of the health care system.

DEVELOPMENT & ENFORCEMENT OF STANDARDS:

Provincial tasks: inspection of institutions, licensing of professionals, developing statistical controls, establishing baselines and norms. Regional tasks: follow-up evaluation results, implement research. Local tasks: internal evaluation of records, internal peer review.

Province retains overall responsibility within a decentralized system

Minister of Health ultimately responsible; should coordinate and finance an evaluation system. Standardized record system should be established. A Council of Health to advise Minister and a Health Disciplines Board to oversee professions.

A Provincial responsibility carried out through the Standards Branch of Ministry which should determine levels of care. A better data system necessary; standard records and information systems needed for monitoring and planning. Health Disciplines Board to ensure standards and accountability of professions.

Standards to be determined for food, water, air, noise and soil pollution; legislation and regulation for advertising and sale of household products, cosmetics, etc. Legislation to be changed where necessary and possible (e.g. seat belts) to provide "negative" incentives.

Basically a provincial responsibility to be decentralized as far as possible
Appendix B.

B.N.A. Act

CONSTITUTIONAL DOCUMENTS OF CANADA


66. The Constitution of the Legislature of each of the Provinces of Nova Scotia and New Brunswick shall, subject to the provisions of this Act, continue as it exists at the Union until altered under the Authority of this Act; and the House of Assembly of New Brunswick existing at the passing of this Act shall, unless sooner dissolved, continue for the period for which it was elected.

5. Ontario, Quebec and Nova Scotia.

69. Each of the Lieutenant-Governors of Ontario, Quebec, and Nova Scotia, shall cause Writs to be issued for the first Election of Members of the Legislative Assemblies thereof in such form and by such person as he thinks fit, and at such time and addressed to such Returning Officer as the Governor-General directs, and so that the first Election of a Member of Assembly for any Electoral District or any subdivision thereof shall be held at the same time and at the same places as the Election for a Member to serve in the House of Commons of Canada for that Electoral District.

6. The Four Provinces.

90. The following provisions of this Act respecting the Parliament of Canada, namely—the provisions relating to appropriation and tax Bills, the recommendation of money votes, the assent to Bills, the disallowance of Acts, and the signification of pleasure on Bills reserved,—shall extend and apply to the Legislatures of the several Provinces as if these provisions were here re-enacted and made applicable in terms to the respective Provinces and the Legislatures thereof, with the substitution of the Lieutenant-Governor of the Province for the Governor-General, of the Governor-General for the Queen and for a Secretary of State, of one year for two years, and of the Province for Canada.

VI. DISTRIBUTION OF LEGISLATIVE POWERS.

Powers of the Parliament.3

91. It shall be lawful for the Queen, by and with the advice and consent of the Senate and House of Commons, to make laws for the peace, order and good government of Canada in relation to all matters not coming within the classes of subjects by this Act assigned exclusively to the Legislatures of the Provinces; and for greater certainty, but not so as to restrict the generality of the foregoing terms of this Section, it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all matters coming within the classes of subjects next hereinafter enumerated, that is to say:—

1. The Public Debt and Property:
2. The regulation of Trade and Commerce:
3. The raising of money by any mode or system of Taxation:
4. The borrowing of money on the Public Credit:
5. Postal Service:
6. The Census and Statistics:
7. Militia, Military and Naval Service, and Defence:
8. The fixing of and providing for the Salaries and Allowances of Civil and other Officers of the Government of Canada:
9. Beacons, Buoys, Lighthouses, and Sable Island:
10. Navigation and Shipping:
11. Quarantine and the establishment and maintenance of Marine Hospitals:
12. Sea Coast and Inland Fisheries:
13. Ferries between a Province and any British or Foreign Country, or between two Provinces:
14. Currency and Coinage:
15. Banking, Incorporation of Banks, and the issue of Paper Money:
16. Savings Banks:
17. Weights and Measures:
18. Bills of Exchange and Promissory Notes:
19. Interest:
20. Legal Tender:
21. Bankruptcy and Insolvency:
22. Patents of Invention and Discovery:
23. Copyrights:
24. Indians and Lands reserved for the Indians:
25. Naturalization and Aliens:
26. Marriage and Divorce:
27. The Criminal Law, except the Constitution of the Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters:
28. The establishment, maintenance and management of Penitentiaries:
29. Such Classes of Subjects as are expressly excepted in the enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces:

3 For the disclaimer of provincial acts, see Kennedy, Constitution of Canada, pp. 415 ff. and Journal of Comparative Legislation, February, 1914, pp. 11 ff.

5 For an exhaustive summary of the interpretation by the courts of sections 81 and 91, 93 and 94, see Letley, Canada's federal system (1913), and Letley and Keith, Federalism, promise on Canadian Constitutional National Law (1918). Since 1918 the interpretation must be sought in the law reports.
And any matter coming within any of the Classes of Subjects enumerated in this section shall not be deemed to come within the Class of matters of a local or private nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

Exclusive Powers of Provincial Legislatures.

92. In each Province the Legislature may exclusively make laws in relation to matters coming within the Classes of Subjects next hereinafter enumerated; that is to say:—

1. The amendment from time to time, notwithstanding anything in this Act, of the Constitution of the Province, except as regards the Office of Lieutenant-Governor:

2. Direct Taxation within the Province in order to the raising of a Revenue for Provincial Purposes:

3. The borrowing of money on the sole credit of the Province:

4. The establishment and tenure of Provincial Offices, and the appointment and payment of Provincial officers:

5. The management and sale of the Public Lands belonging to the Province, and of the timber and wood thereon:

6. The establishment, maintenance, and management of public and reformatory prisons in and for the Province:

7. The establishment, maintenance, and management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Provinces, other than Marine Hospitals:

8. Municipal Institutions in the Province:

9. Shop, Saloon, Tavern, Auctioneer, and other Licenses, in order to the raising of a Revenue for Provincial, Local, or Municipal purposes:

10. Local works and undertakings, other than such as are of the following classes:
   (a) Lines of Steam or other Ships, Railways, Canals, Telegraphs, and other works and undertakings connecting the Province with any other or others of the Provinces, or extending beyond the limits of the Province.
   (b) Lines of Steamships between the Province and any British or Foreign Country:
   (c) Such works as, although wholly situate within the Province, are before or after their execution declared by the Parliament of Canada to be for the general advantage of Canada or for the advantage of two or more of the Provinces:

11. The Incorporation of Companies with Provincial Objects:

12. The Solemnization of Marriage in the Province:

13. Property and civil rights in the Province:

14. The Administration of Justice in the Province, including the constitution, maintenance, and organization of Provincial Courts, both of Civil and of Criminal Jurisdiction, and including procedure in civil matters in those Courts:

15. The imposition of punishment by fine, penalty, or imprisonment for enforcing any Law of the Province made in relation to any matter coming within any of the classes of subjects enumerated in this Section:

16. Generally all matters of a merely local or private nature in the Province.

Appendix C.

Health Security for British Columbians, the Foulkes Report 1973

The basis of its approach to improving the health care system was stated:

(1) a W.H.O. definition of health,

(2) consumerism,

(3) systems approach to health care,

(4) equal access based on needs,

(5) regionalization of services for public participation and rationalization of services,

(6) a government role in health planning, financing, monitoring, research, and education,

The Foulkes Report described the existing health care system of the province, and proposed a number of changes: reorganization of the Ministry of Health; decentralized funding; Community Human Resource and Health Centres; Councils to interface with other government ministries, the public, and health professionals/workers; establishment of 7 - 9 regions for health planning. More specific concerns were also addressed by the report, and the scope of its recommendations included health manpower issues, teaching hospitals, emergency services, rehabilitation, occupational health, environmental health, preventive medicine, mental health, alcohol, native peoples, the aged, children's dental needs, housing and health, etc. Many of the points or issues raised in the report are still applicable in B.C. and in this sense the Report serves as a useful reference for health planners.
Appendix D.

Philosophy and Definition of Long Term Care

(Source: Government Manual for Long Term Care, Jan. 1976.)

Philosophy

1. The advocates of a structured program for long term care in the Province have for years bemoaned the absence of a framework that clearly illustrated the range of services required of this type of care. Although the essence of a system for its delivery was present, the ingredients were fragmentally provided by many widely separated groups who, more or less, worked in isolation of the total need. Moreover, the ministerial responsibility for the control of this care was divided because of the absence of an acceptable definition for long term care.

2. The Province of British Columbia has acknowledged the need for long term institutional care. However, the care for those who are able to and desirious of remaining in their homes in spite of health related problems, has left much to be desired, resulting in the institutionalizing of many who, if they had been able to obtain help, would have remained in their own homes.

3. The need therefore is for the gathering together of those formal and informal segments of health related care and their integration into a formal cohesive structure that will provide a comprehensive and universal standard of care throughout the Province.

4. The Program firmly believes that most people want to
stay in their homes and recognizes the inherent right of an individual to remain in his or her own home for as long as it is desirable and practicable. The support provided must be based on the premise that people are responsible and desirous of caring for themselves and their families for as long as they are capable of doing so. Consequently, only when personal and family resources fail to meet their need will the Program assume responsibility. Furthermore, the program must not only respect the right of the individuals to required care when the family is unable or unwilling to help but, the right of the family to request the transfer of individuals from the family's home to approved facilities in the community, when that individuals continued presence in their home is detrimental to the health of their family.

5. Ideally the many facets of long term care must be immediately available locally for those assessed as being in need, and include in addition to home support care, institutional care at the personal, intermediate and extended care levels.

Definition

1. Long Term Care is therefore to be interpreted as comprising 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 (1978) will range from home sup-
port services and personal care to the more intensive care services provided at the intermediate and extended care levels.
Appendix E.

LEGISLATION

Following are the major Acts in B. C., that affect long term care organizations.

- Alcohol and Drug Commission Act
- Annual and General Holiday Act
- Chiropractors Act
- Community Care Facility Act
- Coroner's Act
- Employment Standards Act
- Essential Services Disputes Act
- Hospital Insurance Act
- Human Rights Code of B. C.
- Labor Code of B. C.
- Limitations Act
- Mental Health Act
- Occupiers' Liability Act
- Ombudsman Act
- Patient's Property Act
- Public Trustee Act
- Society Act
- Trustee Act
- Vital Statistics Act
- Workers' Compensation Act

COMMUNITY CARE FACILITIES ACT (1979): governs the licensing and operation of community care facilities classified under the Hospital Act, School Act, Family and Child Services Act, Corrections Act or Mental Health Act.
### Provincal/Territorial Governmental Programs and Systems, 1982

#### Advisory and Consultative Mechanisms

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<td>DEPARTMENTAL OFFICES AND CONSULTANTS</td>
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<td>Senior Citizens Bureau(3)</td>
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<td>INTERDEPARTMENTAL CO-ORDINATION</td>
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#### Community Support

**Numerical Key**

1. Total general population
2. Special group (e.g., handicapped)
3. Aged 65 and over
4. Aged 60 and over
5. Aged 60 to aged 64
6. Aged 55 and over
7. Aged 65 and over
8. Adult to aged 65
9. Widowed persons who meet certain stated conditions
10. Income or needs tested
11. Fee for some services
12. No fee for aged 65 and over
13. No fee for aged 65 and over dependants

### DAY CARE SERVICES
- Long-term Care Program
  - Adult Day Care(1,11)
- Home Care Services
  - Home Care Program
  - Adult Day Care(1,11)
  - Respite Care(4,11)
- Continuing Care Program
  - Home Care(1,11)
  - Adult Day Care(4,11)
  - Community Setting(1,11)
  - Day Care Program(6,11)
  - Nursing Home(1,11)
  - Other Homes for the Aged(4,11)
  - Homes for the Retired(6,11)

### HOME CARE/ SUPPORT SERVICES
- Co-ordinated Home Care Services
  - Home Care Program
  - Adult Day Care(1,11)
  - Home Care(1,11)
  - Home Help(1,11)
  - Home Making(1,11)
  - Nursing(1,11)
  - Respite Care(1,11)
- Home Care Services
  - Long-term Care(1,11)
  - Home Care(1,11)
  - Home Help(1,11)
  - Home Making(1,11)
  - Nursing(1,11)
  - Respite Care(1,11)
- Continuing Care Program
  - Home Care(1,11)
  - Adult Day Care(4,11)
  - Community Setting(1,11)
  - Day Care Program(6,11)
  - Nursing Home(1,11)
  - Other Homes for the Aged(4,11)
  - Homes for the Retired(6,11)

### SENIOR CITIZEN CENTRES AND GROUPS
- Alva Council on Aging(5)
- Family & Community Support Services(3)
- Senior Citizen Centre(3)
- 615 Senior Citizens Activity Centre(4)
- Senior Citizens' Groups(grantsX3)

### TRANSPORTATION SERVICES
- Free B.C. Ferry Services(5)
- Free Driver Exam(5)
- Handy-Door, Individual Transport Program(2)
- Reduced Licence Fines(3,11)
- Reduced Metro, Transit Fees(3,11)
- Subsidized Bus Pass Program(3,10)
- Minimal Fee Bus Pass(X3,11)
- Special Transportation Services for Elderly and Handicapped Persons(grantsX3,3)
- Community Transportation Services(grantsX2,3)
- Discounted Travel Fares for Seniors(3,11)
- Handi-Transit(Winnipeg & Brandon)(2)
- Senior Driver Program(3)
- Transfer for the Disabled(2)
- Reduced Transit Fees(Metro, Toronto & other centres)(2,11)
- Wheel Transport(Buses for Disabled)(2,11)
- Special Public Transportation(1 urban centreX2,3)
- Reduced Transit Fares for Senior Citizens(2,11)
- Reduced Transit Fares for Handicapped Persons(2,11)
- Municipal Services for Other Public Transportation(1 rural centreX2,3)
- Bus Fare Discount(1 rural centreX3,11)
- Free Dartmouth Ferry(3)
- Transfers to Other Public Transportation(1 rural centreX2,11)
- Reduced Fares for Public Transport(1 rural centre)(11)

### COMMUNITY SUPPORT
- Include grants and consulting services.
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<tr>
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<td><strong>INCOME SUPPLEMENTS</strong></td>
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<td>Seniors’ Guaranteed Annual Income (2,10)</td>
<td>Assured Income for the Severely Handicapped (2,10)</td>
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<td>Family Benefits - Guaranteed Annual Income System (GAINS) - Disabled (2,10) - Seniors (4,10)</td>
<td>GAINS-Aged (1,10)</td>
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<td>Municipal Social Assistance (3,10)</td>
<td>Special Social Assistance (5,10)</td>
<td>Senior Citizens’ Benefits (3,10)</td>
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<td>Principal Residence Policy Program (discounts) (3)</td>
<td>Tenant Package Program (3)</td>
<td>Seniors’ Automobile Insurance Grant (3)</td>
<td>Renters’ Package Program (3)</td>
<td>Discounts on Property Insurance &amp; Insurance on Possessions (3)</td>
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<td>Quebec Pension Plan (3)</td>
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<td>Social Assistance (1,10)</td>
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<td><strong>PUBLIC PENSION PLAN</strong></td>
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<td>Rent Supplement (1,10)</td>
<td>Shelter Aid for Elderly Renters (3,10)</td>
<td>Property Tax Rebate for Senior Citizen Homeowners (3 &amp; 5,9)</td>
<td>Property Tax Rebate for Senior Citizens’ Property Tax Reduction (3)</td>
<td>Rent-Geared-to-Income for Senior Citizens Program - Rent Supplement (6,10)</td>
<td>Rent Geared-to-Income for the Elderly (3,10)</td>
<td>Housing Grant Program (3,10)</td>
<td>Social Assistance (1,10)</td>
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<td>Social Allowance Program (1,10)</td>
<td>Seniors’ Assistance Program (1,10)</td>
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<td>Family Benefits - General Welfare Assistance (1,10)</td>
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<td>Family Benefits - Municipal Social Assistance (1,10)</td>
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<td>Home Owners’ Grant (1)</td>
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* All other provinces and territories are participants in the Canada Pension Plan.
** Renters and/or homeowners.
# Provinces/Territorial Governmental Programs and Systems, 1982

## Economic Support (Cont.)

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<tr>
<th>Province</th>
<th>Workmen's Compensation</th>
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## Education and Recreation

### Adult Education Courses
- Courses at
  - Several Institutions(1,11)
  - Knowledge Network (universities)(1)
  - Various Summer Universities for Seniors (U. Victoria)(1)
- Further Education Services:
  - Non-credit Courses(1)
  - Seminars for Seniors at 2 Universities(1)
  - Tuition Fee Waived at Post-secondary Institutions(1)
- Most Tuition Fees Waived at 2 Universities & Community Colleges(1)

### Information Services
- Large Print Books, Talking Books, Bookmobile(1)
- Large Print Material, Talking Books, Home Delivery of Books(1)
- Large Print Material, Talking Books, Workshops for Librarians on Needs of Seniors (1)
- Public Library Services:
  - Grants, Large Print Material, Talking Books, etc.
  - Municipal Library Service(1)
  - Public Library Materials Available(1)
  - Free Library Service(1)

### Other Information Services
- Consumer Counselling(1)
- Financial Planning & Investment Consultations(1)
- Pre-retirement Planning(1)
- Local Information Services for Seniors(1)
- Pre-retirement Program(1)
- Pre-retirement Program(1)
- Pre-retirement Planning for Rural Residents(1)
- Senior Home, TV(1)

### Workmen's Compensation
- Cost of Living Tax Credit(1)
- Political Contributions Tax Credit(1)
- Low-Income Tax Reduction(1,15)
- Senior Citizens' Tax Reduction(3)
- Ontario Retail Sales Tax Credit(1)
- Provincial Personal Income Tax Credit(1)

### Other Courses
- Elderhostel(4,11)
- English as a Second Language(1)
- Geriatrics & Gerontology Courses at Some CEGEPs & Universities(1)
- Community School Programs(1)
- Elderhostel(3,11)
- Free University Tuition(3)
- Local School Board Programs(1)

### Economic Support
- Including pre-retirement counselling.
### PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982

**RECREATION PROGRAMS AND SERVICES**

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<td>Community Recreation Grants (1)</td>
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<td>Free Entry to Provincial Parks (3)</td>
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<td>Add to Senior Citizens' Programs in Outdoor Recreation Centres (3)</td>
<td>Improvements to Facilities &amp; Travel Assistance - Little Red Schoolhouse Program &amp; Regional Fitness Development Program (3)</td>
<td>Add to Senior Citizens' Programs in Outdoor Recreation Centres (3)</td>
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**HEALTH**

### AMBULANCE AND OTHER TRANSPORTATION SERVICES

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### EXTENDED HEALTH BENEFITS

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### GERIATRIC ASSESSMENT CENTRES

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* Including hearing aids, dental care, medical and surgical supplies and equipment.
## Provincial/Territorial Governmental Programs and Systems, 1982

### Health (Cont.)

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### Heating and Insulation Programs

- **British Columbia**: "Warm-up" Sask. Program (1)
- **Alberta**: Man. Home Owners’ Insulation Loan Program (1,11)
- **Saskatchewan**: Critical Home Repair Program (2)
- **Manitoba**: Ont. Temporary Home Heating Grant (3,10), Temporary Home Heating Tax Credit (9,10), General Welfare Assistance (2,10)
- **Ontario**: Home Insulation Loan Program (1)
- **Quebec**: Pioneer Utility Grant (3,5,9)
- **New Brunswick**: Home Adaptation Program (2)
- **Newfoundland**: Municipal Housing Office (1)
- **Prince Edward Island**: Access A Home Program (2)
- **Yukon Territory**: Pioneer Utility Grant (3,5,9)

### Housing

#### Low-Income/Public Housing

- **British Columbia**: Senior Citizens’ Housing Construction Program (5,10), Subsidization of Social Housing (1,10 & 3)
- **Alberta**: Self-contained Apartments (3,10)
- **Saskatchewan**: Public Housing Program (1,10)
- **Manitoba**: Elderly Persons’ Housing Program of Men’s Housing & Renewal Corp. (4,10)
- **Ontario**: Ont. Housing Corp. Apartments (4,10), Public Housing (1,10), Rent-Geared-to-Income for Senior Citizens Program (4,10)
- **Quebec**: Municipal Senior Citizens’ Residences (3,10), Subsidized Housing (1,10)
- **New Brunswick**: Public Housing for Senior Citizens (3,10)
- **Newfoundland**: Apartment Conversion Program (1), Public Housing (1,10), Rental Assistance Program (1,10), Senior Citizens’ Program (3,10)
- **Prince Edward Island**: Senior Citizens’ Subsidized Apartments (4,10)
- **Yukon Territory**: Self-contained Apartments (3,10)
- **Northwest Territories**: Senior Citizens’ Homes (3,10)

#### Non-Profit Housing

- **British Columbia**: Provincial Rental Assistance Program (4,10), Rent Supplement for Non-profit Societies (6,10), Residential Subsidy - Gleschell & Brentwood Houses (6,10)
- **Alberta**: Interest Subsidies on Loans to Homeowners to Build Rental Units (1), Senior Citizens Capital Grant Program (3,10)
- **Saskatchewan**: Co-op Housing (1), Non-profit Housing for Senior Citizens Program (3)
- **Manitoba**: Grants to Non-profit Housing Units (6), Rent Supplement, Elderly & Infirm Persons’ Housing (4,10)
- **Ontario**: Grants to Non-profit Housing Limit Dividend Housing (church, ethnic, service club groups) (4,10), Rent Supplement, Elderly & Disabled Persons’ Housing (3,1,10)
- **Quebec**: Aid to Co-op Housing (1,10), Rental Subsidy Program (1,10)
- **New Brunswick**: Provincial Contribution to Seniors for Materials (5,10), Community Development Program (4,10), Programs in Native Communities (2)
- **Newfoundland**: Provincial Housing Emergency Repair Program (1,10), Senior Citizens’ Assistance Program (3,10), Small Loans Assistance Program (1,10)
- **Prince Edward Island**: Home Restoration Aid (1,10)
- **Yukon Territory**: Dwelling Restoration Program (1,10)
- **Northwest Territories**: Senior Citizens’ Homes (3,10)

#### Residential Repair and Rehabilitation Programs

- **British Columbia**: Alta. Pioneer Repair Program (3,10 & 5,9,10)
- **Alberta**: Residential Rehabilitation Program (1,10), Senior Citizens’ Home Repair Program (3)
- **Saskatchewan**: Critical Home Repair Program - Low-income Families’ Program (8,10), -Pensioners’ Program (3,10)
- **Manitoba**: Ont. Home Renewal Program (1,10)
- **Ontario**: Home Improvement Loans for Senior Citizens (6,10)
- **Quebec**: Provincial Contributions to Seniors for Materials (4,10)
- **New Brunswick**: Home Improvement Loans for Senior Citizens (4,10)
- **Newfoundland**: Provincial Community Development Program (4,10), Programs in Native Communities (2)
- **Prince Edward Island**: Provincial Housing Emergency Repair Program (1,10), Senior Citizens’ Assistance Program (3,10), Small Loans Assistance Program (1,10)
- **Yukon Territory**: Dwelling Restoration Program (1,10)
- **Northwest Territories**: Senior Citizens’ Homes (3,10)
**PROVINCIAL/TERRITORIAL GOVERNMENTAL PROGRAMS AND SYSTEMS, 1982**

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**OTHER, INCLUDING LABOUR AND EMPLOYMENT**

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<thead>
<tr>
<th>BRITISH COLUMBIA</th>
<th>ALBERTA</th>
<th>SASKATCHEWAN</th>
<th>MANITOBA</th>
<th>ONTARIO</th>
<th>QUEBEC</th>
<th>NEW BRUNSWICK</th>
<th>NOVA SCOTIA</th>
<th>PRINCE EDWARD ISLAND</th>
<th>NEWFOUNDLAND</th>
<th>YUKON TERRITORIES</th>
<th>NORTHERN TERRITORIES</th>
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<td>Edmonton &amp; Calgary Senior Centres (3)</td>
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<td>&quot;Over 45&quot; Program (Edmonton &amp; Calgary X7)</td>
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<td>B.C. Human Rights Commission (1)</td>
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* Including nursing homes, homes for the aged, long-term care hospitals, etc.
** Including apprenticeship programs.
Appendix G.
Some fundamental differences between acute care and long term care models:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Hospital</th>
<th>Community Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility</strong></td>
<td>As defined under the Hospital Act</td>
<td>As defined under the Community Care Facilities Licensing Act</td>
</tr>
<tr>
<td></td>
<td>Designed and constructed as a hospital</td>
<td>Often designed and constructed for some other purpose and requiring renovation to meet standards</td>
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<td></td>
<td>Exists primarily to resolve a specific health problem</td>
<td>Exists as one solution to a social and medical problem</td>
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<td></td>
<td>Built for use by all citizens when requiring treatment for specific medical problems</td>
<td>Built for populations with special needs, who qualify for Long Term Care</td>
</tr>
<tr>
<td></td>
<td>A temporary place to visit for the diagnosis and resolution of a health problem</td>
<td>Becomes the new home of the resident and all of his or her problems</td>
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<td></td>
<td>A clean, sterile atmosphere is the norm</td>
<td>A home-like atmosphere is encouraged</td>
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<tr>
<td></td>
<td>Segregation of patients according to diagnosis is the practice</td>
<td>Integration, interaction and tolerance between residents is encouraged</td>
</tr>
<tr>
<td><strong>Clientele</strong></td>
<td>Commonly referred to as a patient</td>
<td>Commonly referred to as a resident</td>
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<tr>
<td></td>
<td>Of varying age groups</td>
<td>Ages often similar</td>
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<tr>
<td></td>
<td>Of varying health problems, although each patient is often being treated for one primary diagnosis</td>
<td>Resident is often experiencing a number of and a variety of complex diagnoses, some of which are health related and for which no cure is available</td>
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<tr>
<td><strong>Staff</strong></td>
<td>Large numbers required</td>
<td>Small numbers the norm</td>
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<tr>
<td></td>
<td>Have prescribed academic preparation</td>
<td>Variable academic preparation and specific upgrading often required</td>
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<td></td>
<td>Have highly technical, specialized skills</td>
<td>Are usually generalists, and qualifications vary</td>
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<td></td>
<td>Have specialized roles in the hospital</td>
<td>Usually have diverse roles within the facility</td>
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<td></td>
<td>Fall under the Master Agreement</td>
<td>Many still non-unionized</td>
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<tr>
<td><strong>Budget</strong></td>
<td>High per diem ratio</td>
<td>Low per diem ratio</td>
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<tr>
<td></td>
<td>List of necessary accounts diverse and large</td>
<td>List of necessary accounts fewer, but relevant to community care facilities</td>
</tr>
</tbody>
</table>
Social and Community Support Systems

Intervention Model in Management of Chronic Illness

Killilea, 1982: 195
Appendix I.

ANALYSIS OF MATRIX IN HEALTH CARE

Beckhard presents an interesting discussion of structures that are appropriate for the health team concept: in health delivery systems, the practitioners (the deliverers of health care) tend to be located at the bottom of the organizational totem pole. Everybody else in the organization is there to support their efforts. Yet the organization is the traditional, hospital oriented reporting system. Each specialist directly reports to his functional counterpart. This structure does not support the team work to be done. Rather it maintains the separation of the various members by having them report up functional lines.

If the chart is redrawn from the point of view of the service delivery, the members of the health team 'report' to the manager of their team or unit. He is the administrative boss. His job is to facilitate the team delivery of health care. The chiefs of service are supports - technical and educational resources available to guide, counsel, and plan with all team members.

There are two major types of structure: "Functional", based on technology (Medical specialities); and "Produce/Service", based on "market" (client) needs and demands. The nature of the requirements for service include preventive care, treatment care, and improvement of social conditions, which probably means that a third organization structure or design is required. This matrix structure is used in complex organizations when the inter-dependencies of the work are such that no simple reporting structure will do. A matrix structure comprises a series of operating units along with a set of capabilities. The operating units and the capabilities must interact regularly for the work to be accomplished. A variety of combinations of people will be needed to collaborate on specific tasks.

To make matters even more complicated, all of the above-mentioned reporting lines refer only to the delivery of services - the work of the organization. In addition, a separate reporting line is needed for career planning and personal development. For this purpose, a functional hierarchy is usually appropriate.

One more complication is the need for a separate organizational structure for planning and development. Many non-medical organizations have a separate chart of organization for future planning.

Organizations are, in fact, multi-structured. Realistic managements recognize this and explicitly design their structural charts to reflect it. Multiple organizational structures are necessary in health care institutions.

Beckhard, op. cit. p.299