Report of the

Community Health Centre Project

to the

Conference of Health Ministers

INTRODUCTION

In recognition of the potential importance and significance of this Report to health care in Canada and to Canadian physicians, it is presented by CMA Journal in its entirety. The Report was submitted on July 21, 1972 to the Honourable John Munro, Minister of National Health and Welfare, in his capacity as Chairman of the Conference of Health Ministers, by the Committee Chairman and Director of the Community Health Centre Project, Dr. John E. F. Hastings.

The Report is based on a one year study by the Committee during which it commissioned 92 position papers, received 126 briefs and conducted numerous private discussions with governmental and private agencies and individuals. The Committee also conducted invitational seminars on physicians services, nursing services, services of allied health personnel, pharmacy services, dental services, social work services, administrative and managerial services, personnel, public health services, hospital services, mental health services, legal aspects, social policy and social services, citizen involvement, design aspects, cost and financial aspects.

The Report, which was unanimously approved by the Committee, is currently under study by Provincial Divisions and the Councils on Medical Services and Medical Economics of the CMA. Members of The Canadian Medical Association are urged to study the Report carefully and to send their opinions and views as public letters to the Editor of the Journal or as private correspondence for the consideration of the Association to Communications Department, CMA, Box 8650, Ottawa, Ontario K1G 0G8.
PRINCIPAL RECOMMENDATIONS

1. The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres, as described in this Report, as non-profit corporate bodies in a fully integrated health services system.

2. The immediate and purposeful re-organization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assure a more economic and effective use of all health care resources.

3. The immediate initiation by provincial governments of dialogue with the health professions and new and existing health services bodies to plan, budget, implement, coordinate and evaluate this system; the facilitation and support of these activities by the federal government through consultation services, funding, and country-wide evaluation.

Foreword

The Community Health Centre Project was set up by the Minister of National Health and Welfare on behalf of the Conference of Health Ministers of Canada for three reasons:

1. A growing concern of both federal and provincial governments about the accelerating rate of spending in health services. During the 1955-68 period the average rate of annual increase in the cost of providing all health services in Canada was approximately 10.7 per cent. In 1968, government sources accounted for 69 per cent of combined operating and capital spending in health services in Canada. Spending from all sources in the same year represented some 6.6 per cent of the gross national product. In the last three years, the rate of increase was running well above the 10 per cent average and for 1971 the indicated rate of increase in spending is about 12.5 per cent. The rate of increase in the expenditure on acute hospital care has been around 14 per cent and shows no sign of slowing.

2. A growing belief that some shift from the present emphasis on acute hospital in-patient care to other forms of health care, including types of community health centre, offer a means of slowing the rate of increase in health services spending. This idea has arisen in part from a few recent Canadian reports on the Saskatchewan community clinics and on two Ontario group health centre programs. These reports have indicated that such programs can achieve important reductions in hospital in-patient bed use. This finding is similar to American reports on the experience of the various group practice prepayment programs and on the experience of the Office for Economic Opportunity health centres in that country. The current proposals for Health Maintenance Organizations in the United States are also in part based on potential savings which it is hoped will result from a reduction in in-patient hospital use.

3. A growing belief that community health centres, variously defined, offer an effective response to many problems other than costs in the existing ways health services are provided. It is suggested that they offer a setting in which the community's resources can be brought to bear in a more dynamic relationship with the health professionals and services in trying to solve people's health and related problems. This newly aroused interest in "people-centred" and "problem-centred" approaches to health care has arisen among other sources from the Castonguay-Nepveu [Commission on Enquiry on Health and Social Welfare, Quebec, 1970] and Celdic Reports [Commission on Emotional & Learning Disorders in Children, Toronto, 1970. In Canada, the American O.E.C. and H.M.O. experience, current developments in the United Kingdom and elsewhere, as well as from a general awareness that better ways are needed for meeting the many-sided problems people, families and communities now face and will be facing in the future.

In summary, community health centres are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities, and relationships which society wishes to establish for health care in the future.

The Committee's task was to examine available evidence, to seek opinions, to consider proposals, and then to make specific recommendations on the provision of health services through community health centres and the possible role which governments and others might play in encouraging their development. We have done our best to fulfill our mandate. The choice is now for Society to make—in other words for each of us as responsible Canadian citizens.

THE COMMUNITY HEALTH CENTRE—WHAT IS IT?

The Committee sees a community health centre as a facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality. Such care must be provided in an acceptable manner through a team of health professionals and other personnel working in an accessible and well-managed setting. The community health centre must form part of a responsive and accountable health services system. In turn, the health services must be closely and effectively co-ordinated with the social and related services to help individuals, families, and communities deal with the many-sided problems of living.

What does this mean?

"a facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality . . . ."  

A community health centre is an organization and service concept, a financial and administrative integration of re-
sources to help people to deal humanely and rationally with one another in receiving and providing health services. It recognizes and gives form to the dynamic interaction necessary between the helper and the helped. It promotes personal and community responsibility.

The emphasis must be on high quality initial and continuing care for meeting the health needs of individuals and families. There must be a balance in services among health promotion and prevention, diagnosis and treatment, and rehabilitation.

There must also be provision for dealing with urgent problems. All services must meet accepted, current, and system-wide standards of quality.

Health promotion and prevention includes counselling to prepare people for the various phases of life, education to improve living habits, family planning, and specific protective measures, such as immunization. Diagnosis and treatment includes reception and direction to the appropriate service within the centre, history-taking (including record retrieval and up-dating), initial diagnosis, decision on specific therapy, follow-up, and continuing supervision of care. Rehabilitation includes medical and social restorative measures within the competence of the centre and/or referral to more specialized services.

No organized setting can by itself assure high quality service. But there are measures that support quality which can more readily be taken in organized settings, such as the community health centre. These include peer review, records review, accreditation and audit measures, encouragement of clinical and organizational research and continuing education (both extra-mural and in-service). The involvement of the public in advisory and monitoring capacities can be helpful in assuring other facets of quality such as responsiveness and acceptability.

"... in an acceptable manner ..."

Provision of health services of high quality is not enough. Services are for people and must be given in an atmosphere and in ways which people understand and accept. Care must be taken not only to assure acceptability by the majority of people but also to assure that services for particular groups, such as the young, the aged, the poor, and people of different cultural backgrounds, are offered in imaginative and problem-centred ways.

In turn, services are provided by people—health professionals, other professionals, technologists, auxiliaries, and support personnel of many different types. They, too, have expectations and needs which must be recognized. The manner in which their skills and services are used will in large part determine not only their feelings of responsible involvement and work satisfaction but also the atmosphere of the community health centre and the quality of care which it provides.

In short, the community health centre can only be effective if it is a mutually acceptable partnership of the members of the community and the members of the health care team.

"... through a team of health professionals and other personnel . . ."

Central to the concept of a community health centre is the provision of care through an integrated team of various types of health professional, other professionals, technologists, and other personnel working together to try to solve people's problems. Each member of the team should be encouraged to use his training and skills to the best of his ability and in mutual support of his colleagues. [It should be noted that not all of the skills required are those of health care professionals and technologists, as for example, telephone crisis centres and other forms of "lay" involvement have shown.] The particular functions of team members, even the team's precise composition, should vary in response to the specific needs of the person and community being served. This requires a careful matching of skills to problems so that no skills are over or under used. Only through such teamwork can a safe transfer of tasks be achieved and high quality care be assured.

For providing the basic medical services the minimum service unit should consist of personnel whose combined skills are those usually now found in the general or family physician, the public health nurse, and registered clinical nurse. [Precise population/service unit ratios are, at best, an informed judgment on work productivity but the type of minimum service unit outlined could serve between 1800 to 3000 people depending upon such factors as geography, accessibility and age structure and other special population characteristics, e.g. any characteristics which might require an above average psychosocial emphasis in a practice, usually more time consuming.] In isolated areas, skilled nurses have for some years been serving as de facto nurse practitioners who, to a large

Terms of reference: The terms of reference of the Community Health Centre Project as approved June 30, 1971:

1. To collect and assess information on existing types of Community Health Centre in Canada and in other selected countries.
2. To identify the objectives and characteristics of various kinds of Community Health Centres as parts of the health delivery system. Alleged or expected advantages should be assessed.
3. To describe models of Community Health Centres recommended for development in Canada.
4. To identify possible problem areas in the development of Community Health Centres of various types in Canada and to recommend ways of dealing with them.
5. To describe in detail important economic characteristics and incentives such as government grants and loans, and the operating and capital costs relating to different models of health care delivery through Community Health Centres.
6. To explore important social, psychological considerations involved in the development and operation of primarily comprehensive continuing health care units in Canada as they relate to professional and consumer acceptance.
7. To recommend on the desirability of more active development of specific kinds of Community Health Centre in Canada on:
   (a) a demonstration-research basis
   (b) a general service basis.
8. To recommend on the possible roles of the various levels of government and other interested groups in Canada in the development of Community Health Centres.
extent, have substituted for the physician. The addition of a formally prepared nurse practitioner-midwife or her substitute for the physician in special circumstances is a logical means of giving acceptable care, provided workable communications and supervision arrangements exist.

The basic dental service unit should consist of personnel whose combined skills are those usually now found in the dentist, dental hygienist, and chairside assistant. [In our view such a service unit could serve some 2000 to 3500 people, again depending upon such factors as geography, accessibility, age structure, emphasis on health education, etc.] The addition of a qualified dental nurse practitioner or an expanded role [As for example, in New Zealand, the United Kingdom and the Canadian north with dental nurses. A course for dental nurses, who will carry out some therapeutic procedures as well as preventive procedures under supervision, is being started in Saskatchewan in the autumn of 1972.] dental hygienist or even their substitution for the dentist in special circumstances is a proven means of giving preventive care. If workable communications and proper supervision exist, such a substitution has been demonstrated as a way to give basic dental treatment of acceptable quality.

Although such basic service units can function effectively in providing medical and/or dental care, they do not in themselves have all of the attributes of a full community health centre team as envisioned by the Committee. First, the active and responsible involvement of people in their own health care and the care of others is essential to our concept. Second, for inter-collegial relationships and task sharing to be fully possible and for other basic personnel, such as the social worker and laboratory technologist to be economically and efficiently included as team members, a grouping of three or more medical and two or more dental units [In the absence of dental services, the centre would be a community medical care centre.] is necessary. [This postulates a base population for a basic community health centre of some 6,000 to 9,000 people, again depending upon specific circumstances.] Only when these two criteria are met can the service group be regarded in our view as a community health centre team.

As the number of service units in a community health centre is increased, other types of basic professional and technological personnel, such as the pharmacist, optometrist, and x-ray technologist may be economically and efficiently added to the team. More specialized medical personnel, such as the psychiatrist, obstetrician-gynaecologist, internist, psychiatrist, general surgeon, orthopaedic surgeon, radiologist, and pathologist, as well as personnel such as the physiotherapist, health educator, community nutritionist, clinical psychologist, dentist, and podiatrist, may be usefully added. [The future role of other groups such as osteopaths and chiropractors, in the health services system is currently under review in several provinces. We would only note that if they are to be included it should be in the supervised team setting of the community health centre, so that their services may be used in an integrated fashion with other team members.] Such larger and more varied community health centre teams permit greater specialization and some reallocation of tasks among the team members. The types and numbers of personnel added to the basic team of any specific community health centre should take account of factors such as the size and particular health needs of the population being served, and the distance and ease of access to specialized services based in referral hospitals.

The Committee feels that there is an upper limit in size for a single health team in a community health centre. Experience with existing centres, group practices and community clinics suggests that, in terms of effective internal communication, colleague interaction and organizational efficiencies, the upper limit for the number of physicians is around a dozen if the physicians are all family physicians. If specialist medical personnel are included then this upper limit appears to be around 20 physicians. The number of other types of team member would be varied accordingly. Dental groups are rare in Canada but, in terms of personal interaction and economies of scale, a figure similar to that for family physicians seems appropriate. Depending upon the population density in the area served, a community health centre could, of course, consist of more than one health team. Such multi-team community health centres could add less common specialized personnel. In other words, the actual composition of staff and the number and types of team in any community health centre must change in response to the particular situation.

For special diagnosis and care, single specialty medical groups, and large multi-specialty specialist medical groups, as they now exist, and large hospitals would serve as referral and consultancy resources for several community health centres. Multi-specialty medical referral groups and larger hospitals could also have one or more community health centre teams integrated to them for providing basic health care to the people in their immediate area. The university health sciences centres and the highly specialized services they offer should be outside the regular system in the sense that they should be ultimate referral, consultancy and back-up resource centres for the entire system. [See discussion of referral systems.]

People using a centre's services should recognize the team concept of health care and be encouraged to establish a relationship with an appropriate member of the health team. In times of emergency, outside regular hours, or on a long-term basis, only a team, relying on an effective records system can assure continuing and competent care.

While the community health centre has been defined in terms of medical and related health services and the team approach, several provinces are extending or planning to extend the concept to include social services. In Quebec, for example, the centre is called a local community service centre (C.L. S.C.) and, in Manitoba, a community health and social development centre. This combination of health and social services reflects a growing recognition of the intimate relationship between these two services fields. In such situations, the basic social service unit should provide, co-ordinate and integrate individual and family counselling and supportive services for families, such as day care and homemaker services. The basic social service unit should play a dynamic and key role in community education, organization, and development.

"... working in an accessible setting ..."

The population to be served by a community health centre must have ready access to its services. The location of a particular centre and whether or not it is a single facility or also has sub-centres [In which one or more basic service units but not a full community health centre team would be located.] and/or mobile units linked with it would depend upon the time needed to reach the centre by the common means of transportation, whether for urban or rural people. It should be close enough to reach by public or private means of transportation, whether for urban or rural people. The committee recognizes the advantage of such centres being close to the home of the people.

Two related questions are whether a community health centre should provide regular 24 hour service and whether it should offer services to handle other than minor emergencies. Both types of service should be reasonably available within any given area or district. But their precise location will depend on local circumstances, such as one or more hospitals in an area providing 24 hour emergency and other
coverage. This may suffice in some communities whereas in others factors of geography or size of population may necessitate some or all of the area community health centres offering regular care and/or full emergency services on a 24 hour basis. In all cases, an efficient communication and records exchange system within the health services system in an area is essential.

Finally, the question arises whether a community health centre should include beds of some type. It is the Committee's firm opinion that a community health centre is not and should not be committed to becoming a mini-hospital since one goal in developing community health centres is to reduce the present level and dependence on in-patient acute hospital bed care. On the other hand, especially in situations remote from a hospital and under certain difficult geographic and climatic conditions, a very few short term emergency holding beds would be necessary. It should be emphasized that such holding beds are only for use until transfer to an appropriate hospital setting can be effected.

"... well managed setting . . ."

Efficient techniques of management must be employed both to support the professional operation of the health services team and to ensure courteous and prompt care for the public. A professional administrator is necessary for good relations with the public, linkage with the health services administration, and handling problems of case management. He must assure the records and communication system is used for purposes of audit, evaluation, and referral. Educational programs must train management personnel for the health services system and for its component elements, such as community health centres. [There are presently courses for public health personnel, hospital administrators, and other health administrators at both the basic and advanced level in the university and on an extra-mural basis through the Canadian Hospital Association. But these existing courses require adaptation to assure curriculum relevance in the changing period ahead.]

"... part of a responsive and accountable health services system . . ."

The community health centre and the health services system of which it is a part must be responsive to the health needs of people. Health needs are of two types. First, there are needs as determined by epidemiological methods. Continuous evaluation of health services is necessary if there is to be awareness of the changes in health indices and the ways in which scientific developments can be applied in responding to them. An integrated system and the team approach of the community health centre provide a setting for monitoring change, communicating new knowledge and methods, and evaluating the results of services.

Second, there are the felt needs of individuals, families and society. Such needs vary from person to person and from group to group. So, also, must the ways in which responsiveness to perceived needs is assured.

Responsiveness may be further assured by people actively involving themselves in programs of health promotion and health maintenance, assuming a wider responsibility for their own health and that of their families, and using services in an as intelligent and effective way as possible. Responsiveness may be promoted by involving the community in policy-making, priority-setting and decision-making through various forms of boards, councils, and advisory or grievance bodies. It may be helped by the use of "lay" health workers or "members relations" personnel serving as intermediaries between the public and the health services; in other words, by assuring effective "two-way" communication.

Responsiveness does not require or even desirably mean the same kind of individual and community involvement in each and every situation. For example, a community which has experienced poverty and neglect or which has different cultural values will require means for relating to community health centres different from other segments of the population.

Our concept of a community health centre as part of an integrated health services system is a flexible one which responds to the felt needs of people and which may be adapted to the circumstances of each particular situation. Whether community health centres need a distinct policy board is in our view a factor of the size and complexity of the centre.

In every case, the community health centre should be an integral part of a wider health services system which is responsible and accountable to the public interest. Only in this system setting will its full economic and service potential be achievable. It must not simply be an additional independent functioning component in an already fragmented service pattern.

The concept of the health services system is discussed later in the Report.

"... closely and effectively co-ordinated with the social and related services to help people, families, and communities deal with the many-sided problems of living . . ."

It has been recognized for some time that many health problems have a psycho-social and economic component and that many psycho-social and economic problems have a health component. Thus, health care programs often include consultant and supportive social work services and social welfare programs often include supportive and consultant medical services. But in both instances, one purpose or function is clearly dominant.

Now, however, it has become clear that more and more of the problems which affect individuals and families cannot be neatly classified as health, social, economic, legal, education, employment, or housing problems. Among examples of this sort of personal and societal "disease" are mental illness, drug and alcohol dependency, delinquency, alienation between parents and children, personal violence and violence against society's established institutions, and many problems of the aged. Because the number and nature of such problems will undoubtedly increase in the future, community health centres must have practical working relationships with social services and with other community resources. As in the case of citizen involvement, community needs differ and, therefore, community service patterns will vary. For many communities, a well-developed records system and communication between services may suffice for achieving effective joint action. Cross-appointments at the planning, administrative and service levels would facilitate the development of a referral network.

However, as noted, some provinces additionally propose a fuller integration of health services with other personal services at the community and/or provincial levels. Quebec and Manitoba, for example, are implementing integrated health and social services at all jurisdictional levels and proposing a "single unit" and/or "social unit" for providing community services. Although not all members of the Committee are agreed on the immediate need and practicality of a fully integrated personal services system, we all agree that there are circumstances in which it is the only effective approach. In a smaller community, for example, there are reasons (financial, administrative, geographic) for establishing integrated units to provide all personal and family support services. These combined units may also be an
effective means for helping communities whose people find it difficult to deal with a variety of service agencies. In the long run, the combined unit may prove to be the most effective means of meeting the needs of all communities. Such developments should be supported, encouraged, and evaluated.

In summary: The central concept of the community health centre is teamwork. The kind of teamwork which is meant is not the kind of teamwork which has been developed in hospital operating theatres, a para-military system to deal with the inert patients, but the milieu therapy approach, developed first in mental hospitals, and later in community psychiatry. This approach recognizes that all those who have contact with the client may influence his behaviour and his self-concepts, but that professionals have a special responsibility in making their interventions not only to help the patient but to help others to help him, and to help him to help himself. The focus is not upon the physician as team leader but upon problem-solving processes for the client/patient. Naturally, the physician is better equipped to treat organic [i.e. medical] problems, but other members of the team may have more useful contributions to make to psychosocial or social difficulties, and this approach focuses upon helping the patient to take greater responsibility for his own health and the community to take greater responsibility for its members (Crichton).

THE COMMUNITY HEALTH CENTRE—WHY?

Economic reasons

Studies for the 1969 Task Force Reports on the Cost of Health Services in Canada, based on projections of economic growth and allowing for an annual rate of increase in health services costs of 10 per cent (a marked reduction in the current annual rate of increase) arrived at a predicted level of spending of 7.4 per cent of the gross national product for health services in Canada by 1981. [Task Force Reports on the Cost of Health Services in Canada, Committee on the Costs of Health Services, Ottawa, 1969, Vol. 3, p. 431f.] Government expenditure is predicted as accounting for 92 per cent of all health spending by that year. The Economic Council of Canada in its 1969 Report went so far as to predict that spending on health and education in Canada was accelerating in a manner which, if unchecked, could lead to the full use of the gross national product for these purposes by the end of the century. Although the precise figures and the precise manner of their derivation are open to some differences of interpretation by economists and other finance experts, there is no questioning of the facts that the rate of spending in health services is now increasing at an annual rate which, if unaltered, will either result in the use, in the near future, of a greater proportion of Canada’s gross national product for these purposes than at present or in limitations on existing essential services. The real question is, therefore, not how much we will be spending but what we will be getting for the money.

How many community health centres help in achieving the potential economies of a health services system?

Reducing hospital in-patient use

It is generally accepted that the greatest potential for economies in the use of health care resources lies in reducing expenditures in the largest and most rapidly growing area of spending within the health services—the hospital, especially the acute general hospital. We recognize that reductions in hospital costs may be achieved (and are now being realized by many hospitals) through increased efficiency in the operation of the hospital itself. Emphasis on earlier discharge, day care surgery, progressive patient care, careful planning of admissions so that they are more closely timed for the carrying out of specific procedures, sharing physical support services with other hospitals, and the increasing emphasis on modern managerial and administrative methods are all steps toward greater economy. However, their impact is presently limited by the economic disadvantages under present funding arrangements of the hospital being "too efficient" (i.e. in having too many beds not in use at any given time), by the absence of sufficient alternative care services and facilities in the community, and by the absence of an effective communications and referral system among the existing community services and facilities.

But the chief means of controlling costs within the hospital sector is to be found in a reduction in the present acute bed/population ratio and a consequent reduction of in-patient services and facilities. Increased emphasis on alternative forms of care, such as extended care facilities, home care programs and community health centres, are seen as ways for achieving this goal. However, it must be emphasized that any real savings from a reduction in hospital in-patient utilization can only result if alternative forms of care not only replace some proportion of care presently provided on an in-patient basis but also if there is a co-incident reduction in available in-patient facilities. [Overall hospital costs would be reduced but it should be noted that removal of "lower cost cases", who could be cared for under out-patient forms of care, would result in a higher per diem patient cost since the more serious and acute cases requiring intensive use of staff and facilities would remain.] Unless both steps (substitution and reduction) are planned and taken together, evidence has shown that freed in-patient beds are almost always filled by new patients. [It is not directly germane to the argument that some of this new bed use in certain communities may represent previously unmet needs.]

It should also be noted in passing that staff and plant requirements are not reducible in direct relation to a reduction in beds. Certain basic levels have to be maintained in respect to quality and the ability to meet changes in work load.

It should be stated here and borne in mind in other sections of the Report that one of our basic problems in gathering and assessing evidence was that examples of the full concept of a community health centre as proposed in this Report do not presently exist. We must, of course, hasten to add that a wide variety of existing and proposed forms of practice and services in Canada and elsewhere have many of the attributes (in different combinations and to varying extents) of our concept. Our conclusions, therefore, had to be based on inferences from the existing available data.

There is some evidence that there is a lower in-patient hospital utilization rate among group medical practices compared with solo medical practices in similar fields of work. However, the magnitude of the reduction varies with such factors as size of group, type of physician composition of the group, field of work, locality and province.

There is stronger evidence from the small number of existing Canadian cases that, with proper incentives and management, community clinics and group health programs do result in lower hospitalization rates than do either solo medical practices or physician-sponsored medical group practices in generally similar situations. [Hastings, John E. F., Mott, F. D., Hewitt, D., and Barclay, A. "An interim report on the Sault Ste. Marie study": C.J.P.H. 61: 289, 1970, and Anderson, D. O., "What price group practice?" (in course of publication), and Crichton, Anne, "The organization of group practice in Saskatchewan, 1967-70," (in course of publication). American experience with group practice pre-payment programs shows definitely reduced hospitalization rates but differences in funding and other circumstances make difficult reliable inference from these situations to the Canadian
context of universal government hospital and medical insurance.] The reduction in hospital utilization is mainly a function of lower admission and readmission rates rather than shorter lengths of stay once a patient is admitted. Substantially lower surgery rates and possibly the increased use of out-patient laboratory and x-ray diagnostic procedures are also factors. [Hastings, J. E. F., and others, "Prepaid group practice in Sault Ste. Marie, Ontario, Part I: Analysis of utilization records." (in publication, Medical Care). A problem in assessing the impact of greater out-patient diagnostic work-up is that procedures carried out by laboratories and radiological facilities other than those of the admitting hospital are frequently regarded as having to be repeated by the hospital after admission.] The resultant savings from reduced hospitalization should more than offset higher initial costs of out-patient care in the group health clinics. [There are indications that hospital savings are more difficult to achieve under universal medical care insurance. This doubtless indicates that the usual medicare payment methods contain dis-incentives to reduction in hospital use. To ensure hospital savings occur, management of the centre must be able to direct policies of the centre towards that end.]

It is difficult to determine the extent to which the cost-savings shown in the studies of the community clinics and group health associations arise primarily from factors of internal organization or from other variables such as public involvement and motivation, professional ideologies and treatment theories, and the existence of alternative facilities. Thus, we cannot predict the extent to which the cost savings achieved in these settings is capable of generalization. Reduced hospitalization (and the consequent savings) will definitely occur to the extent that community health centres and other low cost alternative forms of out-patient service replace in-patient general hospital services within the health system.

Increasing productivity and effectiveness

Experience within a wide variety of health service programs in Canada, including the de facto "nurse practitioner" in the north or in the Newfoundland and Labrador nursing outposts, the experience of an integrated private dental group practice, [Data from the Assiniboine Clinic in Winnipeg showed greater productivity and significantly reduced unit costs.] various experiments and demonstrations of substitution of public health nurses for doctors in private practice, the use of optometrists in community clinic-group health settings for refraction work, the experience of pharmacists in hospital pharmacy and community clinic-group health settings, the use of selected critical screening procedures carried out by non-physician personnel in community clinic-group health settings, the use of health aides or intermediaries in special communities (Indians, Eskimos, urban core communities, etc.), and the extensive hospital experience with special surgical teams and intensive care units, show that:

1. In organized and supervised settings, a team of various types of personnel, each member of which carries out specific functions, definitely increases the efficiency and productivity of the physician, dentist, and other professional personnel as compared to situations of solo and largely unsupported forms of practice.

2. It is also definitely possible to substitute less highly trained professional and technological personnel for more skilled personnel in organized and supervised settings, such as hospitals, health centres, and group practices, without any danger to public safety or diminution in quality of health care. This is also true in situations where only limited supervision is possible, such as the north, provided back-up and referral services are reasonably available.

However, it must be pointed out that team-work and/or substitution (devolvement of functions) while leading to greater efficiency in the use of resources do not automatically produce cost savings. They may in fact bring about greater costs because they allow (and may cause) a greater volume of work to be done. Savings result when there is a real reduction in the numbers of more skilled and expensive personnel used for the same volume of work. [As noted elsewhere, there would in many circumstances be a shift of some of the costs to the individual and family. Attention must be given to assuring that such new costs are included in any cost comparison.]

The concept of community health centre we have outlined offers one setting in which the efficiencies of team work and substitution of personnel can be actively encouraged and achieved. Whether actual reductions in expenditure will result is another question which is chiefly related to disease incidence, willingness to delegate by physicians, dentists and other professionals and receptiveness to the team approach among the health centre population. Present funding arrangements and legislation as well as regulatory provisions would have to be modified, as noted elsewhere, for the full benefits of team work to be achieved. A health services system which includes community health centres would make these changes easier to effect.

Achieving other economies

Experience in Canada and elsewhere in hospitals, group health-community clinic and many group practice settings has demonstrated that better cost/benefit ratios are possible through the employment of professional managerial and administrative personnel, modern records and communications methods, bulk drug purchasing of suitably prepackaged unit amounts and the development of unofficial and regularly updated formularies, and the fuller use of special facilities (laboratories, x-ray, rehabilitation, pharmacy). [Legal changes in provincial Pharmacy Acts are necessary in most jurisdictions.] Community health centres make possible the use of these measures but their full economic benefit can only be gained within a health services system which allows their effect to spread beyond a single situation.

Social, political and organizational reasons

One of the main reasons for establishing the Community Health Centre Project was the feeling that "better health care is not coming out of an (increasingly) expensive medical care system and that medical care delivery could be better organized. It is the system rather than the individuals in it which is at fault." (Crichton).

Might community health centres provide answers to some of the social, political, and organizational questions and issues which are concerning the public, the health professionals and governments?

Attitudes and concerns of the public

The concerns of the public about health services are difficult to pin down. [Attempts were made by the Project to determine public feeling through solicited citizens' organization submissions, newspaper advertisements (country-wide), letters to Members of Parliament and Senators and personal interviews.] This is undoubtedly due to the fact that most people rarely think about health services except in times of need. When people do express concern, their remarks tend to be about the organizational rather than the clinical aspects of health care. They want care provided promptly and in ways which they understand and except. When they move to another town or province, they want to be able to establish a relationship
with a physician quickly and easily. They want easy access to on-going treatment for the special problems they or their families may have. They are more concerned with the particular way they are cared for than they are with any general measurement of "health outcomes."

In other words, although they do not use the "jargon", the public are concerned about availability, accessibility, continuity, and the process of care.

Many of these concerns reflect problems in the existing health services pattern. Present services do not take sufficient account of the special needs of many groups (the aged, the youth, the Indians, the poor). Access to services often seems to be concealed in complex bureaucratic procedures that confuse people of all socio-economic groups. Mounting pressures on out-patient and emergency departments indicate, in part, a lack of alternative services. Procedures and treatments are often not clearly explained and little attention is paid to evaluating individual satisfaction during an episode of care.

We have already described in considerable detail the way community health centres can assure acceptable services, provide on-going care, and cope with individual concerns. They can also become easily identifiable and accessible points where appropriate decisions can be taken about solving people's health care problems. They can offer a balanced service program and relate, as necessary, to other health care services and community social services on a co-ordinated and integrated basis. They provide the opportunity to involve individuals more fully in decisions about service provision as well as in personal and family health care.

The changing of public expectations is a more difficult matter.

The Committee believes that community health centres can and should provide a setting for formal [See discussion of community health centres as learning settings for health services personnel.] and informal education necessary to change attitudes. The public should understand that modern scientific medicine is limited in what it can accomplish—many ills cannot be remedied. Individuals must take real responsibility for personal and family health (diet, smoking). They should be made to feel confident that nurses and other non-physician personnel can give high-quality care and that community health centres can provide many services as effectively and safely as hospitals.

Finally they must understand that any demand for "more" or "better" health care has a price—both economic and social.

Attitudes and concerns of health professionals

We have been forcibly struck by the feeling, frequently strongly expressed, of many professionals and technological groups that their skills are presently not being used to full effect in the care and treatment of individuals and families. They point out that in a field which is as complex and specialized as health care, no one person can have understanding and competence in all areas. These groups of professionals, particularly the nurses, also made clear their unwillingness to continue accepting the dominance of the physician in providing health care. They see themselves as possessing a depth of knowledge and skill in their particular area that surpasses the knowledge and skill of the physician. Most do not question the general leadership role of the physician in the medical supervision of families and individuals and, in particular, his special position in decisions affecting illness and death, but they do state unequivocally that they are no longer willing to accept an auxiliary or purely subsidiary role in the health care process. They feel that the insights and skills they possess can only be effectively used to help people when a collegial or team relationship exists among all health personnel.

Some of these feelings undoubtedly arise from the normal ambition of any group to achieve greater status in the health manpower hierarchy and the consequent emotional (self-image, public image, more education and training, self-government) and economic rewards. More often, they are the result of what are seen as unnecessary restrictions placed on the role these professionals could play by the medical (and dental) profession. Such restrictions are often presented as necessary steps for protecting the public and insuring quality of care. While such motives are worthy, they are not always easy to distinguish from self-interest.

The Committee feels that community health centres should allow flexible and innovative uses of manpower which will, by concentration on patients' problems, offer more comprehensive care to people. This approach requires the skills of many professionals whose particular contribution varies with the individual problem. We feel that decision-making must be shared and many functions reallocated. Transfer of tasks must not simply be the passing down of unwanted, uninteresting and unrewarding procedures but a proper matching of resource to problem. In addition, the health professions as a whole should use the resources of other people in the community (e.g. clergymen, teacher, youth worker, policeman) and of the general public themselves.

Health professionals feel some unease about the slow response of health services institutions and organizations to changing health care needs and to the impact of technological advance. They also feel a conflict at times between the priorities and desires of the patient and their own objectives and those of the institutions. There is a consequent conflict between the ideal of always doing all one can for a patient and the constraints of practical realities and even the request by society that, in some situations, health professionals act as "rationers" of service.

Many of the concerns of health professionals cannot be eliminated by community health centres. Rather they are a sign of the need to reorganize the health services system, evaluate both the process and the result of care, and, most difficult of all, to remain flexible and open to new ways of doing things. But community health centres can be a major factor in helping to cope with these difficulties and in facilitating the more effective provision of health services.

Concerns of government and problems of public policy

Governments face questions not only in the provision of health services but also in relation to wider issues of public policy.

One of the chief concerns of ministers and treasury board officials is cost—the high cost of health services, the rapid rate at which spending is increasing and the "open-ended" piecemeal financing arrangements. Cost problems are aggravated by fragmentation and duplication of facilities, by current methods of payment to professionals, and by weak joint planning for facilities, manpower, and services.

Questions of wider public policy involve the more precise delineation of federal and provincial roles in the provision of health services, the assumed right to health care vis-a-vis society's willingness to provide the resources necessary to fulfill that right, and the ability of governments to adapt and respond to change.

We would be foolish to pretend that community health centres can cope with all these issues. We do believe that they (and the system of which they are part) can have an impact on
costs and the rate at which costs are escalating as well as going a considerable way towards reducing fragmentation and duplication of services. They can make a better use of resources in providing health services to people and do offer a means of better co-ordinating health services with social services. In the area of wider public policy, we feel that the federal and provincial governments now realize they must do more than simply “pay the bills”. They must assume an effective leadership role.

Reconciling the needed planning and control with the rights of the individual is a political and administrative challenge that must be met if the system is to be workable and if potential economies are in fact to be realized. (Ruderman).

THE COMMUNITY HEALTH CENTRE—SOME IMPLICATIONS

(Throughout the following discussion, the Committee has attempted to keep in mind the differences between the common law provinces and the civil law province of Quebec, especially in the light of actual and pending changes in health care legislation in Quebec.)

Although present legislation does not specifically prohibit the emergence of community health centres, it is the Committee’s view that appropriate legislation could help to create a climate in which their growth might be encouraged. For example, community health centres should be recognized as legal entities with the status to contract and to sue and be sued.

The concept of community health centre we have proposed requires “corporate” or collective responsibility for the professional actions of all its personnel whatever their individual status in law may be (i.e., irrespective of their position as “independent contractor” or employee). Traditionally, the practitioner has been individually responsible to the patient. That responsibility has been extended to or shared by another person or corporation only where the relationship between the practitioner and that other person or corporation was that of employer and employee. While individuals should continue to be held responsible for their performance, this traditional basis of vicarious liability may not be an equitable or meaningful notion or, indeed, an appropriate mechanism for protecting the patient, in an era of patient care by an integrated team of health professionals in an institutional setting. Such corporate responsibility would complement the team approach since it would foster flexibility and diversity in the provision of care. In addition, direct corporate responsibility would clarify some problems relating to volunteer workers and student practitioners. At present, it is unclear where responsibility lies for these persons since they are likely not employees of the institution in which the care is provided.

Corporate responsibility would give persons cared for through a health centre redress against the centre for professional negligence on the part of team members, encourage physicians and other professionals to delegate tasks which can safely be carried out by other health workers by removing the basis for their continually expressed belief that responsibility for quality of care resides in them alone, and, finally, would enable professionals and other health workers to enter into contracts of service with the centre and thus give them a sense of security.

Certification of competence by appropriate bodies and/or institutions, self-governance and discipline by the various health care professions, peer review, and standard setting are issues that have implications for the entire health care system as will be discussed later. At this point in discussing the community health care system it should, however, be noted that precise and rigid fixing of roles, responsibilities and functions of professionals and institutions through statute or licensing regulations would constitute a serious obstacle to the development of effective programs, true teamwork, and innovation. There are, for instance, real disadvantages and practical problems in trying to distinguish a “medical act” from a “nursing act” in a situation where changing and flexible roles are necessary.

Professional licensing legislation will also require review and modification to the extent that statutes currently in force may prevent some prospective members of the health team from becoming true colleagues of other members who are not members of the same profession. The most notable example of an impediment of this kind may be found in the field of pharmacy where, in some provinces, unless the pharmacy legislation is changed, it may be difficult or even impossible for the community health centre to have a pharmacy as an integral part of the centre’s services.

Employment of staff

The Committee believes that minimum staffing requirements and broad personnel policies, (terms and conditions of employment, income-ranges, payment methods, benefits and incentives) for particular service entities, including community health centres, should be set by negotiation at the provincial level. Flexibility must be allowed for meeting particular circumstances. But, the actual employment and discharge of personnel and their internal deployment should rest with the community health centre administration. The specific form of employment entered into with a particular staff member could be a general employment agreement for clerical and auxiliary personnel or some form of individual or group contract for professional personnel which would specify the nature of the services, and the conditions under which they would be rendered, including payment arrangements. A group contract arrangement could allow a group of physicians, for example, to distribute the money received for services on a basis agreed to by the centre and the physician group. Specialized personnel serving more than one community health centre should be employed by the area or district administrative level and sub-contracted to the centres.

Payment of health personnel

Payment methods must permit health services planners to prepare budgets with a reasonable degree of precision. They must promote multi-disciplinary teamwork and a balanced emphasis in service. They must also meet the personal expectations of the members of the health team for adequate, fair and competitive remuneration, for professional status and for requisite professional independence.

Most types of health services personnel are presently paid on a salaried basis. Subject to negotiation and safeguard arrangements, this method would appear to be generally satisfactory. Nevertheless, the use of sessional payment techniques in the case of people wishing to work part time would make possible access to a wider pool of potential staff (e.g. married women).

Some health professionals, notably the physician and dentist, receive their incomes mainly on a fee-for-service basis. There are difficulties in reconciling the planning and administrative interests of the system and the team approach—both essential for the success of the community health centre—with the present fee-for-service payment system. (For example, it is hard to separate out the work of each team member in any given situation.)

What then are the alternatives? It should first be noted that approximately one-third of the physicians and a small proportion of the dentists in Canada already obtain their in-
comes from some method or combination of methods other than pure fee-for-service, such as a direct salary or a redistribution of pooled income. [The pool of income came as a rule from fee-for-service payments or in a few cases from a block contract arrangement.] Thus, many appear to be willing to work under other payment arrangements provided some degree of choice of method and/or combination of methods is open to them and the levels of remuneration are deemed fair and adequate. It is likely that more would be willing to do so in return for the security of a planned system of remuneration, incentives, and other benefits which could be arranged.

Although at present it is difficult to recommend any one specific form of payment, the Committee agrees that the present form of fee-for-service payment makes the achievement of the objectives of the community health centre impossible. Some Committee members feel that any fee-for-service system is incompatible with the objectives of the community health centre and the health services system.

The mode of payment for all health and social service professionals in a community health centre should provide remuneration which is adequate, competitive, and includes recognition of the following factors: basic and equitable remuneration for the particular profession, training, expenses, seniority, effort in continuing education, workload (including administration, teaching and research duties), and income security benefits (pensions, sick leave, etc.). Assorted incentive payments for the achievement of specific goals could be helpful.

For remuneration of physicians, dentists, and other professionals who will choose to practice outside community health centres, similar payment options are equally applicable.

It will be necessary not only to experiment with varying combinations of payment methods but also to develop standards, ranges for normal variation in practice patterns, and monitoring and surveillance methods to assure that the interests of both society and the professionals are met. Such sensible and crucial arrangements can only be arrived at by mutual negotiations among the health services system and the professions concerned. These negotiations could also be used as a mechanism for resolving present recognized imbalances, even inequities, in payment amounts and overall incomes within various professional groups, such as medicine, and between the various professions.

Incentives for health personnel

Any system of incentives should both give the individual health professional something to strive for and also help in achieving the objectives of the community health centre and the health services system.

The Committee sees the attractions for health personnel to work in community health centres as a combination of the psychological and professional rewards inherent in the challenge of working with others in an innovative team which functions in a responsive and accountable partnership with the community being served, and of the material rewards and benefits possible through working in an organization or large enterprise. The latter tangible benefits should include regularly revised and negotiated minimum levels of basic income for all types of personnel (escalator mechanisms included), guidelines on the application of the possible additional payment methods outlined above, and "fringe benefits", such as shared-cost pensions, life insurance and disability insurance, guaranteed holidays, regular study leave, maternity leave, sickness leave and moving and relocation benefits. The benefits should be set on a province-wide basis and, by interprovincial agreement, be fully portable across Canada. Other benefits include good secretarial help, adequate technological back-up and pleasant office facilities.

For isolated and "hardship" living areas, additional incentive payments, assurance of adequate housing at reasonable rent, opportunities for continuing education, assurance of good schooling for children (or if necessary subsidization of outside education), regular trips outside the area for personnel and their families, credit towards further professional qualification or preference in gaining entry to further training programs are among the kinds of incentive envisaged. Experience in comparable situations in the health field and in other sectors of life in Canada and elsewhere have indicated the effectiveness of such incentives.

Incentive payments should be made to encourage the achievement of desirable objectives for these new centres, such as keeping people out of inappropriate use of hospitals, limiting to essentials the use of investigative procedures, encouraging consultancy by experts, and promoting health educational activities. These incentive payments should be determined by comparisons of practice profiles with provincial norms and by other external evaluation procedures.

We also believe that governments should consider offering to buy at a fair market price, during an initial time period, existing facilities owned by health professionals such as physicians, dentists and pharmacists, by other individuals and by community groups that they wish to convert their investment. Provision should be made for reasonable integration of private pension and insurance plans into the area of the health services system. These two steps would in our view go a long way to freeing personnel and thereby encourage an improvement in distribution of health professionals.

Although it is a thorny approach, some provinces may wish to consider removing some incentives to the present forms of practice, i.e. they may wish to institute charges for the use by a physician or dentist of hospital, out-patient, and other support facilities. Provinces may also wish to study the possibility of limiting the numbers of various kinds of personnel to be covered through public financing arrangements in areas that are considered "over-serviced" (i.e. area quotas). Additional professionals would be free to locate in such areas but their services would not be covered by Medicare; they would be reimbursed on a purely private basis. On the other hand, those who agree to work for a set period in "hard to service" areas might receive first choice when openings occurred in the preferred living areas.

Funding

The funding of the community health centre should be tied into the broader financing arrangements for the health services system. Present financing arrangements must be modified so as to relate to the objectives of the centre and not to remotely designed and fragmented federal-provincial cost sharing agreements.

Operating and maintenance

It is our view that the community health centre should be financed through a total global budget related to the number and type of population and the nature and scope of services. It should include incomes of professional and other staff and all other operating expenses. This would permit needed flexibility in the planning of service patterns, development of staff, and operating and maintenance funding.

Capital funding

Many of the capital cost problems now encountered by innovative health care programs and most medical group practices will also be problems for community health centres. The difficulties of providing construction capital and funds
for the start-up phase of a community health centre must be taken into account.

Capital expenses might be met in several ways. In each case the public must ultimately pay the cost. Direct provincial grants-in-aid could be made to the district health services administration to cover all capital costs, including community health centres. Thus, the community health centre would not be burdened with interest payments or start-up capital expenditures. Grants-in-aid, however, involve large expenditures of monies that might be useful elsewhere in the system. Nevertheless, such grants, given appropriate surveillance measures, may be the most practical way of providing capital funds to health centres in some areas (e.g. northern, semi-isolated) or for specific purposes (e.g. teaching centres, innovative centres for special groups).

Secondly, a province could provide low interest loan capital, again subject to appropriate surveillance measures, to the district health services administration for community health centres. Interest and related costs would have to be included in the block budgets provided to the district health services administration and, in turn, to the specific community health centres.

Finally, private capital sources could be encouraged to provide funds. Such capital might cover construction costs only, with start-up costs being included in the budget of a community health centre in the initial years. Private sources could also build and lease premises to the district health services administration and, if desired, provide maintenance services as well. In short, any of the current construction and leasing arrangements used in the business sector might be helpful in capitalizing community health centres and, thereby, free government funds for other purposes such as providing facilities in areas unable to attract private capital.

Design

The Committee did not attempt to explore in any depth specific designs for community health centres where new physical facilities are required. This area requires further detailed study. However, our investigations and the evidence we had presented to us did lead to certain general conclusions.

1. Good design affects the ways in which services are provided within the facility and can educate professionals to do better work. Design can encourage or inhibit group interrelationships by its physical lay-out and aesthetic qualities. It can indicate a sense of warm welcome to the public and, hence, an openness to their involvement. Considerable research has been done on these more subtle effects of design by architects, engineers and health professionals; new dimensions of understanding are being added by psychologists, sociologists, interior designers, and others. Further co-operative research and demonstration is required in putting the essential lessons from these various sources into practice.

2. Choice, variation and adaptation of design to meet the precise needs for a given community health centre at any given point in time may be enhanced by using industrial engineering techniques including new computer applications.

3. The potential flexibility and economy of modern building techniques, such as shell and modular construction, and the use of standardized, readily available and easily serviced equipment should be fully explored.

4. Provinces should develop consultant services in the field of design, which go beyond the purely architectural and engineering aspects. A range of model plans should be developed. With federal initiative, a national clearing house of information and ideas should be developed. The interest and support of the professional groups and other private organizations with special expertise in this field should be actively developed through, for example, seminars, design contests, research and demonstration grants.

5. All major building and renovation should be approved at the district and provincial levels in the health services system to assure local conditions, standards, etc., are met.

Education of health personnel

In a changing field such as health care, regular continuing education and re-education are essential. The community health centre provides a setting for interprofessional and multiprofessional in-service education. The universities and other educational institutions should also provide programs of continuing education and re-education.

A change to a "patient-centred" and "problem-solving" emphasis in educational curricula is necessary if graduates are to be able to function in the community health centre team, with colleagues in the social services and other related services, and the public.

Undergraduate and basic preparation for health personnel must include active learning experience in the work setting of the community health centre if attitudes of personnel and patterns of care are to be changed and greater emphasis on out-patient care is to become accepted as normal. This experience may be gained either through an agreement between a health teaching institution and a nearby district health services administration or through community health centres directly allied to a health sciences centre. Care must be taken to avoid altering community health centres used as learning settings more than absolutely necessary from the usual service-orientation. Otherwise the student learns "ideal" patterns of health care provision which are not duplicable in the real service setting [Future Arrangements for Health Education. Ontario Council of Health. Monograph I, 1971. (Mustard Report).] and there is danger that community participation may become illusory.

THE COMMUNITY HEALTH CENTRE

Summary

In the light of the three issues noted in the Foreword, the Committee believes that:

1. In order to emphasize community care and to shift service patterns, community health centres should be established and linked with hospitals and other health services in a fully integrated health services system; they must not simply be added onto the present system. Nevertheless, the introduction of community health centres need not await the full integration of the health services system. They are in themselves the catalysts for the development of the new system—in fact, they are essential to its concurrent development. Community health centres should be established now as non-profit, ["Non-profit" excludes the standard share corporation where profit accrues only to the shareholders.] corporate entities and in sufficient numbers so that new funding methods develop to promote the best use of resources. Enough community health centres must be introduced into the system to allow effective evaluation of their impact on the process of health services delivery.

2. Community health centres must offer a setting where care is provided through a multidisciplinary team. They should allow flexible and innovative uses of manpower which will, by concentration on patients' problems, offer more comprehensive care to people. Payment systems,
alternative to the present form of fee-for-service, which are conducive to the team approach and which are attractive to health professionals must be developed.

3. Community health centres must be clearly identified and accessible points where appropriate decisions can be taken about solving people's health care problems. They must promote a better balance between health promotion and prevention, diagnosis and treatment, and rehabilitation. They must, as necessary, relate to other health care services and community social services on a co-ordinated and integrated basis.

4. Community health centres must involve individuals more fully in decisions about service provision as well as in personal and family health care.

Recommendations

The Committee recommends:

1. The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres, as described in this Report, as non-profit corporate bodies in a fully integrated health services system.

2. The review and modification, in consultation with appropriate public and professional groups, of existing provincial legislation and regulatory measures affecting health professionals and practices to allow for flexibility and innovation in service provision.

3. The funding of community health centres through global or block budgets given by the province to the district level covering all capital operating, maintenance, and amortization costs.

4. That employment and deployment of personnel rest with the community health centres administration.

5. That payment for professional services in community health centres be based on training, experience, responsibility and workload; that payment systems be equitable, competitive and promote the objectives of the community health centre.

6. That payment mechanisms alternative to the present form of fee-for-service be developed and evaluated in discussions between governments, the health services system and the professions concerned.

7. That measures be developed by governments, in concert with appropriate public and professional groups, to assure that community health centres and the professionals working in them make the most appropriate use of other facilities, such as hospitals, and programs in the health services system.

8. That scientific evaluation of the impact of community health centres on the health of the population served and on the overall costs of the health services system be cooperatively carried out by governments, universities, educational and research bodies, and professional groups during the planning, demonstration and implementation phases; that regular evaluation, through professional and administrative audit mechanisms (internal and external), of performance and utilization become an integral part of the operation of a community health centre.

9. That by agreement between the provincial, district and university health authorities, designated community health centres be affiliated with university health sciences centres and other educational institutions for the preparation of health and social services personnel.

10. That the development of integrated health and social service centres in various settings be studied and evaluated by government, the universities and professional groups.

11. That a comprehensive and co-operative campaign by governments, professional groups, and community and citizen organizations be carried out to inform the public and the health professions of the objectives of community health centres.

THE HEALTH SERVICES SYSTEM

The community health centre is one way of controlling costs, introducing new patterns of care, and providing a communications network to put people in touch with services when they need help. But our investigations have led us to the conclusion that real economies in using resources to meet the needs of people can be achieved only if the community health centre is part of a health services system which is fully integrated administratively and financially.

It must be kept in mind that health services even when under different administrative and funding authorities are, from an economic viewpoint, indivisible.

"The share of national product devoted to the health care sector comes from a single source: [the public]. Its allocation among the agencies or functions involved in the health care system—can be viewed as a single transfer payment. The greater the freedom to reallocate funds among the various functions that comprise the total health care system and the greater the emphasis on co-ordinated planning for the system as a whole, the greater is the probability of achieving the most rational use of resources . . . (Radner).

In the Committee's view, the logic of these statements is indisputable. We believe the present health services system requires re-organization.

Planning and allocating resources

Any body can only take effective decisions to the extent that it has power to implement those decisions—in other words, upon its freedom and capacity to plan and allocate resources.

Provincial Powers

The Committee believes that the provinces must retain the major responsibility and the ultimate approval for planning, allocation of resources, and evaluation. But, we also believe this must be done in concert with the professions and the public and should not be on an "all or nothing" basis. The provinces must be prepared to delegate to the district or area level of administration—subject to basic guidelines, standards of province-wide equity and a system of accountability—sufficient responsibility and power in these three areas to meet local needs. Only through such a system can responsible public involvement be achieved.

More specifically, the province must have the major responsibility and ultimate decision-making authority for:

1. Planning the overall pattern of services and the basic levels and standards for specific services to assure balance and equity throughout the province.

2. Planning and maintaining an effective manpower policy attuned to the needs for obtaining, distributing and retaining the kinds and numbers of health personnel required to meet provincial health objectives. [Provincial manpower policies should be interrelated in a national manpower policy and clearing house system to the fullest extent possible in order to get the benefits of a nation-wide use of manpower resources.] This requires effective joint
planning between the ministries responsible for health services, education and labour. This would include the development of province-wide uniform standards of qualification, the establishment of effective negotiating arrangements between the health services system and professional associations, syndicates, and unions which are increasingly assuming the functions of area-wide bargaining units for income scales and terms of employment. Health personnel would, thus, be assured of easy province-wide mobility and choice in work setting.

3. Establishing appeal mechanisms, as outlined elsewhere in the Report, to deal with any grievances.

4. Assuring the money necessary for meeting the plans and standards established and approved for the health services system. We believe that this requires the allocation of funds on a block or program budget to the district or area health services administrations in line with budgets submitted by them for provincial approval. [At the early stages in the establishment of the health services system, the block budget would probably be based on the experience of the current component programs but as integration of services and programs increased and began to affect service patterns, for example, reducing hospital in-patient use, effective and efficient rationalization of services through real program budgeting could be developed.] In order to achieve equity and balance, the block budgets would probably have to consist of two elements: first, a per capita cost or experience portion and, second, an additional portion aimed at raising the service level in economically disadvantaged districts or areas.

5. Providing the province-wide communications and records systems, including the central records storage and data processing services.

6. Assuring an ongoing evaluation of the provincial health services system, district or area sub-systems, and the individual program and service elements by measuring them against province-wide basic standards and the extent to which overall objectives for the health services system are being met. Evaluation is also essential for planning and taking decisions about changes in priorities, programs, and resource allocation.

We have considered the possible addition of larger regional administrations between the provincial level and the district or area health services boards but we feel that these may be required only in large provinces or for special political reasons. Otherwise, the regional level merely adds another layer to the decision-making process with consequent delays and loss of flexibility.

District or area powers

The district or area health services administration should have authority for:

1. Detailed planning and development of proposals for the priorities and kinds of services within its area, consistent with the provincial health services system requirements and subject to final overall budgetary approval by the province. This will require planning: first, to meet the basic provincial standards and, second, to put forward additional proposals which the community feels are appropriate to its area. Detailed service planning includes determining the location of community health centres and basic medical and dental units within its area, deciding which elements would be developed as specialized service centres, and shifting service patterns from an institutional basis to a program basis (e.g. a cardiac care program might include facets of service now in hospitals, health units and home care programs).

2. Assuring an effective link with other personal services in the district.

3. Developing an effective area manpower recruitment, retention, and in-service education program.

4. Compiling the budget requirements for individual services and facilities in its area and presenting a total "package" to the province. No building, renovation, or program should be begun without the approval of the district or area administration but the province may decide not to accept the total program budget.

5. Distributing the funds to the specific services and programs in its area.

Boards

The community health centres, hospitals and other institutions of the health services system should be corporate entities and, therefore, require some sort of responsible governing body. The composition of these boards and their functions is outlined later. [As noted, the district board could fulfill these responsibilities in certain circumstances.]

Regulatory and licensing bodies

The Committee is convinced that the positive effects of regulatory bodies, whether they are licensing or merely certifying in nature, in ensuring professional competence would be strengthened if the appropriate role and responsibilities of the regulatory body were clearly understood by members of the profession, the public and governments. The regulatory body of each health care profession, in the Committee's view, exists to protect the public and not to advance the interests of the profession; this latter and clearly important function is properly the concern of the voluntary professional association. To ensure effective community and individual involvement in the mechanisms of the health system, there must be an effective "lay", that is, non-professional, participation and representation of the regulatory bodies of the health professions. Professional statutes should be amended, where necessary, to ensure that no profession can directly or indirectly, regulate the members of another profession or occupation. Amendments of this kind would also have the effect of eliminating the inhibiting effect which some licensing statutes, for example, provincial Medical Acts, have on the rational allocation of functions or roles among members of different health professions.

In order to facilitate effective manpower policies, allow choice of work location and portability of benefits, and take into account the mobility of professionals and patients, the Committee feels that the legal mechanisms and standards relating to roles, responsibilities, functions and institutions should be as uniform as possible from one jurisdiction to another in Canada.

We are aware that laws and standards cannot guarantee the highest quality medical care and that, realistically, they may only be able to secure protection against very poor health care. But we do not wish to underestimate the value of licensing regulations and legislation as positive educational and guidance tools.

Provision of drugs

We have noted that the fullest involvement of the pharmacist as a drug usage consultant, peer review of prescribing practices, and the development of patient profiles, the use of regularly revised drug formularies, bulk purchasing and prepackaging in suitable unit amounts [Care in carrying out such steps should be taken to assure that a stimulus for pharmaceutical research continues to exist in Canada.] can provide economies consistent with quality in a community health centre. However, the
real value of these approaches can only be achieved through a health services system. Any steps taken by a province should involve co-operative dialogue with the pharmaceutical manufacturers and distributors and the health services personnel involved in drug provision. Where pharmacists remain in solo practice they should be included in the district health services system and more fully used in the consultant role. A health services system allows the development of a drug information system and the many advantages for quality care and evaluation flowing from it.

Public health programs

Within a reorganized health services system, many personal services presently provided by public health programs, especially by public health nurses, could be provided through the community health centres. But there remain essential public health functions, such as epidemiological surveillance, the assessment and evaluation of community and area health problems and services, the development of area preventive programs and co-ordination and control [The area authority must be able to control, as necessary, essential protection services; however these may be usually carried out in community health centres.] over their application (for example, immunization levels, selected screening programs health education), and the protection of the environment from a health standpoint, which cannot be delegated to community health centres. These public health functions must continue to be carried out on area-wide, province-wide and, in certain instances, country-wide bases through the health services system. [This may be a separate public health program under the district and other administrations. In Quebec under Law 48, it will be carried out through designated hospitals. Also see Crichton for further discussion of this matter.] Direct personal preventive programs, such as public health nursing, will continue to be required for people obtaining their health care from sources other than community health centres. [For example, from existing types of solo and medical group practice.]

Mental health services

The community health centre by involving the public and using the multidisciplinary team, including the clinical psychologist and other mental health personnel, provides a setting in which there can be greater emphasis on the psycho-social aspects of care. A health services system makes the wider involvement of all the community's potential "front line" mental health resources (clergy, teachers, police, recreation counsellors, voluntary agencies and the public themselves) easier to achieve. However, consultant mental health teams and services must continue to be provided for referral and for support of community health centres and other basic care settings.

Rehabilitation services

As to rehabilitation services, our observation is that their provision is also presently fragmented among a variety of public and voluntary institutions and programs, and an increasing number of private agencies. It is our view that those programs which emphasize medical rehabilitation can best be rationalized through the health services system. Community health centres as a rule should not include more than basic medical rehabilitation facilities and personnel whenever fuller services are available through hospital and rehabilitation centres in the community area. It should, however, be noted that there is a whole field of vocational rehabilitation which is essentially in the social service, education and manpower fields. There are also rehabilitation services for the socially disadvantaged where the main problem is not health. Specific cross-relationships among health oriented programs and these other rehabilitation programs are necessary, since it is often difficult to separate the different aspects of rehabilitation into distinct programs.

Extended care facilities

Convalescent and chronic care institutions, nursing homes, "half way houses", and other extended care facilities must be integral components of the district health services system. Rationalization of the use of these facilities and funding arrangements for them can then be achieved. In addition, the system would permit more effective continuing medical, nursing, and other care and supervision in these facilities. A health services system which is intimately related to the social services also makes possible easier provision of health care to residential facility settings. The social service contribution to the direction and program of extended care institutions is important in assuring the quality of life, as well as the quality of care, for the people in these institutions.

Home care programs

Although some home visiting for initial diagnostic and/or simple therapy as well as for health education purposes will be carried out by public health nurses and other personnel in community health centres, the need for a co-ordinated home care service, including visiting nursing, visiting homemaker, chiropody, and other social services (child care counselling, friendly visiting, etc.) will remain. Because these programs are not only for the ill but also for people with any need requiring home care, it seems advisable for such services to be jointly provided through the district health services administration and its counterpart organization(s) in the social services area.

Day care

Community health centres may decrease the need for in-patient hospital care and may relieve burdens upon families by developing day care services for geriatric and mentally disordered (disturbed and/or retarded) patients when they require minor surgery and investigative procedures. Moreover, 8-hour "sick-child" care for the children of working mothers might be made available. The extent of these services would depend upon the availability of staff and development of volunteer services. This is an activity which could integrate the community health centres more closely into the local community.

Voluntary health agencies

Voluntary health agencies should be encouraged to continue their emphasis on innovative and demonstration programs to meet special needs of particular groups of people as well as their roles in public and professional health education and in research. They may also be usefully employed on a contractual basis for carrying out official programs. But they must become integral components in the district health services system in order to prevent duplication of effort and permit equity in funding. This may be achieved by provincial insistence on co-operation and basic standards as a requirement for receipt of public grants, contractual funds, or preferential tax status.

Education of health personnel

The fundamental intellectual independence and research characteristics of the education system must be respected; at the same time the education system must be responsive to the manpower needs of society. Serious over- or under-production of certain types of health personnel [The supply requirements will vary in time and place with factors such as the way various types of personnel are used and with the impact of scientific and technological advances.], curricula which fail to reflect modern advances in science, technology and in
Social organization, and courses which are "closed ends" for those who take them result from unco-ordinated planning between the health services system and the education system. Rigid use of specific types of personnel, slowness in responding to new work patterns and skills, failure to include effective planning, evaluative, and research functions are examples of the fragmentation which we see requiring urgent attention.

Admission requirements for the various health professions should be set jointly between the educational institutions, the profession concerned and the public interest as represented by government to assure courses which realistically balance the educational needs of the individual in modern society and the functions he will be expected to fulfill in the health services system.

Curricula should be designed to give as much academic credit as possible to personnel wishing to transfer their area of work in the health field or to become more specialized. Practical experience, although sometimes hard to equate with academic experience, should be taken into account.

Finally, the educational institutions and the health services system must co-ordinate the planning and provision of continuing education programs. At present these programs, both in-service and extra-mural, tend to be developed on an ad hoc and individually planned basis by specific educational institutions and/or by specific health services. The changed emphasis within the health services system will require a much more extensive educational program and co-operative approach if the need for skilled manpower is to be met.

Evaluation and innovation

An essential element in the development of the re-organized health services system is careful and on-going scientific evaluation. This will allow the appraisal of the result of the new methods of health care delivery, as well as of existing approaches, and different treatment theories and concepts. It also will allow for an assessment of alternative methods for reaching the desired outcomes and objectives of the health services system. The evaluation process should involve the expertise of a variety of specialists including health care administrators, epidemiologists, social scientists, economists, and finance and managerial personnel.

A sufficient portion of budget will, therefore, be required for an evaluation of new projects both in the design and demonstration phases, and for training the various types of personnel to carry out evaluation procedures. [Some monies are now available through federal and some provincial granting arrangements but more will be required if substantial changes in the health services system are carried out. ] In addition, operating budgets in the health services system should provide for regular on-going evaluation of new and existing projects through internal and external auditing of performance and utilization. [There may be significant and important costs to the individual and family (through such factors as loss of income from time off work, convenience, and costs of supporting care of people in the home) which also require evaluation.]

It is vital that a record system be employed, in community health centres and throughout the health services system, which is capable of supporting the activities of teaching, monitoring of norms, and evaluation.

The communications network

Since many health professionals are now grouped together because of difficulties in communication and service referral, the establishment of a communications network would permit greater variety and flexibility in the forms of services provision within the community or within a given facility. In fact, such a system could encompass more than simply health services; it could be the principal means of co-ordinating the health and social systems.

We feel that the communications network is a basic requirement for assuring a dynamic, responsive and co-ordinated health services system. Without a communications network, the present problems of fragmentation of health services cannot be solved except through a rigid hierarchical bureaucracy such as has grown up in several other countries.

The technological component

A linkage system built upon elements now available (telex, telephone, radio, television, computer systems) would allow the health system to be rapidly responsive to the particular needs of any individual patient, professional, and service facility. Such a network would enable prompt referral to services and facilities, avoid duplication of record-keeping, facilitate consultation and continuity of care, and allow greater choice for an individual of initial, continuing and referral care settings. It is directly suited to the increasing mobility of our population while permitting those who chose to remain in one location to obtain most of their care through a single service point. [Confidentiality of records can be assured by special coding and retrieval techniques.]

Once the basic levels of service are established, we feel the introduction of modern communications technology into the health services system should assume a top priority for planning and expenditure at federal and provincial levels. This priority applies particularly to the development of modern management information systems.

Referral systems

One of the issues which must be resolved in a health services system is the question of patient referral within the system. At present, since each hospital and each specialist clinic is an independent entity, it is hard to get agreement in an area or district for any one hospital or clinic to be built up as area referral centres and thereby attract and support a good cross-section of specialist medical nursing, and other personnel. Present patterns often lead to the appropriate treatment being bypassed by nearby physicians and patients. This is partly because of feelings of physicians and the public that a university teaching centre may be a better place for all specialized care. But it is also related to the fact that many specialist groups do a considerable amount of general family care, and are, therefore, in a competitive position with the family physicians. We believe that a health services system, including the modifications in payment we have suggested, would resolve the problem of competition for fee income and, through the planning and funding functions of district or area boards, permit the development of adequate district referral hospital and other specialist referral services. It could also provide a mechanism for assuring a hospital relationship for all district physicians.

The consultancy and specialized referral functions of the university, especially those of its health sciences centres must be more fully developed. In the present health services pattern, the university centre with its teaching clinical personnel and hospitals cannot attain its full potential because it competes for patients (and therefore for funds) with non-university personnel (especially physicians) and hospitals. Only an overall health services system which eliminates this competition can allow a full development of specialized referral and consultancy services. We see the health sciences centres as fulfilling these functions not just for one region or
province but for a number of regions, several provinces, or even nationally. Rigid regional and provincial parochialism, all too evident today, are major barriers to the full exploitation of the potential of the health sciences centres. Some equitable solution must be found to the funding and jurisdictional problems presently existing as reasons, sometimes excuses, for lack of co-operative planning and use of such resources. We believe that the payment proposals for health professionals, especially physicians, made earlier in the Report would help in reducing the importance of income as a competitive factor.

Laboratory services

Provincial laboratory services and larger hospital laboratories have demonstrated over the years a capacity to provide economic and accurate test results with a minimum use of expensive supervisory personnel. However, they have been unable, because of budget restrictions and bureaucratic constraints, to compete on equal terms with private laboratories. Partly because of this, private, automated laboratory operations have developed which have been reimbursed on fee schedules for older manual methods. The fees have permitted quick and high profits to these private laboratories which have, in some cases, amounted to a markedly increased cost to the public purse. An additional consequence is that duplication of laboratory services, with built-in incentives to excessive utilization, has developed. The increasing costs of laboratory services have deleteriously affected other parts of the health care system.

What is required, therefore, is the development of provincial laboratory systems, without duplication and without incentives to excessive utilization, which fully exploit the resources of private, hospital, and provincially-owned laboratories. In particular private laboratories should be required to equal or improve upon costs and services of hospital or provincially-owned laboratories. [If a fee payment schedule is retained, the professional medical component should be separated in payment from equipment and technical staff costs wherever possible—e.g., electrocardiograms and other special diagnostic procedures.]

As noted previously, community health centres should as a rule provide only very basic, common and easily done laboratory tests. Whenever possible other work should be done through the improved and unified provincial laboratory-hospital laboratory system.

Diagnostic radiological services

In the case of diagnostic radiological services, we have again seen in other studies and noted in our own investigations that there is considerable overprovision and underutilization of sophisticated equipment. Competent technicians and professional supervision are not always as available as quality and safety demand. It is our view that the more expensive and sophisticated diagnostic equipment and staff should be located in the major hospitals or other referral settings within each district health services system. Community health centres should only, as a rule, have simple radiological equipment suitable for common diagnostic procedures (e.g.—fractures, chest films, etc.) and this equipment must be regularly inspected for quality and safety.

Effective public participation

Public involvement can only assure effective service when boards develop a recognition of what quality service is and how to go about obtaining it. The role and authority of any board must be defined very early and very precisely. Without this process, a board’s enthusiasm and its impact on service provision that frequently occurs in the initial stages of its existence can be dissipated.

Misunderstanding of its role and authority can lead, for example, to frustration in a board on discovering in certain instances that it is an advisory rather than an implementing body, or to friction because the board has impinged on the management function intended to be performed by staff. Such situations immobilise a board’s efforts towards effective action.

Great care needs to be taken to ensure that boards are in a position to provide the dynamic and continuing contribution of which they can be capable. This should be in their defined area of policy and program development and decision-making, and as conveyors of informed concern and opinion between the community and the agency.

District or area boards

We believe that a health services system must be responsive to the priorities set by the community. Thus, we believe that the district or area health services administration must be a representative public board. The district health services board must be supported by administrative and other professional personnel to help it gather and assess data, to plan, to implement and to evaluate its functions.

The staging of the introduction and assumption of full responsibilities and the exact composition of the district or area health services administration board should be determined by each province according to its own circumstances; we feel the following general ideas are essential.

1. There should be representation from citizen organizations, voluntary agencies, municipalities, and the province. All members should regard themselves as area-wide representatives and not only as representatives of a particular interest group.

2. Any professional and/or institutional representation should be commensurate with the technical and administrative knowledge required for responsible board functioning.

3. There must be a means to assure that significant minority group interests are represented.

4. Continuing education of the board and means for regular introduction of new members are essential.

5. The selection and functioning of the district or area health services board must reflect the essential element of accountability in our system of democratic government.

6. There should be a technical advisory committee to advise the district or area health services board about technical and professional questions.

Individual service boards

The formation of a district or area board should not necessarily mean that all existing hospital, institutional, and health agency boards cease to exist. For many years hospital and other boards have worked successfully to raise the level of care for the people served. So much has this been the case, that efforts are now being made at various government levels to establish boards for mental hospitals, veterans hospitals, and tuberculosis sanatoria as a means for improving standards of care and responsiveness to need and to scientific advance. Moreover, major impetus for concepts of accreditation, audit and peer review as means for raising standards of patient care has come from active and sensitive citizen boards and administrators.

On the other hand in rural and smaller urban communities where relatively small institutions and services exist, it may be wise for many reasons (political, administrative, planning,
staffing) for the district or area board to assume responsibility for all services or to establish local health boards for each community in the district. Any change, however, will only be successful where careful attention is given to preparatory education, dialogue and involvement of the public, the existing boards, and the health professionals in a district. It should also be noted that the responsible corporate body in a hospital or institution is the board. It can sue and be sued. It can, if it wishes to assume its full powers, have a material effect on the priorities and quality of care, through active standard setting, approval of staff appointments and through emphasizing patient priorities in relation to those of the health professionals, education, and research. There is, of course, ample evidence that many boards do not in fact live up to their potential. But this is not a reason for eliminating them. Rather it indicates a need to strengthen them through being part of a health services system of the type detailed.

Should all community health centres have boards? The Committee feels that the decision should be made on exactly the same bases as just outlined for hospital and other service boards. If a board can serve useful purposes then it should be established; in other instances these purposes may better be fulfilled by the district or area board.

Complaints and grievance mechanisms
In each district, a body to handle grievances and complaints, both of the public and of health professionals, with powers to investigate situations and redress wrongs should be established. This body must have its own budget and staff separate from the district or area health services board, so that it is free to effectively carry out its responsibilities. It should be directly related to the provincial ombudsman's office or to the provincial health ombudsman's office, where one exists.

Monitoring and evaluation body
At the provincial level there should be an independent body with its own budget and staff with the responsibilities to monitor and evaluate the performance of existing and new programs and of the health services system as a whole and in co-operation with the universities, professional groups, and other expert resources. Findings should be made public on a regular basis. As the new health services system develops, these essential activities might, in the larger and more populous provinces, be carried out at the district level with particular reference to the services in the area. Several smaller provinces may wish to carry out their functions on a co-operative basis.

The federal government should continue to carry out national evaluation studies and co-operate with provinces desiring mutual studies.

Financial implications of a health services system
There are fundamental financial implications in our proposals for a health services system which places greater emphasis than at present on various forms of out-of-hospital care, including community health centres.

Because of the proposed shift from in-patient care and institutional care, greater responsibility for health maintenance and care falls on the individual and the family. This new emphasis will incur increased cost and inconvenience to families. Public schemes for financial coverage will have to be extended to forms of basic care other than hospitalization and physicians' services. [Additional charges for covered services should be avoided.] such as extended care, home care, out-of-hospital prescribed drugs, and dental services. Payments will be necessary to permit a family member to give care in the home or to employ someone to provide it without loss of earning potential for the family. [As is now the case under Workmen's Compensation provisions.]

Extra money may also be required to cover increased social work costs, absorb the expense of necessary transportation, etc. Without such incentives the pull of presently insured services and of institutional forms of care will continue to be irresistible for people, even though they may often be more costly to the public purse as a whole.

If a province were simply to introduce community health centres, a reduction of in-patient hospital costs would not automatically follow. Community health centres and an integrated health services system can make possible greater value for the money spent on health care. But this will require hard decisions to set ceilings and to hold the line on the amounts of capital and operating funds available for various existing facilities and services in order to divert a greater proportion of money to the newly emphasized out-of-hospital services, including community health centres.

This will not be either politically or socially easy in many communities and areas. Although some of the money needed could, therefore, come from transfers and from the greater efficiencies in resource use, it is clear that additional substantial amounts of money will be required. “Seed” and “change-over” monies such as the proposed federal thrust fund of $640,000,000 and similar provincial sources are fundamental to the changes we have described.

There is a further facet to the funding picture. Visits to each province revealed wide variation of service levels not only between areas of the country but also within the provinces. Despite inter-government cost-sharing arrangements and income redistribution programs, there is clear evidence that within Canada the speed of change has widened the gap between the extremes of health services provision. The present federal proposals to the provinces on new cost-sharing arrangements in the health care field do contain an important element of financial redistribution in favour of the less wealthy provinces. Even so, it has been suggested to us that the proposals do not sufficiently allow for the basic problem. Some provinces do not have enough money to make the necessary system changes and to achieve a standard of service equal to the wealthier provinces. [It is, of course, clear that changes in the health services alone are not the answer to poverty and underdevelopment.]

It should also be noted that the proposals do not include arrangements on welfare cost-shared programs, such as the Canada Assistance Plan, which contain substantial health care provisions, or which affect social services and community facilities, such as homemakers services and homes for the aged, etc., with a direct bearing on health services provision. In this sense, social policy and economic policy are indivisible. It is not our place to enter into the merits of the social and economic policies and proposals of either the federal government or any provincial government as they affect the present negotiations on shared cost health programs or into the sometimes difficult constitutional jurisdiction questions involved. But we do stress that if nationhood means anything, it requires a common basic standard of service throughout Canada and within a province and territory.

The magnitude of the amounts of money these essential changes will require may at first glance appear as a powerful argument against our recommendation. However, further thought reminds us that the alternative is a steady worsening of our capacities to provide and fund the health care which scientific and technological advances will make possible and our people will expect.

In the Committee's view, we have no choice as a responsible nation but to take the fundamental decisions for change presented in this Report.

C.M.A. JOURNAL/AUGUST 19, 1972/VOL. 107 377
THE HEALTH SERVICES SYSTEM

Summary
In order to make community health care a priority and to fully achieve the goals noted in the Foreword, the Committee believes that:

1. All health services must be integral parts of a health services system. This entails a whole-hearted commitment to common objectives and policies established through dialogue among governments, the professions, and the public.

2. Health care is becoming more and more accepted as a right. This idea must be defined and acceptable boundaries placed on it, if society is to give rational direction to the planning, financing, development and evaluation of health services. Just as the concept of right must have its limits defined, so also must the idea of choice for the individual whether as recipient or as provider of service.

These two concepts must be consistent both with the prevailing ethical and moral bases in Canadian society and with the willingness and capacity of society to allot the necessary resources for the attainment of broad health objectives. Some type of device acceptable to society must be found for distributing the resources available at any given point in time.

There must be an acceptable level of equity in availability and accessibility of health services for all Canadians. This does not preclude additional special help in meeting the basic level for provinces or areas with special economic and other needs.

3. Creative planning and use of resources in furthering local priorities in addition to wider provincial and national ones requires some degree of decentralization of planning, policy setting, budgeting and implementation. Clear definition of functions, responsibilities and powers is necessary at all levels. All responsibilities and powers must be exercised so as to assure provincial and national basic standards of availability and accessibility.

Although the Committee recommends decentralization, we recognize the wisdom of central planning and administration within a province, or group of provinces (or even federally) of certain services. [e.g. data bank, manpower licensing and clearing house, surveillance and monitoring of services, laboratory services, watershed control, cancer radio-therapy, highly specialized rehabilitation (thalidomide children), etc.]

Decentralization in the actual delivery of a service (as in the case of laboratory services) does not preclude such central planning. Account should be taken not only of political, economic, and communications areas but also of technological, referral, and consultation resources (e.g. health sciences centres).

Responsible and effective exercise of power requires substantial availability and control of money through some form of global or block program budgeting. Federal-provincial cost sharing should encourage effective provincial planning. In turn, provincial financing arrangements with district and/or local areas should encourage effective planning, consistent with both the wider national and provincial interests and equity.

4. There must be clear information, referral and planning links between and among all elements in the system.

5. Any health services system can function effectively only when participants are willing to work together. They must all accept the responsibility to understand the purposes of services and use the system wisely. This will require a massive and continuing information and education program. It will mean real compromises and difficult decisions. It implies the active involvement of citizens in planning, advisory and policy making bodies, such as regional and individual institutional boards, whether government or voluntary. In order to assure equitable treatment within the system, grievance mechanisms are necessary for both recipients and providers of service.

6. Continuous evaluation, assessment and regular reporting of the extent to which policies and services work towards the achievement of objectives are necessary. Internal and external audit and review methods carried out under appropriate public and professional auspices must be integrated into the health services system.

Recommendations

The Committee recommends:

1. The immediate and purposeful re-organization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assure a more economic and effective use of all health care resources.

2. The immediate initiation by provincial governments of dialogue with the health professions and new and existing health services bodies to plan, budget, implement, co-ordinate and evaluate this system; the facilitation and support of these activities by the federal government through consultation services, funding, and country-wide evaluation.

3. The establishment by the provinces of district or area administrations consisting of
(a) a representative citizens board and
(b) a technical advisory body.

4. The use by provinces of program or block budgeting methods in the health services system.

5. The fullest practical introduction by federal and provincial governments of modern communications technology into the health services system.

6. The development by provincial government through negotiation with the professions and with new and existing services of less-costly and more appropriate alternatives to acute hospital in-patient care; coverage for these alternatives and for care in the home under federal and provincial "health insurance" schemes.

7. The setting by governments, in negotiation with appropriate public and professional groups, of priorities for allocating funds for new and existing facilities.

8. The reduction by provincial governments of acute general hospital in-patient bed facilities.

9. The development and co-ordination at federal, provincial and inter-provincial levels of manpower policies, funding policies, educational programs and teaching curricula to assure an appropriate supply of personnel for the health services system.

10. The setting by provincial statute of representatives of the general public on professional licensing and regulatory bodies.

11. The development by the provinces of adequate grievance and complaints bodies with powers to investigate and to redress wrongs.

12. The regular scientific evaluation of all planning, demonstration, and implementation of new and existing health services and of the overall health services system in terms of performance (including quality) and utilization, by the provinces, universities and other education and research resources, and professional groups in mutual co-operation.
1. Urban health (and social) services system. Diagram 1 shows a possible urban system based on an existing community hospital in a growing district (pop. 50,000) of a large metropolitan city (pop. 500,000). The social service components are underlined. If they are excluded, the diagram shows a health system; if included, a health and social services system.

![Diagram 1](image)

The implementation of the district health and social services program might be staged in the following way:

- recreation
- housing
- education
- private social service agencies
- dental practices
- medical practices
- public social services
- public health
- public nursing homes
- extended care units
- hospital(s)

Stage 1 Stage 2 Stage 3 Stage 4

2. Rural health services system. Diagram 2 shows a rural area with a principal town of 8,000 people, 2 medical groups, several pharmacies, a 70 bed local hospital and a mental health centre. There are several outlying villages, some with local hospitals, and a reserve. The physicians in the medical group refer to the university hospital rather than the regional hospital (located in the district centre—250,000 people) because they fear losing patients to mixed general practice—specialist groups in the district centre.

In Diagram 3, one of the medical groups, the mental health centre and a pharmacy decide to form a community health centre. The province closes the small local hospitals and establishes sub-centres. In some cases, the hospital buildings might be converted into sub-centres (or even a full centre) and day-care centres or facilities for handicapped children. Because the income of the physicians in the health centre cannot be jeopardized they refer to the secondary level hospital at the district centre.

The procedure for changing a local hospital into a community health centre or sub-centre can be briefly outlined.

In the diagram, the hospital in the community of 1,000 (for example) serves a large, well-defined rural catchment area. The hospital has 10 beds, an out-patient department, 2 physicians, 4 registered nurses, a secretary-administrator and a maintenance staff. Since the hospital operates under the Health Insurance and Diagnostic Act, there is little incentive to establish a home care program in the community and catchment area, a mental health program, or to assure effective community input. The hospital should be converted to a health centre by the following steps: 1. Discontinue in-patient activity. 2. Develop
a more comprehensive range of ambulatory care services. Include: home care, preventive programs, mental health program. 3. Run an orientation program for all staff, trustees, and the public. 4. Expand the health care team by adding, for example, a nutritionist, public health nurses, social workers. 5. Evaluate the new program (a) develop a records system capable of providing a basis for evaluation (b) develop appropriate evaluative skills backed up by provincial or district personnel. 6. Consider mechanisms of effective consumer involvement, e.g. community health association. 7. Integrate the centre into the health care system. This requires an organizational response at the district or area level (i.e., an area health board).


### Diagram 4

**A POSSIBLE COMMUNITY HEALTH CENTRE**

- **ENTRY**
  - Surveillance screening
  - SICKNESS
  - SYMPTOMATIC
  - ASYMPTOMATIC
  - Health care team (Physicians and nurses, etc.)
  - Pharmacy
  - Rehabilitation
  - Eye services
  - Dentistry
  - Podiatry
  - Laboratory
  - Further Screening
  - Health Education
  - Personal counselling
  - Family planning
  - Personal preventive services
  - Mental health services
  - Social work services
  - Home care
  - Hospital
  - Other ambulatory care settings
  - Special Rehabilitation
  - Chronic care settings
  - Specialized social services
  - Specialized mental health services

### Diagram 5

**SINGLE UNIT CENTRE**

- **reception**
- records
- referral
- linkage

- **health unit**
  - Family Health Program
  - (Health team)
  - Special Programs,
  - -school health
  - -mental health
  - -industrial health
  - -health education

- **social unit**
  - Family Counselling
  - Individual Counselling
  - Day Care
  - Homemaker Service
  - Community Organising
  - Legal Aid
  - Housing
  - Recreation

4. Combined centre. The "single unit" centre to provide both health and social services consists of 3 basic components, reception, health services, social services (Diagram 5). Such units might service 30-40,000 people in an urban setting, 10-20,000 in a rural setting.