ASIAN JOURNAL OF PUBLIC ADMINISTRATION VOL. 17, NO. 1 (JUNE 1995): 116-139

RECENT DIRECTIONS IN CANADIAN HEALTH POLICY: A CASE FOR MORE BEACONS

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Introduction

A former Minister of Health and Welfare for Canada, the Honourable Perrin Beatty, recently set down his thoughts on what Canadians believe about our health care:

> In Canada, we believe deeply that just as equal treatment under the law is essential, equality in terms of service for health care is a human entitlement. It's not something that comes to you as a result of your ability to earn money.[1]

That belief is expressed in law through the principle of accessibility: a guarantee of satisfactory access to publicly insured services, without barriers such as extra billing or user fees. A closely related principle, one of four others described in more detail below, is that of universality: all Canadians are covered for all insured benefits.

But no system is perfect, and as this one strove towards maturity in recent decades, some people found themselves with access to more care than they really needed, while others had less. When our daughter was born in Toronto twenty-one years ago, the happy event took place in a mid-city teaching hospital specializing in obstetrics and gynaecology, affiliated with the University of Toronto's medical school. My wife and daughter were attended by an obs-gyn specialist and by hospital residents. On the whole, they enjoyed access to the highest standards of medical, nursing and housekeeping care, in this sophis-

ticated, high-tech facility, for a full week, despite the fact that a normal, healthy birth was anticipated in advance and realized at the time. We were surrounded, for the most part, by other healthy babies and parents, in an agreeably festive atmosphere. About fifty kilometres directly southeast, across the border into the United States, an equivalent sojourn would have cost us several thousands of dollars - much more if we had been among those unfortunate enough to face complications. In keeping with the principles that hallmark the Canadian system, we paid not one brass farthing nor a thin dime in direct, out-of-pocket costs for this "Rolls Royce" model of human resources and technology for birthing arrangements.

With the benefit of hindsight, however, we now know that this was symptomatic of a range of unrealistic and unsustainable habits of lavishing technology, physical plant and professional skills on healthy or slightly ill people. Other common examples included hospital emergency units functioning as primary-care clinics, and surgical wards for post-op rehabilitation. The hospital-medical fraternity has trained its initiates to deal with and avert disasters, but they have been left at liberty to congregate disproportionately in urban facilities. In recent years, alternative practice settings such as community health centres (CHCs) and trial models of pre-agreed salaries for teaching and research posts have begun to wean physicians off the fee-for-service system. Most, however, are still paid on a piece-work basis that rewards illness care to a vastly greater extent than promoting good health and sustaining wellness. In reforming our approach to health human resources, medical school enrolments and postgraduate specialities are now being reduced to match real needs for both generalist and specialist physicians, and the specialists are encouraged to target their skills towards serious pathology, such as obstetricians for high-risk pregnancies. The average length of stay in Ontario teaching hospitals for normal childbirths is now just 2.75 days.2 Healthy mothers-to-be may exercise their right of choice between a family physician or a midwife, called in French a *sage-femme* ("wise woman"). The latter profession provides appropriate expertise along with savings to the public purse, while restoring a traditional role that was almost lost in the shuffle of industrialization.

Why Is Canadian Health Policy Changing Direction?

The main thrust for restructuring Canada's multiple systems of health promotion and care began just a few years ago with the onset of a major economic recession, that is now showing signs ofslowing down. Financial necessity became the parent of invention of reform initiatives, which collectively are now understood to be essential for the very survival of Canada's health systems. Despite tremendous advances in preventing certain illnesses such as TB, polio and smallpox, and in developing sophisticated diagnostic technology and treatment modalities, it also became evident that the rates of other illnesses such as cancer, AIDS and Alzheimer's were increasing. It was also clear that certain segments of the population remained underserved and that other groups, such as senior citizens, would soon greatly increase relative to the total population.

These concerns were addressed through a number of wide-ranging commissions of enquiry and special studies sponsored by the federal and provincial governments. For the most part, they followed the logic of the general systems model as modified by the strategic planning approach, outlined in Figure 1. From those studies, a number of important realizations became apparent:

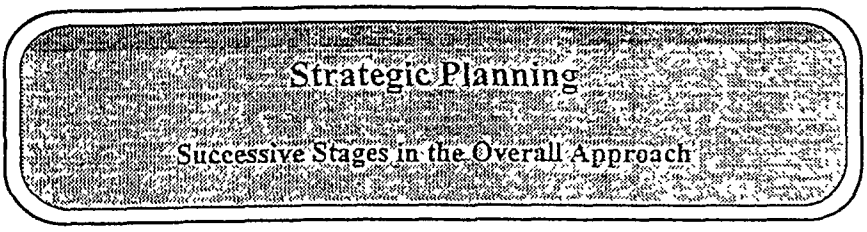
(a) The nationwide values and principles for health and care have not changed.

(b) Health and well-being, as now understood through the World Health Organization's definition,[3] includes, but is not limited to, the avoidance of illness, disability and premature death; equally vital to us are the positive aspects of wellness.

(c) Given the prerequisites, or determinants, of health which contribute to good health and well being, a disproportionate share of resources has been deployed towards the treatment and curative systems, and an insufficient share to prevention of the negative aspects and promotion of the positive factors.

(d) The latter conclusion relates to the relative weights and internal

Figure 1 A strategic planning model



1. **Consideration of Values**
   ie., beliefs, assumptions, vision statement

⇓

2 **Principles**

⇓

3. **Goals**
   ie., desired outcomes

⇓

4. **Directions and Priorities**
   near-term outcomes and resources' (re-)deployment

⇓

5. Operational Planning → **Initiatives** → Operational Management
   ie., strategic and operational inputs, the means for achieving the ends

⇓

6 **Monitoring and Evaluation**
   ie., assessing progress, cost-benefit analysis, benchmarking, etc.
   for informed judgements on adjusting or altering the above stages

⇑ ⇐

distribution of resources; in absolute terms, it is widely held that the resources now available overall are adequate to address the issues, and appropriate in relation to the broader economy such as a percentage of gross domestic product (Fig. 2).

Closer Monitoring of Health Reform - Essential Aids to Navigation

Based on the foregoing understandings and the planning that followed, substantial reform is now under-way, frequently described by other "re" words: restructuring, retooling, re-skilling, redeployment, and leading or following those is the reallocation of resources. Referring back to the strategic planning approach, it appears that the weak link at the present time is that of evaluation and the feedback loop. Commissions of enquiry and special panels should produce an agenda for change but, by definition, they are time-limited in scope, and hence not left in place to monitor progress. I suggest that the work of health reform is sufficiently advanced, and unarguably complex, that we should now "re-skill" one or more informed, independent review panels to monitor, assess and make recommendations on the following:

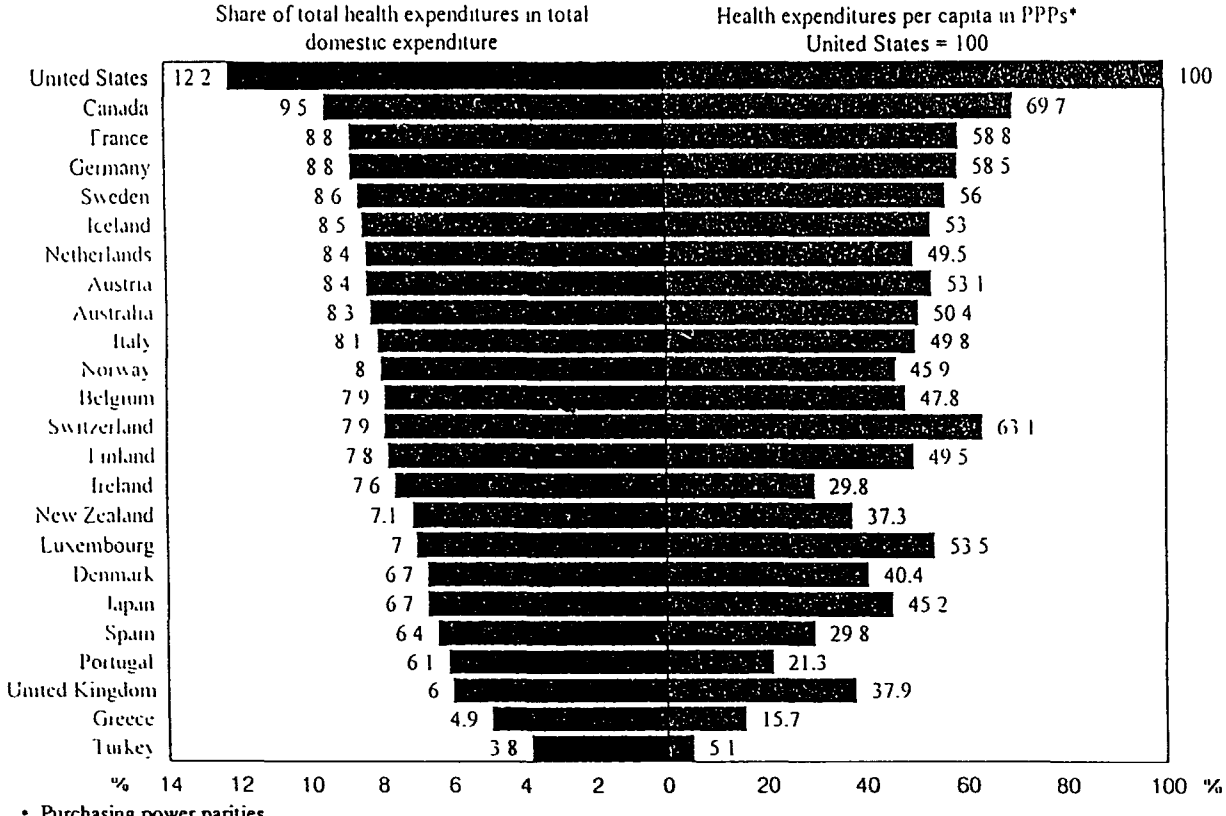
(a) The validity of long-range goals and assumptions, and short-term objectives, for the likelihood of their sustaining the agreed values and principles to be upheld.

(b) The *progress* of change in relation to agreed or generally-understood time-lines.

(c) Assessing the prospects for success of large and small measures, proposed or currently under way, to achieve reform in the ways intended and targeted.

(d) Evaluating with cost-benefit frameworks, both qualitative and quantitative, the results and consequences of reform measures, including their impacts on external systems or environments as well as their value for achieving reform.

Figure 2 Combined private and public health spending for OECD nations, 1990



• Purchasing power parities

Source: Reproduced from: Organization for Economic Co-operation and Development. OECD Health Systems. Facts and Trends 1960-1991 Paris: OECD, 1993, Vol. 1, p 17, Chart 2.

The basic need which a review body would address is to provide a consistent and timely feedback loop. Informed opinions are essential on whether reform strategies will work, while they are still in the early stages of implementation, along with checks on the progress of strategies recently undertaken. I think of this function as an essential aid to navigation, like lighthouse beacons. Lest the form to follow this function be mistaken for bureaucracy, let us be clear that such bodies should be advisory in scope; consultative and research-oriented in approach; mandated to sort out the complexities of the broad public interest from special or competing interests; and directly accountable to cabinet or to the minister responsible for health.

A few agencies in Canada are already immersed in the intricacies of health and closely related issues, which could bring both an established credibility and an arm's-length perspective. Bearing in mind those criteria, the candidate bodies might well include the federally constituted National Forum on Health, chaired by the Prime Minister; the provincial Premier's councils on health, or a special-purpose office such as Nova Scotia's recently appointed Commissioner of Health Reform; and for certain needs evident at the local level, an evaluation committee of broadly based, volunteer planning advisers such as Ontario's district health councils.

Canadian Values Impacting on the Organization of Health Services

Knowing what a people value and believe in is the key to understanding how they will, or even rationally should, organize their affairs. For example, this could include knowing what principles they will or should espouse, what goals will be pursued, and an indication at least of how they will respond in particular circumstances. What, then, do we value?

Canadians are modestly proud that the United Nations Development Programme (UNDP) again in 1994 declared us to be the most livable country in the world. This is for the second time since the "human development index" was begun in 1990, and puts us ahead of other proudly livable countries like Switzerland and Japan. Among the factors on which the UNDP computes this index are levels and

equality of income, health status, life expectancy, personal safety, and standards of education and literacy.[4] It is noteworthy that these UNDP criteria for assessing quality of life are also, in a separate context, essentially the same as the factors now identified as being the determinants of health. With respect to one other determinant, opinion surveys regularly report that Canadians are anxious to preserve the relatively high quality of our physical environments.

Of course, Canada is far from perfect. We have come to realize that a high quality of life cannot be taken for granted; nor is it consistent with a situation of certain population groups living in inadequate conditions. For example, another cross-national study found that Canada is among those generally well developed countries that have an unacceptable proportion of children at high health risk and living in unacceptable social circumstances, relative to the mainstream population. Children in at least one other G7 nation - France - are less likely to be poor than children in North America, thanks mainly to substantial child-allowance transfers to all parents. In addition, France has developed a fully funded, preschool system for all children from age three, *les ecoles maternelles,* exceeding in scope anything comparable in Canada or the United States.[5] To address such issues and try to "level the playing field," we in Canada have been prepared to address various means towards achieving a degree of equity that has been compared favourably with our neighbour to the south:

> Like Seymour Martin Lipset in *Continental Divide*, which explores the full spectrum of Canadian - U.S. differences, [Robert] Evans concludes that, despite superficial similarities, the two societies are fundamentally different. The US believes, and its system shows, that health care is a purchasable commodity. In most European countries, even with universal insurance, private care (more genteel surroundings, choice of physician, and shorter queues) is also purchasable. Most Canadians, Evans feels, find this belief offensive. They have a deep-rooted suspicion of class-based systems of any kind and are unwilling to accept class-specific medical care because that implies that some people's lives are worth more than others.[6]

Under a constitutional credo of "peace, order, and good government," Canada's three levels of government are charged with maintaining civility ("peace, order"), while operating an affordable social safety net. These measures are well short of democratic socialism but do place a high premium on human rights, equality and fairness, along with self-reliance and competition in the market place. I believe that we try to respect our own and each others' cultures of origin and strive to respect other viewpoints. We could nod in agreement with Governor Christopher Patten, who is held in high regard in Canada, when he reminded Hong Kong's Legislative Council at the opening of its 1994-95 session that: "Cooperation ... is not a one-way street; nor is sincerity to be judged by whether one party always agrees with the other. That is not what the real world is like."[7]

In their second, thorough clarion call for Canadian health reform, Rachlis and Kushner posit that the three essential values for health care in particular are "equity, quality, and informed choice." These are supported by four "instrumental" values, "healthy environments, accountability, efficiency, and citizen participation." All of these are defined in Table 1.

The Fundamental Principles for Canadian Health Services

Next to be considered in the strategic planning framework are the principles espoused for respecting and realizing the values which, as already noted, have been legally articulated and tested over several decades. Primary constitutional responsibility is assigned to our provincial governments. The federal government, through its funding role, has a responsibility to ensure that the system as a whole, called "medicare", is sustained and that the five following fundamental principles are upheld:

Universality

Requires that 100 per cent of the insured persons of a province be entitled to the insured health services provided by the plan, on uniform terms and conditions.

Table 1

Canadian Values for Health and Health Care

Essential values

1. Equity
   - Canadians should have equal opportunity to achieve health and well-being.
   - Canadians should have equal opportunity to receive health services according to their needs.

2. Quality
   - Canadian should enjoy as high a quality of life as possible.
   - Canadians deserve high-quality health care.

3. Informed choice
   - Canadians should be encouraged to make informed choices about their health care.

Instrumental values

1. Healthy environments
   - Public policy should focus on ensuring that all Canadians live in social, economic, human-built and natural environments that enhance health and encourage healthy choices.

2. Accountability
   - Health care providers should be accountable for the public money they receive, including being accountable for the quality of care that patients receive.
   - Citizens should be accountable for their choice of primary care provider.

3. Efficiency
   - Because resources are finite, it is important that health care services are delivered in the most efficient fashion possible.

4. Citizen participation
   - Canadians should be encouraged to participate fully in their own care and the care of their families.
   - Canadians should be able to participate meaningfully in decisions about their health care system.

Source: M. Rachlis and C. Kushner, Strong Medicine: How to Save Canada's Health Care System (Toronto: 1994).

Accessibility

Insured health services must be provided on uniform terms and

conditions, and Canadians must be guaranteed satisfactory access to insured services without any direct or indirect barrier such as extra billing and/or user fees. Accessibility also means that reasonable compensation must be provided for all insured health services rendered by doctors or dentists and that adequate payment must be made to hospitals in respect of the cost of insured health services.

Portability

Ensures that when people take up residence in another province, the province of origin must pay the cost of insured health services during a minimum period of residence, or a waiting period not in excess of three months, imposed by the new province of residence. Portability also means that insured persons who are temporarily absent from their provinces and who receive health services will have those costs paid in accordance with agreed terms and conditions.

Comprehensiveness

The system must deliver all insured health services provided by hospitals, medical practitioners or dentists and, where authorized, services provided by other health professionals.

Public Administration

The provincial system must be administered on a non-profit basis by a public authority appointed or designated by the government of the province and subject to audits of its accounts and financial transactions.[8]

Health Vision and Goals for the Reform Agenda

Based on studies that began with a review of Canada's health values and principles undertaken by the various commissions of enquiry and special review bodies, a range of inadequate health outcomes were identified. Consequently, a reform agenda began to coalesce around a new approach to health and wellness. One of the most significant

wellsprings for this new approach was the World Health Organization conference held in Canada's capital city in 1986. The communique was issued as *The Ottawa Charter*.[9]

Since then, the federal government and the provinces have generally adopted this approach as a matter of policy, based as well on their own fundamental reviews of health status and strategy. Some of these, as for the Province of Ontario, were established as standing advisory panels - think-tanks chaired by the head of government - called Premier's councils. The vision statement and health goals proposed by the Ontario Premier's Council on Health Strategy in 1990 and formally adopted by the Government in 1992 are given in Table 2.

Table 2

Vision Statement and Health Goals for Onterio, 1990

A Vision of Health	Health Goals for Ontario
We see an Ontario in which people live longer in good health, and disease and disability are progressively reduced. We see people empowered to realize their full health potential through a safe, non-violent environment, adequate income, housing, food and education, and a valued role to play in family, work and the community. We see people having equitable access to affordable and appropriate health care regardless of geography, income, age, gender or cultural background. Finally we see everyone working together to achieve better health for all.	1. Shift the emphasis to health promotion and disease prevention. 2. Foster strong and supportive families and communities. 3. Ensure a safe, high quality physical environment. 4. Increase the number of years of good health for the citizens of Ontario by reducing illness, disability and premature death. 5. Provide accessible, affordable, appropriate health services for all.

Source: The Premier's Council on Health Strategy, 1990

Strategic Priorities for Health Reform in Ontario

With these signposts in place, Ontario's Health Ministry followed through the remaining steps for the strategic planning of health reform,

viz., reform principles, goals, directions, priorities and operational initiatives. The ministry's seventeen strategic priorities were outlined in a 1993 progress report, with examples of the initiatives under way for each:[10]

Major programme reviews:
- Hospital reform
- Laboratories review
- Drug benefit reform

Development and implementation of:
- Cancer strategy
- Tobacco strategy
- Community health strategy
- Diabetes strategy
- Substance abuse strategy
- Health human resources strategy

Implementation of :
- Long-term care redirection
- Mental health reform

Equity in:
- Aboriginal health
- Women's health
- Children's health
- AIDS
- Rehabilitation

The New Directions for Health - Not All are "Paradigm Shifts"

Important as these new directions are, the people most closely involved in working with them, and their affiliated chroniclers such as academic departments of health economics and administration, have occasionally been guilty of exaggerating the magnitude and significance of change. Caught up in the excitement of the "third wave," to borrow Alvin Toffler's phrase, we have too often been told that various aspects of health reform are tantamount to a "paradigm shift" that requires moving from one broad, theoretical framework to another. For assessing the real magnitude of change as it progresses, and to keep the various reform initiatives in perspective I believe that we should bear in mind what the paradigms for health have actually been. On the understanding that a paradigm is a theoretical model which

describes a total system - not an operational model, nor one relating to a subsystem - Canadians and most other western societies have progressed through the following health paradigms:

(a) Folk remedies and traditional healers.

(b) Curative and treatment modalities, in a theoretical context stemming from Classical scholars, the Renaissance and industrialization; important aspects included the rise of medical schools and the nursing profession in the nineteenth century.

(c) The public health movement, which began in the late-nineteenth century with a focus on disease prevention through cleanliness in human environments and anti-bacterial agents.

(d) Primary-care providers focused on diagnosing and treating illness, linked to institutional treatment centres drawing on modem science and technology.

(e) The population health approach, focusing on the consumer and a broad definition of health.

Another risk, along with overemphasizing the basis of change, is to lose sight of the fact that each of the above ways of understanding health has evolved from, and built on, that of its predecessors. Hence, a major thrust of the population health approach involves rationalizing the distribution and use of high-tech knowledge and equipment, while re-skilling certain aspects of the work of the dedicated people engaged in the health professions. Change of a lesser order than paradigm shifts should be described, for the sake of perspective, in a hierarchy based on the order of magnitude and significance of change, along the lines of, quantum shifts, internal shifts, and internal adjustments.

Some Trends in the Recent Canadian Changes of Direction

The following are just a few examples of the trends that have begun to emerge in Canada over recent years. The full range has been described

in published reports by all three levels of government and their agencies, and only a bare sampling of these are mentioned here. Along with official documents are several published commentaries and "prescriptions" for change by independent authorities. Of these, almost all betray a fondness for health analogies or puns in their titles, notably Second *Opinion* (1989) and *Strong Medicine* (1994) by Michael Rachlis and Carol Kushner.[11]

Broadening the Base of Planning and Management

There is a trend towards favouring devolution of planning and management from the central government authorities to local agencies. Genuine devolution should not be confused with the often controversial and politically motivated inclination to "decentralize" the bureaucracy. Devolution involves a significant transfer of power and authority to local or regional bodies, ideally with a meaningful consumer involvement. Table 3 surveys recent experience in the health sphere across this country and in four others. Table 4 outlines Ontario's present approach to sharing the responsibilities for policy development and implementation between different levels of the Ministry of Health (MOH), district health councils (DHCs) and front-line providers.[12]

Altering the Economic Equation

During the era of high growth in facilities and practitioners that lasted through the 1970s and 1980s, the economy was expected to sustain enormous increases in the treatment and curative subsystems, such as double-digit annual rates of increase in spending on hospital operations. As a consequence, Canada has the second-highest per capita spending on health among twenty-four OECD countries, second only to the United States (Fig. 2). This contributed to high accumulated budgetary deficits for the national and provincial governments, leading to retrenchment measures at both levels.

The federal government thus far has largely confined itself to unilateral rollbacks of its cost-sharing commitments, without viable restructuring solutions, thus further "downloading" the problem to the

Table 3

Devolution by Area of Authority, Hierarchical Body and Jurisdiction

AREA OF AUTHORITY*	JURISDICTION										
	Ontario 1992	B C # 1993	Alberta # 1989	Saskatchewan 1992	Québec 1991	New Brunswick 1992	Nova Scotia 1990	Sweden 1983	Finland 1972	New Zealand 1990	United Kingdom 1990
Central Body											
Planning	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Management	yes	yes	yes	yes	yes	yes	yes	no	yes	yes	no
Delivery	yes	yes	yes	yes	yes	yes	yes	no	no	no	no
Funding/Allocation	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Revenue Gereration	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Governance	elected	elected	elected	elected	elected	elected	elected	elected	elected	elected	elected
Regional Body		RHB	HA	-	RHSSA	RB	RHA	County	-	AHB	RHA'S
Planning		yes	yes		yes	yes	yes	yes		yes	yes
Management		yes	yes		yes	yes	yes	yes		yes	yes
Delivery		yes	yes		no	yes	yes	yes		yes	no
Funding/Allocation		yes	yes		yes	yes	yes	yes		yes	yes
Revenue Gereration		yes	no		no	no	no	yes		no	no
Governance		appointed	elected		elected	appointed	appointed	elected		appointed	appointed
Local Body	DHC	CHC	-	HD	CLSC	-	-	Municipal	Municipal	-	Trusts
Planning	yes	yes		yes	yes			yes	yes		yes
Management	no	yes		yes	yes			no	yes		yes
Delivery	no	yes		yes	yes			yes (elderly)	yes		yes
Funding/Allocation	no	yes		yes	no			yes	yes		yes
Revenue Gereration	no	no		yes (potential)	no			yes	yes		no
Governance	appointed	elec'd/appt'd		appointed	appointed			elected	elected		appointed

* The difficulty in classifying the various models as "yes" or "no" for the functions listed is that only in rare instances is the answer absolute
The division of functions is blurry at best and characterized by constant shifting and evolution

\# Proposed, but not yet implemented

Source: Vandna Bhatia and Stephen Dibert, *Devolution and Decentralization of Health Care Systems A Review of Models* Ontario: Premier's Council, 1993

Table 4

Policy Development and Implementation Framework

What \ Who	Government MOH	Health Strategies Group MOH	Operations MOH	DHCs	Providers
Strategy policy	Lead	Support	Support	Support	Support
Planning framework	Support	Lead	Support	Support	Support
Implementation plan	Support	Support	Lead	Support	Support
Local/regional planning	Support	Support	Support	Lead	Support
Local service delivery Support	Support	Support	Support	Lead	

provinces. Facing the challenge, in 1992-93, health expenditure by the Ontario government was still about one-third of its total spending and were confined to an increase of less than one per cent. Weaning health services off dependencye on economic growth over the longer term will continue to call for creative solutions, many to be identified by local planning partners. Other measures will involve quantum re-arrangements in services' funding and payments. For example,

> Over the past twenty years a mountain of research has indicated that fee-for-service as a method of paying doctors increases overall costs by 20 to 40 percent with no clear benefits to patients.[13]

Progress in resolving the economic conundrums of health human resources groups is much less advanced than the rationalization of facilities and services. Through their mandate for comprehensive planning at local and regional levels, as noted above, and with

representation from consumers, providers and municipalities, DHCs are bringing volunteer and staff leadership to cooperative studies which address the health needs and priorities of their communities.[14]

Reaching Beyond the Traditional Boundaries to Enlist New Partners

A close look at the second and third Ontario health goals shown in Table 2 above, reveals that they, too are based on important determinants of health. Also, they encompass spheres of political and bureaucratic influence that are outside the usual purview of health authorities, with the occasional exception of a "super-minister" responsible for more than just the health portfolio. Bridging the solitudes between health on the one hand and other public sectors such as the physical environment, social services, land-use planning and education on the other, has thus far been a major stumbling-block in coming to grips with the health determinants rooted in those fields. This is despite the case that they are all, like health, constitutionally the prime responsibility of the provinces.

Some important work was initiated to assess the nature and dimensions of how those determinants do in fact create impacts on health, including both positive well being and illness. In some provinces, planning and research bodies such as premier's councils which cross-ministerial boundaries have pulled together expert panels to investigate and make recommendations.[15] Joint follow-up action, however, has been slow to materialize.

On the plus side, health is one of fourteen Ontario ministries required to post a "Statement of Environmental Values", under the newly enacted *Environmental Bill of Rights,* indicating how they will take account of physical environment issues in their decision-making. The Ministry of Health has also recently begun to acknowledge the need to establish lateral links between the policy "islands", through a community health framework project. Figure 3 outlines the cyclical planning and decision-making process that has been devised to begin to address the environmental, social and economic determinants. This is undoubtedly a creative approach with significant potential. Under this scheme, quite creditable priority projects are now under way and include:

(a) the community health profile project:
- to develop the guidelines, tools and procedures communities will use to measure their health status and develop their health profile;

(b) the population health promotion project:
- to develop a provincial plan for a population health promotion system;

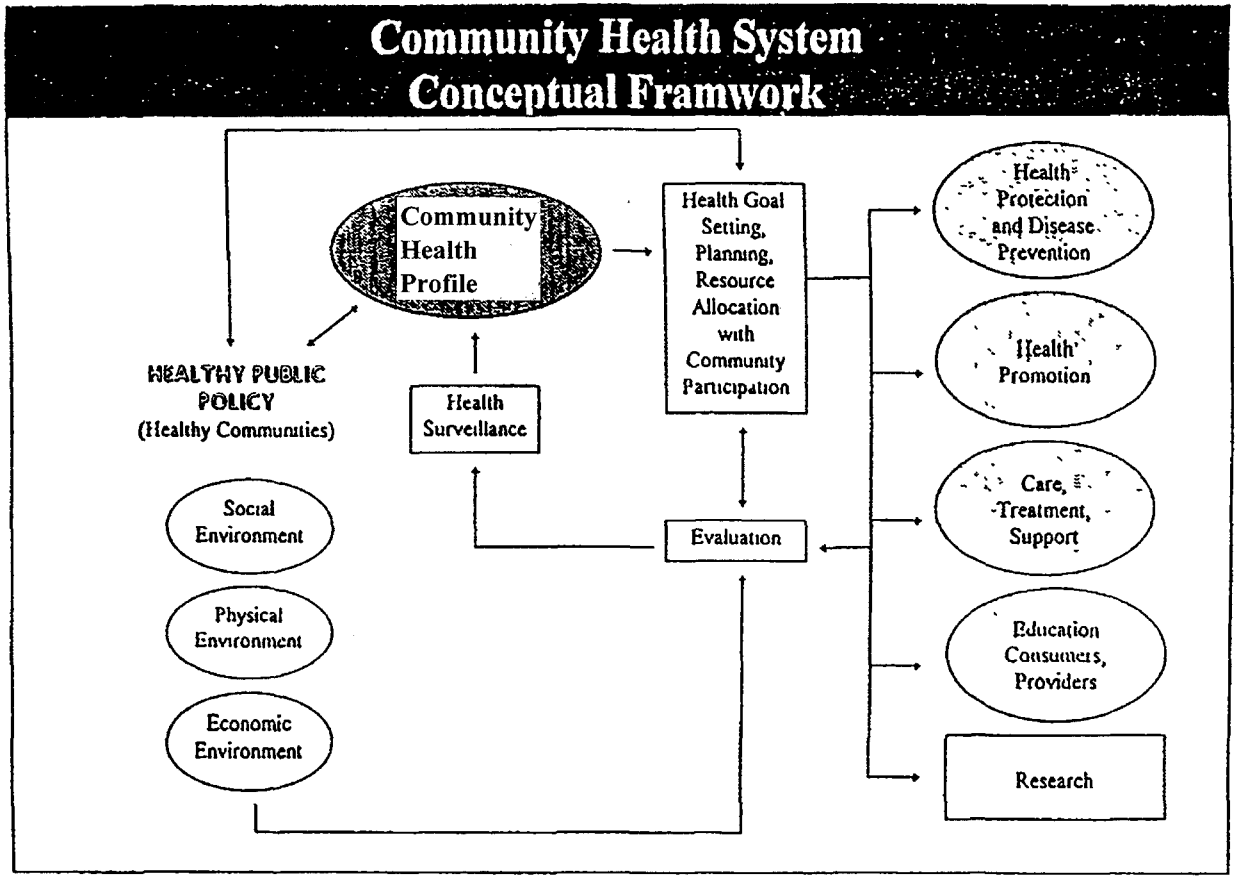
(c) the primary health care models project:
- to develop different ways to deliver primary health care, building on Ontario models such as CHCs;

(d) the funding methodologies project:
- to develop funding models that Ontario can use to ensure that it is distributing its health resources fairly and in a way that will have a positive impact on health;

(e) the system integration and coordination project:
- to identify ways to strengthen coordination of service delivery within a community health system.

These priorities do reflect, however, that processes for building bridges to other ministries have not yet begun. Part of the problem is a reluctance for politicians and civil servants to stray off their own traditional "turf", especially with so many complex reform priorities that are clearly their own to oversee. Those other fields are not only terra incognita for health people, but also realms having their own internal corporate cultures and ways of doing things. For example, public education has an extra layer of politicians at the municipal level. Social services providers and special-interest groups seem to be excessively confrontational in airing their differences. Environmental battles are often fought with the gloves off by highly motivated public defender groups against titanic private interests; and land-use planning can be similarly controversial. Michael Valpy of T*he Globe and Mail* once quipped that in Ontario's rural Grey County, "land-use planning is a blood sport."

Figure 3 The planning cycle



Source Ontario Ministry of Health (1994)

There is no shortage of opportunities to experiment with initiatives that seem to cry out for partnerships between the health sector and one or more others. Two further examples from Ontario emphasize this point. First, the urgent need to replace antiquated biomedical waste facilities was identified several years ago; and second, a large, natural moraine area of ground-water recharge just north of Toronto is in the early throes of a vital planning exercise.

Peer Review and Practitioner Benchmarking

This grouping of initiatives falls into the category of "working smarter, not harder" and at the same time improving the quality of services delivered, by cooperating with one's peers (institutions or solo practitioners) to determine best practices. This has evolved through formal channels as nation wide or provincial accreditation standards for certain facilities such as hospitals and for locally based services such as public health units. Other approaches of a more individual nature for institutions, notably total quality management or continuous quality improvement (TQM/CQI) have involved self-help systems to refocus the organization in tune with the needs of its clients.

Among the strengths of the TQM/CQI approach, along with a service-quality and consumer focus, are its emphasis on research into operational processes, and analysis of performance and outcome data. These features were rigorously incorporated into "a wake-up call for Ontario's health care system" published this year by the Institute for Clinical Evaluative Sciences. The Institute is a cooperative venture of the medical profession, the University of Toronto Medical Faculty and the provincial health ministry, with cooperation from others such as the Ontario hospital and DHC associations. The first edition of the institute's *Practice Atlas*[16] employed scientific methods to discover clinical trends and variations in physician and hospital based procedures. Selecting one procedure as an example, orchidectomies - surgical castration in response to advanced prostate cancer — increased by 55 per cent over the ten years from 1982 to 1992, despite the fact that:

> new hormonal therapies for treating prostate cancer have reduced the risks of cardiovascular side effects without loss of efficacy. However, these new drugs have not led to a decrease in the age-adjusted rate of bilateral orchidectomy. We have also observed wide variability in the rate at which orchidectomy is used to treat prostate cancer by regions in the province.[17]

Specific variations are often perplexing, such as the statistical spread, or "drift" of 41 per cent between the hospital groups for the six local municipalities within Metropolitan Toronto, reporting rates from 93.1 orchidectomies per 100,000 men aged 50 and over, to a high of 131.7. Moreover, the City of Ottawa, with a similar mix of university-affiliated teaching as well as community hospitals, had a much lower rate of 52.7. Far from being a finger-pointing exercise, however, even though in this instance "practice styles appear to be the most likely explanation" for the differences, findings such as these and other examples (Table 5) are intended to encourage discussion between physicians, hospitals and consumers with the prospect of practice guidelines emerging. A guidelines' approach will, of course, inform and enhance practitioners' and hospitals' clinical judgements, rather than interfere intrusively.

Lighting the Beacons

Evaluation serves as a lighthouse, guiding the way and warning of hazards. The hospital and medical sectors are to be commended for taking the lead, via the Institute for Clinical Evaluative Sciences in their frequently provocative demonstration of public review and accountability. They have set high standards for peer review protocols and functions, which should be encouraged more broadly. The many and complex responsibilities for mobilizing changes to a whole population's health outcomes deserve similarly rigorous feedback. This should be undertaken while the change process is unfolding, not afterwards.

Table 5

Selected Surgical Procedures (Province of Ontoria): Percentage Change in Use of Services, 1981/82 - 1991/92

Total hip replacement	86%
Total knee replacement	371%
Abdominal aortic aneurysm repair	42%
Carotid endarterectomy	-19%
Peripheral vascular disease procedures	-23%
Coronary artery bypass graft surgery	48%
Cholecystectomy	6%
Primary appendectomy (positive primary)	-18%
Incidental appendectomy	-66%
Radical prostatectomy	333%
Orchidectomy	55%
Transurethral resection of teh prostate	-0.2%
Hysterectomy	-15%
Cesarean section (per 100 deliveries)	-5%

Source: *ICES Practice Atlas, Highlights*, 1994

NOTES

1. Hon. Perrin Beatty, in A. Bennett and O. Adams eds., *Looking North for Health: What We Can Learn from Canada's Health Care System* (San Francisco: 1993), p.31.
2. C.D. Naylor, G.M. Anderson and V. Goel, eds., *Patterns of Health Care in Ontario* (Ottawa: Canadian Medical Association, 1994).

3. The WHO definition: "Health is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and on the other hand to change or cope with the environment. Health is therefore seen as a resource, for everyday life, not an objectice of living; it is a positive conception emphasizing social and personal resources as well as physical capacity."
4. Peter Cook, "The Worst Country, Aside from All Others," *The Globe and Mail*, 1 June 1994; and "Emerging Market Indicators," *The Economist*, 6 June 1994, p.110.
5. Carol Kushner, personal communication, 1994.
6. Eugene Vayda, book review of A. Bennett and O. Adams, eds., in *Journal of Public Health Policy*, Vol. 14, No.4 (1993), pp.495-499.
7. *Hong Kong: A Thousand Days and Beyond. Address by the Governor, the Right Honourable Christopher Patten, at the Opening of the 1994/95 Session of the Legislative Council, 5 October 1994* (Hong Kong: Government Printer, 1994), p. 34.
8. B. Porter, et al., *The Health Care System in Canada and its Funding: No Easy Solutions*. Report of the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, June 1991.
9. The World Health Organization, Health and Welfare Canada, the Canada Public Health Association, *Ottawa Charter for Health Promotion* (Ottawa: 1986).
10. Ontario, Ministry of Health, *A Healthier Ontario: Progress in the '90s* (Toronto: Queen's Printer for Ontario, 1993), pp.14-32.
11. Michael Rachlis and Carol Kushner, *Strong Medicine: How to Save Canada's Health Care System* (Toronto: 1994) and *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix it* (Toronto: 1989). See also M.B. Dexter, *Healing Medicare: Managing Health System Change the Canadian Way* (Toronto: 1994)
12. Association of District Health Councils of Ontario and the Ministry of Health, *Moving Forward: Strengthening Health Planning in Ontario* (Toronto: Report of the Joint Task Force to the Minister of Health, 1993), p.39.
13. Rachlis and Kushner, 1994, op. cit., p. 54, supported by citations.
14. For example, Essex County DHC, *The Essex County "Win-Win" Model: An Evolving Plan for Total Health System Reconfiguration* (Windsor: 1994).
15. See, for example, Ontario Premier's Council, *Our Environment, Our Health, Healthy Ecosystems, Healthy Communities, Healthy Workplaces*: Report of the Goal Three Working Group (Toronto: Queen's Printer for Ontario, 1993).
16. Naylor et al., op. cit.
17. Ibid., pp.111-115.

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