

ORGANIZATIONAL BEHAVIOUR IN TIMES OF FINANCIAL
RESTRAINT: A POLICY ANALYSIS OF THE IMPACT OF THE ECONOMIC
STABILIZATION PROGRAM ON HOSPITALS IN THE LOWER MAINLAND OF
BRITISH COLUMBIA

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Kevin Michael Mercer

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APPROVAL

Name: Kevin M. Mercer

Degree: Master of Arts

Title of Thesis: Organizational Behaviour in Times
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of British Columbia

Examining Committee:

Theodore H. Cohn (Doctor)
Chairperson

Patrick J. Smith (Doctor)
Senior Supervisor

Arthur M. Goddard (Doctor)

Gloria M. Gutman (Doctor)
External Examiner
Coordinator, Gerontology Program
Simon Fraser University

Date Approved: August 10, 1984

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ORGANIZATIONAL BEHAVIOUR IN TIMES OF FINANCIAL RESTRAINT:
A POLICY ANALYSIS OF THE IMPACT OF THE ECONOMIC
STABILIZATION PROGRAM ON HOSPITALS IN THE LOWER
MAINLAND OF BRITISH COLUMBIA

Author:

(signature)

KEVIN MICHAEL MERCER

(name)

SEPT. 7 / 84

(date)

ABSTRACT

This thesis is a study of the effect of the B.C. provincial Economic Stabilization program on hospitals in the lower mainland of the province. The E.S. program was introduced by the provincial government as a policy directed at restraining the growth of public sector budgets. Over the years 1982-83 and 1983-84, the thesis examines, by means of Etzioni's systems theory, the changes implemented in hospital operations as a response to the E.S. policy. The operating budgets for the years 1982-83 and 1983-84 are compared to the pre-restraint year 1981-82 for nine hospitals in the lower mainland.

The thesis seeks to demonstrate through the use of organizational theory, that hospitals as bureaucratized institutions, will resist long term change. Chapter II of the thesis outlines the historical development of health care in Canada and describes this development in terms of three predominant themes. Those themes are:

- (i) The historical development of federal-provincial relations with respect to health care policy;
- (ii) The cost patterns of delivering health care services;

and

- (iii) Lifestyle issues and their influence on the health care organization.

Through a discussion of these three themes and A. Downs' ossification syndrome, the paper illustrates the bureaucratization and institutionalization of the present day hospital.

The thesis next tests the hypothesis that hospitals are resistant to change in the short term by examining the effect of the E.S. program on nine hospitals in the lower mainland of B.C. The staffing statistics are compared for the pre-restraint and post-restraint periods. Interviews are also conducted with hospital officials in order to define the changes in hospital operations as a result of restraint.

The analysis and conclusion of the thesis presents a discussion on differing types of organizational change and the effect of reduced funding on the health care organization and on the quality of health care services delivered. The specific findings of this paper indicate that of the hospitals surveyed, two-thirds experienced financial restraint. These hospitals responded to the restraint by implementing bed closures and staff reductions. The actions of the organizations experiencing restraint are analogous to organizations operating in a crisis situation.

Dedicated to my wife,
Cathy,
and to my sons,
Christopher and Andrew

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TABLE OF CONTENTS

Approval	ii
Abstract	iii
Dedication	v
Acknowledgements	vi
List of Tables	viii
List of Charts and Figures	ix
Chapter I : Introduction	1
Chapter II : The History of Federal-Provincial Health Care in Canada and its Effect on the Health Care Organization	37
The First Phase 1867-1945	40
The Second Phase 1945-1977	53
The Third Phase 1977 to the Present	75
Chapter III: The Methodology for Analyzing the Impact of the E.S. Program on Hospital Operations	100
Chapter IV : Findings	113
Chapter V : Analysis	161
Chapter VI : Conclusion	173
Appendices	178
Bibliography	195

LIST OF TABLES

Table A:	Provincial Health Insurance Plans: Extra Billing/User Charges by Hospital	96
Table B:	1982-83 Funding Increases in Operating Budgets from Hospital Programs	118
Table C:	The Percentage Change in Hospital Beds Classed as Open for 1982-83 Compared to 1981-82	121
Table D:	Comparison of Minor to Major Changes for Hospitals Receiving a Budget Increase of Less Than 9.9% in 1982-83	125
Table E:	Comparison of Minor to Major Changes for Hospitals Receiving a Budget Increase of 12% or Greater in 1982-83	127
Table F:	Hospitals Receiving Budget Increases in 1982-83 Less Than 9.9% Over the 1981-82 Level	128
Table G:	Hospitals Receiving Budget Increases in 1982-83 Greater Than 12% Over the 1981-82 Level	130
Table H:	Changes in Staffing for Hospitals Receiving a Budget Increase of 9.9% or Less in 1982-83	137
Table I:	Changes in Staffing for Hospitals Receiving a Budget Increase of 12% or Greater in 1982-83	145
Table J:	Changes in Staffing for Hospitals Surveyed for the Nine Months Ending Dec. 31, 1983	153
Table K:	Changes in Staffing by Department	159
Table L:	Change in the Number of Beds Classed as Open for the Time Period Mar. 31, 1983 to Dec. 31, 1983	160

LIST OF CHARTS AND FIGURES

Charts

Chart I	: Real Economic Growth B.C. and Canada	2
Chart II	: Employment Growth B.C. and Canada	3
Chart III	: Natural Resource Revenues	7
Chart IV	: The Bureaucratic vs The Adaptive System of Organizational Structure	17
Chart V	: Administration and Payments to Hospitals	103
Chart VI	: Typical Organizational Chart of a General Hospital	115
Chart VII	: Typical Organizational Chart of an Extended Care Hospital	116

Figures

Figure 1	: Lifestyle/Health Status Model	99
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Chapter I

Introduction

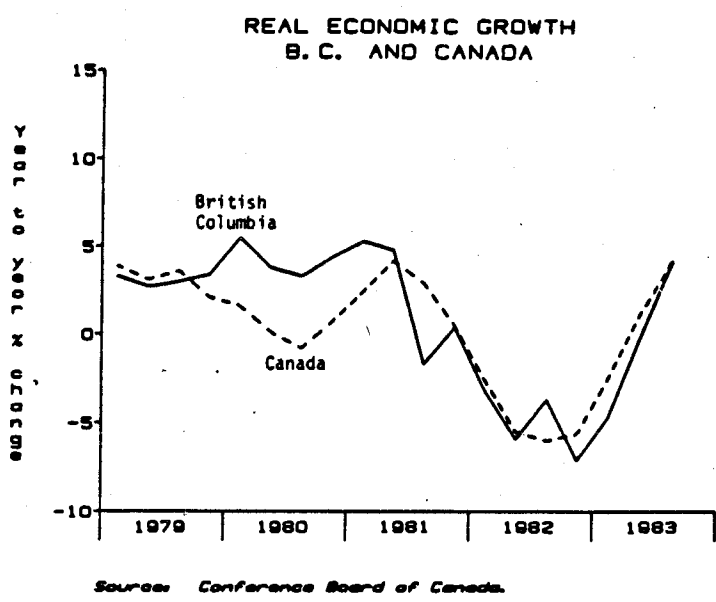
British Columbia, like the rest of Canada, has experienced the recessionary ills of high unemployment and low economic growth in the early part of this decade. The unemployment rate in British Columbia for January 1983 was 16.1% and the Canadian average for the same time period was 13.7%.¹ Real economic activity declined significantly during this recessionary period. In 1982, real economic activity in British Columbia decreased 6.17% from the 1981 level.² A review of the employment and economic growth trends (in Charts I and II below) clearly reveal that 1982 was the most depressed year in this recent economic recession. The charts also indicate that during this recession, British Columbia has experienced greater economic hardship than the Canadian average during 1982, particularly in terms of employment growth.

¹Public Employers of British Columbia, Vol. 6 (Oct./Nov., 1983), p. 34. Charts I and II indicate this was the most depressed time period of the recession.

²Province of B.C., Ministry of Lands, Parks and Housing, Housing Quarterly, (Dec., 1983), p. 1.

Chart I

Real Economic Growth
B.C. and Canada³



³Province of B.C., Ministry of Lands, Parks and Housing, Housing Quarterly, (Dec., 1983), p. 1.

Chart II

Employment Growth
B.C. and Canada⁴



Source: Statistics Canada.

⁴Province of B.C., Ministry of Lands, Parks and Housing, Housing Quarterly, (Dec., 1983), p. 3.

The fact that the economic hardship experienced in British Columbia is higher than the Canadian average is largely due to the nature of the province's economy. The B.C. economy is primarily based on the activities of the extractive industries of lumbering, mining and fishing. Manufacturing and agriculture are not strong economic activities in the province. The biases towards the extractive industries have been attributed by G. Galbraith to the early historical habitation and development of the province.

The mountainous terrain gave rise to the province's mining industry, its first source of wealth. This feature, the exposed and nearly exposed seams of ore, first brought British Columbia to the world's attention. The seaside location of the coastal parts of the province meant rains, which in turn meant vast forests of valuable timber, and fish...

...it required the advanced technology and the sophisticated organization of the Europeans to fully exploit the natural resources of British Columbia.

Large fish canneries, forest firms and mining and ore processing firms came to control the British Columbia economy and provided employment for large numbers of manual and clerical workers and ancillary business for lawyers, merchants, and various types of small commercial enterprise.⁵

⁵Gordon S. Galbraith, "British Columbia", The Provincial Political Systems: Comparative Essays, eds. D.J. Bellamy, J.H. Pammett, D.C. Rowat (Toronto: Methuen, 1976), p. 63.

Galbraith further explains that the physiographic conditions of British Columbia have never allowed it to become as agriculturally strong as other regions of Canada.⁶

The dependence of the British Columbia economy on the primary industries has also meant a dependence on external markets. The decline in demand by external markets for lumber and metallurgical products caused the major extractive industries to cut back operations in the province. A recent 1983 provincial report on provincial economic activity stated the following with respect to mining:

The mining industry in B.C. this year benefitted from higher average prices for some metallic minerals such as copper, compared with a year ago. Nevertheless, overall production activity is still very depressed compared with a few years ago because of global overcapacity and low levels of industrial demand. A number of existing mines remain closed and major new metal mine developments are on hold pending further improvements in market conditions.⁷

⁶Ibid., p. 64.

⁷Province of B.C., Ministry of Lands, Parks and Housing Housing Quarterly, (Dec., 1983), p. 2.

Lumbering in British Columbia has also improved in 1983 over depressed 1982 levels due to an increase in external market demand.

Total B.C. lumber production should exceed 12 billion board feet in 1983 - up 22 per cent over the depressed levels of 1982.⁸

Chart III also indicates that revenues from the forestry sector are to increase in 1983-84. The 1982 levels of production in both the lumbering and mining sectors will be recorded as the lowest experienced in recent years.

The provincial government realized in 1982 that the reduction in primary industrial activities would mean a substantial reduction in revenues from resource taxation. The actual and estimated natural resource revenues reductions are cited in Chart III. As can be clearly seen from the chart, revenues from natural resources decreased drastically in the years 1981-82, 1982-83 and 1983-84 in comparison to the growth noted in 1978-79, 1979-80, and 1980-81. Expenditures though, for public programs in 1982, were estimated to increase.⁹ With an equation of reduced revenues to

⁸Ibid., p. 1.

⁹The 1981-82 estimates for health costs alone for example, were calculated to increase from \$795,254,313 in 1980-81 to \$1,043,175,935 in 1981-82. An increase of over 20%.

Natural Resource Revenues¹⁰
(\$ millions)

	<u>1978/79</u>	<u>1979/80</u>	<u>1980/81</u>	<u>1981/82</u>	<u>1982/83p</u>	<u>1983/84e</u>
Forests	351.7	632.4	291.2	99.4	85.7	131.0
Petroleum and Natural Gas	382.0	587.5	415.7	356.9	228.8	179.0
Other*	<u>62.5</u>	<u>98.1</u>	<u>155.5</u>	<u>142.1</u>	<u>229.4</u>	<u>215.6</u>
Total	796.2	1,318.1	862.4	598.4	544.0	525.6

p Preliminary Actual

e estimate

* Other includes fees and licences under the provisions of the Wildlife Act, water rentals and recording fees and minerals.

¹⁰Province of B.C., "Restraint and Recovery: The Next Steps" (Victoria, B.C., 1983), p. 5.

manage increasing program costs, the province decided to implement policy measures to control government expenditures.

On February 18, 1982, Premier W.R. Bennett announced the introduction of a public sector financial restraint program entitled The Economic Stabilization Program (hereafter referred to as the E.S. program). The program contained the following directives:

1. Operating expenditures of the province shall not exceed 12 per cent growth over actual expenditures in 1981/82.
2. Expenditures by major program shall not exceed 12 per cent.
3. Ministries may vary in growth in grants to various institutions within a program.
4. Municipal operating expenditures may not exceed 12 per cent growth over 1981/82 expenditures, except with approval of the Inspector of Municipalities.
5. School boards in total may not exceed a growth rate of 12 per cent over their previous fiscal year, beginning September, 1982.

6. Educational tax on residential properties shall be restricted during 1982.¹¹

The E.S. program was viewed by the Bennett government as an effective means to restrain the growth of public programming budgets. The facts to date though, reveal that the government did not strictly adhere to the directive of 12% maximum growth in operating budgets. The Ministry of Human Resources for example, increased their expenditures in 1982-83 by 33% more than their 1981-82 budget.¹² In health care, there was an increase of only 7.3% in the 1982-83 budget over the 1981-82 budget.¹³ The Consumer Price Index for 1982 was 10.5% and for 1983 was 5.5%.¹⁴ It would seem arguable that the government established a program priority system independent of the E.S. program. The one element of the E.S. program which was adhered to though, was The Compensation Stabilization Program (hereafter referred to as the C.S. program). The C.S. program was created as a sub-program of the E.S. program. The purpose of the C.S. program was to restrict compensation

¹¹Government of British Columbia, "Highlights of the Economic Stabilization Program", (B.C., 1982), p. 1.

¹²Province of British Columbia, "Restraint and Recovery: The Next Steps", (Victoria, B.C., 1983), p. 5.

¹³Ibid., p. 16.

¹⁴Government of Canada, The Consumer Price Index, (Dec., 1983, Statistics Canada) p.1.

to labour, as manpower costs are the largest expense item in public sector budgets.¹⁵ The C.S. program restricted wage increases in 1982 to 10% with a possible plus or minus 2% for experience and a further 2% for increases in productivity.¹⁶ The July 7th, 1983 provincial budget has amended this compensation level to a maximum of plus 5%.¹⁷ The commissioner of the C.S. program, Mr. Ed Peck, has been responsible for reviewing all public sector compensation settlements to ensure that they are within the guidelines established by the C.S. program.

At an Institute of Public Administration of Canada (I.P.A.C.) conference on "Public Administration in a Time of Inflation and Restraint", Mr. Larry Bell, the provincial Deputy Minister of Finance, outlined the rationale supporting the government's restraint policy. The E.S. program, according to Mr. Bell, was directed at restraining the growth of expenditures in the public sector operating, capital, and construction budgets. The need for restraint was a result of projected losses in provincial revenues

¹⁵Chapter IV will demonstrate this point in terms of health care budgets. See p.123.

¹⁶Government of British Columbia, "Notes for an Address by the Honourable William R. Bennett on Strengthening the British Columbia Economy", (Feb., 1982).

¹⁷Province of British Columbia, "The Budget Speech of the Honourable W.R. Bennett", (July, 1983).

and the government's unwillingness to support deficit financing.¹⁸ Education and health care officials have been extremely vocal about the effects of the E.S. program on operations. The media has conveyed testimonials by public officials regarding the reduction in quality of service due to the cut in funds to health care and educational institutions.¹⁹ For example, on August 19, 1982, the Coquitlam Today published such a testimonial. The following is an extract:

Concern over the quality of health care offered local residents prompted Coquitlam's council's decision

¹⁸Statements made by the Deputy Minister of Finance in a speech at the April 19, 1982 I.P.A.C. conference on "Public Administration in a Time of Inflation and Restraint", (Vancouver, B.C.).

¹⁹The Vancouver Sun, Editorial Section (June 26, 1982). "The government's policy of underfunding medical care will cost us much more than it will save. More than a week ago I put a very urgent patient on a waiting list, one who would have been admitted within one or two days a couple of years ago. She will not die if not admitted, so I cannot call it an emergency. She can still walk but with rapidly increasing difficulty because of pressure on the spinal cord in the neck. If treated, she may continue walking..." (Dr. C.A. Simpson).

to send a letter to Health Minister Jim Nielson about the "drastic" hospital funding cutbacks.

...the elimination of 25 staff members at Queen's Park Extended Care Hospital will "seriously affect the well-being of the residents".²⁰

Similar statements have been made with respect to the educational system, but this paper is concerned only with the health care component. One of the issues this thesis will address is the question of whether or not there is any validity in statements of quality change with respect to the health care component of the public sector.

This thesis will also address the question of whether organizational change has resulted from the E.S. program. The literature on organizational theory would indicate that hospitals as organizations, will be resistant to change. As noted by F. Rourke:

This tendency of established organizations to become wedded to routines and resistant

²⁰The Coquitlam Today, "Grave Concern Expressed Over Hospital Cutbacks" (Aug. 10, 1982).

to change has frequently been used to justify the creation of new institutions to administer innovative programs.²¹

The thesis of this paper predicts that financial restraint will cause minimal change to hospital organizational structure and methods of production. In fact, in economic terms, restraint will cause short to intermediate run decisions as opposed to long run decisions. Short/intermediate run decisions include those decisions "in which the inputs of all factors of production may be varied but in which the basic technology of production is unchanged".²² Long run decisions are those decisions "in which the technological possibilities open to the firm are subject to change".²³ This paper maintains that hospitals will have implemented short/intermediate run decisions which resulted in changes in level of operations and not changes in production methods or technological processes (this would include structural adaptation). The decisions relating to changes in hospital operations as a response to financial

²¹F.E. Rourke, Bureaucracy, Politics, and Public Policy (Little, Brown, and Co., Canada, 1976), p. 92.

²²R. Lipsey, G. Sparks & P. Steiner, Economics (New York: Harper & Row, Publishers, 1973), p. 180. The authors discuss the difference between short, long and very long run decisions. In this paper, short and long have been treated as short/intermediate and very long has been treated as long.

²³Ibid., p. 180.

restraint are tied to the level of funding which the hospital receives and would be reversed if funding was returned to the pre-restraint level. More sustained, permanent organizational changes in production methods, technology utilized and organizational structure will not result from the E.S. program. The rationale supporting this hypothesis is that hospitals, like most contemporary social organizations, are highly structured, bureaucratic organizations which are resistant to change.²⁴ Hospitals will resist any environmental change requiring a significant change in their traditional behavior. A. Downs refers to this organizational resistance to change as "inertia".

²⁴See C.A. Meilicke and J.L. Storch, eds. Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends (Ann Arbor: University of Michigan, 1980). In the introduction, the editors discuss the bureaucratic state of the health care delivery system and the likelihood that social services will become increasingly bureaucratized in the future. "Indeed the signs indicating that the fifth era may be characterized by increased bureaucratization of social security programs are so clear that one wonders whether the near future may not see a need for major efforts to correct the problems which are so often the result of rapid growth in organizational size and complexity." p. 14.

Organizations, like individuals, are reluctant to accept any change in their environment - whether good or bad - as permanent if such acceptance would require them to make significant alteration in their customary behavior patterns. It is usually more rational to continue these behavior patterns while conducting an intensive search to see whether the old status quo ante will return. Hence the costs of readjusting behavior patterns create a certain discontinuity of behavior at the level to which the organization or individual has become accustomed. This characteristic is commonly known as inertia.²⁵

Downs further states that organizations which have experienced rapid growth also experience a bureaucratization process known as the "rigidity cycle".

The first phase of the rigidity cycle occurs when an operating bureau (or set of bureaus) greatly expands. The larger it gets and the faster it grows, the more likely it is that the entire cycle will occur.²⁶

²⁵A. Downs, Inside Bureaucracy (Boston: Little, Brown and Co., 1967), p. 174.

²⁶Ibid., p. 158.

Hospitals have been reknowned for their rapid growth since the second world war. The next chapter will outline the history of the health care system in Canada and will demonstrate that the historical/contextual factors influencing hospital development have resulted in the bureaucratization, institutionalization and rigidity in organizational structure in Canadian hospitals. The result is that hospitals as organizations, more closely parallel the bureaucratic model as opposed to the adaptive model. The bureaucratic model is characterized by "impersonal; ascribed roles and rules, rational efficiency, rigid hierarchical structure, mainly vertical communications and specificity of tasks and expectations".²⁷ The adaptive model is the opposite to the bureaucratic model and is characterized by "personal involvement, achievement oriented, adaptive efficiency, continual adjustment and redefinition of individual to achieve the shared group task,...".²⁸ Chart IV compares the differing characteristics of the bureaucratic and adaptive models. One must remember when comparing the bureaucratic and adaptive models that there is the possibility of an organization being predominantly bureaucratic and having

²⁷See Chart IV.

²⁸See Chart IV.

The Bureaucratic System

Impersonal; ascribed roles and rules, rational efficiency, rigid hierarchical structure, mainly vertical communications, specificity of tasks and expectations. (Weber's model, McGregor's "Theory X", Goulder's "punishment-centred bureaucracy", Argyris's "directive leadership", Shepard's "mechanistic systems".

Effective for handling complex stable processes, dispensing justice to definable classes of persons in identifiably similar circumstances and providing secure careers for persons with identifiable qualifications. Essential in public or semipublic sectors of a mass society as an impartial, efficient instrument of a large number of taxpayers or shareholders. Deficient in adaptability, in flexibility, in tempering policies to particular cases, and in coping with emergencies or unexpected contingencies.

The Adaptive System

Personal involvement, achievement oriented, adaptive efficiency, continual adjustment and redefinition of individual task to achieve the shared group task, lateral and vertical communications with an emphasis on consultation rather than direction.

(McGregor's "Theory Y", Burn's and Stalker's "organic systems", Goulder's "mock bureaucracy".

Effective for coping with change, innovation, and critical situations, and providing a means of personal expression and responsibility. In its extreme form may lead to some anxiety for those who find the lack of definition and security a strain, and may encourage dysfunctional opportunism.²⁹

²⁹Cyril Sofer, Organizations in Theory and Practice (New York: Basic Books Inc., 1972), p. 294.

adaptive characteristics, and vice versa. What is emphasized here is that the hospital, because of its historical evolution, has organizational characteristics which more closely align the bureaucratic model.

Evidence will be set out in the thesis to support the contention that the hospital has developed in conformity with Downs' ossification syndrome in providing health services in British Columbia. It is the intent of this thesis to examine and analyze the changes implemented by hospitals as a response to the E.S. program in British Columbia. The purpose of this analysis is to determine whether financial restraint has caused changes in levels of operation or changes in production methods and organizational structure. The research will determine if organizational changes resulting from the restraint program are significant or minimal. It will also allow for examination of the effect of restraint on quality of services delivered.

Through the use of organizational theory, this thesis will set out the likely effects of restraint on hospital behaviour/structure and what the subsequent effects have

been on the quality of health care services delivered. The use of organizational theory in policy analysis is an effective mechanism for understanding the consequences of government policy on agencies delivering social services. But, as noted by V. Wilson, organizational theory is a complex subject area and is composed of several disciplines. In a recent article in Canadian Public Administration, Wilson discussed the relevance of organizational theory to public administration:

To embark on a study of organizational theory and its relevance to Public Administration is analogous to undertaking Homer's Odyssey: like Ulysses one is never quite sure if the journey has begun, where one is located at any point of time, or when the whole nightmarish experience will eventually end. Part of this bewildering experience is undoubtedly due to the proliferation of possible routes open to the unsuspecting traveller; for although a vast number of studies, concepts and approaches have been developed for the study of organizations there is little apparent unity among them. This state of affairs is partly due to the number of "basic" and applied disciplines involved - psychology, economics, industrial management, political

science, sociology to name a few.¹ Partly it may also be due to the absence of an integrative framework to guide and give sharper focus to the disparate strands of research.³⁰

Wilson may be correct in his assertion that there may be a lack of unity amongst the various theoretical frameworks and concepts of organizational theory. The study of organizations is multifaceted and no one framework could integrate all facets of organizational theory. The study of organizational behaviour includes theories on leadership, organizational design, group behaviour, motivation, organizational change, communications, organizational development and decision-making, to name a few.³¹ The diversified nature of organizational theory and the lack of an integrative framework should not discourage an analyst from using organizational theory in analysis. The analyst has the capability of studying a specific aspect of organizational theory, such as leadership, or can combine different aspects of organizational theory to address a particular organizational problem. For example, an analyst may want to construct

³⁰Vince S. Wilson, "The Influence of Organizational Theory in Canadian Public Administration", Canadian Public Administration, Vol. 25 (Winter, 1982), p. 545.

³¹Hodgetts and Altman, Organizational Behavior (Miami, Fla.: W.B. Saunders Co., 1979), pp. viii and ix.

a methodological framework using leadership and organizational design theories to study a motivational problem in an organization.

The problem requiring a methodological framework in this paper is how to adequately analyze the effect of a change in the environment (the introduction of the E.S. program) on organizational behaviour (impact on hospital behaviour/structure). There are two organizational theories which provide a basis for analyzing the impact of the E.S. program on hospitals. The first is institutional theory and the second is effectiveness theory. Each of these theories provides a different perspective on organizational behaviour and together they provide a more complete understanding of the problem being studied. Institutional theory explains organizational behaviour in terms of the interaction of the organization with its environment.³² Effectiveness theory focuses more on the internal dynamics of the organization and explains organizational behaviour in terms of the distribution of resources to the sub-units of the organization.³³ The institutional theory suggests

³²C. Perrow, Complex Organizations (Glenview, Ill.: Scott, Foresman and Co., 1972), p. 189. "The major area of contribution of the institutional school must surely be the emphasis upon the environment. No other model of organization has taken the environment into account as much as the institutional school."

³³F. Baker, Organizational Systems: General Systems Approaches to Complex Organizations (Homewood: Ill.: R.D. Irwin Inc. 1973), p. 462.

a useful understanding of the development of organizational structure; effectiveness theory provides an excellent framework for measuring the change in distribution of resources to the sub-units in an organization. Both of these theories will be considered in more depth at this point.

The institutional theory of P. Selznick is based on the sociological theory of structural-functionalism.³⁴ The structure of the organization, according to the theory, evolves as a product of functions and is influenced by environment and history. The organization evolves and develops systems in accordance with the function it is expected to perform. The institutional model states that organizations must be viewed as a whole:

For institutional analysis, the injunction is to analyze the whole organization. To see it as a whole is to do justice to its "organic" character. Specific processes are, of course, analyzed in detail, but it is the nesting of these processes into the whole that gives them meaning.³⁵

³⁴Perrow, p. 177. "Its major conceptual framework is that of structural-functionalism, indicating that functions determine the structure of organizations and that structures can be understood by analyzing their function."

³⁵Ibid., p. 178.

The viewing of the organization as a whole allows the analyst an understanding of how the organization developed its structure. According to the model, organizations are tied to their "natural history". "Natural history" has been explained by Perrow as the historical development of the organization's structure as defined by function.³⁶ An example of this is the emergence of radiology departments in hospitals to provide x-ray services once x-rays had been invented and their utility in patient services was realized. Natural history is an account of the events and happenings which resulted in the organization adapting and evolving to its present state.³⁷

Institutional theory provides that some organizations have a natural history that indicates they are highly valued by the community, and these organizations become institutionalized.

³⁶Ibid., p. 178. "The present is rooted in the past; no organization (and no man) is free to act as if the situation were de novo and the world a set of discrete opportunities ready to be seized upon at will."

³⁷Ibid., p. 178. "Because the interchange of structure and function goes on over time, a "natural history" of an organization is needed."

Some organizations are merely organizational tools in which there is little personal investment and which can be cast aside without regret. Others become institutionalized. They take on a distinctive character; they become prized in and of themselves, not merely for the goods and services they grind out. People build their lives around them, identify with them, become dependant upon them. The process of institutionalization is the process of organic growth, wherein the organization adapts to the strivings of internal groups and the value of the external society.³⁸

The organization which is institutionalized has values characterized by:

1. an internal value system controlled by a "committed polity, with clear identity and purpose, serving the selfish strivings of its participants"³⁹, and
2. an external value system of "adaptability, responsiveness, impregnated with community values".⁴⁰

³⁸Ibid., p. 202.

³⁹Ibid., p. 191.

⁴⁰Ibid., p. 191.

The committed polity within the institution serves to resist change in organizational behaviour unless the change is in accordance with community values. Community values are norms which do not change quickly. Institutions as a result, strive to continue their pursuit of goals in terms of established values; variations in these goals are resisted.

Their notion of organizational vocabularies and the stabilizing force custom, well-worn communication lines, and so on resemble the institutional view of basic identity, or character, and the "conservative" nature of institutions that resist fortuitous change.⁴¹

The process of modifying the basic organizational structure of the institution to accommodate changes in the environment, aside from a change in community values, is therefore quite difficult as the organization resists altering its behavioural patterns to make these accommodations.

⁴¹Ibid., p. 202.

Canadian hospitals are institutions which have become "prized" by the communities they serve. They have a structure which reflects the "equity principle" with an emphasis on the curative approach.

The concept, equity, and the method, the insurance approach, seem to have become thoroughly associated in most people's minds. The point that it was equality of access that was intended and not equality per se, and only equality of access to a certain type of service seems to be forgotten in what many regard as the general march toward equity implied by the sum total of "welfare state" actions in the postwar period.⁴²

The development of the state-financed universal Medicare program has become institutionalized in the health care system. Modern hospitals and the services which they deliver are a reflection of:

1. The high priority Canadians place on a universal health care system and
2. The importance of equity in Canadian health care programming and culture.

⁴²P. Manga and G. Weller, "The Failure of the Equity Objective in Health: A Comparative Analysis of Canada, Britain and the United States," Comparative Social Research (Vol. 3, 1980, JAI Press Inc.), p. 233.

Redistribution has become part of Canadian culture and has been noted as such by H. Hardin:

All the memories, prejudices, passions, habits of mind, expectations, folklore and humour which make up Canadians' sure sense of regionalism are part of the redistribution culture, and the culture in turn is a partial, practical, eminently civilized expression of that rich vein in the Canadian character, and always will be so, as long as Canada is so. Behind equalization payments and regional development programs is identity.

Like the public enterprise ethic, the redistribution has become internalized over time so that now Canadians are psychologically predisposed to it. Redistribution has come to replace the American dogma as a code of the natural justice.⁴³

Universal health programs are a reflection of the equity principle and the redistributive culture of Canada. These health programs have become institutionalized in the structure of the bureaucracies delivering the programs. These institutions are particularly resistant to change as the cultural

⁴³H. Hardin, A Nation Unaware (Vancouver, B.C.: J.J. Douglas Ltd., 1974), p. 314.

attitudes and community values are institutionalized in their structure. The Canadian cultural attitude towards the state delivered health care system is reflected in the results of a recent Southam newspaper poll. The question and subsequent response in the poll was as follows:

Thinking of Medicare as a government service in relation to other government services such as defence, education, pensions, housing, would you say that Medicare is one of the more important or less important services government provides?

More	-	85 per cent
So-So	-	6 per cent
Less	-	4 per cent ⁴⁴

Hospitals, it is believed, are institutions which have become ossified and policy changes affecting their behaviour are incremental.

Limited flexibility and incremental change - major lines of organizational action are straight - - ie. behavior at one time, t, is marginally different from behavior at t-1. Simple-minded

⁴⁴The Globe and Mail (Southam Press, Sept. 12, 1983).

predictions work best: behavior at $t-1$ will be marginally different from behavior at the present time...New activities typically consist of marginal adaptations of existing programs and activities.⁴⁵

This paper contends that the E.S. program will cause incremental or short/intermediate run changes in organizational structure or operations.

In order to empirically examine the validity of this hypothesis, Etzioni's effectiveness model will be used. The effectiveness model is derived from systems theory and the utility of systems theory in analysis has been adeptly defined by A. Melcher.

Systems theory provides an essential perspective for developing social sciences and studying social organizations. The approach focuses upon complex interrelationships among variables and provides a set of concepts to describe and analyze those relationships. Systems theory holds great promise for furthering our understanding of the structure and functioning of organization.⁴⁶

⁴⁵G. Allison, Essence of Decision (Little, Brown and Company, 1971), p. 91.

⁴⁶A. Melcher, General Systems and Organization Theory: Methodological Aspects (Kent State University: Center for Business and Economic Research, 1975), p. (i).

Etzioni's effectiveness model focuses on the organization and its sub-units for purposes of analysis. By means of this approach the level of adaptation of the organization caused by financial restraint will be assessed. The effectiveness model advocated by Etzioni is quite distinct from the goal model usually used in this type of analysis. A goal model analysis would measure how well the organization has met its goals after the policy had been implemented. In terms of cost-benefit analysis, the goal model is the approach which is usually used as it demonstrates whether or not an organization can accomplish its goals on more or less funds. According to Etzioni, the goal model has basic methodological deficiencies.

One of the major short-comings of the goal model is that it frequently makes the studies findings stereotyped as well as dependant on the model's assumptions. Many of the studies show (a) that the organization does not realize its goals effectively and/or (b) that the organization has different goals from those it claims to have.⁴⁷

⁴⁷Baker, p. 460.

Etzioni maintains that goals are targets and are cultural norms while organizations are social systems and should be studied as such. Etzioni's systems model would not evaluate an organization's effectiveness by how well it has met its organizational goals, but would evaluate the optimality of the distribution of resources amongst the sub-units.⁴⁸ It is the distribution of resources amongst the sub-units of the organization which define the impact of a public policy on an institution. This paper supports Etzioni's emphasis on distribution of resources in an organization, as the determinant of change and effectiveness. By utilizing Etzioni's effectiveness model, Chapter IV will provide an examination of the changes in distribution of resources to the sub-units of several B.C. hospitals.⁴⁹

⁴⁸ Ibid., p. 462.

⁴⁹ "An alternative model that can be employed for organizational analysis is the system model. The starting point for this approach is not the goal itself but a working model of a social unit which is capable of achieving a goal... A measure of effectiveness established the degree to which an organization realized its goals under a given set of conditions. But the central question in the study of effectiveness is not, 'How devoted is the organization to its goal?' but rather, 'Under the given conditions, how close does the organizational allocation of resources approach an optimum distribution?'" Baker, p. 462.

The magnitude of change on hospital operations and structure for the three years 1981-82, 1982-83 and 1983-84 caused by financial restraint will then be determined and the validity of the hypothesis with respect to bureaucracies and change will also be established.

It should be noted that the research of this paper is directed at examining and analyzing only the internal processes of the organization as they relate to financial restraint. Management initiatives that direct changes in hospital operations such that they will conform to the expenditure directives are the processes to be examined.

The set of processes which will not be examined to any great extent in this thesis are the external processes caused by the restraint program. It is felt though, that these processes should be briefly discussed as they are recognized by this research as being an important but separate, element of organizational behaviour. The only reason why they are not being considered in this research is that the analysis of the internal processes is the subject of a thesis by itself.

Several studies have demonstrated the relevance of organizational effectiveness in terms of the external processes. R. Presthus, in his advocacy of "support theory" reveals the importance of external processes to the organization.

One theoretical frame for analyzing effectiveness is so-called "support theory" which holds that all organizations depend upon their environment for certain needed resources (including a market for their product) and that the capability of any organization is importantly a function of the extent to which it is able to capture such resources.

...Like the theory which sees personal interaction as a system of exchange for approval and consensual validation, support theory concerns itself with bargaining between the organizations and the relevant external groups.⁵⁰

Presthus used the support theory in his study of the effectiveness of two U.S. private hospitals. Through the use of this theory, he demonstrated the importance of the

⁵⁰R. Presthus, Behavioral Approaches to Public Administration (University of Alabama, University of Alabama Press, 1965), p. 74.

external environment on organizational effectiveness. Factors such as composition of hospital boards, linkages with outside associations and the local community support all determine organizational effectiveness. ⁵¹

The environment which the hospitals are dependant upon for their effectiveness can be utilized by the organization to protect their operations. In particular, pressure groups and interest groups representing the hospitals' interests can enhance the organizations' effectiveness. P. Pross has written extensively about the role of pressure groups and their importance to organizations at different points in time. He has concluded that

The first responsibility of any pressure group is to attend to the immediate needs of its clients. This usually means dealing with quite routine problems: alleviating the too stringent application of regulations, negotiating a minor shift in policy, bringing about the slight extension of a service.⁵²

⁵¹The importance of these elements will be discussed briefly in Chapter V.

⁵²A.P. Pross, "Pressure Groups: Talking Chameleons", Canadian Politics in the 1980's, eds. M.S. Whittington and G. Williams (Toronto, Ont., Methuen, 1981), p. 234.

The thesis will take note of the potential political activity of the organization with the external groups. But, organizational effectiveness will be evaluated from the point of view of internal processes and the changes in distribution of resources amongst the organization's sub-units. The thrust of this paper is to determine if the E.S. program has caused short or long run changes on ossified hospital bureaucracies. An examination of the distribution of resources to the sub-units will indicate the type of change implemented.

Chapter IV will evaluate the internal processes of the organization in terms of the magnitude of change caused by the E.S. program.⁵³ This evaluation will ultimately lead to questions regarding the effect of restraint on the quality of health care services being delivered. The question of quality of services will be addressed (in Chapter V, the analysis) but definitive conclusions may not be reached. Quality of service is a difficult variable to measure in a health care setting as there are many indicators of quality which cannot always be properly identified or measured. The question of quality though, and the methodological and philosophical problems associated with it will be

⁵³The threshold of change from minor to major will be discussed in Chapter III.

addressed in Chapter V.

The belief of this paper is that this research is more than a case study in organizational behaviour. The importance of this research lies in its ability to explain the changes in internal organizational behaviour that resulted from the E.S. program in British Columbia and the subsequent effects on quality of services.

Chapter II

The History of Federal-Provincial Health Care in Canada and its Effect on the Health Care Organization

The purpose of this chapter is to describe the historical context within which hospitals have evolved in Canada and, in particular, in British Columbia. Through an understanding of the historical context, this chapter will demonstrate that hospitals have evolved into complex, bureaucratic organizations. The significance of this evolution has been posed in Chapter I and will be discussed in subsequent chapters. In addition, the health care organization has become institutionalized in the fabric of contemporary Canadian society. The bureaucratization and institutionalization of hospitals will be demonstrated through a discussion of three themes or historical relationships with respect to health care development. These themes are:

1. The history and development of federal-provincial relations with respect to health care policy;
2. The cost patterns of delivering health care services, and

3. Lifestyle issues and their influence on the health care organization.

To understand these three themes and their subsequent effects on hospitals, it is best to consider the development of health care policy during three time periods. The three time periods have been chronologically defined as 1867-1945, 1945-1977 and 1977 to the present.¹ There are predominant health policy characteristics during these time periods which notably distinguish one era from the next. Weller described the distinction as follows:

The first stage, from 1867 to 1945, could be described as one of benign neglect when health care was basically in the private realm...

The second stage from 1945 to 1977, could be called the era of shared-cost agreements, for it was one in which several federal-provincial shared cost programs were initiated by the federal government. In this period Canada moved in slow steps toward a system of national health insurance...

The third and present stage, in existence since 1977, could be called the era of the Established

¹G.R. Weller and P. Manga, "The Development of Health Policy in Canada", The Politics of Canadian Public Policy, eds. M. Atkinson and M. Chandler (Toronto: University of Toronto Press, 1983), p. 223.

Programs Financing Act. In this stage the provinces began to exercise greater control over their health systems.²

These three phases have been described slightly differently by M. and W. Chandler. They characterize the first phase of health policy as being one of community disease control.³ Government regulation and intervention in health during this period was limited to issues regarding sanitation and disease control.⁴ The second phase, which would coincide with Weller's 1945-1977 period, is characterized by the Chandlers as being a shift of responsibility from the private to the public sector for health.⁵ Finally, the third phase the Chandlers perceive as being distinct from the other phases by the development of community health centres.⁶ The third phase would coincide with Weller's 1977 to present period. Through the use of the Chandlers' and Weller's historical

²Ibid., p. 224.

³M. Chandler and W. Chandler, Public Policy and Provincial Politics (Toronto: McGraw-Hill Ryerson Ltd. 1979)

⁴Ibid., p. 202.

⁵Ibid., p. 205.

⁶Ibid., p. 213. "In the efforts to solve the problems of the insurance stage, provincial health policy has developed into a third stage. It may be called the community health centres stage because these centres are the pivotal institutions in the evolving health care system."

stages, the evolution of health care policy will be traced. This description will demonstrate how the structure of hospitals became increasingly bureaucratized in order to accommodate the changes in health policy.

The First Phase 1867-1945

The first period from 1867 to 1945 (as was stated), was predominantly characterized by neglect. The emphasis of this time period in terms of public policy, was focused on community disease control. In the early part of this period, notably 1867-1920, many volunteer organizations were formed in order to deliver much needed health and social services.⁷ As the B.N.A. Act did not define which level of government was responsible for health, most of the responsibility rested with the municipalities. The most renowned health legislation implemented during this period was The Union Hospital Districts. This legislation was introduced in Saskatchewan in 1916 and it allowed municipalities to join together on the construction and maintenance of hospitals.⁸ Both Alberta and Saskatchewan put together

⁷"...Toronto Children's Aid Society in 1891, the Red Cross in 1896, the Victorian Order of Nurses in 1897, the Canadian Mental Health Association and the Canadian National Institute for the Blind in 1918..."
C.A. Meilicke and J.L. Storch, eds. Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends (Ann Arbor: University of Michigan, 1980), p. 4.

⁸Chandler, p. 203.

programs directed at allowing municipalities to join together to finance hospital operations. They also developed hospital prepayment plans for municipal residents. Local taxes and provincial grants provided the funding for these plans.⁹ Saskatchewan also developed legislation in 1916 which authorized municipalities to levy a tax to guarantee a doctor's payment.¹⁰ The "Municipal Doctor System" as it was called, spread rapidly throughout the Prairies with over two hundred agreements in place by 1948.¹¹

The municipal doctor system as it evolved in Saskatchewan (and to a much lesser extent in the sister province of Manitoba) became well known in both Canada and the United States. It was based on the simple method of taxing the residents and land owners of a rural municipality to raise funds to pay a doctor a reasonable income. Any resident could consult him without paying fees.¹²

The municipal doctor plan was instituted as the result of support by immigrant farmers who were accustomed to "much superior" public health plans in their homelands.¹³

⁹Ibid., p. 203.

¹⁰Ibid., p. 203.

¹¹Ibid., p. 203.

¹²R.F. Badgley and S. Wolfe, Doctors' Strike: Medical Care and Conflict in Saskatchewan (New York: Atherton Press, 1967), p. 8.

¹³Ibid., p. 7.

The federal government became involved in health in 1919 with the establishment of the federal department of health. The department was established to administer programs of disease control and veterans' affairs. In 1920 the federal government passed the Soldiers Settlement Act, an act providing special benefits for veterans.¹⁴ At the end of the first world war there was also increased pressure on provincial governments to provide public assistance for health care. During the interwar years the provinces became more involved in the administration of health services. Chandler has summarized this involvement as follows:

Starting with New Brunswick in 1918 each province created a cabinet department for health. Health functions remained divided between provincial and municipal governments. But based on variations in the degree of decentralization, three distinct provincial patterns of responsibility began to emerge. The Maritimes and Quebec moved towards centralization of public health policy... In Ontario the municipalities had more responsibilities than those in the East and more autonomy than those in the West. The established tradition of municipal government

¹⁴Meilicke and Storch, p. 5.
"...the Soldiers Settlement Act and other special plans for the benefit of veterans and surviving dependents. These programs appear to have paved the way for the 1927 Old Age Pension Act which was Canada's first nation wide income support plan and the first major continuing federal-provincial cost-shared social security program."

and strong voluntary agencies resulted in provincial departments primarily providing supervision and financial aid... Public health in the Prairies and British Columbia depended on both the provincial and local levels.¹⁵

The health care system developed quite differently in the various regions of Canada during this period. The provinces though, became increasingly involved politically and financially from this point in time onward.

In 1919 British Columbia established a Royal Commission to consider the feasibility of public health insurance. The Commission recommended implementation of a public health insurance plan.¹⁶ The legislature was obviously concerned about the financing of the plan because three years later, in 1922, the legislature passed a resolution for the federal government "to give early consideration to legislation providing for an adequate insurance against sickness".¹⁷ The question of jurisdictional responsibility over health had not been addressed.

¹⁵Chandler, p. 204.

¹⁶Chandler, p. 206.

¹⁷S.M. Gelber, "The Path to Health Insurance", Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meilicke and J.L. Storch (Ann Arbor: University of Michigan, 1980), p. 157.

The Canadian constitution as set out in the British North America Act of 1867 had clearly allocated jurisdiction over most hospitals to the provincial governments, although it was silent on the general subject of health. The question as to which level of government was responsible for a system of insurance against sickness had not been tested or tried.¹⁸

The federal government at this time though, did not see their role as including the provision of public health insurance.

Also during this period, health units were established in municipalities in order to carry out the tasks of public health. The result was rapid development of public health services from 1918 onward.¹⁹ As a result of increased services in public health, the provincial governments eventually became involved in the delivery of these services.

The role of the provinces at the beginning was limited to general regulatory and supervisory functions and, therefore, full-time provincial health departments

¹⁸Ibid., p. 158.

¹⁹J. Hastings and W. Mosley, "Introduction: The Evolution of Organized Community Health Services in Canada", Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meilicke and J.L. Storch (Ann Arbor: University of Michigan, 1980), p. 150.

were not formed in the early years. All provinces now have well-established provincial departments responsible for public health matters.²⁰

The growth in the application of public health required increased financial assistance and regulation. The federal government did not take any initiative in this area, therefore the provinces assumed this responsibility and in most provinces, the provincial government now delivers public health programs.

The advent of an increasing number of public health programs also saw an increasing labour specialization in this field. Labour specialization is one of the main characteristics of bureaucratization.²¹ The bureaucratic structure is dependent on labour specialization as its foundation.

The division of labour, for example has two purposes. On the one hand,

²⁰ Ibid., p. 150.

²¹ P. Blau and M. Meyer, Bureaucracy in Modern Society (New York: Random House, 1971), p. 18.
"The main characteristics of a bureaucratic structure (in the "ideal typical" case) according to Weber, are the following: 1. The regular activities required for the purposes of the organization are distributed in a fixed way as official duties. 2. The clear-cut division of labour makes it possible to employ only specialized experts in each particular position and to make every one of them responsible for the effective performance of his duties."

it makes a functionary capable of developing highly specialized skills. The advantage of this may be that the bureaucracy can bring to bear on a specific problem an individual who has the ideal capacities to resolve that problem.²²

The expansion of public health required labour specialization in order to effectively provide services and it also signalled the first stages of bureaucratization in health care.

In 1929, the Depression brought a number of Royal Commissions on health insurance and differing patterns of health care delivery emerged from province to province.²³ In 1929 the

²²R. Hummel, The Bureaucratic Experience (New York: St. Martin's Press, 1977), p. 30.

²³See footnote 15.

government of British Columbia appointed a Royal Commission to investigate the possibility of health insurance. The report recommended:

... a compulsory health insurance plan for all persons below a fixed level of income, voluntary admission to the plan being available for all other persons.²⁴

The government of British Columbia proceeded to implement the new insurance plan. During the Depression though, immediate medical assistance was required for those on relief. The provincial government therefore transferred funds to municipalities to cover a portion of the costs for doctors' services and drugs for those receiving relief. The program later included the unemployed and those receiving social assistance.²⁵ Ontario also was providing funds to municipalities for a part of the cost of health services for those on relief and Alberta was considering the implementation of a province-wide health insurance plan.²⁶ In 1935, Alberta passed legislation regarding the provision of health insurance to residents and in 1936 British Columbia presented

²⁴Gelber, p. 158.

²⁵Ibid., p. 159.

²⁶Ibid., p. 159.

a Health Insurance Act to the legislature.²⁷

The period between the mid-thirties and the post-war reconstruction was dominated by the provincial attempts, particularly in the West, to implement health care insurance. The Depression had indicated to western provinces that municipalities could not finance public health insurance by themselves. The devastating effect of the Depression in the West had left a strong desire to obtain state provided health care insurance. The B.C. Health Insurance Act was a provincial attempt to insure hospital and doctor services, but due to opposition by the doctors, the plan was not implemented until 1948.²⁸ The western provinces seemed to follow each others' example and slowly adopted or tried to adopt some form of health insurance. The provincial health policy seemed to diffuse from one western province to the next. Dale Poel has written extensively on the phenomenon of legislation diffusing across provinces. Quite clearly Poel has indicated that the

²⁷Ibid., p. 160. "Reference has already been made to the Ontario legislation for a medical care plan for recipients of public assistance passed in 1935. The following year, British Columbia placed on the statute books of that province a Health Insurance Act which made provision for a program designed to provide services for all residents of the province."

²⁸Chandler, p. 206.

adoption or implementation of policy across provinces is a function of more than physical proximity. The socio-economic and political variables influence policy development according to Poel.

The factor analysis using the provinces as variables (Table V) shows a clustering of the provinces which are not geographically contiguous and suggests a diffusion process which must be based upon something other than physical proximity or even socio-economic similarity. Future research might explore with individual level data the behavioral reality of Establishment Canada.

The correlation and regression analysis determined that both socio-economic variables (wealth, urbanization, industrialization) and political variables (party ideology, civil service size, malapportionment) are important determinants of legislation in the provinces.²⁹

Due to the Depression, the West shared a certain commonality in socio-economic and political variables. The Depression had severely affected the lives of the new agrarian immigrants in the West and is a possible explanation of the rapid diffusion of health care policy from one western province to the next. Poel further demonstrated that Saskatchewan, with

²⁹D. Poel, "The Diffusion of Legislation Among the Canadian Provinces: A Statistical Analysis", Canadian Journal of Political Science (Vol. 9, No. 4, 1976), p. 626.

a high "socialism factor", was a major innovator in policy development as opposed to other provinces. Certainly, this chapter will demonstrate that Saskatchewan led the way in health care policy developments.

In 1935 the federal government tabled the Employment and Social Insurance Act, an act which would deliver health and welfare services and would be funded through the collection of premiums.³⁰ This legislation was part of Bennett's "New Deal" which was intended to address social problems. The act though, was determined to be ultra vires by the Judicial Committee of the Privy Council as they determined that the jurisdictional responsibility for health was not assigned to the federal government under the B.N.A. Act.³¹ The Rowell-Sirois Commission wrote in the 1939 report on Dominion-Provincial relations, that health should be a provincial concern, but there should also be flexibility on this jurisdictional line.³² World War II brought such discussions and this era of health care policy to a close.

The first era had established the ground work for further

³⁰Gelber, p. 159.

³¹Meilicke and Storch, eds., p. 5.

³²Gelber, p. 160.

public medical insurance. This era though, is basically noted for neglect by governments in terms of providing assistance for health care services. The private system of health care delivery which characterized the period prior to World War II led to municipalities offering limited health resources after the first world war and during the Depression. The western provinces grew more active in this time period and passed legislation offering limited medical assistance. This time period also saw the growth of public health units for the treatment of disease. The health units eventually became a provincial concern and bureaucratic structures developed to deliver this service. This specialization of labour and function in the delivery of public health were the first elements of its bureaucratization.

In terms of the doctor's role during this first time period, Weller has made the following comments:

In the field of personal health services, Canadian health care system approximated the "closed"

or "medical" model of health in which the dominant health professionals controlled the system. Both the federal and provincial governments permitted a maximum of self-regulation and control by the medical professionals. Government in Canada had a lower profile in health care than those in the United Kingdom and the United States...The Canadian health care system in this era was characterized by the primacy of a physician in a structure that provided care largely in terms of services to individuals in a doctor-patient relationship.³³

The dominance of the physician in the health care system was to begin to shift in the post World War II era. This shift was largely the result of a move from private to public health insurance schemes. The move to public health insurance also had an impact on the increasing complexity of government relations and the delivery of health services. One important result was the growth of hospitals and the resulting bureaucratization. These developments are central to this thesis.

³³Weller and Manga, p. 225.

Phase Two 1945-1977

At the end of the second world war, public sentiment was anchored in the belief that people should be protected against poverty and sickness.³⁴ Amidst the public mood, the federal-provincial conference on reconstruction considered the federal proposal of a shared cost medical insurance plan. The health insurance proposal was composed of four components:

- (a) a grant for planning and organization
- (b) health grants
- (c) financial assistance in the construction of hospitals (in the form of low interest loans) and
- (d) health insurance ³⁵

The proposal was not accepted by all provinces and therefore it was never implemented. The outcome of the conference was adeptly summarized by Taylor:

³⁴M.G. Taylor, Financial Aspects of Health Insurance (Toronto: Canada Tax Foundation, 1957) p. 2.

"There was a mood of rebellion against the universal risks of unemployment and sickness, disability and old age, widowhood and poverty."

³⁵Taylor, p. 79.

1. All provinces appear to believe that some agreement is essential, indeed urgent...

3. Three provinces (Manitoba, Saskatchewan and Alberta) have agreed to accept the Dominion Proposals as they stand. Only one province (Ontario) has submitted what might be called an alternative to the Dominion's proposals. The proposal does not differ very greatly in kind from the Dominion Proposals, but its effects would be to throw so great a net increase in obligations upon the Dominion that it could not be accepted by the Dominion. Nor as any other province expressed the view that it would be acceptable to it.

4. The remaining five provinces expressed a desire to see some changes in the Dominion Proposals, most of which would be of some benefit to themselves at the expense of the Dominion.³⁶

The provinces and the federal government could not unanimously agree on the taxation and grants formula required to finance the health proposal. The wealthiest provinces did not want to give up provincial jurisdiction "over personal

³⁶Taylor, p. 65.

income, corporation income, and succession taxes in order to obtain health insurance".³⁷

As a result, in 1946 Saskatchewan went on its own way and introduced the Saskatchewan Hospitalization Act which established a universal compulsory medical insurance plan for all residents of the province. The plan was implemented in 1947. The program was implemented as part of the socialist doctrine of the newly elected C.C.F. government led by T.C. Douglas.³⁸ The adequacy of the municipal hospital plans had been outlived and the municipalities now needed more financial assistance. In 1940 the Saskatchewan Association of Rural Municipalities (SARM) had made a presentation to the legislative assembly on the problems they were experiencing in delivering health care services:

"But" said the S.A.R.M. "neither the tax on the land nor the per capita tax has proven capable of providing sufficient revenue to give complete medical and hospital services."³⁹

³⁷M.G. Taylor, "The Canadian Health Insurance Program", Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meilicke and J.L. Storch (Ann Arbor: University of Michigan, 1980), p. 187.

³⁸Ibid., p. 167

³⁹M.G. Taylor, Health Insurance and Canadian Public Policy (Montreal: McGill-Queen's University Press, 1978), p. 85.

When the Hospital Insurance Plan was introduced in 1947 municipalities were guaranteed the operating costs of hospitals; therefore, communities proceeded to expand facilities and build new hospitals.

The expansion of hospital building was accelerated by the introduction of the health grants component of the 1945 federal government health program proposal.⁴⁰ All provinces utilized these grants and between 1948 to 1970, when the program ended, 130,000 beds were added to the system.⁴¹ The provision of capital funds by the federal government for the construction of hospitals was an incentive for the provinces to promote hospital construction. It also marked the transfer of hospital capital financing from municipalities to the provincial and federal governments. Unfortunately though, the planning and provision of hospital services was done without much provincial coordination.

About the end of World War II most provinces began to provide capital grants for hospitals and in one of the 1948 National Health Grants, responsibility for

⁴⁰ Ibid., p. 108.

⁴¹ Chandler, p. 207.

federal support was recognized. However, these efforts were modest in degree and were largely unrelated to any concept of overall hospital planning in a province.⁴²

There was a general lack of central provincial or regional planning with respect to the provision of hospital services. This lack of coordinated planning would later prove to be expensive to governments. Later legislation would try to control the planning and administration aspect of hospital operations. As provincial and federal governments became more involved and cost-committed to hospitals, they also imposed more regulations and caused the increasing bureaucratization of the hospital.⁴³ The movement of the regulating function

⁴²J.F. Hastings, "Federal-Provincial Insurance for Hospital and Physician's Care in Canada", Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meilicke and J.L. Storch (Ann Arbor: University of Michigan, 1980), p. 211.

⁴³Ibid., p. 211.
"Provincial governments now have a determining role in capital questions (capital projects must be sanctioned by the provincial hospital authority in order to receive government grants) and overall programs by means of grants and budgetary requirements (common budgetary methods and acceptance of each hospital's annual budget is required by provincial hospital authorities). In addition, special provincial consultant advice and services are rendered to the individual institutions. The federal department of National Health and Welfare also has special consultant services available to the provinces in the hospital and other health services fields."

from the municipalities to the provincial and federal government increased "the hierarchical distance" between hospital administrators and their regulators. According to A. Downs, the greater this hierarchical distance, the more bureaucratization of the organization.

The greater the hierarchical distance between low level officials and the points where final approval can be obtained, the more difficult and time consuming it is for them to carry out their function.⁴⁴

The increasing role played by the provinces and the federal government in hospital administration has certainly contributed to hospital bureaucratization in Canada.

The injection of funds into the system by federal and provincial governments accelerated the rapid expansion in the growth and utilization of services. Areas of Saskatchewan noted an increase in the number of practising physicians after the introduction of health insurance.

⁴⁴A. Downs, Inside Bureaucracy (Boston: Little, Brown and Co., 1967), p. 159.

In 1946, following one recommendation made in the Sigerist Report, a pilot health program was set up in Swift Current Health Region, about 10,000 square miles of rolling prairie in south-west Saskatchewan with a population of about 50,000. The area was chosen because it was economically depressed and there was a shortage of doctors. Doctors practicing there had many unpaid accounts. ...The number of doctors in the region increased from nineteen in 1946 to forty-one in 1960, during which time the size of the population remained static.⁴⁵

State-provided health care increased the level of service offered to the residents of Saskatchewan. It also signalled the beginning of a complex, costly health care delivery system. The new health insurance plan in Saskatchewan had increased costs to the province and caused the levying of an education and hospitalization tax.⁴⁶ British Columbia implemented its medical coverage plan in 1949 and like Saskatchewan, experienced higher costs due to the program.

Examination of the B.C. costs indicates, as in Saskatchewan, a continuing increase in costs

⁴⁵Badgley and Wolfe, p. 19.

⁴⁶M.G. Taylor, Financial Aspects of Health Insurance (Toronto: Canada Tax Foundation, 1957), p. 58.

each year, resulting from three factors: higher costs, higher rates of utilization, and an expanding population. It is interesting to note that in 1949, the first year of operation of the plan, per diem costs in hospitals rose by \$1.35 over 1948.⁴⁷

British Columbia's medical plan, like Saskatchewan's, offered hospital insurance regardless of means. British Columbia also introduced a medical care plan for recipients of relief assistance in 1949.⁴⁸ In 1950 Nova Scotia also passed legislation offering medical care for recipients of public assistance;⁴⁹ in 1953 Alberta approved the Hospitalization and Treatment Services Act offering government payment of hospital services for persons suffering from the effects of rheumatic arthritis and cerebral palsy.⁵⁰ During this time period the provinces were becoming increasingly involved in the state provision of health services.

At the federal-provincial conference of 1956, the federal government once again proposed a shared cost health insurance plan. The proposal was the Hospital Insurance and Diagnostic Services Act (HIDSA) and it was adopted as statute in 1957.

⁴⁷Ibid., p. 68.

⁴⁸Gelber, p. 162.

⁴⁹Ibid., p. 162.

⁵⁰Ibid., p. 162.

This new legislation offered uniform insurance coverage to residents for routine hospital and diagnostic services.⁵¹ Initially only four provinces participated in the plan, but the federal government's offer of cost-sharing the program enrolled all ten provinces.⁵² In addition, the federal government introduced uniform definitions of waiting periods and benefits thus accommodating many earlier provincial concerns.

The federal government, by establishing a commitment to the delivery of national health care services, had also established itself as the monitor of the system. Since provinces had to meet federal conditions before agreements would be entered into. As mentioned by A. Downs, the introduction of a monitor into the system caused rigidity.

⁵¹Gelber, p. 163.

⁵²Taylor, p. 234.

"With the irresistible offer of federal cost-sharing, six provinces that had not previously been involved in hospital insurance launched programs...By 1961 almost the total population of Canada was entitled to the same comprehensive hospital care benefits enjoyed by the people of Saskatchewan and British Columbia for over a decade."

First the monitor imposes ever more complex and ever more restrictive regulations upon the operating bureau. As a result, the latter may have itself in a virtual straight-jacket of rules hardly conducive to flexible behavior.⁵³

Over time, the federal government, as will be demonstrated, became increasingly the regulator and monitor of the health care system and this caused further bureaucratization of hospitals.

After the introduction of the HIDS Act the next major piece of legislation was the Medical Care Insurance Act passed in Saskatchewan. In 1962, Saskatchewan passed this legislation which established universal medical coverage for all provincial residents.⁵⁴ For Saskatchewan, this legislation completed the move from private medical insurance to a complete public medical insurance scheme. The state had become the regulator of the health care system. Residents of the province were now able to obtain doctors' services at

⁵³ Downs, p. 158.

⁵⁴ M.G. Taylor, "The Canadian Health Insurance Program", Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meilicke and J.L. Storch (Ann Arbor: University of Michigan, 1980), p. 188. "...the provincial government despite the opposition of the medical association, introduced its Medical Service Act to go into effect on April 1, 1962, but administrative problems forced a postponement to July 1."

no direct cost other than through taxation. The legislation though, was not passed without opposition. The doctors of the province held a strike in retaliation against the government-controlled scheme. Doctors saw that they were losing their monopolistic hold on the health care system and resisted that move.

The doctors wanted a **monopoly** only if they controlled it, and did not have to negotiate the price of the product they were selling to consumers. Perhaps it was for this reason that the spokesmen for the profession spoke so vehemently against the possibility of government becoming "the monopoly buyer and seller of all medical services".⁵⁵

It was only after a severe confrontation between the doctors and the government that the Saskatoon Agreement was signed ending a three week doctors' strike. The provincial government had brought in doctors from Great Britain to supply services while the strike was on. This brought immense pressure to bear on the doctors thus causing them to finally settle.⁵⁶ The signing of the Saskatoon Agreement marked a shift in power in the health system from the doctors to the

⁵⁵Badgley and Wolfe, p. 46.

⁵⁶Ibid., p. 71. The medical community in general disagreed with the withdrawal of services by Saskatchewan doctors. Doctors from Great Britain were providing required medical services to the residents of Saskatchewan.

provincial government. Other provinces also followed Saskatchewan's example and established partial public medical insurance plans.⁵⁷ The partial plans involved the government being responsible for:

(1) paying the full costs of services for those in receipt of continuing welfare support, and

(2) subsidizing those whose incomes fell below a threshold calculated on their taxable incomes...⁵⁸

After the Saskatchewan incident, the doctors and the insurance companies joined together to oppose any further government move towards public health insurance.⁵⁹ Public pressure for

⁵⁷Weller and Manga, p. 230.

"Moreover, following Saskatchewan's example, other provinces began to introduce public insurance schemes to cover physicians' services; none of them was universal in scope or comprehensive."

⁵⁸M.G. Taylor, Health Insurance and Canadian Public Policy (Montreal: McGill-Queen's University Press, 1978), p. 338.

⁵⁹Ibid., p. 337.

"Thus the profession was ideologically and politically joined with the insurance industry in its opposition to a government program..."

public health insurance stirred the federal government to appoint a Royal Commission. The Hall Commission was appointed in 1964 to investigate the feasibility of a National Health Insurance Program.

At the 1965 federal-provincial conference, the federal government discussed the possibility of cost-sharing medical services with the provinces under the Canadian Assistance Plan. The federal government promoted the insurance plan in large measure because of its popularity with the public.⁶⁰ In 1968 the Medical Care Act was passed and by 1972 all provinces and territories were participating.⁶¹ Alberta, Ontario and Quebec initially resisted the Medical Care Act but eventually dropped their disputes with the federal government.

Alberta, opposed to compulsion, found it necessary to abandon its insurance company consortium...

In Ontario, consideration was given over a long period of time to the future of Physicians' Services Incorporated and finally ...ceased its prepayment operations...

The Quebec battle had two objectives: to stay out of the

⁶⁰Weller and Manga, p. 230.

⁶¹Ibid., p. 231.

plan and, when it was clear that was impossible, to force Ottawa to hand over to Quebec the revenues from the social development tax collected from the residents of that province before the Quebec plan began.

...Trudeau was not inclined to accept the Quebec argument and so, finally, that demand ceased to be made.⁶²

With the introduction of Medicare, the hospitals now had two levels of government regulating the standard and expenditures in the system. The hierarchical distance discussed by A. Downs had once again been increased with the federal government becoming a major player.

The introduction of Medicare though, has caused vast increases in fiscal costs to the federal and provincial governments. Health care costs have been taking an increasing

⁶²M.G. Taylor, Health Insurance and Canadian Public Policy (Montreal: McGill-Queen's University Press, 1978), p. 376.

amount of G.N.P. The figures are quoted below:

Total expenditures from all sources grew from 8 billion in 1949 to 1.2 billion in 1955 and 4.4 billion in 1968. These figures represent 4.35 per cent of the gross national product in 1955 and 6.6 per cent of the gross national product in 1968. The rate of increase averaged about 10.7 per cent over 1955-1968 but during 1965-1968 it was running at 13.9%.⁶³

By 1976 the cost of health care had reached almost 7% of G.N.P.⁶⁴ Hospitals and physician services were being utilized more with the introduction of the HIDS Act and Medicare. Between 1957, the year of the introduction of the HIDS Act, and 1974, average provincial spending on health went from 15% of the provincial budget to 25%.⁶⁵ The increase in the number of hospital facilities was also a contributing factor to the increasing costs. The Hospital Construction Grant introduced in 1948 by the federal government encouraged the increase in hospital beds from 130,000 in 1948 to 198,000 in 1970.⁶⁶ Medicare was also a major

⁶³Hastings, p. 207.

⁶⁴A. Blomqvist, The Health Care Business (Vancouver: The Fraser Institute, 1979), p. 1.

⁶⁵Chandler, p. 202.

⁶⁶Ibid., p. 207.

contributing factor to increased use of the system and higher costs associated with physician services:

The Medical Care Act also had a number of negative, and to some degree unexpected, policy impacts. Physicians' incomes were significantly increased largely because patients' demand for care increased and bad debts were eliminated. By 1971, the relative incomes of physicians were at their peak.²⁷ The effect of Medicare was to redistribute income from the general taxpayer to physicians. In the long run Medicare was also inflationary. It placed great pressure on provincial and federal public finances for spending in the health care field.⁶⁷

The fiscal pressure for the governments to continue increased spending on health care led to the appointment of several task forces given the mandate to seek out more efficient means of health care delivery. Government reports written during this period include: The 1970 Commission of Inquiry on Health and Social Welfare (Castonguay Report), Report of the Health Planning Task Force (Mustard Report), 1974 - A New

⁶⁷Weller and Manga, p. 231.

Perspective on the Health of Canadians (Lalonde Report), The Community Health Center in Canada (Hastings Report), and the 1971 Task Force on the Cost of Health Services in Canada.⁶⁸ The recurring theme presented in these reports was the attempt to find ways and means of balancing the delivery of quality health care against cost. Basically, the problem addressed by the task forces and commissions was the type of health care which was being promoted by the shared cost programs.

The shared-cost agreements distorted the type of health services to which people had access. Access to expensive highly technological, curative, individually oriented medicine was improved and these services were emphasized to the detriment of preventative and less costly forms of health care services. The Lalonde Report²⁸ was one of a number of studies that questioned the assumption, built into the insurance approach and the shared-cost agreements, that doctors plus hospitals equal health.⁶⁹

Hospitals continued to develop according to the theme of curative as opposed to preventative health care. Hospitals and doctors insisted on having state of the art technology

⁶⁸These references are fully noted in the bibliography.

⁶⁹Weller and Manga, p. 232.

in the system. Much of the equipment for curative care was expensive to acquire and needed additional technical staff to operate and service. Labour in hospitals thus became increasingly specialized and differentiated, an important contributing part of the bureaucratization process. Biomedical engineers, electro-cardiograph technicians and respiratory technologists became an integral part of hospital services. This paramedical staff required additional health funds in order to deliver their services.⁷⁰

The federal government tried to find a means to deter the increase in demand for additional resources. One of the more reknowned task forces addressing this question was the 1971 task force on The Cost of Health Services in Canada. This report identified three major alternatives for deterring the costs of health care. Those alternatives were:

- (1) The standards of health care now available can be reduced; or
- (2) Taxes, premiums, deterrent fees, can be raised even higher; or

⁷⁰ "Advances in scientific knowledge also have resulted in increases in the number of professional and technical paramedical staff members and in the need to purchase more expensive equipment. All of these developments have contributed to a steady rise in hospital costs." Hastings and Mosley, op. cit.; p. 152.

- (3) Ways can be found to restrain the growth of cost increases through the better operation of the health service structure now in existence and serious consideration be given to a future major revamping of the entire system.⁷¹

The third alternative was the approach which the task force actively pursued. It identified seven areas of health operations and made recommendations to restrict costs in those areas. The seven areas of inquiry were:

Hospital Services

1. Utilization
2. Operational Efficiency
3. Salaries and Wages
4. Beds and Facilities

Health Services

5. Method of Delivery of Medical Care
6. Price of Medical Care
7. Cost of Public Health Services⁷²

⁷¹ Department of Health and Welfare, Task Force Reports on the Cost of Health Services in Canada (Ottawa, Information Canada, 1971), p. 1.

⁷² Ibid., p. 2.

In terms of operational efficiencies, the task force concluded that there were three major problems in hospitals which attributed to their operational inefficiencies. Those problems were:

1. The lack of financial accountability to the hospital by the members of the medical staff.
2. Traditional patterns of medical and nursing practice are allowed to over-ride the need for the application of modern management techniques.
3. Financial restrictions prevent the modernization or replacement of old and inefficient hospital facilities.⁷³

As can be seen by the above comments of the federal task force, hospitals were expected to play an increased monitoring role over the practices of medical staff. In addition, the government itself, was increasing its role as monitor of hospitals as can be noted from the appointment of the task forces and royal commissions during this period. As

⁷³ Ibid., p. 170.

described earlier, the "monitoring function of an operating bureau" causes the increased rigidity of the organization. The direct impact of increased government involvement on hospital administration has been noted by White:

The expansion in governmental involvement has produced a demand for administrative personnel both to develop and administer the plans and regulations on behalf of the government and to respond to them within hospitals and other health agencies. In addition, the substantial levels of public funding in the health field requires an impressive increase in accounting and budgetary services.⁷⁴

With respect to the health services, the task force concluded that better planning and utilization of resources be practised in the seven areas identified in order to control cost. The regionalization of services and an increase in labour productivity were two of the major recommendations. The recommendation of the implementation of regional health

⁷⁴ Rodney, F. White, "The Administrative Component in Canadian Health Services: A Comparative View", Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meillicke and J. L. Storch (Ann Arbor: University of Michigan, 1980), p. 494.

planning boards, although possibly necessary, also was a further increase in bureaucraticization of the hospital. The regional boards represented further restrictions on the operations of hospitals. Duplication of function by hospitals in close proximity to one another was costly and unnecessary. Regional hospital boards were established to eliminate costly duplication of function and to coordinate existing activities.

The recommendation made by the task force for increased labour productivity through task simplification and specialization is also the cause of further bureaucraticization in the system, according to A. Downs.⁷⁵ Specialization in a large organization requires more coordination and steps to follow before goals are met.

The 1971 task force report summarized the cost impact of a policy move from private health insurance to a public health insurance plan. The inability of the provincial governments to contain health costs led to changes in the

⁷⁵ Downs, p. 159. "True intensive specialization produces important economies of scale which improve the quality of the product, and may even cause faster performance of each step in making it. But beyond a certain degree of specialization, greater speed in performing each operation is nullified by greater sophistication of each step and more time spent coordinating the increased number of steps."

shared-cost formula.

In 1975 Ottawa gave notice to the provinces of changes in its sharing of health costs. It announced a ceiling on the annual rise in costs that it would share, and the replacement of the open-ended medical services agreement with a per capita grant.⁷⁶

In 1977 the federal government replaced the shared-cost funding with block funding and the open-ended funding of the public insurance period came to an end.⁷⁷ The era of increased cost control and regulation of health care began. The efforts to contain the costs of health care were escalated from this point onward.

The Third Phase 1977 to the Present

The third phase of the historical analysis of health policy in Canada is 1977 to the present. This era is marked with federal and provincial attempts to curb spending on health care. The first federal attempt was the dissolution of the shared-cost program and the introduction of block funding. In 1977, the federal government introduced

⁷⁶Chandler, p. 213.

⁷⁷R. Van Loon, "From Shared Cost to Block Funding and Beyond: The Politics of Health Insurance in Canada", Perspectives of Canadian Health and Social Services Policy: History and Emerging Trends, eds. C.A. Meilicke and J.L. Storch (Ann Arbor: University of Michigan, 1980), p. 343.

the Federal-Provincial Fiscal Arrangements and Established Programs Act (E.P.F.) as a means to control spending. The new act allowed the provinces to collect increased taxes in the corporate and personal tax fields. The "catch" was that the federal treasury would no longer provide the shared costs of Medicare. Instead, the federal funds would provide a 25% unconditional block grant of the total program's cost. Richard Van Loon viewed the change in the funding formula as a transmuting of medical care politics into the politics of cost control. He concluded that the new funding formula and the politics it evoked would not curb spending.

This paper concludes that instability due to cost escalation--or, what politically is equally important, to the public perception that costs are increasing--is likely to persist. This will be the case in spite of (and perhaps even because of) the financial arrangements enacted in 1977.⁷⁸

⁷⁸ Van Loon, p. 343.

Van Loon was correct in his projection as demonstrated by the federal government contributions for health care to the provinces for the years 1977-1984.

Federal Government Contribution (Excluding Revenue Guarantee) to Provinces in Respect of Health Care⁷⁹

<u>Year</u>	<u>Contribution</u> <u>(\$ million)</u>	<u>Increase Over</u> <u>Previous Year</u> <u>(\$ million)</u>
1977-78	4,673	
1978-79	5,345	672
1979-80	6,094	749
1980-81	6,814	720
1981-82	7,631	817
1982-83	8,512	881
1983-84	9,354	842

The ever-increasing health budget expenditures have caused the provinces to try to restrain health care costs. With block funding the provinces no longer received matched

⁷⁹ Government of Canada, Preserving Universal Medicare (Ministry of Supply and Services, 1983) p. 29.

grants for health care costs. Provincial concern over health care costs heightened, from the point of E.P.F. onward.

In this current phase of health policy, the most important level of government is the provinces... The initiative that resided with the federal government has been returned to the provinces...⁸⁰

In their new role as regulators of the costs of health care, the provinces started their cost control campaign to restrain the costs for physician services. The physicians in turn have voiced their dissatisfaction with fee schedules by extra-billing and opting-out of Medicare by many physicians in Ontario.⁸¹ The doctors opting-out charge fees which are higher than the fee allowed under the insurance scheme. Other doctors have initiated the practice of extra-billing. Extra-billing is a financial charge levied against the patient and is in addition to the payment offered by Medicare. From a few of the provinces' points of view, extra-billing

⁸⁰ Chandler, p. 216.

⁸¹ A.D. Wolfson and Carolyn J. Tuohy, Opting Out of Medicare: Private Medical Markets in Ontario (University of Toronto Press, 1980), p. vii. "The late 1970's however, have seen the development in a number of the provinces, including Ontario, of a serious threat to universal medicare: the growth of private markets for services insured by the public program ...Rather than accepting payment from OHIP at OHIP rates... they choose to opt out."

solved the conflict over the fee schedule. But, from the federal point of view, extra-billing threatened the universality of Medicare.⁸² Table A indicates that few provinces extra-bill to any great extent. Ontario and Alberta lead the other provinces in this practice.

In 1980, as a result of these dilemmas, Emmett Hall was appointed to lead a Royal Commission to review the status of Medicare. The 1980 Commission was especially concerned with the loss of universality of Medicare due to these financial practices by physicians.

The real problem which I face in this regard is how the concept of adequate remuneration can be achieved without finishing up with a two tier system which would cast the poor, the aged and the unemployed into a category apart from those who are able financially or considered financially able by individual physicians to absorb an extra-charge.⁸³

The preservation of the universality of Medicare has become a major policy thrust of the federal government. The 1981

⁸²Government of Canada, Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements (Ottawa, Ministry of Supply and Services, 1981) p. 115.

⁸³E. Hall, Canada's National Provincial Health Programs for the 1980's (Ottawa, Government of Canada, 1980), p. 26.

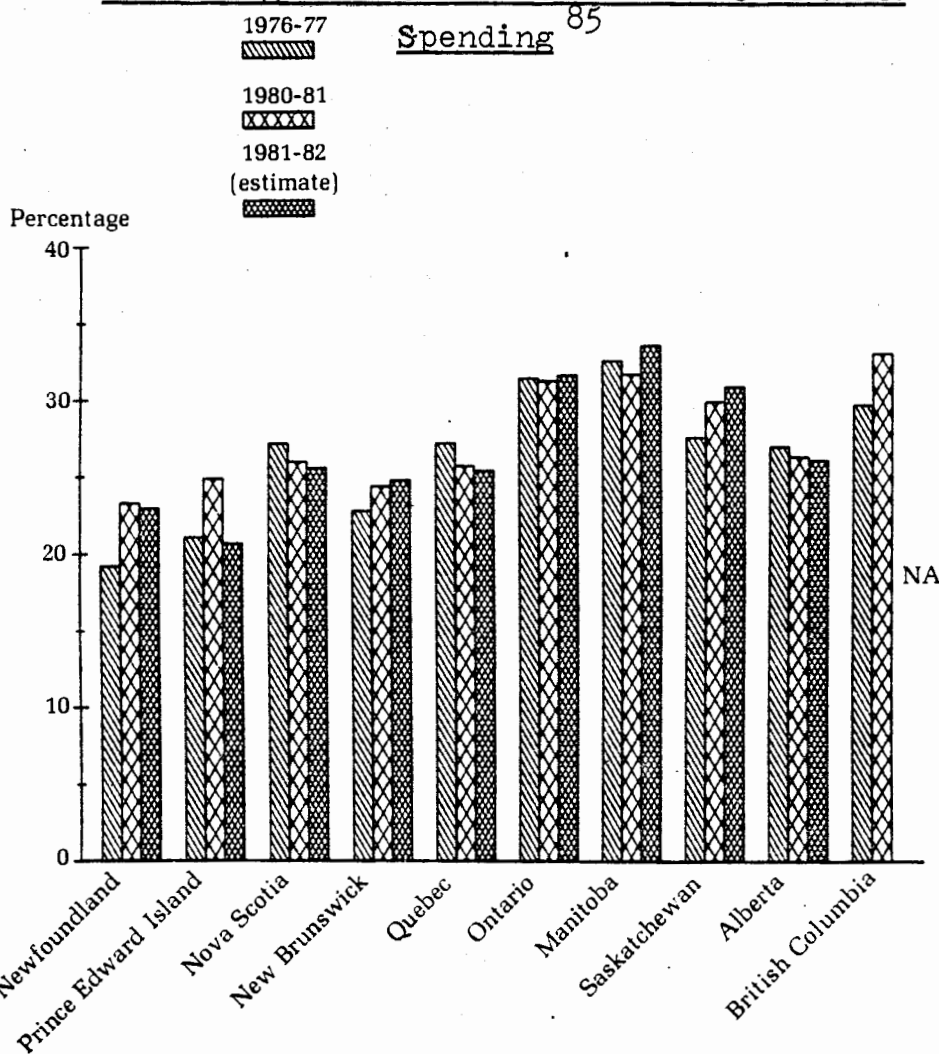
Task Force on Fiscal Federalism in Canada addressed national standards and universality in its final report. Specifically, the task force tried to determine whether or not the E.P.F. Act had provided sufficient restrictions to ensure provinces allocated enough monies to health care. Under the 1977 Established Programs Financing Act (EPF) provinces were allowed to determine program priorities. The task force report indicated that provincial ministers favoured the fiscal system established by the E.P.F. Act. Other groups making presentation to the task force did not agree with the provincial ministers.

In contrast, however, most of those making presentations to the Task Force, though not unhappy with block-funding in principle, argued that E.P.F. had been unsuccessful in terms of its program objectives. It was charged that the provincial spending in the areas in question had not grown as fast as federal transfers, and not fast enough to maintain services. Consequently, it was argued, some of the national standards in the health field were not being honoured. ⁸⁴

⁸⁴ Government of Canada, Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements (Ottawa, Ministry of Supply and Services, 1981), p. 71.

The chart below indicates the level of provincial spending on health expressed as a percentage of total provincial spending.

Provincial Government Health Spending as a Percentage of Total Provincial Government



⁸⁵Government of Canada, Preserving Universal Medicare (Ottawa, Department of National Health and Welfare), p. 15.

These federal figures reveal that four of the ten provinces, Prince Edward Island, Nova Scotia, Quebec, and Alberta, had decreased their allocation of resources to health in comparison to the percentage of the budget expended for health in 1976-77, the year before E.P.F. The figures indicated though, that six provinces had expended an increasing amount of their budget on health.⁸⁶ Many of the witnesses before the Task Force on Federal-Provincial Fiscal Arrangements suggested that federal funds were being channeled from health care and post-secondary education into other program areas.⁸⁷ Certainly in terms of the health care component, it would seem by the results of the federal study that the provinces were basically spending the same proportion on health in their budget. The statistics did not indicate that there was any major shifting of policy priorities from health to other government functions for the years 1976-77, 1980-81 and 1981-82.⁸⁸

The report on Federal-Provincial Fiscal Arrangements stated that the introduction of the E.P.F. Act removed

⁸⁶ Ibid., p. 14.

⁸⁷ Government of Canada, Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements (Ottawa, Ministry of Supply and Services, 1981), p. 75.

⁸⁸ Important to this discussion is an analysis of the revenue raising mechanisms which have been implemented during this period. The increase in user fees must be considered in terms of their contributory power to maintaining the present level of expenditure on health. This discussion will ensue in Chapter VI.

disincentives for the levying of user fees. The prior fiscal arrangements under the Hospital Insurance and Diagnostic Services Act, deducted user fees charged by the province from the federal transfer. The task force recommended against user fees and extra-billing as they felt they destroyed the universality of Medicare. They further recommended that federal transfers for health care and post-secondary education be separated and the transfers be made contingent upon programs achieving national standards.⁸⁹ The implementation of this recommendation would replace the existing unconditional grant with a conditional grant. Through a separation of education and health care in the grant structure, the federal government could ensure that all monies intended for a given sector were expended on that sector and the transfer would only be made if national standards were being adhered to.

Since the 1981 Task Force Report, the federal government has introduced a new piece of health legislation which embraces many of the concerns raised by the Task Force on Fiscal Federalism. The Canada Health Act is viewed by the

⁸⁹ Government of Canada, Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements (Ottawa, Ministry of Supply and Services, 1981), p. 115.

federal government as the appropriate legislative mechanism required to preserve the universality of Medicare. Legislation in reference to the education system has not emerged and possibly indicates the prioritization of the health care system over the education system at this point in time.

The Canada Health Act will replace the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. This act will place conditions on the transfer of federal monies to the provinces. The purpose of the act is cited below:

...to advance the objectives of Canadian health care policy, while recognizing the primary responsibility of the provinces for the provision of health care services, by establishing criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services⁹⁰ provided under provincial law.

The Canada Health Act is designed to eliminate extra-billing and user charges. As recommended by the 1981 Task Force on Fiscal Relations, the Health Act will transfer the payment for health only if the province has met the criteria

⁹⁰The Minister of National Health and Welfare, The Canada Health Act (Ottawa, The House of Commons of Canada, 1983), p. 5.

established by the act. Provinces allowing the levying of user charges will be penalized in the federal transfer by an equal amount. British Columbia and Alberta are opposed to the new act.⁹¹ These provinces feel that user fees and extra-billing provide reasonable means to offset increasing health care costs while the federal government argues that extra-billing and user fees build economic barriers to participation in the system. The federal government argues that the universality of the health care system will be destroyed if extra-billing and user fees are allowed, hence the Canada Health Act. If the Health Act is passed, the provinces will have to find alternative means of financing that portion of health care presently being financed by user fees. It could mean that further restraint will be placed on hospitals or the federal government will be pressured to transfer further funds to health care. The present Social Credit government of British Columbia certainly would be most reluctant to transfer additional funds to hospitals.

The Social Credit government introduced a draft Medical

⁹¹ The Vancouver Sun, Southam News (Vancouver, B.C., Aug. 8, 1983). "Alberta and British Columbia, with heavily conservative governments, seem to be placing the greatest emphasis on Ottawa's plan to financially penalize provinces that allow hospital user fees or extra-billing by doctors...B.C. Health Minister Jim Nielsen calls the federal stance 'ridiculous and retrograde' ...Alberta Intergovernmental Affairs Minister Jim Horsman wants the premiers to talk strategy to counter the move, perhaps in the courts."

Services Act on July 7, 1983. This bill was one of several bills introduced by the Social Credit party directed at reducing the costs of the delivery of government social services. Bill 24, The Medical Services Act, was directed at establishing different types of health care for the residents of British Columbia. This provincial draft legislation allowed for the establishment of regulations for the practice of extra-billing.

Regulations

53 (2) Without limiting the application of sub-section (1), the Lieutenant Governor in Council may make regulations for the following purposes and respecting the following matters:

(a) prescribing

- (i) health care services and benefits rendered by practitioners as insured services, and
- (ii) medical services rendered by practitioners that are not insured services, including
- (iii) prescribing different benefits and services for different classes of insured persons, and

(iv) imposing monetary limits on services and benefits available to different classes of insured persons.⁹²

The bill attempted to establish the principle of different types of care for different insured groups. It allowed for the provision of extra-billing which undoubtedly would cause the disintegration of the universality of the present system. The Medical Services Act caused a significant public protest as it was viewed as a direct threat to the universality of Medicare.⁹³ The public response to Bill 24 caused its withdrawal from this session of the legislature. The public protest to Bill 24 was indicative of the Canadian attitude and support for the Medicare system. A recent Southam news survey found the following results to a poll on Medicare:

A cross-country public opinion survey conducted for Southam News found Canadians over-

⁹²Minister of Health, James A. Nielsen, The Medical Services Act (Province of British Columbia, 1983), p. 18.

⁹³The Vancouver Sun, Southam News (Vancouver, B.C., July 12, 1983), p. 1.
"The legislation is the most serious and potentially the most dangerous product of the 'new right'. It is dangerous to the public health." Several labour and social service organizations held large public rallies protesting the government's new legislation.

whelmingly support medicare with 85 per cent rating it as one of the most important services government provides.

The poll found that 56 per cent don't think doctors are justified in more than they are paid by medicare while only 16 per cent backed extra-billing. About 17 per cent thought doctors should be able to bill extra in some cases.⁹⁴

Organized labour has also indicated their support for Medicare and preserving its universality as indicated in a recent speech delivered by Shirley Carr, the Executive Vice-President of the Canadian Labour Congress:

"We will protect (medicare) even if it means walking the streets" she said. "Medicare will never go down in Canada." This is labour's biggest fight and it won't be won easily, Mrs. Carr warned because the opposition has every intention of allowing profits for doctors far in excess of anything we can imagine.⁹⁵

⁹⁴ Ibid., (Sept. 12, 1983), p. 1.

⁹⁵ The Globe and Mail (Aug. 3, 1983), p. 4.

There is no doubt the issue of extra-billing and user rates will be contentious between the federal government, the provinces, doctors, and the public. A House of Commons Committee is presently hearing presentations on the proposed health act and they have heard objections from the doctors and support from such notables as Emmett Hall.⁹⁶ British Columbia has recently introduced a new mechanism for financing health care. Effective July 1, 1984, an 8% health maintenance tax will be levied on all provincial residents.⁹⁷ This new tax will be a part of the provincial income tax and is the province's method of getting around the new Health Care Act. Revenues lost due to new federal restrictions on user rates will be recouped through personal income tax. The residents of British Columbia will be paying increased taxes for the maintenance of the health care system.

The emphasis of the third phase of health care policy development has basically been one of continuing conflict between the provinces and the federal government over who should bear the burden of costs. The costs of the health

⁹⁶Ibid., (Feb. 15, 1984), p. 3.

⁹⁷H. Curtis, Budget 1984 (Province of British Columbia), p. 15.

care system continue to rise and hospitals seem unable to contain costs. (See footnote 79)

Recent discussions on rising health care costs have focused on lifestyle.

Thus an increasing proportion of the money we spend on health care is spent on taking care of the consequences of the behaviour of those who drink, smoke, and eat too much, drive too fast and sit still all the time, or the consequence of environmental pollution. At the same time the types of diseases associated with those conditions (heart disease and cancer) are also those where medical intervention with present technology tends to be expensive and of somewhat uncertain effectiveness.⁹⁸

The lifestyle of Canadians, according to Blomqvist, has been a major contributing factor to the escalating costs of the health care system. In addition, hospitals have evolved as organizations designed to treat and cure such lifestyle diseases. The focus of the system is on treatment rather than prevention.

⁹⁸Blomqvist, p. 118.

As the cost of health care, of research, of medical education, and of other components of the health enterprise continues to rise, society will probably be able to invest an even smaller proportion of the total in efforts to control the causes of illness, because virtually all the money will be needed to correct what went wrong--after the fact. Thus, we would appear to be caught in a no-win situation, nurtured by inflation, but exacerbated by the overwhelming pre-occupation of the health care system with remedial as opposed to preventative care.^{98a}

Expenditures associated with the lifestyle-related diseases are a major cost of health care. The population's expectations of the health care system are centered around the fact that it will provide longer life. In order for the system to meet this goal, it must deal with the diseases associated with lifestyle factors. This is a significant expense to the system.

The Canada Health Survey conducted by Statistics Canada was directed at identifying which groups in society expose themselves to lifestyle risks and what the projected long

^{98a}J.Alex Murray, ed. Health Care Delivery Systems in North America: The Changing Concepts (Canadian-American Seminar, University of Windsor, 1977) p. 28.

term consequences of exposure to the risk will be. The attached figure extracted from the study summarized the data in terms of the risk factors, health status and consequences model. (See Figure 1). Exposure to the risk leads to a given set of consequences in terms of the increased utilization of the health care system. Some health programs are now trying to direct health care programming at preventative health care, and through community educational programs, health care professionals are trying to educate Canadians to practise preventative health care.

In terms of the total expenditure pattern on health, the majority of funds are still being expended on the curative approach, but programs directed at prevention are being implemented. For example, the federal government has a 10 million dollar Health Promotion Program designed to "encourage and assist Canadians to adopt a lifestyle that enhances their physical, mental, and social well-being".⁹⁹ The federal government though, transfers 4 billion dollars in total for health services to the provinces. The Health Promotion Program represents only .025% of the total transfer

⁹⁹Government of Canada, The Expenditure Plan to 1985-86 (Ministry of Supply and Services, 1982), p. 21.

for health. It would therefore be spurious to state that health promotion is a major policy thrust if dollars expended is an indicator of major policy thrust. The hospital though, is being required to become more of an agency for the promotion of good health. Daycare programs offering educational services to the public on health care are becoming more popular. This type of service requires the hospital to change from its treatment-oriented focus to a prevention-oriented service. The hospital of the future may well become more of an educational mechanism than a treatment centre.¹⁰⁰ The shift to an educational approach would require a major change in hospital organizational structure. There would likely be a department of community education designed to educate the community in preventative health. Treatment related departments would be lessened in size and role. The change and evolution of organizational structure, as noted in Chapter I, is a slow adaptive process for the bureaucratic organization.

In concluding this chapter, the following points should be emphasized. First, the development of Medicare has

¹⁰⁰White, p. 500.

"Several of the recent proposals advocate the establishment of different forms of community health centres, which would provide health education and certain social services in addition to direct medical care."

been the product of strong populist support in Canada. After the Depression, people demanded health care services of a quality better than what local governments could offer. Provincial governments initially provided some funding and the federal government became involved after the second world war. The commitment to insured health care services has been established by both the federal and provincial governments. Secondly, the provision of universal health care programs has led to spiralling expenses since the second world war. The fiscal responsibility for health programs has been the subject of dispute between the two levels of government. The new Canada Health Act has been prepared to protect the universality of Medicare and provinces allowing extra-billing and user fees outside of the federal regulations will be penalized.¹⁰¹

Hospitals at the same time, have grown at a very fast rate and their expansion was encouraged by the increase of public funds at the end of World War II which were directed at health. The hospital became increasingly bureaucratized as it grew. This bureaucratization was the result of the fast growth, the increased involvement of the

¹⁰¹Although it is noted here that the provinces may seek alternate means to subsidize the costs of health care. A good example is B.C.'s new health maintenance tax. The province is levying an 8% income tax to compensate for user rate revenues lost due to the new Health Care Act.

state in health and the specialization of labour within the hospital. The introduction of cost-shared programs increased the usage of hospital services and hospitals. Hospitals continued to expand to meet this demand. The lifestyle of the population also helped to define the emphasis of the thrust of medical care. The lifestyle-related diseases have represented a major portion of the caseload of hospitals and they also have represented some of the most expensive treatments contributing to the high cost of health care.

Table A

PROVINCIAL HEALTH INSURANCE PLANS:
Extra-billing/User Charges by Hospitals

PROVINCES/ TERRITORIES	SOURCE OF FUNDING	EXTRA-BILLING FOR INSURED SERVICES BY PHYSICIANS	USER CHARGES*
British Columbia	Premiums and general taxation; pre- miums paid on behalf of social assistance recipients: up to 90% premium assistance for low income earners; temporary premium assist- ance in cases of financial hardship.	Virtually all doctors have agreed not to opt out of the plan, or extra-bill. Estimated annual amount of extra-billing \$0.00.	Has user charges of \$8.00 per visit for day care surgical services, \$10.00 for emergency services and \$8.50 a day for a hospital bed. (Estimated annual amount \$35 million) Also daily charge for chronic care patients.
Alberta	Premiums and general taxation; pre- mium exemptions for elderly, and very low income; premium assistance for low income.	No opting in or out required. Doctors may extra-bill if patients agree beforehand. Doctor bills plan for authorized fee and patient for extra amount/or patient for full amount. Estimated annual amount of extra-billing \$13 to \$14 million.	\$10.00 admission charge. Also daily charge for chronic care patients after 120 days. Extensive increases planned for Jan. 1/84 include up to \$20 a day for hospital services.
Saskatchewan	No premiums; financed from general taxation	Doctors may extra-bill and remain in plan by billing patient directly who then seeks reimbursement from the plan. If patients not charged more than plan schedule, doctor bills plan directly. Estimated annual amount of extra-billing \$2.3 million	No user charges.
Manitoba	No premiums; finance from general taxation, including a 1.5% payroll tax levied on employers.	To extra-bill, doctor must opt out of plan and bill patient directly. Patient applies to plan for reimbur- sement of plan schedule portion. Estimated annual amount of extra- billing \$1.2 million.	Daily charge for patients awaiting nursing home placement.

PROVINCES/ TERRITORIES	SOURCE OF FUNDING	EXTRA-BILLING FOR INSURED SERVICES BY PHYSICIANS	USER CHARGES*
Ontario	Premiums and general taxation; premium exemptions for welfare recipients and elderly; premium assistance for low income; temporary premium assistance in cases of financial hardship.	To extra-bill, doctor must opt out of plan and bill patient directly. Patient applies to plan for reimbursement of plan schedule portion. Estimated annual amount of extra-billing \$50 million.	Daily charge for most chronic care patients.
Quebec	3% payroll tax levied on employers, and general taxation.	To extra-bill, doctor must opt out of plan and bill patients directly. Patients cannot seek reimbursement from plan. Very few doctors opted out. Amount of extra-billing \$0.00.	Daily charge for prolonged care patients.
New Brunswick	No premiums; financed from general taxation.	Doctors may extra-bill and remain in plan by billing patient directly who then seeks reimbursement from the plan. If patients not charged more than plan schedule, doctors bill plan directly. Estimated annual amount of extra-billing \$0.2 million.	Daily charge for patients awaiting nursing home placements. \$6.00 user charge for out-patient services.
Nova Scotia	No premiums; financed from general taxation.	Doctors may extra-bill and remain in the plan. Doctor bills plan for fee and patient for extra amount. Estimated annual amount of extra-billing \$3.4 million.	No user charges.
Prince Edward Island	No premiums; financed from general taxation.	Doctors may extra-bill and remain in plan by billing patient directly who then seeks reimbursement from the plan. If patients not charged more than plan schedule, doctors bill plan directly. Doctors may also opt-out for all patients. Estimated annual amount of extra-billing \$0.05 million.	No user charges.

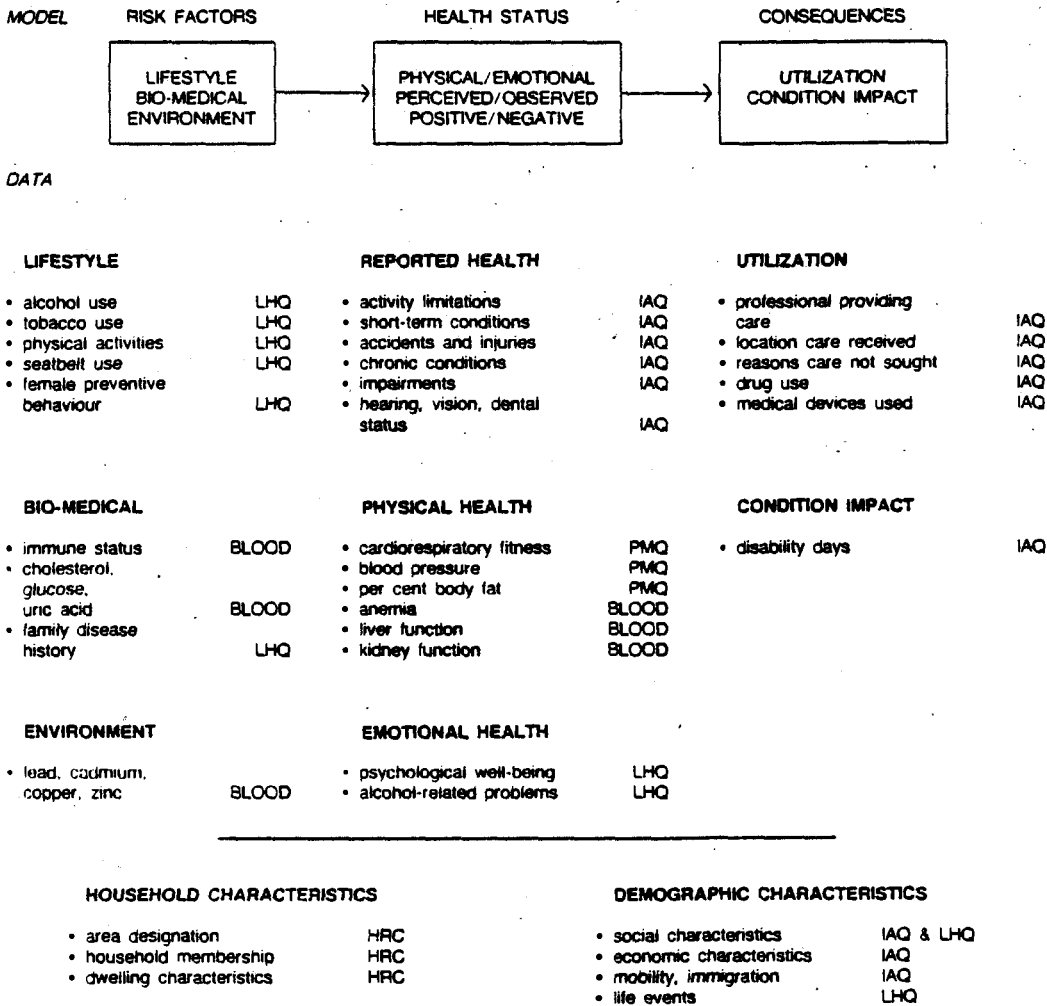
PROVINCES/ TERRITORIES	SOURCE OF FUNDING	EXTRA-BILLING FOR INSURED SERVICES BY PHYSICIANS	USER CHARGES*
Newfoundland	No premiums; financed from general taxation.	To extra-bill, doctor must opt out of plan and bill patient directly. Patient applies to plan for reimbursement of fee schedule portion. Estimated annual amount of extra-billing \$0.03 million.	\$5.00 daily charge to a maximum of \$75.00 (estimated annual amount \$1 million).
Yukon	Premiums and general taxation. Premium exemptions for welfare recipients, elderly and no taxable income; premium assistance for very low income.	No doctor opted out of the plan and able to extra-bill.	No user charges.
Northwest Territories	No premiums; financed from general taxation.	No doctor opted out of the plan and able to extra-bill.	No user charges.

* Each province has unique exemptions to these charges which have not been included in table.

Source: Health and Welfare Canada,
November 10, 1983

Figure 1

Figure II. A Summary of Data Items



KEY: HRC - Household Record Card
 IAQ - Interviewer Administered Questionnaire
 LHQ - Lifestyle and your Health Questionnaire
 PMQ - Physical Measures Questionnaire
 BLOOD - Blood sample

} Interview component
 } Physical measures component

Chapter III

The Methodology for Analyzing the Impact of the E.S. Program on Hospital Operations

The previous chapter has outlined the "natural history" of the health care system and the present political and economic environment which health care organizations face. The purpose of this chapter is to outline the methodological approach which will be used to measure the hospital's internal response to a change in the political-economic environment, namely, the introduction of the E.S. program. In addition, the hypotheses derived from the theory are operationalized in terms of the methodology. The survey sample and the justification for the selection of sample are also discussed. The intent of this chapter is to establish the research framework for the data collection and analysis in the next chapter.

As stated in Chapter I, this thesis views the health care organization as a bureaucratic institution which is resistant to change. The thesis therefore, has predicted that the

E.S. program will cause minimal change to hospital behaviour. In order to measure the changes caused by the E.S. program the conceptual model for measuring effectiveness developed by A. Etzioni will be used. The model will focus on the organization and its sub-units.¹ By means of the systems model, the level of adaptation of the organization to a change in the political environment will be measured. The systems model advocated by Etzioni is quite distinct from the goal model traditionally used in this type of analysis. A goal model analysis in this thesis would measure how well the organization has met its goals after financial restraint was introduced. According to Etzioni, the goal model has basic methodological deficiencies:

One of the major short-comings of the goal model is that it frequently makes the studies findings stereotyped as well as dependant on the model's assumptions. Many of the studies show (a) that the organization does not realize its goals effectively and/or (b) that the organization has different goals from those it claims to have.²

¹See footnote 49, Chapter I.

²F. Baker, Organizational Systems: General Systems Approaches to Complex Organizations (Homewood, Ill.: Richard D. Irwin Inc. 1973), p. 459.

Etzioni maintains that goals are targets and are cultural norms while organizations are social systems and should be studied as such. Etzioni's systems model would not evaluate an organization's effectiveness by how well it has met its organizational goals, but would evaluate the optimality of the distribution of resources amongst the sub-units.³ It is the distribution of resources amongst the sub-units of the hospital which will be determined in this study. A qualitative statement regarding the impact of the E.S. program can only be made if one has defined how the restraint has been distributed amongst the sub-units of the organization.

Etzioni's systems model will be used to examine three scenarios with respect to hospital operations. The first scenario is considered to be the normal situation and is focused on the fiscal year 1981-82. A review of the funding increases for the fiscal years prior to 1982 indicate hospital programs were providing funding which was equal to or greater than inflation. See Chart V below. Quite clearly, hospital programs made budget allocations to

³Ibid., p. 462. "But the central question in the study of effectiveness is not 'How devoted is the organization to its goal?' but rather, 'Under the given conditions, how close does the organizational allocation of resources approach an optimum distribution?'"

Administration and Payments to Hospitals

	<u>1977-78</u>	<u>1978-79</u>	<u>1979-80</u>	<u>1980-81</u>	<u>1981-82</u>
Total Payment ⁴	577,758,118	631,382,771	700,643,828	965,279,009	1,085,857,935
Increase Over Previous Year's Payment	-	53,624,662	69,261,057	264,635,171	
Increase Exp- ressed as a Percentage		9.2%	10.9%	37.7%	12.5%
Average CPI for Time Period for Canada ⁵		8.9%	9.2%	10.8%	12.3%

Chart V

⁴Ministry of Health, Annual Report (Province of B.C., 1981), p. 36.

⁵Statistics Canada, Consumer Price Index (Ministry of Supply and Services, Ottawa, 1984), p. 11.

hospitals which, in the aggregate, were in excess of inflation. A study conducted by W.T. Dyke in 1979 confirms that hospitals were receiving adequate financing⁶ in the late seventies. Dyke discusses though, the inefficiencies of the hospital programs' funding process from an administrative point of view.⁷ These inefficiencies will be discussed further in Chapter V, the analysis. In 1981-82 hospitals received a total budget allocation increase of 12.5% over their previous year's allocation.⁸ As inflation was only 12.3% in 1981 this will be considered a normal funding situation to at least maintain hospital operations in the aggregate. This is not to say that there were not differing budget increases from one institution to the next.

⁶W.T. Dyke, "Hospital Financing in B.C., Is There a Better Way?" (MBA thesis, Simon Fraser University, B.C., 1979), p. 1. This is confirmed by the fact that Dyke states that the present budgetary system of "tight budgets" causes "unnecessary concern and unrest at all levels of management."

⁷Dyke, p. 12. "Table 2 shows that 81% 'agree' or 'strongly agree' that the B.C.H.P. method of 'tight' budgets with adjustments after the close of the fiscal year, causes unnecessary concern and unrest during the year. This appears to indicate that although the respondents perceive a problem in the 'per diem' method of payments, they are even more concerned with the dysfunctional aspects of the 'tight budgets' situation."

⁸See Chart 1.

The second scenario is fiscal year 1982-83 and it is being considered the abnormal situation. The funding increase allocated to health in 1982-83 was 7.3%.⁹ Inflation in 1982 was 10.8%.¹⁰ It therefore appears that health was underfunded by the province during 1982-83.

The third scenario covers the time period 1983-84 and at the time of this research, year-end adjustments had not been made to hospital budgets. It is therefore difficult to determine if the third scenario is a normal or abnormal situation. This research will examine the hospital financial and operational data for the first nine months of 1983-84 and will determine what changes have occurred in hospital operations since 1982-83. This comparison will at least indicate how hospitals are operating after an abnormal fiscal year.

The thesis of this paper, as explained in Chapter I, predicts that changes to hospital operations, as a response to the E.S. program, will be short/intermediate run in nature; structural organizational changes of a long term nature will

⁹Province of British Columbia, "Restraint and Recovery: The Next Steps" (Victoria, B.C., 1983), p. 5.

¹⁰Statistics Canada, Consumer Price Index, p. 11.

not result from the E.S. program.¹¹ This prediction will be tested and is presented in the form of a hypothesis. The hypothesis states that the E.S. program will cause "minor" organizational changes and hospitals will continue their normal operations in the short run. It is the intent of this research to assess the types and significance of changes which result from the E.S. program. The research will also attempt to assess the impact of the E.S. program on quality of services.¹²

The important variables requiring operationalization in the hypothesis are "E.S. program", "minor change", and "major change". The "E.S. program" is being operationally defined as the level of financial restraint administered during the term of the program by the provincial government. The percentage increase or relative decrease in operating budgets for each hospital surveyed will constitute the level of restraint. An important examination with respect to this variable will be the uniformity of restraint from one hospital to the next. In addition, this variable will be examined over the fiscal year 1982-83 and further changes to any or all

¹¹See page 13 of Chapter I.

¹²This assessment will be discussed in Chapter V.

hospitals surveyed will be accounted for. If hospitals were given further increases or grants during the fiscal year, this will be considered in the analysis.

"Change" is a crucial concept to this study. In the hypothesis the prediction is that the E.S. program will cause "minor" changes and "major" changes will not occur in the short term. The "minor" organizational changes are defined as small shifts in the organizational structure or operations. Essentially all departments continue their established organizational function. Cuts in production to reduce costs are considered changes in operation levels of the organization. The effect the change in operation levels has on level of service and effect on quality of health care delivered will be discussed in Chapters V and VI.

"Major" organizational changes are defined as changes which result in new technologies being introduced and significant organizational restructuring. Any major changes noted will also be discussed in Chapter V and VI in terms of impact on quality of service delivered. The "change" in hospital operations or organization processes will be

measured in terms of the change in distribution of resources amongst the sub-units. Each hospital department will be evaluated for all three scenarios in terms of their increase or relative reduction in appropriations from the annual budget. Specifically, the man years and the operating monies allocated to a hospital department will be compared and contrasted to the other hospital departments for 1981, 1982, and the nine months of 1983. Each department will also be considered in terms of its own level of operation over these years. This comparison will reveal whether or not one department has been affected by the same or differing amount as another hospital department.

The difference between a minor and major change in operating levels is difficult to evaluate but this paper has defined minor change as any shift in resources to -5%. It is felt that any reduction greater than 5% in a growth-oriented industry when inflation is at 10.5%¹³, must be considered as a major change.¹⁴ Therefore, the operational definition for minor change in this study, is a reduction of resources to 5% and a major change is greater than 5%.

¹³Statistics Canada, Consumer Price Index

¹⁴This is an arbitrary definition but is based on the assumption that there is some "fat" in the system to a possible 5 per cent. This assumption is also based on the author's personal experience in the public sector during this time period.

Overall, hospital "expenditure patterns" will also be examined for the time period studied. The expenditure patterns will reveal if there has been major or minor organizational restructuring. If the hospital adapts to the financial restraint by deleting an area of operation such as a treatment centre or a public relations function, then this will be noted. Also if a hospital introduces new technologies to adapt to restraint, this will also be noted.

To substantiate the findings and to further assess the impact of the E.S. program, interviews were conducted with senior hospital administrators. By conducting the interviews in the Spring of 1984, the short term impact of the E.S. program was determined. The perception of the problem and the impact of the policy on the organization was also determined through the interviews.

The statistical comparative data was obtained for select hospitals from the Ministry of Health H.I.A. 35 reporting forms (See Appendix A). These forms contain all of the operating information necessary to assess the impact of the E.S. program. They also contain the statistical information pertaining to level of service being offered

by the hospital. The indicators of level of service are such items as the number of beds, lab tests, number of treatments and number of examinations. These statistics are contrasted against the statistics showing the level of demand for services, ie. the number of admissions, the number of out-patient visits and the percentage occupancy. By comparing the output statistics with the demand statistics one will be able to assess whether or not sub-unit services have been reduced for a stable or a changing demand, or conversely, sub-unit services have been increased or remained the same for a changing demand. The changing demand, it must be realized, is not necessarily a function of market factors but could conceivably be the result of restrictions on admissions put in place by hospital officials.

The last consideration in this chapter is a discussion of the hospitals surveyed. As has been mentioned, this analysis includes statistical analyses for two one-year periods and a nine month period. The comparison will be conducted in terms of hospital sub-units. The survey sample of this study was to include all general hospitals and extended care hospitals in the lower mainland of B.C., up to 600 beds in size. Hospitals over 600 beds in size were

not included as it is believed that the number of operational variables affecting these hospitals' operations are too numerous and difficult to control for. For example, the large institutions share more services with other institutions thus making the assessment of certain costs difficult. In addition, it is believed that the major institutions exert greater political control over their environment thus changing the impact of policy on their operations.

There are nineteen hospitals in the lower mainland of B.C. in the category of general hospital services and extended care, under 600 beds (See Appendix B). Of the nineteen hospitals requested to participate in this study, nine hospitals agreed to participate. The nine who agreed are more than a representative sample of the total group based on their size, area of location, and types of services delivered. Of the four general hospitals (acute and extended services) with 200 to 300 beds, ~~three~~ agreed to participate. In the 100 - 200 bed general hospital group, one of the four participated in the study. Of the six 300 - 600 bed general hospital group, four participated in the study. Finally, one hospital participated from the four extended care hospitals. In total, 47% of the eligible hospitals agreed to participate.

The names of the hospitals have been omitted to respect confidentiality. The hospitals are described in terms of their size and the type of service offered (i.e. acute and/or extended care).

<u>Hospital</u>	<u>Beds</u>		<u>Total</u>
	<u>Acute</u>	<u>Extended</u>	
1st Street	386	215	601
2nd Street	60	100	160
3rd Street		300	300
4th Street	519		519
5th Street	401	169	570
6th Street	157	75	232
7th Street	121	150	271
8th Street	369	207	576
9th Street	107	119	226

The next chapter will discuss the results of the survey and the operational change comparison for the hospitals reviewed.

Chapter IVFindings

The intent of this chapter is to define what the E.S. program has meant to hospitals. It reports on the findings with respect to changes in hospital sub-unit operations and management as a result of the E.S. program. The survey included a sample of nine hospitals in the Lower Mainland. Through the use of Etzioni's systems model, the distribution of resources amongst the sub-units will be examined and changes between the years 1981-82, 1982-83 and the nine months of 1983 ending Dec. 31, 1983, will be noted. This empirical data has been substantiated with interview information obtained from senior hospital personnel. Through an analysis of the empirical data and the interview information, an assessment of the impact of the B.C. financial restraint program on health care will be addressed.

Before embarking on a discussion of the empirical findings, it is important to first discuss the organization of the sub-units in a hospital. The hospital organizational structure is basically the same from one hospital to the next. The general hospital is hierarchically structured along the lines

outlined in Chart VI.¹ An extended care hospital is structured differently in that it does not have the same patient services as those offered by the general hospital. Many of the diagnostic and treatment services associated with acute care are not offered by the extended care facility. These include services such as lab and radiology. Extended care is primarily hospitalization for the aged, due to chronic or long term illness; it is not for the treatment of acute illness. The typical organizational chart of an extended care hospital is contained in Chart VII.² As can be readily discerned from the organizational charts, there are more services and staff required to deliver acute care services as opposed to extended care services. The costs for acute care services are calculated as five times greater than the services required for extended care.³

The organizational charts provide an understanding of the

¹This is the typical organizational structure of the hospitals included in the survey.

²This is the typical organizational structure of the hospitals included in the survey.

³L.A. Leferbvre, Z. Zsigmond, M.S. Deveraux, A Prognosis for Hospitals (Government of Canada, 1979), p. 16. "...patient days could be spent in nursing homes which are one-fifth of the cost of acute care."

Medical Director

Executive Director

Assistant Executive Director
(Support Services)

Assistant Executive Director
(Patient Services)

Finance

Materials Management

Personnel

Public Relations

Nursing

Admitting

Medical Records

Dietary

Housekeeping

Stores

Central Supply and Distribution

Out-Patient Services

In-Service Education

Lab

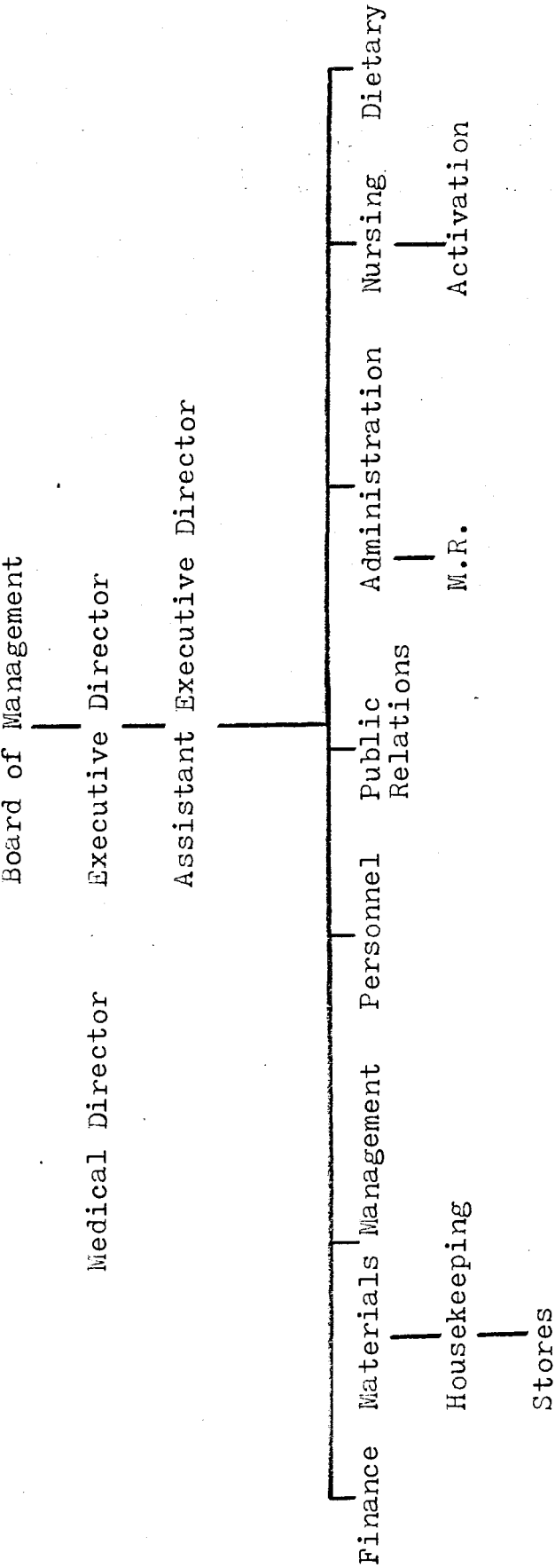
Physiotherapy

Social Services

Radiology

Respiratory Technology

Typical Organizational Chart of a General Hospital



Typical Organizational Chart of an Extended Care Hospital

organizational structure of the sub-units in the hospitals surveyed. It is the change in distribution of resources to these sub-units which will be examined over the years 1981-82, 1982-83, and the nine months ending Dec. 31, 1983. This distribution will indicate how organizations have coped with financial restraint.

The first step in the survey analysis was to establish the level of restraint which was imposed on the hospitals surveyed. Level of restraint has been operationally defined as the percentage increase or decrease in budget received by the hospital from one year to the next. As established in Chapter III, 1981-82 is being treated as a normal year as the level of funding to hospitals, from the Ministry of Health, for operating, was equal to inflation.⁴ The year of financial restraint was 1982-83, as the Ministry transferred less money to hospitals for operating than the level of inflation.⁵ The nine months of fiscal year 1983-84 will be considered later in this chapter.

Inflation for 1982-83 was 10.8%⁶, therefore hospitals

⁴See footnote 8 in Chapter III.

⁵See footnotes 9 and 10 in Chapter III.

⁶Government of Canada, Consumer Price Index (December, 1983).

receiving operating budgets of less than 10.8% will be considered as experiencing financial restraint. Hospitals receiving operating budgets greater than 10.8% will be considered as receiving normal financing or growth-oriented financing depending on the magnitude of increase over the 10.8%. The budget allocation increases from Hospital Programs for 1982-83 are outlined below:

Table B

1982-83 Funding Increases in

Operating Budgets from Hospital Programs

Number of Hospitals
Receiving This Increase

Less than 6.0%	
6.0 - 6.9%	
7.0 - 7.9%	
8.0 - 8.9%	3
9.0 - 9.9%	3
10.0 - 10.9%	
11.0 - 11.9%	
12.0 - 12.9%	1
13.0 - 13.9%	1
14.0% and greater	1

Table B indicates that six of the hospitals in the survey received a budget increase of less than 10.8% over their 1981-82 budget and three hospitals received an increase greater than 10.8%. Quite clearly, two thirds of the hospitals surveyed received a budget allocation in 1982-83 which represented financial restraint.

The next step in the research was to define how hospitals had operationally adapted to the financial restraint. From an overall organizational perspective of operations it is important to define whether or not hospitals maintained their level of operations. Hospital operating level is defined largely by the number of beds which are classed as open. For each bed which is open, there are staff and resources allocated to servicing a patient in that bed. Therefore a determination of the change in number of beds will indicate the change in hospital operations as a response to financial restraint. Bed closures allow for the reduction in staff, medical supplies, food and general overhead, thus lowering costs to balance budgets. For example, the closure of a ten bed medical ward means the nursing staff and supplies allocated to that ward are no longer required. It also means that the dietary staff are required to make fewer meals and

the operating rooms must do fewer operations. The production level of the hospital is decreased thus lowering costs. Of the hospitals surveyed, the following table indicates the percentage change in hospital beds for 1982-83. For the purpose of this study, the acute and extended care beds have been treated as separate divisions. The separation of the categorization of beds allows one to determine if changes have occurred in the acute or extended care operations. Table C indicates that there was no change in extended care beds for the time period 1982-83, with the exception of one 25 - 29.9% increase in these beds. Acute care beds though, did change significantly during this time period. Five of the eight hospitals with acute care operations implemented reductions in acute beds varying from 5% to 24.9%. Two hospitals expanded acute care beds in the range of 10% to 24.9% of their 1981-82 level and one hospital had no year end change in acute care beds. (Note that this hospital did implement a temporary closure during the year.) The table indicates that in 1982-83, 62% of the hospitals surveyed with acute care beds implemented bed closures in 1982-83. It also indicated that of the hospitals with extended care beds, there were no reductions.

Table C

The Percentage Change in Hospital Beds ClassedAs Open for 1982-83 Compared to 1981-82

<u>Change in Hospital Beds</u>	<u>Number of Hospital Divisions Implementing This Percentage Change (1982-83)</u>	
	<u>Acute</u>	<u>Extended</u>
<u>Increase</u>		
0% - 4.9%		
5% - 9.9%		
10% - 14.9%	1	
15% - 19.9%		
20% - 24.9%	1	
25% - 29.9%		1
<u>No Change</u>	1	7
<u>Decrease</u>		
0% - 4.9%		
5% - 9.9%	2	
10% - 14.9%	1	
15% - 19.9%	1	
20% - 24.9%	1	
25% - 29.9%		

It is interesting to note that the hospitals with acute care beds which received budget increases of less than 9.9% are the hospitals which reduced acute care beds in 1982-83. The hospitals with acute beds which received budget allocations of greater than 12.0% in 1982-83 were able to maintain their level of operations and, pending the budget increase, show growth in the number of beds. The next step in the research was to examine how financial restraint was distributed amongst the sub-units of those organizations which had shrinking budgets.

Etzioni's systems model provides for an examination of the reduction of resources to the organizational sub-units, in order to define organizational change. This type of conceptual perspective allows the researcher to understand the impact of financial restraint on services. By examining where resources have been reduced to the organizational sub-units, one can assess if the reduction has been evenly distributed throughout the organization or if some departments have experienced greater reductions than others. The difficulty experienced in assessing the distribution of reduction in resources is that the measuring of the total change in resources to the sub-units is a difficult task.

This is largely a function of the lack of complete information available. The study was not able to obtain a total breakdown of distribution of supply expenses to the sub-units. But for the purposes of this study, it should be noted that employment in a hospital represents 80% of the total hospital operating budget.⁷ Employment distribution statistics, therefore, represent an excellent indicator of the distribution of resources throughout the hospital. Medical supplies and overhead costs which compose the other 20% of the budget are basically utilized in proportion with the number of beds which are open. Therefore, bed closures represent a reduction in the utilization of medical supplies and overhead costs. The major savings though are obtained through staff reductions, as manpower is the largest and most expensive element of the budget.

The sub-units of the hospital will be considered in terms of two major groupings, namely, nursing and support services. The tables in Table H of this chapter illustrate the staffing changes between 1981-82 and 1982-83 for hospitals receiving a budget of less than 9.9%. This table sets the basis for understanding the effects of financial restraint

⁷Of the hospitals surveyed, two were randomly sampled and the manpower budget composed approximately 80% of the total operating budget.

on the organization. The information in Table H will be contrasted with Table I of this chapter, which is the same staffing comparison for hospitals receiving a budget increase of 12% or greater (normal or growth-oriented budgets).

Table H indicates that major cuts in departmental operations were implemented in 1982-83 in order to cope with restraint by those hospitals receiving budget increases of 9.9% or less. It will be remembered that Chapter III defined a major reduction as a loss of resources of greater than 5%. A minor reduction was up to 5%. Table below indicates the distribution of minor and major changes for the hospital departments surveyed in Table H. Of the five hospitals in this group, all implemented more major changes than minor changes. Forty-nine of the total sixty-nine departments compared experienced major reductions in staffing. Specifically, twenty-three reductions were between 5.0 - 9.9% and twenty-six were greater than 10.0%. Twenty changes were considered minor as they involved a change of 4.9% or less.

Table D

Comparison of Minor to Major Change
for Hospitals Receiving a Budget Increase
of Less Than 9.9% in 1982-83

	<u>Hospitals</u>						<u>Total</u>
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F*</u>	
<u>Minor Changes</u>							
0 - 4.9% increase	1	2		1	1		5
no change	1				3		4
0 - 4.9% decrease	<u>4</u>	<u>2</u>	<u>3</u>	<u>1</u>	<u>1</u>		<u>11</u>
Sub total	6	4	3	2	5		20
<u>Major Changes</u>							
5.0 - 9.9% decrease	4	5	6	6	2		23
10.0 - 14.9% decrease	2	4	2	3			11
15.0 - 19.9% decrease	2	2	2	2	2		10
greater than 19.9% decrease	<u>1</u>	<u>—</u>	<u>—</u>	<u>1</u>	<u>3</u>		<u>5</u>
Sub total	9	11	10	12	7		49
Total	15	15	13	14	12		69

*Hospital "F" was excluded from this part of the study as only aggregate data was reported and could not be used.

In the group receiving a budget increase of greater than 12% in 1982-83, over 1981-82, Table E below indicates the major versus minor changes for this group. The results of the comparison in Table E reveal that 73% of the changes implemented for this group are minor or growth-oriented changes. Only 27% of the changes are major operational reductions. It is interesting to note though that reductions of a significant nature were implemented for this group, even though the majority of the changes were minimal or growth-oriented.

Quite clearly, when comparing the two groups discussed in Tables D and E, it is evident that the group receiving budgets of less than 9.9% were required to make more major changes in the form of staff reductions. The distribution of percentage reductions in staff for the group receiving budgets of less than 9.9% are contained in Table F and are in Table G for the group receiving budgets of 12% or greater. The staff have been aggregated into two major groupings, nursing and support services and an overall comparison has been established.

Table E

Comparison of Minor to Major Changes
for Hospitals Receiving a Budget Increase
of 12% or Greater in 1982-83

	<u>Hospitals</u>			<u>Total</u>
	<u>G</u>	<u>H</u>	<u>I</u>	
<u>Growth</u>				
greater than 19.9% increase	2			2
15.0 - 19.9% increase	2			2
10.0 - 14.9% increase	3			3
5.0 - 9.9% increase	<u>4</u>		<u>1</u>	<u>5</u>
Sub total	11		1	12
<u>Minor Changes</u>				
0 - 4.9% increase			1	1
no change	1	3	2	6
0 - 4.9% decrease	<u>2</u>	<u>6</u>	<u>4</u>	<u>12</u>
Sub total	3	9	7	19
<u>Major Changes</u>				
greater than 4.9% decrease	<u>1</u>	<u>5</u>	<u>5</u>	<u>11</u>
Sub total	1	5	5	11
Total	15	14	13	42

Table F

Hospitals Receiving Budget Increases
in 1982-83 Less Than 9.9% Over
the 1981-82 Level

<u>Total Change in</u> <u>Support Service Staff</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.*						
no change						
0 - 4.9% dec.*						
5.0 - 9.9% dec.	1					
10.0 - 14.9% dec.		1	1	1		
15.0 - 19.9% dec.					1	
<hr/>						
<u>Total Change in</u> <u>Nursing Staff</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.					1	
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.	1			1		
10.0 - 14.9% dec.		1	1			
15.0 - 19.9% dec.						

* inc. means increase
 dec. " decrease

Table F (continued)

<u>Total Changes in Staff</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.	1		1	1		
10.0 - 14.9% dec.		1				
15.0 - 19.9% dec.					1	

Table G

Hospitals Receiving Budget Increases
in 1982-83 Greater Than 12 % Over
the 1981-82 Level

	<u>Hospitals</u>		
<u>Total Change in</u> <u>Support Service Staff</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.	1		
0 - 4.9% inc.			
no change			
0 - 4.9% dec.			1.
5.0 - 9.9% dec.		1	
<u>Total Change in</u> <u>Nursing Staff</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.	1		
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.			1
5.0 - 9.9% dec.		1	

Table G (continued)

<u>Total Changes in Staff</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.	1		
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			1
0 - 4.9% dec.			
5.0 - 9.9% dec.		1	

A comparison of both Tables F and G illustrates that the group 9.9% or less in 1982-83 made major changes in support, nursing and total staffing. The group with budgets over 12% in 1982-83 showed one hospital making major changes, one making no changes, and one showing growth. It is interesting to note that the hospital showing major changes underwent growth during this period. There was an expansion of 10 - 14.9% in beds for this particular hospital.

In terms of the distribution of changes from one hospital department to the next, Tables H and I reveal that reductions and increases were varied between departments from one hospital to the next. There did not seem to be a consistent pattern of departmental reductions across the hospitals receiving budget incomes of 9.9% or less (See Table H). Nursing experienced reductions of 5.0% to 14.9% (one exception) and the support service staff for the same group experienced reductions of 5.0% to 19.9%. Each hospital varied the magnitude of the reductions from department to department, but basically, the same end was accomplished. Through bed closures, hospitals were able to reduce staff thus reducing the operating costs.

For the nine months ending Dec. 31, 1983, there is basically no decrease in staffing or number of beds opened for the hospitals surveyed (one notable exception). Ninety per cent of changes in staffing are minor or are major increases on the 1982-83 levels (See Table J). Without a doubt, 1982-83 was the year in which the impact of the financial restraint program was felt by the hospitals surveyed. The bed closures and staffing reductions for 62% of the hospitals surveyed represented major change in hospital operations.

Hospital officials were interviewed for the hospitals surveyed in order to verify the statistical findings. Officials at the level of Executive Director, Assistant Executive Director or Finance Director were interviewed in each institution. One official's response was recorded for each institution surveyed. The schedule of questions is contained in Appendix D.

Of the five acute hospitals experiencing financial restraint, the five respondents indicated that the bed closures were a direct result of financial restraint. When questioned about technological innovations or the reorganization of services as a result of restraint, none of the five hospitals experiencing restraint acknowledged any change. When asked if implementation of wordprocessing or computerization had resulted from financial restraint, the answer for the five

hospitals was in the negative.

The three hospitals which did not experience financial restraint perceived the restraint policy as affecting only those hospitals which had not exercised good management in the past. They felt that the hospitals forced to cut back were making long overdue cuts of the proverbial fat.

The hospitals experiencing restraint perceived their reality differently. The longer waits for elective surgery as a result of the closure of beds was cited by officials as proof that more than fat had been trimmed. The level of service according to these officials, had declined as a result of restraint. The increased wait for elective surgery was cited as an indicator of the loss in quality of service.

One of the hospitals with extended care services stated that the reduction of the staff complement from seven to one in their activation department represented a significant decrease in the quality of service given to the elderly. An activation department provides activities and stimulation for older patients. This service was reduced to virtual non-existence in the hospital surveyed as a result of of restraint.

Finally, there was consensus amongst hospital officials, for the hospitals experiencing restraint, that 1982-83 was the worst year of the financial restraint. Hospitals were facing high inflation early in 1982 and labour contracts had expired and were up for renewal. Hospitals faced the uncertainty of labour settlements and they also had no idea what the Hospital Programs budget allocation would be. The budgetary process in place between the Ministry of Health and hospitals was criticized because of its inability to allow hospitals to plan. (The budgetary process will be discussed further in the next chapter.)

In concluding this chapter, it should be noted that 1982-83 represented a year in which 62% of the hospitals surveyed implemented major changes as a response to the E.S. program. The changes though, although major in nature, do not represent long run changes. They are short/intermediate run decisions and do not represent major changes in organizational structure. The preliminary operating reports of 1983-84 indicate that hospitals have at least stabilized at 1982-83 operating levels and there has been an increase in operating levels over 1981-82. The changes implemented in 1982-83, although major, represent short/intermediate run cuts in production levels to balance the budget. The next chapter will consider these findings in terms of the historical context of the health care

system and its bureaucratization.

Table H

Changes in Staffing for Hospitals Receiving a
Budget Increase of 9.9% or Less in 1982-83

<u>Support Services:</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F*</u>
<u>Change in Staffing</u>						
<u>Lab</u>						
0 - 4.9% inc.						
no change						
0 - 4.9% dec.	1	1				
5.0 - 9.9% dec.			1	1		
10.0 - 14.9% dec.						
15.0 - 19.9% dec.						
<hr/>						
<u>Pharmacy</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.			1	1		
5.0 - 9.9% dec.					1	
10.0 - 14.9% dec.	1					
15.0 - 19.9% dec.		1				

*Hospital "F" reported this information in total hours as opposed to full-time equivalents and did not breakdown by department. It was therefore excluded from this part of the study.

Table H (continued)

<u>Radiology</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.				1		
10.0 - 14.9% dec.	1	1				
15.0 - 19.9% dec.			1			
greater than 19.9% dec.					1	
<hr/>						
<u>Administration</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.			1			
5.0 - 9.9% dec.		1				
10.0 - 14.9% dec.						
15.0 - 19.9% dec.	1					
greater than 19.9% dec.				1	1	

Table H (continued)

<u>Material Management</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.	*	*				
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.		1		1		
10.0 - 14.9% dec.						
15.0 - 19.9% dec.						
<hr/>						
<u>Medical Records</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.		1			1	
5.0 - 9.9% dec.	1		1	1		
10.0 - 14.9% dec.						
15.0 - 19.9% dec.						
<hr/>						

*Increase due to restructure of organization - Staff accounted for under nursing were transferred to Material Management.

Table H (continued)

Dietetics

Hospitals

	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.	1					
10.0 - 14.9% dec.		1	1	1		
15.0 - 19.9% dec.					1	

Laundry

A B C D E F

0 - 4.9% inc.					1	
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.						
10.0 - 14.9% dec.		1				
15.0 - 19.9% dec.			1			
greater than 19.9% dec.	1			1		

Table H (continued)

<u>Housekeeping</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.			1			
10.0 - 14.9% dec.				1		
15.0 - 19.9% dec.	1	1			1	
<hr/>						
<u>Plant Operations</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.		1		1		
no change	1				1	
0 - 4.9% dec.						
5.0 - 9.9% dec.			1			
10.0 - 14.9% dec.						
15.0 - 19.9% dec.						
<hr/>						

Table H (continued)

Plant MaintenanceHospitals

	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change					1	
0 - 4.9% dec.						
5.0 - 9.9% dec.	1		1			
10.0 - 14.9% dec.						
15.0 - 19.9% dec.				1		

PhysiotherapyA B C D E F

0 - 4.9% inc.						
no change						
0 - 4.9% dec.						
5.0 - 9.9% dec.	1	1				
10.0 - 14.9% dec.			1	1		
15.0 - 19.9% dec.						

Social Services

Hospitals

	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change						
0 - 4.9% dec.	1					
5.0 - 9.9% dec.		1				
10.0 - 14.9% dec.						
15.0 - 19.9% dec.						
greater than 19.9% dec.					1	

Nursing:

Graduate Nurses

	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc.						
no change					1	
0 - 4.9% dec.	1					
5.0 - 9.9% dec.		1	1	1		
10.0 - 14.9% dec.						
15.0 - 19.9% dec.						

Table H (continued)

<u>Other Nurses</u>	<u>Hospitals</u>					
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>
0 - 4.9% inc. no change						
0 - 4.9% dec.	**		**			
5.0 - 9.9% dec.				1	1	
10.0 - 14.9% dec.		1				
15.0 - 19.9% dec.						

**Restructuring of some of these positions to Material Management.

Note: Small staff specialty departments such as Nuclear Medicine and Respiratory Therapy were omitted from this comparison due to the fact that they do not appear in all of the hospitals surveyed.

Table I.

Changes in Staffing for Hospitals Receiving a
Budget Increase of 12% or Greater in 1982-83

Support Services:

<u>Change in Staffing</u>	<u>Hospitals</u>		
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<u>Lab</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.	1		
0 - 4.9% inc.			
no change		1	
0 - 4.9% dec.			
5.0 - 9.9% dec.			1

<u>Pharmacy</u>	<u>G</u>	<u>H</u>	<u>I</u>
greater than 19.9% inc.	1		
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			1
0 - 4.9% dec.		1	

Table I (continued)

<u>Medical Records</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.	1		
0 - 4.9% inc.			
no change			
0 - 4.9% dec.		1	1
<hr/>			
<u>Administration</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.	1		
0 - 4.9% inc.			1
no change			
0 - 4.9% dec.			
5.0 - 9.9% dec.		1	
<hr/>			

Table I (continued)

<u>Social Services</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.	1		
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.			
<hr/>			
<u>Radiology</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.	1		
0 - 4.9% inc.			
no change		1	
0 - 4.9% dec.			1
<hr/>			

Table I (continued)

<u>Physiotherapy</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.		1	1
greater than 4.9% dec.	1		
<hr/>			
<u>Dietetics</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.	1		
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.			
5.0 - 9.9% dec.		1	1
<hr/>			

Table I (continued)

<u>Materials Management</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.	1		1
5.0 - 9.9% dec.		1	
<hr/>			
<u>Laundry and Linen</u>	<u>G</u>	<u>H</u>	<u>I</u>
greater than 19.9% inc.	1		
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			1
0 - 4.9% dec.		1	
<hr/>			

Table I (continued)

<u>Housekeeping</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.	1		
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.		1	
5.0 - 9.9% dec.			1

<u>Plant Operations</u>	<u>G</u>	<u>H</u>	<u>I</u>
	15.0 - 19.9% inc.		
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change	1	1	
0 - 4.9% dec.			
5.0 - 9.9% dec.			
10.0 - 14.9% dec.			

Table I (continued)

<u>Plant Maintenance</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.	1		
5.0 - 9.9% dec.			
10.0 - 14.9% dec.		1	1

Nursing:

<u>Graduate Nurses</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.			
10.0 - 14.9% inc.	1		
5.0 - 9.9% inc.			1
0 - 4.9% inc.			
no change			
0 - 4.9% dec.		1	

Table I (continued)

<u>Other Nurses</u>	<u>Hospitals</u>		
	<u>G</u>	<u>H</u>	<u>I</u>
15.0 - 19.9% inc.	1		
10.0 - 14.9% inc.			
5.0 - 9.9% inc.			
0 - 4.9% inc.			
no change			
0 - 4.9% dec.			
5.0 - 9.9% dec.		1	1

Table JChanges in Staffing for Hospitals Surveyed for
the Nine Months Ending Dec. 31, 1983Support Services:

<u>Change in Staffing</u>	<u>Hospitals</u>								
	<u>A</u>	<u>B</u>	<u>C</u> [*]	<u>D</u>	<u>E</u>	<u>F</u> ^{**}	<u>G</u>	<u>H</u>	<u>I</u>
Lab									
10.0 - 14.9% inc.								1	
5.0 - 9.9% inc.							1		
0 - 4.9% inc.		1		1					
no change	1								
0 - 4.9% dec.									1
5.0 - 9.9% dec.									

<u>Pharmacy</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
5.0 - 9.9% inc.							1	1	
0 - 4.9% inc.	1			1	1				
no change		1							1

* no information available

** Hospital F reported this information in total hours as opposed to full-time equivalents and did not breakdown by department. It was therefore excluded from this part of the study.

<u>Radiology</u>	<u>Hospitals</u>								
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 and greater inc.									1
10.0 - 14.9% inc.							1		
5.0 - 9.9% inc.		1							
0 - 4.9% inc.				1				1	
no change	1								

<u>Administration</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
5.0 - 9.9% inc.									
0 - 4.9% inc.				1	1		1	1	
no change									
0 - 4.9% dec.	1	1							1

<u>Material Management</u>	*								
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
5.0 - 9.9% inc.									
0 - 4.9% inc.	1	1					1	1	1
no change									

* no information available

Table J (continued)

	<u>Medical Records</u>					<u>Hospitals</u>				
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>	
15.0 and greater inc.									1	
10.0 - 14.9% inc.										
5.0 - 9.9% inc.	1	1					1	1		
0 - 4.9% inc.				1						
no change					1					
<hr/>										
	<u>Dietetics</u>									
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>	
5.0 - 9.9% inc.							1			
0 - 4.9% inc.				1				1	1	
no change										
0 - 4.9% dec.	1	1								
5.0 - 9.9% dec.					1					
<hr/>										
	<u>Laundry</u>									
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>	
10.0 - 14.9% inc.							1			
5.0 - 9.9% inc.									1	
0 - 4.9% inc.	1									
no change										
0 - 4.9% dec.								1		
5.0 - 9.9% dec.		1		1						
10.0 - 14.9% dec.					1					

<u>Housekeeping</u>	<u>Hospitals</u>								
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
5.0 - 9.9% inc.							1		
0 - 4.9% inc.	1			1					1
no change									
0 - 4.9% dec.								1	
5.0 - 9.9% dec.					1				
10.0 - 14.9% dec.		1							

<u>Plant Operations</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
15.0 and greater				1					
10.0 - 14.9% inc.		1							
5.0 - 9.9% inc.	1						1		
0 - 4.9% inc.									
no change					1			1	

<u>Plant Maintenance</u>	<u>Hospitals</u>								
	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
10.0 - 14.9% inc.		1							1
5.0 - 9.9% inc.	1				1				
0 - 4.9% inc.									
no change							1		
0 - 4.9% dec.								1	
5.0 - 9.9% dec.				1					
10.0 - 14.9% dec.									

<u>Physiotherapy</u>	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>	<u>E</u>	<u>F</u>	<u>G</u>	<u>H</u>	<u>I</u>
5.0 - 9.9% inc.	1							1	
0 - 4.9% inc.		1				1			1
no change									
0 - 4.9% dec.									
5.0 - 9.9% dec.									
10.0 - 14.9% dec.					1				

Table K Changes in Hospital Staffing by Department

159

Total Number of Departments (for all hospitals
in the survey)

97

<u>Minor Changes</u>	<u>Depts.</u>	<u>Per Cent of Total</u>
0 - 4.9% inc.	32	32.98%
no change	10	10.30%
0 - 4.9% dec.	<u>14</u>	<u>14.44%</u>
Total	56	57.73%

Major Changes

5.0 % and greater inc.	32	32.98%
5.0 % and greater dec.	<u>9</u>	<u>9.27%</u>
Total	41	42.26%

Minor changes and major increases accounted for 90% of the departmental changes during this time period.

Only 10% of the changes were classified as major decreases.

Clearly this time period was one of predominately minor change and some significant increases.

Table L

Change in the Number of Beds Classed As Open
for the Time Period Mar. 31, 1983 to Dec. 31, 1983

	Mar. 31/83	Dec. 31/83	Percentage Change
Acute Beds	2098	2159	+2.9%
Extended Care Beds	<u>1335</u>	<u>1459</u>	+9.2%
Total	3433	3618	+5.3%

Chapter VAnalysis

The purpose of this chapter is to analyze the findings of this research in terms of the hypothesis and the history of health care policy development. As set out in Chapter I, the provincial government introduced the E.S. program in 1982 as a means to control public sector expenditures. It was hypothesized that hospitals, as ossified, bureaucratic institutions, would not introduce major changes in the short-run to adapt to the E.S. program. The theoretical argument that hospitals are "prized institutions" of the community and are therefore particularly resistant to change in the short-run, was also presented.¹

Chapter II traced the history of the evolution of health care policy and discussed how the "natural history" of the hospital has effected its structural development. It was demonstrated that there has been three periods of development in the history of health care policy. The first period was 1867-1945 and was noted for the neglect of senior governments. The second period, 1945-1977, was a period of growing involvement of the provincial and

¹See Chapter I, footnote no. 38.

federal governments in the delivery of health care services. During this time period, public health insurance was introduced and the creation of a universal health program became a reality. It was also demonstrated that during this time period, hospitals grew at an increasing rate, thus causing a bureaucratization process in accordance with A. Downs' rigidity cycle.² Hospitals became an increasing cost concern by senior governments during this time period due to their escalating costs.

The lack of incentives in the federal-provincial shared cost agreements for provinces to contain costs was cited as a major cause of escalating costs. It was noted that during the latter part of the 1945-1977 period, several task forces and royal commissions had been given the mandate to find ways and means of controlling health care costs.

The third period, 1977 to the present, was a continuation of the latter part of the second period, with governments continuing to try to contain health care costs. This period was particularly reknowned for the increasing

²See Chapter I, footnote no. 26.

conflict between the federal and provincial governments over the financing of health care. The federal government introduced the E.P.F. Act in 1977 which changed health financing from shared cost between the federal and provincial governments to a 25% block grant system.³ The provinces also became increasingly responsible for the delivery of health care as a result of the E.P.F. legislation. As a result of the change in federal-provincial financing legislation, the provinces criticized the federal government for underfunding the health care system. A few provinces allowed extra-billing by doctors and user charges in hospitals as a means to offset funding deficiencies in the system. The federal government has most recently retaliated against extra-billing and user charges by introducing the Canada Health Act which will financially penalize provinces allowing extra-billing and user charges.⁴ The federal act is directed at preserving the universality of Medicare. It was also noted in Chapter II that the province of B.C. had introduced in 1983, draft legislation which would have destroyed the universality of health care delivery. The Medical Services Act has subsequently been withdrawn, but had it been passed, it

³See Chapter II, footnote no. 77.

⁴See Chapter II, footnote no. 90.

would have established a two tier health care system.⁵ Finally, B.C. has announced it is levying an 8% health maintenance tax through the provincial income tax system, in order to increase funding to health care.⁶ This last period is noted for the significant increase in federal-provincial conflict over the financing of health care.

At the end of Chapter II, it was explained that hospitals are basically institutions with a treatment curative approach to health care. Specifically, this approach is used in the treatment of diseases related to lifestyle and is a major attributable factor to the escalating cost of health care. The educational approach to health care is not a major policy thrust at this time, even though educational preventative health programs are far less expensive than medical treatments.

Chapter II established that hospitals have evolved as ossified institutions with strong community support to deliver health care services directed at treatment of the lifestyle related diseases. This organizational evolution of hospitals was established by means of A. Downs' theory

⁵See Chapter II, footnote no. 92.

⁶See Chapter II, footnote no. 97.

on rigidity cycles and Perrow's writings on institutional theory. Chapter III established the methodological framework through which the bureaucratization/rigidity of the hospital organizational structure could be tested. As mentioned in Chapter I, the introduction of the E.S. program in B.C. in 1982, presented an opportunity to test the hypothesis that hospitals, as ossified, bureaucratic institutions, would not make major changes in the short-run as a result of the E.S. program. In order to test this hypothesis, Chapter III stated that Etzioni's model of effectiveness would be used rather than a goal model.⁷ It was stated that Etzioni's model measured effectiveness through an examination of the distribution of resources rather than measuring how well the organization has met its stated goals. As the hypothesis of the thesis was predicting no major change, a model which allowed the measurement of change in distribution of organizational resources to the sub-units was deemed to be the most suitable. This chapter also explained that the change in distribution of resources to the sub-units would be examined over three time periods, namely, 1981-82, 1982-83, and the first nine months of 1983. The main indicator of resources was determined to be staffing as

⁷See Chapter III, footnote no. 2.

it represents 80% of the hospitals' budgets. It was also established that a minor change in resources would be 4.9% and less and a major change would be 5% and greater. The consideration of the overall organizational structural changes would be accounted for in interviews with senior hospital officials.

Chapter IV revealed that 1982-83 was the year in which two-thirds of the hospitals surveyed experienced significant financial restraint as compared to the previous year. The findings indicated that major changes were implemented in hospitals in 1982-83 as a response to financial restraint. It was firstly established that two-thirds of the hospitals surveyed received a budget allocation in 1982-83 which represented financial restraint. These hospitals received a budget allocation which was less than the consumer price index for that time period. The findings also established that the hospitals with acute care beds receiving budget increases of less than 9.9% in 1982-83, were the hospitals which implemented bed closures. The hospitals receiving budget allocations greater than 12.0% for 1982-83 were able to maintain their level of operation.

Staffing patterns were examined next and a correlation was established between the hospitals receiving a budget

increase of less than 9.9% and the magnitude of change in staffing in the sub-units. Those hospitals receiving budget incomes of less than 9.9% made substantially more major changes than those hospitals receiving budgets of 12% or greater. The budget year 1982-83 caused significant changes in hospital acute services in terms of level of services. These changes, though in the form of bed closures and staffing reductions, are not considered as long term restructuring of the configuration of hospital systems and operations in order to adapt to restraint. More simply, the hospitals experiencing financial restraint in 1982-83 reduced their production levels in order to reduce operating costs.

The hypothesis of the thesis predicted that the E.S. program would cause incremental or short/intermediate run changes in organizational operations. Interviews with hospital officials verified that the changes noted were based solely on financial considerations. The reduction in funding in 1982-83 and the uncertainty of labour contract settlements caused the changes implemented. Administrators of hospitals experiencing financial restraint also indicated that if additional funding were made available, beds would be reopened and staffing levels would be returned to pre-restraint levels. Certainly, the preliminary findings with respect to the 1983-84 operating statistics, as noted in

Chapter IV, would indicate that there is a marginal increase in 1982-83 levels of operation. The long run changes which are characterized by changes in production methods and technology used, were not noted as a response to financial restraint in the hospitals surveyed. The hypothesis, as stated in Chapter I, was proven correct.

The hospital as an institution and a bureaucracy, responded to the 1982-83 budget cut-backs by reducing operating levels. The hospitals viewed the situation as one of crisis and controlled for the crisis by simply admitting fewer patients. Fewer admissions allowed for a reduction in the resources committed to health care. The question which must be addressed is the change in quality of services as a result of bed closures and staffing reductions.

Discussions with hospital officials revealed the multifaceted nature of quality and the difficulty in measuring a shift in quality. The complexity of quality assessment has been succinctly stated by J. Ashford and V. Riley in the following quote:

The assessment of the outcome of medical care is a complex problem. The state of health of a single patient reflects not only the medical care received, but also numerous

biological, economic, environmental, and sociological factors which may vary both within and between groups of patients. Furthermore, the current state of health of an individual may result from influences extending over the whole of his lifetime, including foetal development.⁸

This research could not attempt to control for the variables of quality involved in patient care. It was therefore impossible to make an assessment of the impact of financial restraint on quality of patient care service. But, the interviews with officials did reveal information with respect to level of services offered to the community. Level of services to the community is an aggregate measurement as opposed to a single unit measurement of quality of direct patient care.

The unanimous observation made by the five officials working in the five acute care hospitals experiencing restraint, was the longer wait for elective surgery caused by bed closures. One official comment that in 1981-82, general surgery required a wait of approximately seven days.

⁸ Ashford and Riley, "An Approach to Monitoring the Quality of Health Care", Measuring for Management, ed. G. McLachlan (Oxford University Press, 1975) p. 55.

In 1982-83, the same surgery required a wait of at least fourteen days. In addition, this official stated that many patients with medical problems were being admitted to surgical beds through the emergency departments in 1982-83. The official went on to say that the closure of medical beds was the cause of the admission of medical patients to surgical beds through the emergency. The admission of medical patients to surgical beds had in turn caused the longer waits for elective surgery.⁹ Longer waits for surgery, although cited by officials as an indicator of loss in quality of service, are more adeptly defined as a loss in the level of service offered to the community. This reduction in level of service is a short term reduction and a return to pre 1982 levels is dependent upon an increase in funding.

Finally, many hospital officials tended to agree that financial restraint was long overdue in the B.C. health care system, but did not agree with the extent of cuts in 1982-83. Most further stated that the present budgeting system in place with the Ministry of Health did not allow administrators to properly plan annual operations.¹⁰ The current system is

⁹Information obtained through interviews with hospital officials, Spring of 1984.

¹⁰Information obtained through interviews with hospital officials, Spring of 1984.

inefficient as administrators do not know their fiscal annual budget until after year end adjustments are determined by the Ministry of Health. These adjustments are made after the budget year is over. The problems associated with the B.C. hospital budgeting system have been noted by W.T. Dyke. He cites the two main problems of the system as follows:

•

These two facets of the problem were (1) the inequity of the "per diem" method of payment, and (2) the inadequacy of the approved budgets, with the concomitant problem of hospitals operating "in the dark", not knowing what their final approved settlements would be.¹¹

Better budgetary systems between the hospitals and the Ministry of Health would allow administrators the opportunity to determine the optimum allocation of resources. Without such a system, there are inefficiencies in operations which result in a poorer quality of service.

In concluding this chapter it should be noted that

¹¹W.T. Dyke, Hospital Financing in B.C.: Is There a Better Way? (Unpublished M.B.A. thesis, Simon Fraser University, British Columbia, 1979), p. 65.

hospital administrators are currently making short-run changes and decisions to adapt to the budgetary system in place. Flexibility to change in the short-run is related to the amount of resources allocated to a given hospital. As noted in this thesis, many hospitals closed beds and reduced staff as a response to budget reductions. From an organizational perspective, these hospitals responded to a short-run crisis.

Chapter VIConclusion

The provincial government in 1982-83, made a policy decision with respect to health care which placed hospitals in a very stressful situation. By opting to essentially underfund several hospitals, the province placed the hospitals in the difficult position of having to decide which services would be cut in order to maintain budgets. The provincial government offered no contingency funds to carry institutions through the recession.

The thesis demonstrated through the use of organizational theory, particularly institutional theory, that hospitals are bureaucracies which are resistant to change. The hospitals surveyed which experienced financial restraint implemented short run changes only as a response to financial restraint. These changes involved a change in the inputs of production but did not involve any changes in the methods of production.

The type of changes implemented as a response to financial restraint were identified and measured through the use of Etzioni's effectiveness model. Etzioni's effectiveness model is a systems model and it determines organizational priorities

by examining the distribution of resources to the sub-units of the organization. This paper used Etzioni's model to determine where hospitals made changes in operations in order to accommodate financial restraint. Through the use of employment distribution statistics, the research examined the changes in sub-unit staffing in order to identify organizational priorities.

The findings indicated though that the changes in sub-unit staffing did not involve any major restructuring of departments. In addition, reductions in staffing for hospitals experiencing restraint were made randomly across sub-units and the magnitude of reductions varied between departments from hospital to hospital.

The findings confirmed that organizations are resistant to long term change but in a crisis situation, as that imposed by financial restraint, are capable of short-term change. Organizational theory provided an effective theoretical base to analyze the effect of a government policy on the organizations' operations. Systems models such as Etzioni's effectiveness model provide a practical framework for evaluating the effect of policy on social service programs.

This study has demonstrated that the E.S. program has caused organizational change which is short-term only, and involves

a reduction in the level of health care services offered to the public. The bed closures resulting from the restraint represent a drop in level of service. In evaluating whether or not the policy accomplished what it was supposed to, one has to ask why certain hospitals experienced financial restraint while others did not. If the purpose of the E.S. program was to implement financial restraint, why was it not uniformly established across all hospitals?

The E.S. program was an effective means to instill short-term restraint in hospitals where it was applied. But, as mentioned, the organizational analysis, including interviews with hospital officials, did not reveal any long run changes as a result of restraint. Government restraint policy such as the E.S. program does not promote efficiency in services, it simply causes a reduction in the level of services.

Policies seeking to reduce hospital costs in the long run will have to take in to consideration the history of health care policy and the institutional nature of hospitals. As demonstrated in this paper, hospitals are bureaucracies resistant to change and their evolution has emphasized a treatment-curative approach. The treatment-curative approach is the most expensive health care approach and is used to treat the lifestyle-related diseases. Lifestyle-related diseases account for an increasing number of medical treatments in hospitals.

A less expensive long-run approach that can be used to treat the lifestyle diseases is preventative health care. By educating a people to practise more preventative health, the costs of expensive hospital treatments can be lowered. As stated by P. Selznick, the institution will change to adapt to the values of the community.¹ It was demonstrated in Chapter II of this thesis, that hospitals are bureaucracies which are institutions that have evolved according to community values. In order to change the expensive treatment-curative approach of hospitals, with respect to lifestyle-related diseases, the values of the community must be changed.

If the community places a higher value on preventative health, then so will institutions. Provincial policies seeking to accomplish long-term cost control should promote community health education programs with respect to lifestyle-related diseases. Provincial programs should also offer incentives and funding for hospitals to establish community education programs in order to start a change in hospital organizational priorities.

¹See Chapter I, footnotes 38, 39 and 40.

The provincial government is presently usurping the power of hospitals to determine their role in the community. The government's actions are motivated by a belief that hospitals are competing with one another and are duplicating services. What the province must realize is that by becoming more active in the management of hospitals, they are further bureaucratizing the delivery of health services. As mentioned in Chapter II, the increasing regulation of an organization caused further bureaucratization. That is, the system of delivery becomes more inflexible and resistant to change.

In concluding this thesis, it is important to note that the organizational literature enhanced the understanding of the behaviour of the hospitals. The organizational literature also assisted in the explanation of the evolution of hospitals from relatively small community organizations to large bureaucratic complex organizations. Certainly, the challenge of subsequent research will be to examine how hospitals adapt over the long-run to financial restraint, and to determine if in fact hospitals, as the institutions which we presently know, are capable of restructuring to contain costs. Or, conversely, are hospitals only able to reduce operations through bed closures in the short-run in order to adapt to restraint?



STATISTICAL REPORT FOR THE _____ HOSPITAL NAME _____ NUMBER _____
_____ MONTHS ENDED _____ 19 _____ LOCATION _____ B.C.

D. SERVICES WHICH MAY BE PROVIDED BY LABORATORY, RADIOLOGY, OR A SEPARATE ORGANIZATIONAL UNIT OF THE HOSPITAL (DO NOT INCLUDE UNITS REPORTED IN SECTIONS C or E)

	NUMBER OF EXAMINATIONS OR TREATMENTS		NUMBER OF STANDARD UNITS		NAME OF ORGANIZATION CARRYING OUT THE SERVICE
	INPATIENTS 1	OUTPATIENTS 2	INPATIENTS 3	OUTPATIENTS 4	
01. ECG					
02. EEG					
03. ULTRASOUND					
04. NUCLEAR MEDICINE					
05. OTHER (SPECIFY) _____					

NOTES _____

E. RADIOLOGY

THERAPEUTIC RADIOLOGY

06. NUMBER OF TREATMENTS

BY HOSPITAL		BY OTHER AGENCIES FOR PATIENTS OF THE HOSPITAL		TOTAL 5
INPATIENT 1	OUTPATIENT 2	INPATIENT 3	OUTPATIENT 4	

SCANNING (C.A.T.)

07. NUMBER OF EXAMINATIONS

08. NUMBER OF STANDARD UNITS

DIAGNOSTIC (INCLUDING FLUOROSCOPY)

09. NUMBER OF EXAMINATIONS

10. NUMBER OF STANDARD UNITS

INPATIENTS 1	OUTPATIENTS (INCL. ROUTINE EXAMINATIONS-STAFF) 2	TOTAL 3	TOTAL	
			DONE BY HOSPITAL 4	DONE BY OTHER AGENCIES 5

NOTES _____

F. PHYSICAL MEDICINE AND REHABILITATION

PHYSIOTHERAPY

11. NUMBER OF PATIENT ATTENDANCES

12. NUMBER OF WEIGHTED UNITS

OCCUPATIONAL THERAPY

13. NUMBER OF PATIENT ATTENDANCES

14. NUMBER OF WEIGHTED UNITS

OTHER THERAPY

15. NUMBER OF PATIENT ATTENDANCES

BY STAFF OF PHYSICAL MEDICINE AND REHABILITATION UNIT		BY OTHER HOSPITAL STAFF OR OUTSIDE AGENCY FOR PATIENTS OF THE HOSPITAL		TOTAL 5
INPATIENTS 1	OUTPATIENTS 2	INPATIENTS 3	OUTPATIENTS 4	

NOTES _____

G. RESPIRATORY TECHNOLOGY

16. NUMBER OF TREATMENTS AND DIAGNOSTIC PROCEDURES

INPATIENTS 1	OUTPATIENTS 2	TOTAL 3

NOTES _____

Appendix A
178



STATISTICAL REPORT FOR THE _____
MONTHS ENDED _____ 19 _____

HOSPITAL NAME _____ NUMBER _____
LOCATION _____ B.C.

H. SURGICAL SERVICES

- 01. NUMBER OF VISITS DURING WHICH OPERATIONS, TREATMENTS OR EXAMINATIONS WERE CARRIED OUT IN THE SURGICAL SUITE.
- 02. NUMBER OF HOURS—OPERATING ROOMS
- 03. NUMBER OF HOURS—P.A.R.

INPATIENTS 1	OUTPATIENTS		TOTAL 4
	SURGICAL DAY CARE 2	ALL OTHER OUTPATIENTS 3	

NOTES _____

I. EMERGENCY UNIT

- 04. NUMBER OF VISITS TO EMERGENCY UNIT (INCLUDE ALL URGENT & SHORT STAY VISITS. DO NOT INCLUDE SURGICAL DAY CARE OR ORGANIZED OUTPATIENT CLINICS.)

INPATIENT VISITS 1	OUTPATIENT VISITS 2	TOTAL VISITS 3

NOTES _____

J. AMBULATORY CARE

- 05. PSYCHIATRIC DAY / NIGHT CARE
- 06. DIABETIC DAY CARE
- 07. RENAL DAY CARE
- 08. PSYCHIATRIC OUTPATIENT
- 09. DIETETIC COUNSELLING
- 10. GENERAL & SPECIAL CLINICS
- 11. OTHER OUTPATIENT

NUMBER OF VISITS		NUMBER OF PATIENTS	
INPATIENTS 1	OUTPATIENTS 2	INPATIENTS 3	OUTPATIENTS 4

NOTES _____

K. DIETETICS (MEAL DAYS)

- 12. PREPARED BY HOSPITAL
- 13. PURCHASED FROM OTHERS

INPATIENTS 1	OUTPATIENTS 2	STAFF AND VISITORS 3	SUPPLIED TO OTHER INSTITUTIONS 4	TOTAL MEAL-DAYS 5

NOTES _____

L. LAUNDRY (SOILED WEIGHT - KILOGRAMS)

- 14. DONE FOR OWN HOSPITAL
- 15. DONE FOR OTHER HOSPITALS / INSTITUTIONS
- 16. TOTAL

DONE IN HOSPITAL 1	SENT OUT 2	TOTAL 3

NOTES _____

Appendix A (continued)

179



STATISTICAL REPORT FOR THE _____ HOSPITAL NAME _____ NUMBER _____
MONTHS ENDED _____ 19 _____ LOCATION _____ B.C.

M. NURSING PERSONNEL

	GRADUATE 1	TOTAL 2		GRADUATE 1	TOTAL 2
1. MEDICAL			14. LABOUR & DELIVERY		
2. SURGICAL			15. NURSERY		
3. MEDICAL/SURGICAL UNDIFFERENTIATED			16. SURGICAL SERVICES		
4. PAEDIATRICS			17. P.A.R.		
5. REHABILITATION			18. EMERGENCY		
6. ICU / CCU			19. AMBULATORY CARE		
7. OTHER SPECIAL CARE SPECIFY _____			20. OTHER NURSING		
8. OTHER SPECIAL CARE SPECIFY _____			21. SUB TOTAL (13-20)		
9. OTHER SPECIAL CARE SPECIFY _____			22. OTHER NURSES		
10. OBSTETRICS			23. NURSING ADMINISTRATION		
11. PSYCHIATRY			24. TOTAL (21-24)		
12. EXTENDED CARE					
13. SUB TOTAL—INPATIENT (1-12)					

NOTES _____

N. OTHER PERSONNEL

	PARA-PROFESSIONAL 1	TOTAL 2		TOTAL 2
25. LABORATORY			39. ADMINISTRATION	
26. E.C.G.			40. MATERIALS MANAGEMENT	
27. E.E.G.			41. LAUNDRY & LINEN	
28. NUCLEAR MEDICINE			42. HOUSEKEEPING	
29. PHARMACY			43. PLANT OPERATION & SECURITY	
30. RADIOLOGY			44. PLANT MAINTENANCE	
31. PHYSIOTHERAPY			45. OTHER (SPECIFY)	
32. OCCUPATIONAL THERAPY			46. OTHER (SPECIFY)	
33. OTHER THERAPY			47. SUB TOTAL (38-46)	
34. RESPIRATORY TECHNOLOGY			48. SALARIED MEDICAL STAFF	
35. DIETETICS			49. STUDENTS-MEDICAL	
36. SOCIAL SERVICES			50. STUDENTS-NURSING	
37. MEDICAL RECORDS			51. STUDENTS-PARA-PROFESSIONAL	
38. SUB TOTAL (25-37)			52. STUDENTS-OTHER	
			53. SUB TOTAL (49-52)	

NOTES _____

O. TOTAL PERSONNEL

	FULL TIME EQUIVALENTS
54. NURSING (LINE 24, COLUMN 2)	
55. OTHER PERSONNEL (LINE 47)	
56. MEDICAL STAFF (LINE 48)	
57. SUB TOTAL (LINES 54+55+56)	
58. STUDENTS (LINE 53)	
59. TOTAL (LINES 57+58)	

NOTES _____

Appendix A (continued)



SUPPLEMENTARY FINANCIAL REPORT FOR THE

HOSPITAL NUMBER _____

MONTHS ENDED _____

19 _____

B.C.

A. AUTHORIZED CHARGES (CO-INSURANCE) INPATIENT (HOSPITAL PROGRAMS DAYS)

CHARGED TO HOSPITAL PROGRAMS

CHARGED TO PATIENTS, ETC.

TOTAL

	ACUTE/REHAB	EXTENDED CARE	LONG TERM CARE
CHARGED TO HOSPITAL PROGRAMS			
CHARGED TO PATIENTS, ETC.			
TOTAL			

B. HOSPITAL PROGRAMS ADVANCES

BALANCE END OF CURRENT MONTH

DEBIT

CREDIT

\$ _____

\$ _____

C. STATEMENT OF WORKING CAPITAL -

CURRENT ASSETS

1. CASH
2. INVESTMENTS
3. ACCOUNTS RECEIVABLE BCHP
4. ACCOUNTS RECEIVABLE OTHER
5. INVENTORIES
6. PREPAID EXPENSE
7. OTHER
8. TOTAL

OPERATING A/C

CAPITAL A/C

CURRENT LIABILITIES

9. BANK LOANS / OVERDRAFT
10. SALARIES & WAGES PAYABLE
11. EMPLOYEE DEDUCTIONS PAYABLE
12. ACCRUED HOLIDAY & SICK RELIEF
13. OTHER ACCOUNTS PAYABLE
14. OTHER
15. TOTAL
16. WORKING CAPITAL

D. CASH FLOW PROJECTION — OPERATING FUND

1. CASH ON HAND, BEGINNING OF PERIOD

RECEIPTS

2. HOSPITAL PROGRAMS

3. M.S.P.

4. OTHER

5. TOTAL CASH AVAILABLE

PAYMENTS

6. PAYROLL

7. EMPLOYEE DEDUCTIONS PAYABLE

8. ACCOUNTS PAYABLE

9. OTHER

10. TOTAL CASH DISBURSEMENTS

11. CASH ON HAND, END OF PERIOD (1+5-10)

MONTH

MONTH

MONTH

PREPARED BY: _____

DATE: _____

TITLE: _____



STATISTICAL REPORT FOR THE _____ HOSPITAL NAME _____ NUMBER _____ MONTHS ENDED _____ 19 _____ LOCATION _____ B.C.

Appendix A (continued) 183

A. BEDS, ADMISSIONS, PATIENT DAYS, ETC.

Table with 5 columns: ACUTE/REHAB (1), EXTENDED CARE (2), LONG TERM PATIENTS (3), NEWBORN (4), LONG TERM CARE PROGRAM (5). Rows include Patient Days, Admissions, Separations, Total Days Stay, Average Length of Stay, Rated Beds, Beds Set Up, and Percentage Occupancy.

NOTES _____

B. TYPES OF CARE

Table with 2 columns: PATIENT DAYS (1), BEDS SET UP (2). Rows include Medical, Surgical, Medical/Surgical Undifferentiated, Paediatric, Obstetrical, ICU/CCU, Other Critical Care, Psychiatry, Rehabilitation, Other, and Total.

NOTES _____

C. LABORATORY UNITS

(ENTER STANDARD LABORATORY UNITS FOR TECHNICAL AND NON-PROFESSIONAL WORKLOAD - DO NOT INCLUDE UNITS FOR PROFESSIONAL COMPONENT OF WORK SUCH AS MEDICAL INTERPRETATION, ETC.)

Table with 5 columns: INPATIENTS (1), OUTPATIENTS (2), REFERRED IN (INCL. PUBLIC HEALTH) (3), ROUTINE HEALTH EXAMS, QUALITY CONTROL ETC. (4), TOTAL UNITS (5). Row 21: STANDARD LAB UNITS DONE BY OWN HOSPITAL.

22. NUMBER OF TESTS REQUESTED FOR SPECIMENS REFERRED OUT

Table with 6 columns: NUMBER OF TESTS REQUESTED FOR (INPATIENTS 1, OUTPATIENTS 2), TOTAL TESTS REQUESTED ON SPECIMENS REFERRED OUT (3), NUMBER OF TESTS REQUESTED FROM (PROV. OWNED LABORATORIES 4, OTHER HOSPITALS, RED CROSS 5, OTHER LABORATORIES 6).

NOTES _____

ALPHABETICAL LISTING OF BRITISH COLUMBIA HOSPITALS
BY LOCATION AND TYPE OF CARE
MARCH 31, 1983

LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
<u>NO.</u>	<u>NAME OF HOSPITAL</u>	<u>ACUTE</u>	<u>REHAB</u>	<u>EXT</u>	<u>INTERMED/ PERSONAL</u>	<u>TOTAL BEDS</u>	<u>BAS</u>
ABBOTSFORD							
603	Matsqui-Sumas-Abbotsford General	179		75		254	1
607	Menno			75		75	
ALERT BAY							
507	St. George's	33		6		39	1
ALEXIS CREEK							
416	Red Cross Outpost - 3 holding beds						
ARMSTRONG							
307	Armstrong and Spallumcheen	16				16	
ASHCROFT							
408	Ashcroft and District General	21		8	6	35	
ATLIN							
914	Red Cross Outpost -3 holding beds						
BAMFIELD							
855	Red Cross Outpost - 3 holding beds						
BELLA COOLA							
906	Bella Coola General	10		2	3	15	
BLUE RIVER							
412	Red Cross Outpost -3 holding beds						
BURNABY							
130	Burnaby General	386		215		601	3
132	Fellburn			75		75	
137	St. Michael's			40	40	80	
	- Dogwood 2				154	154	
BURNS LAKE							
707	Burns Lake and District	36		6		42	1
CAMPBELL RIVER							
508	Campbell River and District General	90		43		133	1
CASSIAR							
916	Cassiar	7				7	
CASTLEGAR							
804	Castlegar and District	55		15		70	1
CHEMAINUS							
505	Chemainus General	27			6	33	
CHETWYND							
716	Chetwynd General	18				18	

Alphabetical List, March 31, 1983

LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
<u>NO.</u>	<u>NAME OF HOSPITAL</u>	<u>ACUTE</u>	<u>REHAB</u>	<u>EXT</u>	<u>INTERMED/ PERSONAL</u>	<u>TOTAL BEDS</u>	<u>BASS</u>
	CHILLIWACK 601 Chilliwack General	181		95		276	17
	CLEARWATER 419 Dr. Helmcken Memorial	10				10	2
	COMOX 502 St. Joseph's General	125		75		200	22
	CRANBROOK 756 Cranbrook and District	80		50		130	18
	CRESTON 654 Creston Valley	44		8		52	12
	CUMBERLAND 504 Cumberland General - 6 holding beds				75	75	
	DAWSON CREEK 704 Dawson Creek and District	77				77	20
	DELTA 134 Delta Centennial	60		100		160	
	DUNCAN 203 Cowichan District	133		100		233	26
	EDGEWOOD 656 Red Cross Outpost - 3 holding beds						
	ELKFORD 757 Elkford and District Diagnostic & Treatment Centre - 3 holding beds						
	ENDERBY 306 Enderby and District Memorial	20		12		32	4
	FERNIE 753 Fernie District	57		8		65	7
	FORT NELSON 714 Fort Nelson General	41				41	9
	FORT ST. JAMES 717 Stuart Lake	25				25	4
	FORT ST. JOHN 701 Fort St. John General	85				85	19
	FRASER LAKE 758 Fraser Lake Diagnostic and Treatment Centre						

Appendix B (continued) 185

Alphabetical List, March 31, 1983

LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
NO.	NAME OF HOSPITAL	ACUTE	REHAB	EXT	INTERMED/ PERSONAL	TOTAL BEDS	BASS
GANGES 206 Lady Minto Gulf Islands		19		31		50	6
GOLDEN 409 Golden and District General		25		8		33	6
GOLD RIVER 860 Gold River Health Clinic							
GRAND FORKS 803 Boundary		35		15		50	6
HAZELTON 901 Wrinch Memorial		27		4		31	4
HOPE 606 Fraser Canyon		38				38	8
HOUSTON 909 Houston Hospital (Diagnostic and Treatment Centre)							
HUDSON'S HOPE 759 Hudson's Hope Gething Diagnostic and Treatment Centre							
INVERMERE 755 Windermere District		31				31	6
KAMLOOPS 401 Royal Inland 421 Overlander - Ponderosa - Intermediate - Personal		377		150	192 64	377 150 256	45
KASLO 653 Victorian		7			3	10	2
KELOWNA 302 Kelowna General		281		251		532	20
KEREMEOS 310 Keremeos Diagnostic and Treatment Centre							
KIMBERLEY 752 Kimberley and District		50		17		67	12
KITIMAT 917 Kitimat General		73		29	6	108	12
KYUQUOT 857 Red Cross Outpost - 3 holding beds							
LADYSMITH 506 Ladysmith and District General		32		10		42	8

Appendix B (continued)

186

Alphabetical List, March 31, 1983

LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
<u>NO.</u>	<u>NAME OF HOSPITAL</u>	<u>ACUTE</u>	<u>REHAB</u>	<u>EXT</u>	<u>INTERMED/ PERSONAL</u>	<u>TOTAL BEDS</u>	<u>BASS</u>
LANGLEY							
	115 Langley Memorial	160		125		285	24
LILLOOET							
	417 Lillooet District	34		3		37	8
LOGAN LAKE							
	423 Logan Lake Diagnostic & Treatment Centre						
LYTTON							
	405 St. Bartholomew's	10		2	8	20	4
McBRIDE							
	713 McBride and District	16		2	3	21	10
MACKENZIE							
	715 Mackenzie and District	18				18	4
MAPLE RIDGE							
	604 Maple Ridge	131		75		206	14
MASSET							
	918 Canadian Forces Station Hospital	12				12	5
MERRITT							
	403 Nicola Valley General	45				45	10
MICA CREEK							
	418 Mica Creek Private (Closed October 1, 1982)						
MISSION							
	602 Mission Memorial	84		75		159	10
NAKUSP							
	655 Arrow Lakes	16		4		20	1
NANAIMO							
	501 Nanaimo Regional General	232		85		317	39
NELSON							
	651 Kootenay Lake District	89				89	10
	657 Mount St. Francis			84		84	
NEW DENVER							
	652 Slocan Community	5		5		10	2
NEW WESTMINSTER							
	135 Queen's Park			300		300	
	109 Royal Columbian	445		40			
	- special extended care (DPU)			40		525	58
	110 Saint Mary's	187				187	0
NORTH VANCOUVER							
	112 Lions Gate	401		169		570	43

Appendix B (continued)

187

Alphabetical List, March 31, 1983

LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
<u>NO.</u>	<u>NAME OF HOSPITAL</u>	<u>ACUTE</u>	<u>REHAB</u>	<u>EXT</u>	<u>INTERMED/ PERSONAL</u>	<u>TOTAL BEDS</u>	<u>BASS</u>
OCEAN FALLS							
905	Ocean Falls General, Diagnostic and Treatment Centre - 2 holding beds						
OLIVER							
309	South Okanagan General	45		75		120	8
100 MILE HOUSE							
708	100 Mile District General	37				37	7
PARKSVILLE							
512	Trillium Lodge			55	50	105	
PEMBERTON							
422	Pemberton and District Diagnostic and Treatment Centre - 3 holding beds						
PENTICTON							
303	Penticton	159		63		222	16
PORT ALBERNI							
851	West Coast General	118		32		150	24
PORT ALICE							
859	Port Alice - 3 holding beds	7				7	2
PORT HARDY							
510	Port Hardy	25				25	5
PORT McNEILL							
511	Port McNeill and District	10				10	2
POUCE COUPE							
706	Pouce Coupe Community			54		54	
POWELL RIVER							
111	Powell River General	77		44		121	12
PRINCE GEORGE							
703	Prince George Regional	285		60		345	51
PRINCE RUPERT							
902	Prince Rupert Regional	123		23		146	20
PRINCETON							
305	Princeton General	20		10		30	4
QUEEN CHARLOTTE CITY							
907	Queen Charlotte Islands General	13		4	4	21	3
QUESNEL							
705	G.R. Baker Memorial	80		40		120	22

Appendix B (continued)

Alphabetical List, March 31, 1983

LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
NO.	NAME OF HOSPITAL	ACUTE	REHAB	EXT	INTERMED/ PERSONAL	TOTAL BEDS	BASS
	REVELSTOKE						
	402 Queen Victoria	30		15	11	56	10
	RICHMOND						
	121 Richmond General	182		75		257	29
	ROSSLAND						
	802 The Mater Misericordiae	26		15		41	0
	SAANICHTON						
	217 Saanich Peninsula	75		75		150	3
	SALMON ARM						
	404 Shuswap Lake General	58		25		83	10
	SAN JOSEF						
	858 Canadian Forces Station Hospital, Holberg	7				7	2
	SECHELT						
	113 St. Mary's	48		22		70	8
	SMITHERS						
	903 Bulkley Valley District	51		7		58	12
	SPARWOOD						
	754 Sparwood General	27				27	6
	SQUAMISH						
	128 Squamish General	21				21	4
	STEWART						
	910 Stewart General	10				10	2
	SUMMERLAND						
	308 Summerland General	28				28	5
	SURREY						
	116 Surrey Memorial	369		207		576	36
	TAHSIS						
	861 Tahsis	10				10	2
	TERRACE						
	912 Mills Memorial	91				91	18
	TOFINO						
	854 Tofino General	21				21	6
	TRAIL						
	801 Trail Regional	170		50		220	22

Appendix B (continued)

189

Alphabetical List, March 31, 1983

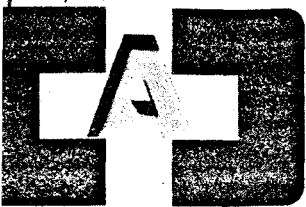
LOCATION		HOSPITAL APPROVED OPERATING CAPACITY					
NO.	NAME OF HOSPITAL	ACUTE	REHAB	EXT	INTERMED/ PERSONAL	TOTAL BEDS	BASS
VANCOUVER							
107	A. Maxwell Evans Clinic	56				56	
105	Children's	176				176	
119	G.F. Strong Rehabilitation Centre		150			150	
104	The Salvation Army Grace	120				120	94
118	Holy Family		80	150		230	
122	Louis Brier			60		60	
106	Mount Saint Joseph	121		150		271	
120	Pearson			182		182	
102	St. Paul's	519				519	49
103	St. Vincent's	157		75		232	
133	St. Vincent's Arbutus			75		75	
125	Shaughnessy	375		200	400	975	
114	Sunny Hill		45	25		70	
123	UBC Health Sciences Centre	266		300		566	
101	Vancouver General	943		198		1,141	0
	- Dogwood 1				154	154	
VANDERHOOF							
702	St. John	45				45	8
VERNON							
301	Vernon Jubilee	137		188		325	15
VICTORIA							
215	Glendale Lodge			75		75	
211	Gorge Road		100	290		390	
220	Juan de Fuca Hospitals			480		480	
	- Aberdeen, 75						
	- Glengarry, 215						
	- Mount Tolmie, 75						
	- Priory, 115						
212	Mount St. Mary			126		126	
204	Queen Alexandra Hospital for Children		40	53		93	
201	Royal Jubilee	500		111	148	759	0
202	Victoria General	422		100	60	582	86
WAGLISLA							
904	R.W. Large Memorial	16		7		23	4
WHITE ROCK							
131	Peace Arch District	107		119		226	16
WILLIAMS LAKE							
406	Cariboo Memorial	84				84	18
TOTAL		10,963	415	6,447	1,387	19,212	1,300
+ 35 holding beds							

Appendix B (continued)

190

NUMBER OF HOSPITALS

Acute Care	-	97
- Federal	-	2
Rehabilitation Care (free standing)	-	5
Extended Care (free standing)	-	14
Red Cross Outposts	-	6
Diagnostic and Treatment Centres	-	10



Canadian Council on Hospital Accreditation Conseil Canadien D'Accréditation des Hôpitaux
192
Appendix C

Member Organizations Membres Associés

Canadian Hospital Association The Canadian Medical Association
The Royal College of Physicians and Surgeons of Canada Canadian Nurses Association
L'Association des Médecins de Langue Française du Canada.

... Swanson M.D., F.A.C.H.A.
Executive Director — Directeur Général

August 30, 1982

Mr. Kevin Mercer
1286 Oriole Place
Port Coquitlam, B.C.
V3B 5K5

Dear Mr. Mercer:

Thank you for your letter of August 17, 1982. The Canadian Council on Hospital Accreditation does not wish to see its program having any involvement with financial cutbacks since they are considered as being beyond the scope of our work. Accordingly, our surveys do not include any indicators which relate to economic pressure or difficulties. For your information I enclose a list of our publications which are available to the public and a copy of our Aims and Objectives which will outline to you the type of work in which we are involved.

I hope this will be useful. Please let us know if you wish to have any of the publications sent to you and thank you for your offer of sharing the results of your research with us.

Sincerely yours,

Fulvio Limongelli, M.D., F.R.C.S.(C)
Executive Director

FL:lp
Encl.

Appendix DInterview Schedule

1. Have you had any staff lay-offs as a result of the 1982 restraint program?
2. Have you had any bed closures as a result of the 1982 restraint program?
3. Have there been any productivity-enhancing programs introduced in your hospital as a direct result of the 1982 restraint program? (et. staff working longer hours, centralization of responsibilities to reduce duplication of effort, etc.)
4. Were any computers or wordprocessing technologies introduced as a direct result of the restraint program?
5. In what ways has the restraint program affected the quality of hospital services?
6. Has any organizational restructuring occurred as a result of the restraint program?

7. Have any new programs or services been introduced as a result of the restraint program?

8. Have any programs or services been discontinued or cut-back as a result of the restraint program?

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