Chapter 2

Health Care Management and the Canadian Context

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Learning Objectives

After reading, studying and reflecting on this chapter's content, you will be able to:

1. Discuss the evolution of theories of management and how they are reflected in current health care organizations
2. Compare the focus and activities of leaders and managers
3. Identify the components of health systems and the factors influencing the organization of health services
4. Distinguish among municipal, provincial/territorial, and federal levels of responsibility and jurisdiction with respect to health care services and the legislative framework governing health care and health care professionals
5. Describe the levels of health care and the range and types of health care services in Canada
6. Discuss the range and types of regulated and unregulated health workers and professionals in Canada
7. Identify trends and issues in health systems in Canada and how performance of health systems might be evaluated

INTRODUCTION

In the first part of this chapter we focus on the concept of management and discuss the evolution of management theories over time. We discuss the key functions of management and compare management activities with those of leadership, which were highlighted in Chapter 1. We discuss health care management, noting particularly nurses' roles in the management of health care. In the second part of this chapter, we provide a "macro" view of the health care system in Canada and the many factors that shape and change health care over time. Although many of you may begin your early nursing career in a staff nurse position within a health care organization or have had such positions in your career to date, we would like you to consider the system within which you work. We aim to help you develop an understanding of the wide-ranging forces that influence your workplace and the management of those organizations in which you work, be they large or small.

THEORIES OF MANAGEMENT

In Chapter 1, we distinguished between leadership and management, noting that management focuses on organizing and directing activities within an organization and is done by individuals who have a role that carries formal authority and responsibility for such activities. Management theories predate the more recent development of leadership theories, so most of the organizations we have dealt with during our lives have been shaped more by ideas of management than ideas of leadership. These theories aimed at explaining how organizations work, while leadership theories tend to focus on individuals and their interaction with groups.

Ideas about how to accomplish goals can be traced back to the earliest human efforts to undertake group projects, but over time, management theories developed as people began to question and examine the best way to accomplish tasks. These theories have been categorized in terms of their major focus or approach and we present them here because, although there have been changes in how organizations and managers function, you will see elements of these theories today in many of the organizations in which nurses work, and these theories will be reflected in the practice of many managers. The categories of theories presented here are: classical management, human relations, open systems/contingency theories, and decision-making theories. You will see parallels between management theories and leadership theories, but theorists in each category provide a differing perspective on management and organizations.

Classical Management Theories

The development of machines at the time of the industrial revolution stimulated a trend of mechanizing work to more efficiently accomplish goals (Morgan, 2006). **Classical management theory** and **scientific management** gained currency at a time when the focus was on production using machinery. Scientific management theorists, such as Frederick Winslow Taylor, were interested in the design of individual jobs or tasks to increase the output of workers and to increase the efficiency of management through the "scientific" analysis of jobs and the training of workers to use scientific principles and managers to carry out their

management functions. Taylor broke production into minute tasks and hierarchical managerial roles were established to oversee the standardized steps carried out by the workers (Dunbar & Statler, 2010). Morgan (2006) sees the approach of McDonald's in the prescribed steps to prepare and serve hamburgers efficiently as stemming from the task analysis approach of scientific management.

Other classical management theorists were interested in the design of organizations as a whole. Henri Fayol developed principles of management that touched on administration, human relations, and production efficiency (Morgan, 2006). He and other theorists in this period viewed management as a process consisting of activities of planning, organization, command, coordination, and control. Included in Fayol's principles are ideas about management that continue today, particularly in large organizations (Fayol, 1949). Some of these principles are:

- Division of work—the idea of specialization in work that increases efficiency.
- Authority—a person in a position should have authority to give orders and be responsible for executing the work.
- Unity of command—an employee takes orders from only one person.
- Scalar chain—there is a line of authority that runs from the bottom to the top of an organization and it is also the line of communication and decision-making.
- Subordination of interest—the individual's interests are subordinate to those of the general interest, so there must be fair agreements.
- Centralization—some degree of centralization of authority is required.
- Discipline—obedience to authority and behaviour in accord with agreed rules.

Classical management theory, either scientific management or management processes for efficiency, views organizations as mechanisms or like mechanisms in the way they should operate.

Management Functions

Although initially identified by Henri Fayol in the 1920s, others have created variations in the categories of management activities (Koontz & Weihrich, 1990). These categories describe the overall functions of managers and management:

- Planning: involves the selection of goals and objectives as well as the means to achieve objectives. This activity involves the consideration of alternatives and the selection of means, so decision-making is required, followed by the mapping of details.
- Organizing: involves establishing structure to achieve the plan, including the roles of individuals and the task assigned to roles. Such activity involves grouping activity and establishing appropriate levels of authority for those involved.
- Staffing: involves recruitment, hiring, and retention of people for positions in the organizational structure. This activity involves human resource activities, such as interviewing, staff development, career planning, compensation, and promotion.
- Leading: involves influencing others to contribute to goals. The more traditional title for this activity was directing, but both terms refer to an interpersonal aspect of the

role of managers, including motivating others, managing conflict, delegating, coaching, and communicating.

- Controlling: involves measuring achievement in terms of performance and taking corrective action as required. Such activity includes measurement of productivity; budget reviews and fiscal outcomes; quality control measures; and ethical, legal, or other reviews.

You will note that "leading" is included here as a management function, but is similar to the earlier discussion of the concept of leadership. Chapter 1 was devoted to what is listed here as one of several functions of management, as thinking currently emphasizes leadership as a behaviour or activity that is not exclusive to management roles. Although leadership behaviour is required of managers, nurses exhibit it in all nursing roles. Many of the subsequent chapters in this book will relate to the foregoing categories of management functions. For example, Chapters 6 and 8 discuss aspects of staffing and Chapter 13 discusses fiscal control, part of the controlling function. As you work in organizations, you will observe and experience the management functions as they operate in your workplace.

Human Relations Theories

Due in part to worker unrest in the era of scientific management, some rejected the hard science approach to management theory and became interested in what motivated workers and how cooperation of workers could enhance performance. Studies of the effects of lighting, coffee breaks, and so on, on the productivity of factory workers (known as the Hawthorne studies) led to the realization that almost anything that was tried as an experiment improved production, a result that initially puzzled researchers. The researchers eventually realized that the attention given to the workers improved attitudes and social relationships, which enhanced cooperation and reduced worker alienation (Dunbar & Statler, 2010).

The human relations school began to examine not only motivation, but also the role of hierarchy in organizations and democratic approaches to management as an alternative to autocratic or authoritarian approaches that had been traditional in most organizations. Organizational psychologists began to examine employee satisfaction and how to alter structures and enrich jobs and leadership styles that promoted employee autonomy, creativity, and decision-making (Morgan, 2006). The emphasis on managerial-command approaches changed to one of leader support of employees who participated in workplace decision-making (Dunbar & Statler, 2010). McGregor's work in the 1960s focused on manager behaviour and worker motivation (1966). His Theory X and Theory Y contrasted a managerial view that people must be rewarded, punished, persuaded, or supervised to ensure things get done, a view that saw workers as passive at best and lazy at worst (Theory X). In contrast, managers who perceive workers as having a willingness to meet organizational goals and the potential to develop and to direct their own work (Theory Y) are less controlling and more democratic in their approach to making decisions.

Such work by those interested in human relations research formed the basis for human resource management, which became an important focus in organizations as a way to improve working life and employee satisfaction while reducing absenteeism and

turnover. This focus ensured that the human aspect of organizations was considered, not just the technical aspect or design of a job or organization, because they were interdependent in a social system like the workplace.

Open Systems and Contingency Theories

Open systems theory was a general one that, when applied to organizations, proposed that organizations were not closed systems, but open to the environment in which they existed. Therefore, the design of an organization and its activities should reflect sensitivity to the environment. In the case of health care organizations, this means that they must consider and respond to other organizations in their environment such as government agencies, unions, other health agencies, and businesses with which they share responsibilities and on which they depend. For example, in the past decade, hospitals have had to respond to what is going on in the wider environment with the development of antibiotic-resistant infections, pandemic planning, or shortages of vaccines or isotopes. Managers must think about the relations between their subsystem and the whole organization and between their subsystem and the environment, an approach that views organizations as organisms, rather than as mechanisms (Morgan, 2006).

Contingency theory emphasizes that there is no one best way to organize and that organizational forms vary depending on the nature of the environment. Classical management principles are not appropriate in certain kinds of firms, like high technology firms that must quickly adjust to new developments in the field. Units and organizations as whole may require different degrees of hierarchy, contingent on the nature of the work or the environment. For example, research and development units in industry have goals that are less specified than production departments, and finance departments require more guidelines and controls than public relations units.

Decision Theories

Theorists who viewed organizations as information processing machines initially used theory and research to focus on efficiency (Dunbar & Statler, 2010). Morgan (2006) likened this approach to viewing organizations as "institutionalized brains" in that these theorists focused on organizations as decision-making systems. While these theorists acknowledged that organizations and managers could not be perfectly rational, given that humans have limited abilities to process information and must make decisions based on limited information, the approach did give emphasis to rationality, routinizing decision-making where possible, and enhancing rationality in practice. These theories led to operations research, goal-setting and management by objectives, management information systems, detailed examination of process, total quality management (TQM), and other widespread management approaches.

While these theorists recognized that there were limits to rationality in decision-making within organizations, the thrust of this approach was to examine not only how managers might optimize decisions and reduce uncertainty, but also propose how to deal with the reality of uncertainty by transcending the rational model. Development of the computer, information technology, the internet and "networked intelligence" have transformed many industries and organizations, speeding information processing, changing

how humans can interact and expanding capacities and possibilities. Morgan (2006) writes that the challenge now is that of constant learning and describes how **cybernetics**, the scientific study of information, communication, and control, arose from the challenge of designing machines that had adaptive capacity. Notions and principles from cybernetics have influenced many ideas about management of organizations, including learning to learn, developing feedback mechanisms to become self-correcting, and the development of a culture that focuses on team learning.

ROLES IN NURSING MANAGEMENT AND LEADERSHIP

What kinds of nursing management and leadership roles are there? Organizations engaged in the provision of health care are concerned with how to best organize and deliver care. Health care organizations range in size and structure from small health centres with one manager or administrator to large multi-hospital systems with several layers of management. Administrative roles in nursing are usually described in terms of two levels: nurse managers and nurse executives (Jones, 2010; Kleinman, 2003). At one time, a distinction was made between a front-line nurse manager and a middle manager. The latter category is less evident now in health care organizations as the trend has moved away from more layers of management. Where there are middle layers, they are usually considered under the broader category of nurse manager, but with fewer layers in organizations, the responsibilities of both nurse managers and nurse executives have expanded (Kleinman). Nurse managers are often responsible for one or more specific clinical services or unit while nurse executives are the top level of nursing administration, often responsible for more than nursing care services. Nurse manager titles differ and may range widely, depending on the kind of organization and level of responsibility, for example, Nurse Manger, Rapid Response Team; Clinical Manager, Surgical Services; or Director, Home Care Services. Nurse executives are typically members of the senior management team in a health care organization. The senior nurse may carry the title of Chief Nursing Officer because he or she is the designated leader for professional nursing, but he or she may also carry other titles, such as Vice-President, Patient Care, because the position's scope of responsibilities extends beyond nursing activities. Position titles within these levels vary from organization to organization and from time period to time period, as titles come in and out of fashion and as management and leadership theory evolves. Many argue that the word "nurse" has disappeared from senior management levels, as such titles as Vice-President, Patient Care, have replaced those responsibilities with the broadening of the scope beyond nursing care.

There are other kinds of management and leadership roles in nursing that do not deal with the provision of health care services, but rather focus on nurses and the profession. For example, there are such positions in institutions that educate nurses and that focus on the socio-economic welfare of nurses (nurses' unions) and on the profession (regulatory bodies and professional associations). Examples of these roles include dean of a school or faculty of nursing, president and chief executive officer of a union or professional association, and executive director of a regulatory college of nurses in a province.

As mentioned earlier, because the concept of leadership differs from that of management, organizations often seek individuals who have strength in both leadership (vision-

Table 2.1 A Comparison of Management and Leadership

Management	Leadership
Dealing with complexity, producing results	Dealing with change, producing change
Order and consistency Quality	Anticipating, preparing for and responding to a changing environment
Planning by setting targets and goals, budgeting and allocating resources	Developing a vision and setting a direction as well as strategies to make needed changes
Organizing by establishing organizational structure and staffing positions with qualified people. Focus on structuring positions to fit together	Aligning people to vision and securing commitment. Focus on communication with those at various levels to understand vision and who can help or hinder
Controlling and problem-solving by comparing results to the plan, identifying deviations from plan and solving problems. Focus on system norms, standards, and processes.	Motivating, inspiring, and empowering people to pursue change and overcome barriers by coaching, role modelling. Emphasis on needs for achievement, values, emotions

ing, inspiring, and motivating) and management (planning, organizing, coordinating, and directing) aspects of a role. Indeed, as mentioned in the section on management functions, leadership is considered a function of anyone in a management position. Kotter (2001, p. 103) described these as "two distinctive and complementary systems of action" that are required by managers in organizations. Although not everyone excels at both the ability to lead and to manage, there is value in seeking to develop the skills and abilities of both dimensions. Table 2.1 illustrates the strengths and abilities of a leader-manager who demonstrates a balance in these abilities.

As you work in health care organizations, you will become increasingly aware of leadership and management in action and likely begin to identify the strengths and weaknesses of the workplaces you encounter. You will take on leadership roles, and perhaps formal management roles, as your career develops, and you will learn more about the broader context of your work and the larger forces that influence what happens in your workplace. Health care management requires you to deal with the complexity of providing health care as well as having the leadership skills to manage a dynamic and changing environment. We now turn to discuss the larger external environment of health care management.

THE HEALTH SYSTEM—THE CONTEXT FOR HEALTH CARE

We begin this section with a model that provides a broad overview of the organization of health care systems and an indication of how these may differ around the world. We will then focus on health care systems in Canada and discuss some of the basics of the health care context, exploring the forces that affect health care services and organizations. This overview will illustrate the complexity of health care and health care organizations, and therefore, some of

the challenges inherent in health care management. We believe that an appreciation of the many factors influencing health care and the dynamic nature of the system within which you work will help you to identify trends that will influence your practice and working life.

A Model of the Health System

For the purposes of learning about the health care system, a model of a health system is presented in Figure 2.1. We will use this model to provide a big picture of the health care system in Canada and to guide the discussion of key elements of the system.

As depicted in the model, the values and goals of a culture and society have an effect on the political system of a country that in turn shapes policy on education, health, health care, and research. These policy areas or fields are ones that influence the way in which health services are organized to address health needs in an attempt to influence the health status of individuals, families, groups, and communities. While health services are designed to influence the health status of citizens, there are other determinants of

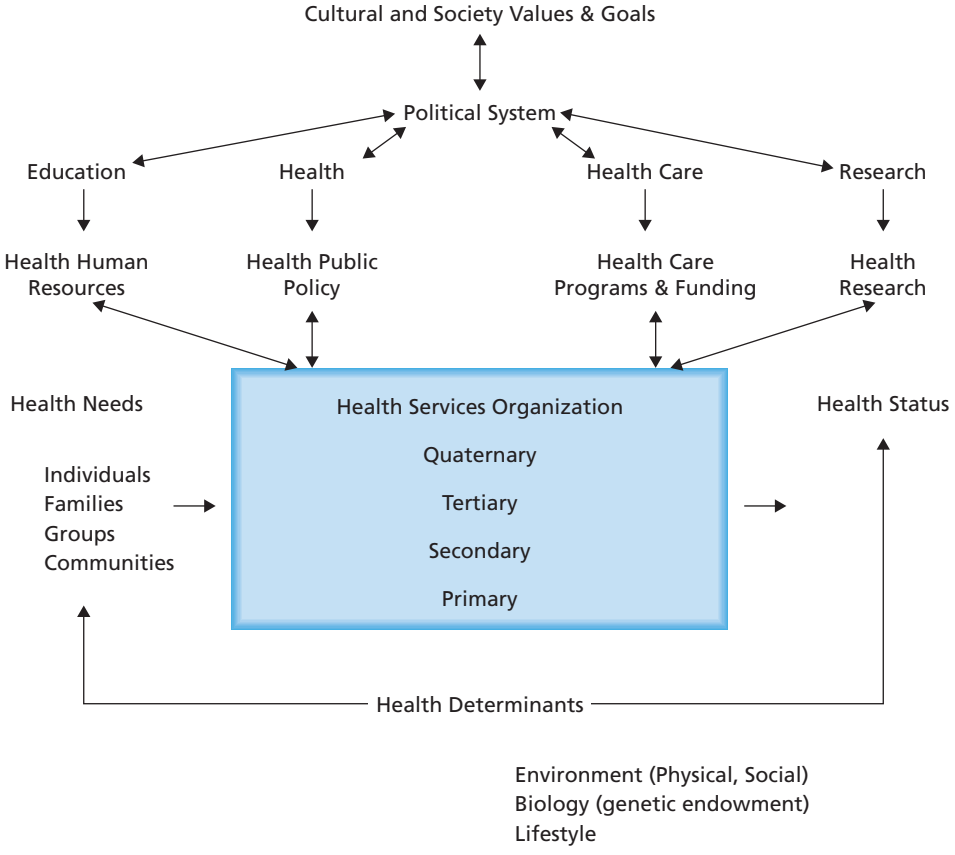

Figure 2.1 Model of Health System

Source: Based on Y. Bergevin and N. Mahamed, Challenge of policy formulation for growth promotion. In *Growth promotion for child development.* Proceedings of a colloquium, Nyeri, Kenya, 12–13 May, 1992.

health, such as the environment, biology, and lifestyle. We will discuss each of these elements, especially as they relate to Canada, in the following sections.

CULTURAL AND SOCIETAL VALUES AND THE POLITICAL SYSTEM

This model of the health system indicates that societal and cultural values shape, and are shaped by, the political system. Canada's political system addresses **public policy** on education, health, health care, and research, all of which have an influence on the way in which we plan, organize, and provide health care.

As cultural and societal values around the world vary, political systems and political values develop differently and influence the way in which national health care systems are developed and structured in various ways. You should not be surprised to find differences in the way in which countries organize health care for their citizens, given differences in resources, priorities, and values. The last major review of health care in Canada was carried out by the *Commission on the Future of Health Care in Canada*. Often referred to as the Romanow Report, after its commissioner, it contains a key message, based on substantial public consultation, which is the importance that Canadians placed on the values that shaped medicare and health care and access based on need rather than ability to pay. According to Romanow (2002, p. 6), "Canadians view medicare as a moral enterprise, not a business venture," and he underscored the values of equity, fairness, and solidarity as ones that formed the basis for health care in the country. He noted that Canadians viewed the system as "a national program, delivered locally" and that they wanted their governments to work together to ensure the system adhered to these values.

Variations in National Health Care Systems

National health care systems are designed and structured in a variety of ways. Roemer (1993) classified systems into four types, based on the degree to which a government was involved in the funding, planning, and management of the system. These range from systems in which the national government provides all of the funding for health services and governs all of the health care facilities in the country, and is thus the employer of health care professionals to systems that are mostly privately funded with services delivered by private enterprise. Table 2.2 provides examples of countries that would illustrate the different types of systems. It must be acknowledged that with time and changes in

Table 2.2 Examples of Types of Health Systems

Classification	Example
Entrepreneurial and permissive	United States
Welfare-oriented	Canada, Japan
Universal and comprehensive	Sweden, United Kingdom
Socialistic and centrally planned	China, Cuba

governments, policy changes in systems may alter the way a particular country would be classified. For example, Canada is considered a welfare-oriented system because our federal legislation with respect to insured services only addresses a portion of services—hospitals and physicians. Countries such as Sweden and the United Kingdom have traditionally addressed a full range of services under national health legislation.

In entrepreneurial systems, individuals purchase health insurance or work for employers that purchase such insurance for employees under private insurance schemes, and most health care services are paid for in this way. In countries with such systems, there is often a mix of publicly funded services for the poor and/or the elderly, with most services being provided and paid for privately. Welfare-oriented systems are publicly funded to a great extent, at least for the expensive components of health care, such as acute care hospital and physician services. Therefore, while citizens may pay for some services, these are typically for less catastrophic services, such as dental care or drugs, for which private insurance may be purchased. Universal and comprehensive services are publicly funded ones that provide a full range of services for all citizens, although there may be access to a private, parallel service in addition to that guaranteed by the government. Socialistic and centrally planned services are the ones available to all citizens and they are designed and delivered by government-funded organizations.

The type of system does not necessarily reflect the economic conditions of the country, and each of the four systems can be found in very poor countries or in affluent and industrialized countries. In entrepreneurial and permissive systems, the private market is very evident, and the government does not intervene to a great extent—people pay for health care through private insurance or private means, and those who provide health services, be they physicians, hospitals, or others, operate as private businesses. In these countries, only a relatively small portion of services and programs are provided by the government through public funding (that is, supported by taxes). In countries with welfare-oriented health systems, governments do take on a larger role, often by financing personal medical care and providing some direct services, especially in rural areas. In comprehensive-type systems, almost all of a country's health services are universally available through a publicly funded system. In socialist health systems, the government centrally plans and delivers health services with almost total elimination of private health care—government not only finances the services, but also hires almost all those who provide the services, educates all health professionals, and produces pharmaceuticals.

Even among Western, industrialized countries, different decisions are made about the degree to which governments will be involved in health care, the extent to which it will publicly finance health care, and how involved it will be in delivering it. In part, these decisions are influenced by cultural and political beliefs about the appropriate role of governments and the responsibilities of the individual vis-à-vis the collective. Furthermore, government policy changes over time, bringing about changes in the health care system. For example, the United States has differed from Canada in health care policy in that it has not had universal health care under a publicly funded scheme. Although health policy reform under the Obama administration has brought some changes in the United States, the majority of Americans must purchase private insurance for health care (to consult a physician or to get a hospital stay covered) in the same

way that we, in Canada, may purchase private insurance for services that are not insured through provincial plans, such as dental care or prescription drugs. The publicly funded plans in the United States are "medicare," a special plan for seniors and others with special needs, and "medicaid" for the poor.

Political values drive the kind of health care system that is and can be adopted in a country. In Canada, society has come to value health care services available to all equally when needed, rather than being based on the ability to pay, and a belief that government ought to be involved in ensuring this kind of system is in place. In countries in which there might be distrust of government involvement and more emphasis on the responsibility of the individual for health care rather than the collective, or a greater emphasis on the role of the free market, there will be marked differences in the context in which health care operates. While it is clear that most Canadians support a publicly funded system, there is a recurring debate about the extent to which there should be more or less privatization of health care funding and delivery. This debate is evident in the numerous federal and provincial reports over the past few decades that have come down on different sides of the private versus public debate in their recommendations (Bryant, 2009).

CANADIAN POLITICAL SYSTEM, GOVERNING AUTHORITY, AND POLICIES AFFECTING HEALTH CARE IN CANADA

In Canada, jurisdiction for various aspects of public life were divided among federal and provincial levels of government in the original British North America Act of 1867 (Vayda & Deber, 1984) and for the most part, matters considered to be of local concern and at that time, matters that were not costly, came under the authority of provincial governments. Therefore, education, asylums, hospitals, and charities came under provincial jurisdiction, while only some aspects of health care were considered matters of national concern and were governed by the federal government, which had a broader tax base and "spending power." Municipal levels of government have also taken on roles in providing physician and hospital services as these services developed in the country, but the nature and specific responsibilities of all three levels of government with respect to health care have evolved over time. Both the federal and provincial governments have had some involvement in the four **policy fields** identified in the model: education, health, health care, and research, but in general, authority for education and health care lies with the provinces and territories.

Federal Government

Under the Constitution Act of 1982, the federal government carries responsibilities for a limited range of health services, such as services for members of the military and for Aboriginals on reserves, while most responsibilities for health care are given to the provinces. However, following the Second World War, the federal government became involved in health policy related to services by virtue of its spending power and the offer to cost share services with the provinces. Following Saskatchewan's lead, the federal government introduced legislation to enable universal insurance for hospital

care and diagnostic services in 1957. Once again, Saskatchewan led the way by introducing **medicare** in 1962, a program to provide physician services under a universal, publicly funded program. (Tommy Douglas, the then Premier of Saskatchewan, is often called the Father of Medicare and his photograph appears at the beginning of this chapter.) Following a Royal Commission on Health Services report, federal legislation was introduced that enabled universal insurance for physician services in 1966. Known in popular terminology as "medicare," the funding of hospitalization and physician services represented a major aspect of federal health policy, perhaps the most popular and politicized program in Canada. As noted by O'Neill, McGuinty, and Teskey (2011) in a review of six decades of political science literature on Canadian medicare, the scholarly community has a "…near-consensus on medicare as a defining characteristic of the country and its people" (p. 49).

Initially, the federal government provided half of the funding for hospitalization and medical care that was spent by a province or territory; however, this arrangement changed in 1977 as the federal government sought to limit the mounting costs of such programs. In changing the basis on which funds were transferred to the provinces, the federal government softened the blow somewhat by providing the provinces with some greater flexibility to use funds for other types of health services. The new funding system moved from 50–50 cost-sharing to block grants, tax point transfers, growth rates, cash transfers, and per capita cash contributions for some extended services such as nursing homes, and ambulatory and home care. Further changes in funding and cost-sharing have occurred since that date, the latest occurring in a 2004 agreement that extends until 2013–14 (Health Canada, 2011).

Over time, concerns began to be expressed about user fees applied in some provinces for emergency room visits or "extra-billing" charges by physicians, requiring people to pay a fee "out-of-pocket" when they received a service that was supposedly paid for through taxes. Following a review of medicare, user fees and extra-billing for insured services were essentially outlawed, and the federal acts for hospital care and physician care were consolidated in 1984 under the Canada Health Act (Department of Justice, 2011). This act also enshrined the principles for the publicly funded system detailing the criteria that must be met for provinces to receive a cash contribution from the federal government (see Table 2.3).

Provincial/Territorial Governments

Provincial/territorial governments play a major role in financing and organizing health services within their jurisdictions and thus reference is often made to Canada's 13 health systems, as there is some variation across provincial and territorial borders. Even if Canadians, as noted earlier, consider health care to be a national system, the provincial government has the jurisdiction and authority to govern health care within a province. While there are transfers of funding to provincial/territorial governments from the federal government that contribute to health care, provincial governments contribute a substantial proportion of their resources to a range of services that extend beyond the original focus on hospitals and physician services. Per capita spending on health by provincial/territorial governments varies with higher per capita spending in the more remote and less populated province/territories. See Table 2.4 for health expenditures by province/territory.

Table 2.3 Program Criteria for Federal Funding to Provinces under the Canada Health Act

Program Criteria	Explanation
Public Administration	Provincial health insurance plan must be administered and operated on a non-profit basis by a public authority
Comprehensiveness	Provincial health insurance plan must insure all insured health services provided by hospitals, medical practitioners, or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners
Universality	Provincial health insurance plan must entitle 100 percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions
Portability	Provincial health insurance plan must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents are eligible for insured services
	During a waiting period of three months or less in a "new" province, the previous province of residence pays for the insured service
	Where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided (unless the two provinces involved agree to a different apportioning)
	Where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province
Accessibility	Provincial health insurance plan must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons

A major area of provincial/territorial health policy relates to the health insurance plan for hospital and physician services, which must be consistent with the principles of the Canada Health Act to receive full federal funding. A substantial portion of provincial/territorial expenditures (34.9% on average in 2010) is devoted to health care spending (CIHI, 2011a). Not surprisingly, health care spending is closely examined for reductions when there are economic downturns. Given the public support for health care however, politicians are reluctant to reduce funding, and generally, must maintain or increase funding to this sector every year.

Beyond administration of the health insurance plans, the provincial and territorial governments have overall responsibility to allocate funding for hospitals and other health

Table 2.4 Per Capita Health Expenditure by Provincial/Territorial Government, 2010

Province/Territory	Per capita Expenditure in Dollars by Provincial/Territorial Government
Newfoundland	4,564
Prince Edward Island	3,988
Nova Scotia	3,944
New Brunswick	3,789
Quebec	3,341
Ontario	3,548
Manitoba	4,155
Saskatchewan	4,077
Alberta	4,295
British Columbia	3,544
Yukon Territory	5,234
Northwest Territory	5,954
Nunavut	8,862

Source: Canadian Institute for Health Information (CIHI), 2011a. Reprinted with permission.

care facilities, negotiate fee schedules for physicians, plan and implement health promotion campaigns and public health services, and address other health policies and services that are not part of the Canada Health Act. For example, nursing homes, workers' compensation, ambulance services, mental health and human resources planning, and regulation of professions all fall within provincial and territorial jurisdiction. Each jurisdiction has legislation that addresses the full range of matters pertaining to health care, such as health insurance, regulated health professionals, health institutions, public health, mental health, etc. Therefore, this level of government has a great influence on the organizations within which most health professionals work and the professions to which they belong.

Municipal Government

The municipal level of government, that level responsible for local matters in cities, towns, and smaller communities, operate under provincial legislation that sets out the framework for local government. Depending on the province, this level of government may have some responsibilities with respect to health care, for example, in Ontario where public health units across the province have local health boards with regional municipal representatives. The costs are shared with the provincial government (Ontario Ministry of Health and Long-term Care, 2011). To a great extent however, the provision of health services by local government has diminished since the early days of Canada's history.

Regionalization of Health Services

Although provincial governments have jurisdiction for health care services within a province, in recent decades all of them have established regional bodies, based on geographic areas, and delegated some degree of responsibility for decision-making about health services to them. This development represents one of the major changes in the governance and organization of health services during the 1990s and the first decade of the twenty-first century. **Regionalization** meant that, in many provinces, individual hospital and agency boards were replaced by regional ones, and decision-making for planning and implementation shifted from central provincial authorities in departments of health to more local ones. The benefits of regionalization were thought to be increasing citizen participation in decision-making, better planning that met more local needs, **horizontal integration** and **vertical integration** of services that improved services, and efficiencies that created economies of scale and better expenditure control (Church & Barker, 1998; Lewis & Kouri, 2004). Horizontal integration refers to an organization becoming larger by joining with a similar organization(s). Vertical integration refers to an organization becoming larger by joining with another organization(s) that is a supplier or purchaser of products or services of the organization. The responsibilities of regional authorities vary across the county—some incorporate a wide range of health services such as home care, public health, acute care, and long-term care while others have a narrower focus. In some provinces, but not all, regional authorities are responsible for allocating budgets to the services within their region while in other provinces they are responsible for planning and implementation of services. Provinces continue to adjust policy on regional health authorities and thus there have been changes over time in the degree to which authority is centralized or decentralized. For example, Alberta abolished its health regions in 2008 and moved to the creation of one health authority or "super board," Alberta Health Services (Duckett, 2011). In Ontario, Local Health Integration Networks (LHINs) were established in 2006 and have engaged in planning and priority-setting in the regions, but without replacing hospital boards or the authority for managing the system as has occurred in some other provinces (Falk, 2011).

Intergovernmental Agreements

As discussed in the previous section, provincial/territorial governments have major responsibilities for policy about how health care is organized within their jurisdictions. Provincial/territorial governments, through their ministries of health, determine the overall structure of the health system, how the system is organized and regulated, the major policies governing system functioning, and the major priorities within the jurisdiction with respect to health and health policy. Given that the federal government has been involved in developing and funding aspects of the health system and health policy, there have been periods of time during which there was considerable conflict between the two levels of government. The tensions over health care funding and jurisdiction that existed between the 1960s and the 1980s gave way by the mid-1990s to what has been described as collaborative federalism (Bryant, 2009), leading to the Social Union Framework Agreement (SUFA) between the two levels of government in 1999. All

jurisdictions except Quebec signed this agreement that aimed to clarify responsibilities and obligations in the area of social policy (that is, health, social services, post-secondary education, social assistance, and training policy). Subsequent to that agreement, the federal minister of health and provincial and territorial counterparts met to come to an agreement known as the Health Accord Agreement. These accords (in 2000, 2003, and 2004) addressed health care issues and established funding for early childhood development, improved medical equipment, primary care reform, and Canada Health Infoway, a not-for-profit corporation established by federal and provincial/territorial first ministers in 2001. This corporation works with governments to develop and adopt electronic health record (EHR) systems in Canada and promote sharing of such development across regions. The 2004 Health Accord set out a 10-year plan to renew the health care system.

Policies Affecting Health Care

As illustrated in the health system model, the political system generates policies in several fields that have an effect on the health system. Education policies affect the training of people who will work in the health field and more attention is given to health human resources later in this chapter. A second set of policies can have a positive or negative effect on the health status of the population. Factors that contribute to one's health include the physical and social environment (for example, war, pollution, natural disasters), biology (your genetic makeup or endowment), and lifestyle (for example, use of tobacco or alcohol, exercise, and eating habits). Public policy that is considered **healthy public policy** refers to those measures that promote health, for example tax incentives for engaging in regular exercise, nutrition labelling that might improve dietary habits, taxes on tobacco products, non-smoking policies in public places, and fines on industries that pollute the environment. It is also well known that housing, income, nutrition, and other factors are important determinants of health. A wide range of public policy can be considered from the perspective of its impact on the health of the population.

A third area of health public policy relates to funding. Most people think of health services as having the greatest impact on the health status of the population, but as noted earlier, it is only one factor, and many challenge the traditional assumption that it is a key one (Evans, Barer, & Marmor, 1994). In Canada, public policy relevant to health services includes both federal policy such as the Canada Health Act and the transfer of funds to provincial governments in support of health care services, as well as an array of programs and funding that fall within provincial jurisdiction, for example legislation regulating hospitals, health regions, health professionals, and diagnostic services. Legislation and regulations governing every kind of health care facility constitute policies that affect how the health system is structured and operates.

A fourth area is research policy. Health research is one aspect of the health system that garners a relatively small share of the spending on health. According to the Canadian Institute of Health Information (2009), in Canada we spent approximately 1.4 percent of the $84 billion in health expenditures in 1997–1998 on health research, while this per-

centage increased to 1.8 percent of the $172 billion in health spending in 2007–2008. A major agency funding health research is the Canadian Institutes of Health Research (CIHR), an organization that was established in 2000 out of the former Medical Research Council of Canada. CIHR (2012) funds the training of researchers through scholarships and awards as well as research projects and programs in four areas: 1) biomedical, 2) clinical, 3) health system services, and 4) social, cultural, environment, and population health. Researchers (usually organized into teams) submit funding applications to CIHR, and there are always many more applications than there are funds available, so the process is highly competitive and many strong applications are not successful. CIHR has 13 Institutes that are organized around particular areas of research and these networks bring together researchers (including nurse researchers) ranging from basic scientists to clinical scientists to population health scientists together with voluntary agencies and policymakers to focus on topics and goals in the following areas:

- Aboriginal Peoples' Health
- Aging
- Cancer Research
- Circulatory and Respiratory Health
- Gender and Health
- Genetics
- Health Services and Policy Research
- Human Development, Child and Youth Health
- Infection and Immunity
- Musculoskeletal Health and Arthritis
- Neurosciences, Mental Health, and Addiction
- Nutrition, Metabolism, and Diabetes
- Population and Public Health

Many provinces also have agencies that fund health research and these are also important organizations for the development and training of researchers and the funding of studies and programs of health research.

Another important research agency is the Canadian Foundation for Healthcare Improvement (CFHI), formerly the Canadian Health Services Research Foundation (CHSRF). Established in early 1997, CHSRF received an initial endowment in 1997 from the federal government, followed by a second endowment of $60 million that included "$25 million that was earmarked for the development and support of nursing research" (CHSRF, 2007). This organization was an important one in the development of research focused on nursing in health care and it supported health services research and the development of researchers. CFHI no longer provides research grant funding for health policy, but does undertake research and analysis to advance improvements in health care, usually by commissioning research on health services topics (CFHI, 2013).

THE ORGANIZATION OF HEALTH SERVICES IN CANADA

The organization of health services varies from one country to another, but in general, there are four levels that are used to describe the kinds of services that are provided in many countries: primary, secondary, tertiary, and quaternary. These levels are depicted in the centre of the health system model and these levels are intended to address the health needs of citizens to achieve optimum health status of the population as an outcome.

Primary Health Care

Primary health care (PHC) is "a comprehensive system of essential health care that is focused on preventing illness and promoting health" (CNA, 2002, p 1). PHC refers to the first level of care, that level sought by individuals requiring health information or assistance for health issues, disease prevention, common health problems, and injuries. This is the level at which people have first contact with the health system, where people can obtain direct service that meets their needs without the requirement of being referred elsewhere. As this level is the most basic and fundamental one in meeting health care needs, the World Health Organization (WHO) made an effort to promote the development of PHC as a priority in the 1970s, particularly in countries with very few resources. At WHO's International Conference on Primary Health Care in Alma-Ata in what was then the USSR, the Declaration of Alma-Ata was adopted by members of the World Health Assembly who supported the principles embodied in the Declaration and expressed in the theme "Health for All by the Year 2000" (WHO, 1978). These principles are identified and described in Table 2.5.

As PHC encompasses the level at which individuals, families, and communities enter the health system and access health services, there is a wide range of organization of services at this level. Perhaps the kind of service that is most familiar to generations of Canadians is the provision of **primary care** by a physician in a solo, private practice. Primary care is the provision of health care to an individual (often called personal health services), typically to assess, diagnose, and treat a common health problem, but also to promote health through advice and teaching or to prevent disease through immunization or education. This kind of health service is also found in group practices, nurse practitioner clinics, urgent care centres and clinics, and a wide variety of community-based clinics and programs aimed at specific services and client groups. All of these fall within the umbrella level of care referred to as primary health care.

Although the terms "primary care" and "primary health care" are often used interchangeably, in Canada, **primary care** is usually one component of a loosely integrated system of primary health care services available in a community that does not usually embody all of the principles of primary health care. There are some organizations that aim to incorporate principles such as public participation, health promotion, and intersectoral cooperation. Some community health centres provide a range of health and social services that are designed for the group of clients they serve. Examples include community health centres in a geographic area with a high number of recent immigrant families, or Quebec's network of more than 140 centre local de services communautaires (CLSCs) or local community health centres.

Table 2.5 Principles of Primary Health Care

Principle	Explanation
Accessibility	Essential health care (promotive, preventive, curative, rehabilitative/palliative services) that address the main health problems in the community
	Universally available to individuals and families in the community
	Integral part and central function and main focus of country's health system
	Brings health care as close as possible to where people live and work
	First element of a continuing health care process
Public participation	Full participation of individuals, families and communities in PHC and services designed at a cost that the community and country can afford to maintain
	Spirit of self-reliance and self-determination
	Participation in planning, organization, operation, and control of PHC
	Appropriate education to develop the ability of communities to participate
Health promotion	Includes at least education on prevailing health problems, prevention and control methods, promotion of food supply, nutrition, supply of safe water, basic sanitation, maternal and child health care, including family planning, immunization
Appropriate skills and technology	Care based on practical, scientifically sound, and socially acceptable methods and technology
	Modes of care adapted to community's society, economy, and culture.
	Application of results of social, biomedical, and health services research and public health experience
Intersectoral cooperation	Recognizing the determinants of health and role of agriculture, food, industry, education, housing, public works, and communications in health
	Ensure collaboration between disciplines and sectors and the coordinated efforts of all sectors in government policy and service delivery

Sources: Data from CNA (2002). *Effective health care equals primary health care* (PHC); CNA (2000). The primary health care approach; WHO (1978). *Declaration of Alma–Ata: International conference on primary health care, Alma-Ata, USSR, 612* September 1978. Geneva: WHO.

Primary care has been the focus of reform in many provinces as governments have introduced incentives to encourage more accessibility to services (24/7 access), team models of care that focus on disease prevention and health promotion, improved management of chronic illnesses, and better coordination of a range of available services. Many younger physicians seek practices other than solo fee-for-service ones because they prefer the more balanced working life group practices provide and the collegial, collaborative working relationships that such centres and interdisciplinary settings can offer them as well as the quality of care that they can provide to patients.

There are a number of settings in which nurses work that are components of the primary health care system, although some would argue that "system" is too strong a word for these somewhat fragmented services. These positions include occupational health nurse in businesses and industrial firms where nurses provide first contact care in the workplace to promote health, prevent disease or injury, and to treat and monitor common health problems or injuries. Public health nurses in geographic communities provide direct services to individuals through immunization clinics, sexual health and other programs, and health promotion strategies to reduce smoking or prevent falls in the elderly. These services, focused on health promotion and disease prevention, are provided in the community through home visits and clinics or in easily accessible locations, such as schools and shopping malls.

Data for 2009 from the Canadian Institute for Health Information (2010) on registered nurses indicates that approximately 14.2 percent of RNs work in the community, a small increase from 2005 when the percentage was 13.5 percent. However, this report includes nurses working in home care, which is not part of primary health care, in addition to those who work at the level of primary health care, such as public health nurses and nurses in community health centres, nursing stations, clinics, and outposts.

Secondary Health Care

The **secondary health care** refers to a more specialized level of care in a variety of settings, such as community hospitals, home care, and long-term and chronic care settings. Individuals are normally referred to this level of health care by someone in the primary health care level, such as a family physician, community agency, or sometimes a family member or the individual themselves. There is a wide variety of services provided in these secondary settings, including medical and surgical treatment, rehabilitation, continuing, and palliative care.

Most community hospitals are governed by community boards of trustees, voluntary organizations, or regional health authorities and are funded by provincial or territorial governments. Most of the hospitals in Canada are of this type and they offer a wide range of services in rural, small, and large communities. In addition to acute inpatient care for an episode of illness and treatment, hospitals may offer emergency and ambulatory care services on an outpatient basis.

Hospitals receive most of their funding from provincial governments. An annual budget is prepared by the hospital, normally based on the previous level of activity, any approved planned changes in services, and any guidelines set by the body that negotiates funding with the hospital, be it a ministry of health or a regional health authority. Hospitals are a major component of health care spending and fall within the Canada Health Act provisions and what many refer to as the five principles of medicare mentioned earlier.

Continuing care is provided in settings that may be termed rehabilitation hospitals, or chronic care, extended care, or complex continuing care institutions. Because acute care hospitals are designed for illness that is typically severe, episodic, and of limited duration, continuing care institutions are designed to care for those who no longer need acute care services, but who require ongoing care to deal with complex health problems.

Two types of secondary services that are not part of the Canada Health Act are home care and long-term care (called nursing homes in some places). Home care is a service that enables individuals with a physical or mental health issue to live at home and receive professional care (nursing, physiotherapy, and so on), personal care (bathing, toileting, and so on) and homemaking services (house cleaning, laundry, and so on) or some combination of these services through home visits by personnel. Although all provincial governments have provided some level of home care, the Romanow Commission found a wide variation in service availability between and within provinces, criteria for eligibility and budgets devoted to this kind of alternative to institutional care. For that reason, the Commission recommended that home care be covered by the Canada Health Act, beginning with three areas of priority: mental health, post-acute care, and palliative care (Romanow, 2002). However, despite an expansion of such services, they have not yet become an insured service in the way that hospitals and physician services are recognized as an essential service under the Canada Health Act. There has been little appetite by governments to expand any health service in this way.

Long-term care refers to residential care facilities for those requiring continuing, 24-hour care that includes nursing care and personal support. These facilities are partly subsidized by provincial governments, but they are not an insured service under the Canada Health Act—residents or their families normally pay a monthly fee for long-term care. As with home care, access to, availability of, and funding for long-term care varies across the country. In addition to issues of access, concerns have been expressed about the quality of care in these institutions (Jansen, 2011; Samuleson, 2011). Many residents in such facilities are elderly, and the number of beds has increased as the population ages, but the numbers have not kept pace with demand and there are waiting lists for admission across the country.

Tertiary Health Care

Tertiary health care includes more specialized services than one would find in a general or community hospital. These services are usually found in larger centres that can bring together the equipment and personnel required. While tertiary level hospitals offer the range of services of community hospitals, they are typically associated with an academic setting, are known as academic health centres, and offer services that are unavailable in community hospitals. For example, kidney transplants and cardiac surgery are available in tertiary care settings. Some specialty hospitals, such as those designed for the care of children, are included within this level of care.

Quaternary Health Care

Quaternary health care refers to yet more specialized services that are only available in limited locations due to the highly specialized equipment and personnel involved. These services may only be available in a few cities in a country and poorer countries may not provide any of these services. For example, some experimental therapies and heart-lung transplantation would be done in a hospital designated as a quaternary level centre for that service. These services are located in the largest Canadian cities.

HEALTH HUMAN RESOURCES IN CANADA

A major component of the model of the health system is health human resources—the people who carry out the work of the health care system. There is a broad range of workers: regulated health professionals; other professionals in finance, management, law, technology, skilled trades, and services personnel; unregulated health workers; administrative and secretarial personnel, and so on. Federal and provincial public policy on education and training has an impact on the planning for and availability of the appropriate numbers and kinds of workers in the health care system. As with health care, the federal government in Canada has played a role in funding post-secondary education, the level at which many health professionals are educated, although education policy is primarily within the jurisdiction of provincial governments.

Major changes in the demand for or supply of health workers can cause problems in the delivery of health care to citizens unless there is planning at some level. For example, the building of a new hospital requires consideration of the requirement for additional nurses and other types of workers. In the past, periods of shortages followed by an oversupply of nurses has resulted in a roller coaster of employment problems. Layoffs of nurses in the 1990s due to health care spending cuts were followed by shortages of nurses. Other shortages will occur as the "baby boomer" nurses retire. Similar concerns arose about a shortage of physicians when many Canadians were unable to find a doctor when their long-term family physician retired. Consequently, more research attention has been given to understanding the factors that need to be considered in planning human resources in the health sector. Educational preparation is one of these factors, as is licensing requirements for some professions. Requirements for some of the health occupations are presented in Table 2.6 as an illustration of the complexity of health human resources.

Please note that data are not available for unregulated health workers, such as physician assistants or health care aides/personal care workers. The minimum education required for any health care group varies over time, as groups seek change in the nature and length of their education programs. For example, the nursing profession at the national level and in many provinces set a goal in the 1980s for establishing a bachelor's degree as the new educational requirement for registered nurses and they set the year 2000 as a target date. At the time of writing, all jurisdictions in Canada require a baccalaureate degree for entry to practice except the province of Quebec, where a diploma in nursing is the minimal requirement.

Health Care Occupations

Specialized preparation is required for health care professions and occupations. Individuals who pursue education in these fields make a considerable investment in time and funds. Many, but not all, occupations in health care are regulated ones, and fairly accurate numbers are available for professional colleges that have members who are registered or licensed, as an active membership is required each year in order to practice. In Table 2.7 we present numbers for selected health occupations over a five-year period to give you a

Table 2.6 Educational Programs and Licensing Requirements for Health Occupations in Canada

Occupation	Minimum Education Required*	Internship/ Practicum Required	National Exam
Audiologists	master's	√	√
Chiropractors	professional doctorate	√	√
Dental Hygienists	diploma	√	√
Dentists	professional doctorate	√	√
Dieticians	bachelor's	√	√
Environmental Public Health Professionals	diploma or bachelor's	√	√
Licensed Practical Nurses	diploma	√	√
Medical Laboratory Technologists	diploma	√	√
Medical Physicists	master's or doctorate	√	√
Medical Radiation Technologists	diploma	√	√
Midwives	bachelor's	√	√
Nurse Practitioners	post-baccalaureate certificate or master's	√	√
Occupational Therapists	master's	√	√
Optometrists	professional doctorate	√	√
Pharmacists	bachelor's	√	√
Physicians	md plus residency	√	√
Physiotherapists	master's	√	√
Psychologists	doctorate	√	√
Registered Nurses	diploma or bachelor's	√	√
Registered Psychiatric Nurses	diploma or bachelor's	√	√
Respiratory Therapists	diploma	√	√
Social Workers	diploma, bachelor's or master's	√	√
Speech-Language Pathologists	master's	√	√
Health Information Management Professionals	diploma or bachelor's	√	√

* The minimum requirements are reported here, but they vary by province/territory.

Source: Canadian Institute of Health Information (2011b). Reprinted with permission.

Table 2.7 Numbers in Selected Health Occupations in Canada, 2005 to 2009

Category	2005	2006	2007	2008	2009
Chiropractors	7,108	7,318	7,434	7,615	7,796
Dental Hygienists	18,403	19,389	20,928	22,365	23,902
Dentists	18,688	18,925	19,201	19,433	19,655
Dietitians	8.135	8,422	8,797	9,027	9,369
Environmental Public Health	1,220	1,375	1,420	1,245	1,288
Medical Laboratory Technologists	20,103	19,873	19,813	19,300	19,238
Midwives	520	626	639	738	826
Occupational Therapists	11,378	11,782	12,297	12,649	13,122
Optometrists	3,999	4,141	4,255	4,507	4,581
Pharmacists	29,471	27,094	28,495	29,010	30,333
Physicians	61,622	62,307	63,682	65,440	68,101
Physiotherapists	15,772	16,108	16,419	16,889	17,312
Psychologists	14,715	15,751	16,097	15,780	16,156
Respiratory Therapists	7,636	7,886	8,211	8,796	9,611
Speech-Language Pathologists	6,331	6,661	6,992	7,316	7,611

Source: Canadian Institute of Health Information. (2011b). Reprinted with permission.

sense of the relative size of some of these groups in Canada. Information on nursing groups is presented in a subsequent table. Normally, one would expect regular growth in the numbers of health care workers that reflects the growth in Canada's population over time. However, as the baby boomers represent a large group within the Canadian population and they have now started to reach retirement age, one can expect that larger replacement numbers will be needed over the next few decades.

Regulated Nursing Personnel

There are four kinds of regulated nursing personnel in Canada: registered nurses (RN), nurse practitioners (NP) (who are also registered nurses), registered psychiatric nurses (RPN) in the four Western provinces and Yukon Territory only, and licensed practical nurses (LPN/RPN) who are called registered practical nurses in Ontario. Table 2.8 indicates the first year in which each group became regulated.

As you can see in Table 2.9, the category of registered nurse is a major one among nursing groups and the largest group of all the health professions. All categories of regulated nursing personnel have increased in number during the past decade, but between 2005 and 2009, percentage growth has varied, 18.5% for licensed practical nurses, 6% for

Table 2.8 First Year of Regulation of Regulated Nursing Personnel by Province/Territory as of 2010

Category	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
RN	1954	1949	1910	1916	1946	1922	1913	1967	1916	1918	1994	1973	1999
NP	1997	2006	2002	2002	2003	1997	2005	2003	2002	2005	NR	2004	2004
RPN	-	-	-	-	-	-	1960	1948	1955	1951	2009	-	-
LPN	1983	1959	1957	1960	1974	1947	1946	1956	1986	1988	1987	1988	2011

Source: Canadian Institute of Health Information. (2011b). Reprinted with permission.

registered nurses and 5% for registered psychiatric nurses. The percentage growth for nurse practitioners was not reported by CIHI (2010) because of data variations and their relatively recent appearance as a regulated category.

The registered nurse workforce is a large one that participates in a wide variety of health care settings. Data from 2009 indicate that 62.6% of employed RNs work in hospitals, 14.2% work in community health (which includes community health centres, home care, and public health) while 9.9% work in nursing homes or long-term care. The remainder is self-employed or works in such settings as educational institutions, government, physician offices, and so on.

Unregulated Nursing Personnel

In many health care facilities and agencies in Canada, unregulated personnel assist in nursing care of individuals and families under the guidance of regulated nursing personnel (RNs, RPNs, and LPNs). The title of these unregulated workers varies by agency, region, or province/territory, and there is also variation in the kind and length of educational preparation that they may have received. They have been called nursing aides, health care aides, personal support workers, personal care workers, and so on. The Canadian Nurses Association (CNA) has referred to them as **unregulated health workers**

Table 2.9 Numbers of Regulated Nursing Personnel by Category in Canada, 2005–2009

	2005	2006	2007	2008	2009
Registered Nurses	251,242	253,819	257,961	261,889	266,341
Nurse Practitioners	976	1,162	1,393	1,669	2,048
Registered Psychiatric Nurses	4,964	5,051	5,124	5,162	5,214
Licensed Practical Nurses/ Registered Practical Nurses (Ontario)	64,953	67,300	69,709	74,380	76,944

Source: Canadian Institute of Health Information. (2011b). *Canada's health care providers 2000 to 2009—A reference guide.*

(UHW). CNA defines UHW as "an umbrella term used to describe care providers or assistant personnel who provide some form of health service and who are not licensed or regulated by a professional or regulatory body" (2009, p. 1). At one time, these workers may have received on-the-job training, but now they tend be prepared in short programs in high schools, private training organizations, community colleges, and other settings. They frequently work in nursing homes, but can be part of care teams in hospitals and community agencies, including home care settings. As they are unregulated and have various position titles, an accurate count of their numbers is difficult to maintain, but CNA (2009) cites a 2003 estimate from Statistics Canada of 188,800 people in such occupations.

As a nursing student or registered nurse, you may have worked with UHWs and can appreciate the contribution they can make to health care and the role of the registered nurse in working with people in this category of personnel. As a registered nurse, you are apt to be in a team leadership position and may work with UHWs who are members of the team. It is important that you develop your leadership knowledge and skills and understand your responsibilities and liabilities with respect to delegating and guiding the work of others. Because of inconsistencies from one workplace to another, it is important to seek clarity about the roles and abilities of UHWs you are working with. CNA and other national organizations have recommended more national discussion of how to integrate this group into the health care system and the need to clarify their roles and levels of education.

HEALTH SYSTEM OUTCOMES AND CURRENT ISSUES IN HEALTH CARE

From the earlier sections it is evident that a great deal of time and attention has been and continues to be given to the development and maintenance of a health system. Considerable amounts of public and private funding support the system, and large numbers of individuals bring a wealth of expertise and professional skill in pursuit of the goals of the health system. As you have already learned through your nursing education so far, the health care system is not the only determinant of the health of a population, and such factors as the physical and social environment, as well as biology and lifestyle, also play key roles in determining health.

There are many ways in which one could look at health outcomes. The Organization for Economic Co-operation and Development (OECD) has examined a number of factors that contribute to health status. The OECD (2012) is an international organization, currently composed of 34 countries, that is interested in sharing ideas on policies that range from economic to social. The member countries share an interest in democracy and market economies. They compile data and generate reports on health matters that provide useful comparisons, because many members of OECD have an economic status similar to Canada. As a member of OECD, Canada uses data and contributes data. This sharing is one of the ways that Canada can assess how well it is doing. How does Canada compare to other OECD countries in terms of health of the population? Figure 2.2 on life expectancy at birth and Figure 2.3 on infant mortality rates present

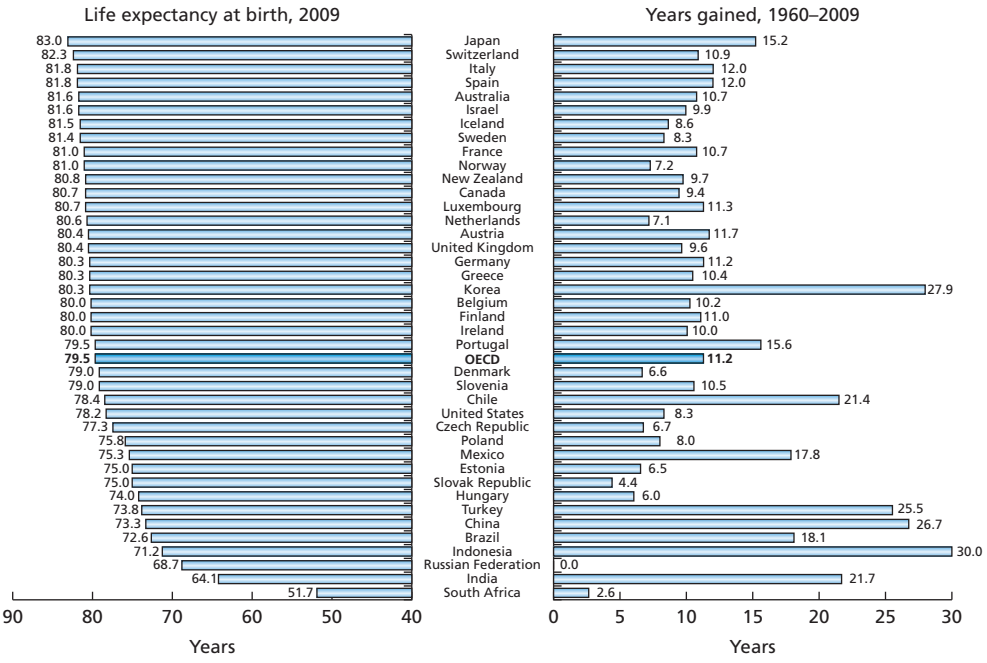

Figure 2.2 Life expectancy at birth, 2009 (or nearest year), and years gained since 1960

Source: OECD (2011), Health at a Glance 2011: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2011-en.

measures that are considered to be two indicators of the relative health status of a population.

The OECD (2011) is interested in how a country's health systems perform and has identified three aspects that can be examined in greater detail: quality of care, access to care, and cost/expenditure. These three aspects are ones that many health authorities and health institutions examine when evaluating performance. A number of the current issues in health care in Canada relate to these three aspects of performance. For example, the 2004 Health Accord, mentioned earlier, focused on improving wait times for services, which is a concern related to access to care. Use of technology and development of electronic health records was another issue addressed in the accord and that issue is viewed as a factor in ensuring quality of care as well as efficiency, which can reduce health care costs. One of the solutions that many believe is key in addressing issues of quality, access to care, and costs is an integrated health system.

Integrated Health Care System

Canada shares the international concern about fragmentation of health care services. A common solution posed in response to those concerns is "integrated care" (Kodner, 2009). The range of concerns include problems in accessing services; lack of coordination of

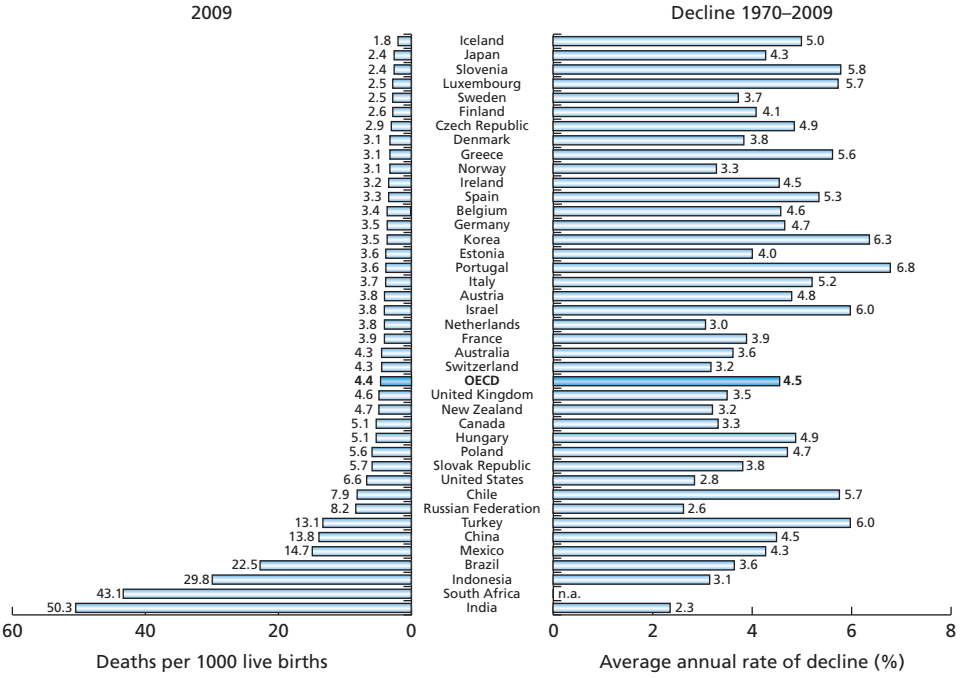

Figure 2.3 Infant mortality rates, 2009 and decline 1970-2009 (or nearest year)

Source: OECD (2011), Health at a Glance 2011: OECD Indicators, OECD Publishing. http://dx.doi.org/10.1787/health_glance-2011-en.

services for individuals, especially those with multiple and complex problems; a focus on acute care that fails to address the needs of those with chronic conditions; disjointed, inefficient, and low quality care; and out-of-control costs. Many examples can be given of patients who "fall between the cracks" in health care or who are "lost in the system," not obtaining the kind of care they require in a timely manner. Given the range of concerns, the meanings given to integrated care also range widely and encompass such phrases as case management, continuity of care, seamless care, patient-centred care, and vertical and horizontal integration of services.

One definition of integration in health care comes from a technical brief by the World Health Organization (WHO, 2008). It defines integrated service delivery as "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money." (p. 5). This kind of service delivery is a way of making navigation through the system easier and more seamless for clients; however, in addition, integration can be more extensive than just service delivery and can extend to include funding, administrative, organizational, and clinical integration. While there are examples of some types and levels of integration, full integration at all levels is an enormous challenge. Some of these challenges have been discussed in proposals in Ontario for integrated health care organizations that combine delivery of acute care, primary care, and homecare in one organization (McLellan, Egberts, & Ronson, 2011).

Leading Health Care Example

Thomas McKeown, meet Fidel Castro: Physicians, population health and the Cuban paradox, 2008.

Robert Evans (2008) discusses the "remarkable" Cuban achievement with regard to health status of the population. Although a poor country in terms of most measures of wealth, such as per capita Gross Domestic Product (GDP), based on data from the World Health Organization, Cuba is comparable to high-income countries on common measures of population health, such as life expectancy at birth and mortality before the age of five. Cuba is considered an "outlier," performing well above what one would expect of a poor country. Evans notes that there has been little examination of how Cuba has accomplished this result and suggests that further scholarly attention should be given to this question. He notes that one of the unusual characteristics of Cuba that can be found in health data is the doctor-to-population ratio in the country, which is the highest in the world. Evans considers those countries closest to Cuba's doctor-to-population ratio to see if they might suggest an answer. In general, poorer countries with a similar physician supply do not achieve the same outcomes as Cuba, while wealthy countries achieve comparable outcomes. The question remains—how does Cuba achieve these outcomes, given their GDP? Evans discusses the nature of primary health care in Cuba and physician training and speculates that these might be factors in Cuba's success:

> The difference appears to be that in Cuba, primary care physician (and nurse) teams have responsibility for the health of geographically defined populations, not merely of those patients who come in the door. These teams are then linked to community- and higher-level political organizations that both hold them accountable for the health of their populations and provide them with channels through which to influence the relevant non-medical determinants. (p. 31)

This article illustrates how a focus on health outcomes leads one to examine what it is that improves health outcomes for a population other than a greater infusion of funds. The data that Evans examines do seem to suggest that an emphasis on primary health care principles, accountability systems, and population health approaches may well help explain improved health outcomes at the national level. The author, who is an eminent Canadian health care economist, has raised questions about health care policy approaches that are applicable to any country, even one like Canada, which would be considered wealthy compared to many other countries.

Source: Evans, R. G. (2008). Thomas McKeown, meet Fidel Castro: Physicians, population health and the Cuban paradox. Healthcare Policy, 3(4), 21–32.

SUMMARY

In this chapter we have focused on management theories and functions and the environment in which managers operate. The idea of management has evolved over time so that, while key management functions remain important, the leadership dimension has taken on equal importance as the pace of change in society increases. Managers and leaders with skills in both spheres are needed to organize and lead complex health care organizations

amid constant and fast-paced change. Health care management occurs within an environment that has great complexity; is affected by public policies and regulations in many sectors; is of great concern to individuals, their families, and communities; and must continually change to ensure accessible, safe, high quality effective care that is provided in an efficient way at a cost the country care sustain.

Glossary of Terms

Classical management theory is a view of management as a process of planning, organizing, commanding, and controlling.

Cybernetics is an interdisciplinary science that studies information, communication, and control. It is considered a technique for designing self-regulating systems and is used in thinking about how organizations learn.

Healthy public policy refers to government policy that promotes health.

Horizontal integration refers to an organization becoming larger by joining with a similar organization(s). In the case of hospitals, horizontal integration is when a hospital joins with another hospital(s).

Medicare is a term used by Canadians to refer to publicly funded health care services to which they have access in provincial and territorial health systems. It refers to insured health services and at a minimum includes hospital care and physician care.

Policy fields refer to areas of policy interest, such as health, transportation, agriculture, education.

Primary care refers to the provision of personal health services to individuals and families, normally on a continuing basis in their home community. This is usually first level of contact that individuals have with the health system, and the provider is the gateway to health services required beyond assessment, diagnosis and treatment of common illness or injuries, disease prevention, or individual health promotion.

Primary health care encompasses the level at which individuals, families and communities enter the health system and access health services and includes the provision of individual health services for injuries and illness, but extends beyond that to include disease prevention and health promotion. There is a range of organizations that provide PHC services.

Public policy refers to courses of action by governments. Public authorities, be they municipal, provincial, or federal, through policy may decide to take actions (or decide not to take action) with respect to problems within their respective jurisdiction or area of responsibility.

Quaternary health care refers to the most specialized services that are only available in limited locations due to the highly specialized requirements for equipment and personnel. These services may only be available in a few cities in a country, and poorer countries may not have any of these services available. Heart and lung transplantation is an example of such a service.

Regionalization refers to the decentralization of authority and responsibility for health services from a more central authority to a regional body. The trend in Canada has been for provincial governments to establish regional bodies based on geographic areas and delegate some degree of responsibility for decision-making about health services to them.

Scientific management refers to an approach to management from the early 1900s that emphasized designing work to maximize time, energy, and efficiency, and training or hiring workers so that skills matched the jobs. The role of managers was to plan and supervise workers.

Secondary health care is a specialized level of care in a variety of settings, such as community hospitals, home care, and long-

term and chronic care settings. Individuals are normally referred to this level of health care by someone in the primary health care level, such as a family physician

Tertiary health care refers to the third level of care that provides more specialized services than one would find in a general or community hospital, so these services are usually found in larger centres that can bring the equipment and personnel together required. For example, cardiac surgery may be carried out in a tertiary health centre.

Unregulated health worker (UHW) refers to care providers or assistant personnel who provide some form of health service and who are not licensed or regulated by a professional or regulatory body. Those who assist with nursing care may have job titles like nursing aide, health care aide, or personal support worker.

Vertical integration refers to an organization becoming larger by joining with another organization(s) that is a supplier or purchaser of products or services of the organization. In the case of hospitals, vertical integration refers to a hospital becoming larger by joining with health care organizations where patients may be referred to the hospital, or go to after hospitalization, such as community health centres and long term care centres.

Critical Thinking Questions and Activities

1. Describe how your current clinical placement or workplace exhibits characteristics of classical management theory or human relations theory.
2. Choose one of the health care organizations in which you have had experience and describe how that organization would be "open to the environment." What has the organization had to respond to in the environment and how has it responded?
3. Interview a nurse in a managerial role in a clinical area and ask him or her to give examples of his or her experience in the five management functions described in this chapter.
4. Identify a nurse at a senior level of management in your organization and give examples of her or his skills and activities as a manager and as a leader.
5. Think about your own experiences as someone who has used and received health care services. At what level of the system were the services provided? What health occupations were involved in providing these services? Now answer the same questions about someone else that you know and that person's health care experiences.
6. Where does the funding come from for the health services you or someone you know received? Who was responsible for the costs of the health services required? Were there health care costs that were paid by the individual?

Self-Quiz

1. The management theory associated with designing positions for work flow and efficiency is known as:
   - **a.** Cybernetics
   - **b.** Human relations
   - **c.** Theory X and Theory Y
   - **d.** Scientific management

2. Leadership is distinguished from management in that:
   - **a.** Leadership is focused on quality standards
   - **b.** Management is concerned with coaching
   - **c.** Leadership is dealing with change
   - **d.** Management involves developing a vision
3. The Canada Health Act criteria require that:
   - **a.** Out-of-country services are available to Canadians
   - **b.** All citizens have access to drug therapy
   - **c.** Provincial health insurance is publicly administered
   - **d.** Long-term care is an insured service
4. Public health services would be considered what level of health care?
   - **a.** Primary
   - **b.** Secondary
   - **c.** Tertiary
   - **d.** Quaternary

Useful Websites

Academy of Chief Executive Nurses (ACEN)
http://acen.ca

Canadian Association of Schools of Nursing
www.casn.ca/en/

Canadian Institute for Health Information (CIHI)
www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001

Canadian Nurses Association
www.cna-aiic.ca/CNA/default_e.aspx

Health Canada
www.hc-sc.gc.ca/index-eng.php

Health Council of Canada (HCC)
www.healthcouncilcanada.ca/en/

International Council of Nurses
www.icn.ch/

Parliament of Canada
www.parl.gc.ca/Default.aspx?Language=E

Public Health Agency of Canada
www.phac-aspc.gc.ca/index-eng.php

Registered Psychiatric Nurses of Canada
www.rpnc.ca/pages/about.php

Statistics Canada
www.statcan.gc.ca/start-debut-eng.html

Victorian Order of Nurses Caregiver Connect Portal
www.von.ca/en/caregiver-connect/home/default.aspx

World Health Organization
www.who.int/en/

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