Health Policy Planning: A Look at Consumer Involvement in Nova Scotia

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Over 20 years ago, health policy analysts criticized Canada’s health care system for its over-reliance on a biomedical perspective, and its neglect of the role of the environment and lifestyle as determinants of health status. 14 More recent critiques have pointed to the structural, procedural and administrative flaws that have made Canada’s health care system the most expensive publicly funded health care system in the world. 1,4 There is general consensus that the future of Canada’s health system will be determined by its ability to effect significant reform in the implementation of strategies to promote health, and to deliver health care services in a cost-effective manner. 1,4

Regionalization of health administration and consumer involvement in health policy planning have been two central themes in the health reform efforts of several Canadian provinces, notably Alberta, Ontario, Quebec and Saskatchewan. 5,8 It has been suggested that regionalized systems are more responsive than centralized systems to the changing health needs of communities, and that consumer participation ensures that health care providers are more accountable to the communities they serve. 9,11 While regionalization and consumer involvement have been discussed as essential components of a viable health care system, both routes to health reform have also been the targets of pointed criticism. 9,12 Criticism has focused on how regionalization has typically served to create only the illusion of local control over health resources and on how consumer participation has been more token than real. 11,12

Currently, in Nova Scotia, steps are being taken to maximize consumer involvement in health policy planning within a regionalized model of service delivery. The primary aim of this paper is to address whether Nova Scotia’s efforts to increase consumer involvement in health policy planning are likely to meet with more success than previous efforts. 14,15 Nova Scotia’s plans for increasing consumer involvement are compared with consumer involvement efforts in Ontario’s district health councils, Quebec’s Centre local de services communautaires, and the United States’ health system agencies. These are presented as illustrative examples of different models of consumer involvement and are not intended to represent an exhaustive list of health systems that have involved consumers in policy planning.

District Health Councils in Ontario

District health councils (DHCs) were established in the early 1970s to serve as advisory bodies to the Ontario Ministry of Health. 16 The primary responsibility of DHCs was to identify local health needs, and develop regional health plans. 17 Each DHC consisted of 15 members, consumers and health professionals each holding six seats, and regional and/or municipal government officials holding the remaining three seats. 18

Mhatre and Deber 14 have argued that by establishing DHCs, Ontario actually succeeded in centralizing rather than decentralizing their health care system. First, the
decision-making authority for DHCs was constrained by policies established by the Ministry of Health, and the government retained control over the allocation of resources. It has also been suggested that because of their lack of expertise and status, consumers were not in a position to exercise a great deal of authority in decision-making processes and, instead, succumbed to the power of administrators and health professionals.

Centre local de services communautaires in Quebec

Quebec's health system consists of five main types of health agencies responsible for coordinating the activities of 1) hospitals, 2) social work agencies, 3) rehabilitation centers, 4) nursing homes, and 5) local community service centres (CLSC: Centre local de services communautaires). These agencies are coordinated at regional, subregional and local levels. On the regional level, the CRESSS (Conseil régional de la santé et des services sociaux) coordinates health and social work facilities in more than 10 geographic regions. The subregional level consists of hospitals, and community and public health agencies. At the local level, CLSCs are the entry point for health and social work services. CLSCs are similar in concept and in practice to the community health centres that operate in Ontario, Saskatchewan and Manitoba. These centres emphasize a multidisciplinary, medical-social orientation to health care service provision, and include a central role for consumer participation.

According to Godbout, consumers have held legitimate positions of power on CLSC boards. They have played an instrumental role in the organization and development of CLSCs, and held 7 of 14 seats on the board of directors. However, consumer involvement has not come without conflict. According to O'Neill, disputes concerning health priorities have arisen within several CLSCs, sometimes severe enough to threaten the survival of the agency. Disputes have also arisen over consumers' lack of status and credibility and their inefficiency in health care issues and government procedures. In addition, many physicians in private practice have refused to be integrated into a state-controlled organization. In fact, most primary medical care in Quebec is still administered in private solo or group practices.

Health System Agencies in the United States

In 1975, the United States' National Health Planning and Resources Development Act mandated the creation of health system agencies (HSAs). HSAs were run by 30-member committees with at least half the membership consisting of consumers. HSAs were responsible for surveying existing health services, assessing the health status of the population served, and developing health goals and priorities. More than 200 HSAs were established between 1975 and 1986. In 1986, the National Health Planning and Resources Development Act was repealed, and this essentially put an end to consumer involvement in health policy planning.

The demise of HSAs has been discussed and found by many to have been predictable and perhaps inevitable. Within the privatized system of health care in the United States, commercial concerns became the primary determinants of adherence to recommendations made by the HSAs. HSAs had veto power over proposals for expansion or development of health resources, but they had no direct control over the allocation of health care financing.

It has also been noted that consumers on the HSAs were ill-prepared to play an active role in health policy planning. Checkoway et al emphasized that the major obstacles to effective consumer involvement were the disparities in knowledge and power between professionals and consumers. In addition, it was noted that consumers, unlike administrators or health professionals, did not have ties to institutional resources in the community that could be used to strengthen their lobbying efforts.

Comparing Different Models of Consumer Involvement

Reviews of American and Canadian efforts at regionalization of health services suggest that regionalization, in the absence of devolution of power, is not a viable strategy for the administration of health services. Of all the regionalized systems discussed in this paper, the HSAs in the United States had the least power. HSAs had no budgetary authority, and they were operating within a privatized health care system in which commercial concerns determined the nature of the health care services provided. The DHCs of Ontario have also been discussed as an unsuccessful attempt at regionalization. As with the HSAs, the DHCs had no budgetary authority and were required to function within established provincial health policy.

There have been several discussions addressing the relative success of efforts to regionalize health care services in Quebec. Although CLSCs (and community health centres) operate on a community rather than a regional level, they are considered in the current discussion because they provide a good example of a model of devolution and consumer involvement. The community boards governing CLSCs have more power over the delivery of health services than either the DHCs or the HSAs. Consumers are responsible for the organization and development of CLSCs, including determining the nature of services provided and the composition of clinic staff. CLSC boards have administrative and budgetary authority over service provision within CLSC clinics. Although private solo and group practices continue to operate outside the network of CLSCs and do not require consumer involvement, the continued viability of CLSCs suggests that at least at the local level, devolution of power and consumer involvement can be combined to yield a successful model of health care service delivery.

Health Reform in Nova Scotia

In 1989, the Royal Commission on Health Care proposed to increase consumer involvement through the regionalization of health services. After the Royal Commission's report, the Task Force on Primary Health Care was established, which held a number of "town hall" meetings where consumers were invited to express their views on community health needs and services. In 1991, the Provincial Health Council also employed methods of public consultation such as town hall meetings to develop a comprehensive health policy for Nova Scotia.
likely absorb the bulk of budget allocations. Regionalization, even with devolution of power, may present only an illusion of regional control over health services. If existing structures and programs absorb the bulk of budget allocations, regionalization may place the Nova Scotia government in a position in which it maintains central control over resource allocation while denying responsibility for the status of the health care system.

Barriers to Effective Consumer Involvement

Assuming that Nova Scotia's health reform plans yield a viable regionalized health care system, the question becomes whether the proposed system will facilitate consumer involvement. The brief review of Ontario's DHCS, Quebec's CLSCs, and the United States' HSAs clearly shows that consumer representation does not guarantee consumer involvement. According to the present review, three main factors appear to have impeded effective consumer involvement. First, there is an implicit power hierarchy in matters of health care made up of prearranged tiers of professionals, administrators, and consumers. The legitimacy of consumers has been easily challenged by professionals and administrators who hold greater status positions. The dominance-subservience issues at play in professional-consumer interactions favor professional authority and consumer complacency.

Second, the power of consumers is frequently compromised by the lack of ties with constituency support networks. Professionals and administrators typically have direct ties to institutions or organizations that can be used to bolster the impact of their lobby efforts. A consumer, speaking only in his or her name, has much less impact than if he or she were known to have a constituency that could be mobilized to create pressure on health care issues.

Finally, the disparities in technical and administrative skills between consumers and professionals undermine the success of consumer involvement. It has been noted that the average consumer does not have access to the information necessary to make decisions related to health policy planning. Pecarich and his colleagues commented that consumers' lack of access to information about health care systems and health care issues "has led to ineffective, uninformed consumer participation, or to no consumer participation at all" (p. 73).

It is in relation to these three factors—traditional power hierarchies, organizational ties, and skill level—that there is a basis for questioning the ultimate success of Nova Scotia's consumer involvement. While it appears that educational programs will be initiated to increase the skill level of consumers on Nova Scotia's health boards, it is not clear that these programs will be sufficient to overcome the skill disparities between consumers and professionals, and there are no indications that the other barriers to effective consumer involvement will be addressed.

Surprisingly, there have been few discussions of strategies to deal with barriers to effective consumer involvement. Government reports continue to proceed from overly simplistic notions of consumer involvement, with little or no specification of the expected role of consumers in decision-making processes, and no discussion of potential barriers to effective consumer involvement. For Nova Scotia, a number of strategies may be useful to ensure the effective involvement of consumers in health care policy activities. First, it may be necessary to educate both the professional and the consumer on how implicit power hierarchies can interfere with the philosophy of consumer involvement on health boards. Second, consumers may benefit from membership in larger consumer organizations. Establishing networks of consumers involved on health boards may be an effective means of increasing their lobby power. Frequent communication among consumers on health boards, through newsletters or electronic mail, would promote information sharing, develop a sense of a consumer community, and at the same time would facilitate learning from others' experiences. Third, there is an urgent need to develop and evaluate methods of increasing the knowledge base of consumers on health boards. Workshops, newsletters, or manuals can be developed that summarize the struc-
ture and function of different components of the health care system. To be effective educational tools, these manuals will need to be presented in a consumer-appropriate format, not in the technical discipline-specific language that currently characterizes much of the literature on health policy.

To summarize, it appears that a combination of system flaws, and social and interpersonal factors have compromised the success of previous efforts to involve consumers in health policy planning. From a systems perspective, it is clear that regionalized models of health care are more likely to succeed when they are given a higher level of authority. It is also clear that consumer representation on health boards does not guarantee effective consumer involvement. The present analysis suggests that more attention will need to be given to the social psychology of professional-consumer interactions, particularly in relation to traditional power hierarchies and organizational ties, and skill level. Only if these issues are addressed can we expect consumers to participate as equal partners with professionals and administrators on Nova Scotia's health boards.

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REFERENCES


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