1974

Physicians And Health Regionalization: Patterns Of Response To Government Policy

Sharon Ann Warren

PHYSICIANS AND HEALTH REGIONALIZATION: PATTERNS OF RESPONSE TO GOVERNMENT POLICY

by

Sharon A. Warren
Department of Epidemiology and
Preventive Medicine

Submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

Faculty of Graduate Studies
The University of Western Ontario
London, Canada
November, 1973

ABSTRACT

The Ontario provincial government is currently considering the implementation of a regional health system. Regionalization refers to the functional integration of services within a geographically defined area. The medical profession can be expected to play a crucial role in the implemenation and success of a regional system, since its cooperation is important. The degree of acceptance which regionalization receives from physicians will probably depend at least in part on how much government involvement is implied; regionalization may imply more or less government involvement depending on the system's actual design. Within a broad conceptual framework, the individual components of a regional health system can be altered to create variations in government involvement. The six individual components include:

(1) the actual boundaries to be used for regions;

(2) an average size for the regions;

(3) the composition of the regional councils, and district councils if the regions are to be subdivided;

(4) a method of selecting council members;

(5) an appropriate division of authority between central and lower tiers; and

(6) the relationship to be assumed between public health and hospital services.

The main purpose of this study was to determine Ontario physicians' opinions about alternative models for health regionalization which indicate varying degrees of government

involvement and the implications of these opinions for possible acceptance of that Province's plans for regionalization. Secondary purposes were to determine: the reasons for doctors' preferences as to type of regional system; their general opinion of the concept's merit; and whether objective background characteristics, including official leadership status, work setting, type and location of practice and place of basic training, are related to the type of regional health system which any doctor preferred or to his view of the concept.

Using information recorded in the Canadian Medical Directory, doctors in southwestern Ontario were classified on the above five background characteristics and a stratified sample was taken. A mailed questionnaire requested doctors to choose an approach to each of the six components of a regional system from several alternatives implying various levels of government involvement. Doctors were also asked to give reasons for their choices and to indicate their opinions of the concept's merit. The two call-back procedures used produced a final response rate of 65.5 per cent (447), with no apparent response bias.

The system type preferred by a majority of physicians implied a moderate level of government involvement, indicating that the Ontario provincial government's proposals will probably be acceptable. In choosing among the alternative approaches to each component, doctors appeared to place more emphasis on patient welfare and on the system's organizational

effectiveness than on a desire to protect the profession's autonomy from encroaching government power. There was considerable uncertainty about the concept's merit and significant opposition to the introduction of such a programme. With the exception of work setting, no background characteristics appeared to be related to the physicians' opinions. Doctors in public practice were inclined to favour a regional system implying more government involvement and were more likely to see merit in this type of organization than private practitioners.

ACKNOWLEDGEMENTS

The author wishes to acknowledge and express her appreciation to the members of her advisory committee, Dr. Carol Buck, Dr. R. Aldis and particularly Dr. J.I. Williams whose help and guidance have been invaluable.

The author was supported during the progress of this research by a fellowship from the Central Mortgage and Housing Corporation for which she is grateful.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER I: INTRODUCTION AND OBJECTIVES

Regionalization of health services represents an increasingly common form of administrative response throughout North America to spiralling costs which result from competing claims among agencies and institutions in the health care system. The opportunity to minimize duplication of personnel and facilities through sharing arrangements exerts a strong economic pressure to rationally plan and coordinate services within reasonable geographic areas. In addition, regionalization is expected to increase the accessability of services to the patient by establishing formal referral channels among various agencies and institutions within each region. Finally, regionalization offers an opportunity for communities to become more involved in the development of their own service networks[1].

Several Canadian provincial governments, Ontario's among them, are currently considering the implementation of a formal regional health system. For Ontario, health regionalization would imply the planning and coordination of programmes and facilities within defined sub-provincial areas, with designated health councils serving under the provincial government[2].

Regionalization tends to be viewed with suspicion by the medical profession, as it could have considerable impact on the organization and practice of medicine[3]. As part of their planning function, the health councils might stipulate the

level of services a particular hospital could offer and hence, the services a doctor attached to it could provide. Or as part of its coordinating function, the health councils might stipulate patient referral networks for personnel and facilities[4]. The potential impact on the health professions is greatest for doctors as they traditionally have controlled planning and patterns of practice through their roles in hospital and as private practitioners.

Regionalization would undoubtedly be accompanied by at least some increase of government influence over the health care delivery system's operation and a consequent decrease in the profession's ability to determine its terms of practice[5]. Doctors realize that the power of the state to control their conditions of work far exceeds that of any other type of third party. Thus the prospect of government control over any aspect of their working conditions, as typified in the above examples, generates concern on the part of the profession[6].

Regionalization may be more or less of a threat to the profession, depending on the level of government influence implicit in the system's actual design. The level of government influence implied by any plan suggested for Ontario may have some bearing on the acceptance it receives from the medical profession. The acceptance accorded by physicians will undoubtedly have a bearing on the ease with which the system can be implemented and subsequently, on its ability to function effectively[7].

The primary purpose of this research is to determine Ontario physicians' opinions about alternate models for health regionalization which indicate varying degrees of government control and the implications of these opinions for possible acceptance of that Province's plans for regionalization. Secondary purposes are to determine: the reasons for doctors preferences as to type of regional system; their general opinion of the concept's merit; and whether objective background characteristics, including official leadership status, work setting, type and location of practice and place of basic training are related to the type of regional health system which any doctor preferred or to his view of the concept.

The following chapter represents an amplification of this brief introductory one. It will discuss in detail:

(1) the purposes of regionalization and the gradual adoption of the concept by Ontario's provincial government as well as two current proposals for regionalization;

(2) how the level of government influence implied can be varied according to the actual design of the regional system within a basic conceptual framework and the implication of patterns which have been suggested for Ontario;

(3) the implications of regionalization for the practice of medicine and the medical profession's ability to control its own terms of work;

(4) the importance of the profession's acceptance to the success of regionalization.

In the third chapter Ontario physicians' reactions to regionalization are predicted, with the predictions based on physicians' reactions to regionalization in other countries and on their reactions to other types of attempt made by

government to organize health care delivery. The fourth chapter describes methods used to determine physicians' opinions on regionalization and in the fifth chapter their responses are analyzed. In the concluding chapter, the findings are summarized and their implications are discussed.

FOOTNOTES

[1]These are generally suggested goals for regionalization which can be found under most definitions used in the literature.

[2]Again this is an adaptation of a generally given framework.

[3]R. Rothman, et al, "Physicians and a Hospital Merger: Patterns of Resistance to Organizational Change", J. of Health and Social Behaviour, 12: 47, 1971.

[4]These are typical examples of health council duties found in already operating regional systems.

[5]Rothman, loc. cit.

[6]B. Blishen, Doctors and Doctrines (Toronto: U. of Toronto Press), 1969, p. 105.

[7]Rothman, loc. cit.

CHAPTER II: REGIONALIZATION AND HEALTH SERVICES - IMPLICATION OF CHANGES IN HEALTH POLICY FOR THE MEDICAL PROFESSION

The Regional Concept in Ontario

Introduction

The increasing complexity of health services, a spectacular rise in costs and the demands of a more sophisticated public for better medical care have resulted in the Ontario government becoming increasingly involved in the provision of health services. In an effort to improve its health care delivery system, the Province is considering new techniques and patterns of organization which might: equalize the availability and accessability of all health services in the province; alleviate the pressure of rising costs; and, decentralize the administration of health services so that the system is responsive to community needs.

Regionalization is one of the experimental approaches which the provincial government is attempting to implement. Regional organization, as it applies to the health field, refers to the functional integration of services within a geographically defined area[1]. Regional health systems have been implemented in a number of countries, including Sweden,

the USSR, Britain and the United States. In Canada, Saskatchewan has had a well developed regional system for public health since the close of World War II and for hospitals since the early 1960's. Ontario is not the only province now moving towards a formalized regional health system. Quebec is perhaps closest to implementing such a system[2], and both Manitoba[2] and Nova Scotia[4] have recently published documents suggesting formal regional health systems for their provinces. Provincial efforts towards regionalization over the past 30 years have been consistently sanctioned by a number of federal commissions formed to suggest better ways of delivering health care, including the Royal Commission on Health Services (1964-65)[5] and more recently the Task Force on the Cost of Health Services in Canada (1970)[6]

Evolution of Government Involvement in Health Care

Traditionally, the Ontario government considered that the provision of health care was the responsibility of physicians and that individuals should bear the cost of their own care. The Department of Health confined itself to providing certain public health services, such as sanitation, which could not be left to independent physicians. Except for psychiatric hospitals for which the Province assumed responsibility and the few hospitals of various kinds sponsored by local government, hospitals were privately owned and operated.

The provincial government's role in public health was expanded during the 19th century, when it was forced to take action aimed at controlling the spread of common infectious diseases. This responsibility necessitated a permanent public health organization from the Province through to the local government level. At the same time, hospital costs were increasing rapidly and pressure for public assistance grew.

Initially the Ontario government preferred to minimize direct provincial control over the health services by delegating authority in public health matters to local government and by allowing hospitals to spend public grants according to their own judgment.

Community boards of health, appointed by local government, and largely responsible for public health services, have retained their original autonomy. Over the years, the provincial government has had to provide increasing financial assistance to local government as the number and type of necessary public health services grew. Even though the Province currently provides much of their operating capital, local boards of health still prepare budgets for submission to their local government councils, which make final decisions as to the allocation of funds. While the Province does have some regulatory power, its Health Department functions for the most part in an advisory capacity.

Hospitals have gradually been losing their autonomy.

Until 1930, the Province had given approved institutions annual block grants which the hospitals could spend relatively freely. About this time, however, the Department of Health introduced arrangements whereby hospitals were to be paid a per day/per patient grant in addition to grants necessary for capital expenditures. With these new arrangements, hospitals became subject to more control by the Province. The Department began to make regulations classifying hospitals and concerning their staff, admission and treatment of patients as well as patient records and to inspect regularly the institutions its government supported[7]. The cost of supporting hospital facilities began to double every five years, both in terms of actual dollars and per cent of gross provincial expenditures (GPE). By 1955, the Province was investing approximately $1,500 million, or 6.1 per cent of its GPE, annually on hospital services[8].

As the Province's responsibility for financing public health and hospital services grew, people began to demand government administered insurance for physician and hospital services[9]. In 1959, under a cost-sharing arrangement with the federal government, Ontario introduced a provincially sponsored hospital insurance scheme. To administer this programme, the Province established the Ontario Hospital Services Commission (OHSC), whose members it appointed.

In addition, the Commission was to be responsible for developing an integrated hospital system across the province.

In this capacity, it provided a variety of consultative services to hospitals on development or administrative problems. It was responsible for approving plans for all hospital construction requiring provincial or federal aid as well as the operating budgets of hospitals[10]. Even with the Commission's efforts to control costs by rationalizing services, the Province was spending an estimated $8,500 million, or 12.5 per cent of its GPE, annually on the provision of hospital services[11]. Part of the increase was accounted for by the insurance scheme, but a sizable proportion was due simply to the increasing capital and operating costs of hospitals.

Recently the Department of Health was reorganized (renamed the Ministry) and the OHSC was disbanded. The OHSC's insurance function was transferred to one branch of the new Ministry and its hospital planning and coordinating functions were transferred to another. A branch of the new Ministry now plays the important role which the OHSC once did in shaping the services available in Ontario's hospitals[12].

The last remaining area of medical care to be financed by the provincial government was physicians' services. By 1968, more than 80.0 per cent of the Ontario population was covered for such services by private carriers. The people without insurance were frequently those most susceptible to illness and for whom any consequent loss of income caused greater suffering. At the same time, carriers were making excessive profits from those covered through high allowance for overhead costs[13].

With federal legislation aimed at encouraging provincial sponsorship of physicians' services insurance, public pressure for such a programme in Ontario grew. In 1969, the provincial government introduced its Medicare scheme. Initially, the Province subsidized private carriers[14]. The private carriers did not benefit financially, however, and the provincial government came to believe that direct government administration would be less expensive than the subsidy arrangement.

Since the Province assumed direct responsibility for administering physicians' services insurance, it has administered the programme centrally. The costs of the programme have continually increased. The causes of this increase have been linked with patients who overutilize physicians and physicians who provide more services than actually necessary[15]. At the Province's urging, the Ontario College of Physicians and Surgeons (OCPS) has been forced to restrict the number and type of services which physicians can perform[16] and the Ontario Medical Association (OMA) has agreed to participate with the provincial government in establishing a joint committee to negotiate the profession's fee schedule as well as to consider alternate methods of paying physicians[17].

Public health needs, the increasing costs of hospital services in Ontario and the expense of provincially sponsored insurance plans have forced the Province to become increasingly

more involved in health care delivery, either directly or through its surrogate, local government. Initially, it sought to minimize direct provincial government control and has effectively maintained decentralization of authority over public health through local government. With its spiralling financial committment, however, the Province was forced to take a direct interest in the regulation of hospital services so that authority over hospitals has been gradually centralized. The insurance plans, first independent of one another but now jointly administered, are also administered centrally. As yet the Province has made no particular effort to decentralize the administration of either physicians' services insurance or hospital coverage, but it has recently moved towards decentralizing the planning and coordination of hospital services through regionalization. Theoretically, a regional system offers the opportunity for increased community input; more important to the Province now perhaps, regionalization's proponents also claim that it promises to alleviate the pressure of costs which have been rising at an unacceptable rate and to deal with such problems as the scarcity of qualified personnel, and of those more specialized.

Early Provincial Experiments with Regionalization

With provincial sanction, the OHSC introduced an informal regional pattern for hospital development shortly after it was established. The new Ministry has continued the Commission's informal regional system and the provincial

government is currently considering its formalization in hopes of increasing the system's potential. The former Department had also introduced public health regionalization. This was not so much to allow decentralization, which has generally existed in the field, but rather to improve the distribution of such services and to control costs.

In Public Health

Early local boards of health serving single municipalities often could not provide certain public health services because the population of the municipality was too small to warrant their provision or the municipality was too poor to afford them. Further, while local boards of health were able to plan and coordinate services within their own jurisdictions, they had difficulty harmonizing their services with those of neighbouring municipalities and much duplication occurred[18].

By the end of World War II, the Department of Health began to feel that this problem could be solved, if municipalities joined to provide public health services on a wider basis. Through various grant programmes, it began to encourage the formation of health units and from 1945, the number of these new units grew steadily. The grants permitted poorer constituent municipalities to provide their residents with full-time public health services[19]. The level of services in health units, which were usually rather limited

in size, improved generally because of the extra money provided by the Province rather than through the economies of scale or other advantages often associated with the concept of a larger unit[20].

The Department gradually became convinced that further amalgamation of local health units would be necessary, if duplication was to be minimized. To encourage the establishment of larger units, the Province provided for an operating costs grant of 75 per cent to be paid beginning in January, 1968 to all municipalities or health units joining to form a health district[21]. After consideration of studies on consumer patterns, transportation networks and health services available and in consultation with local government councils[22], the Department of Health prepared the boundaries for 29 health districts throughout the province. The financial incentives proved effective and by 1970, all but six had been formed[23]. Health districts resulted in an even further improvement in the services provided, since some of the duplication which formerly occurred among the units was erased[24].

In 1966, the Department of Health had grouped the districts into seven regions. Regional offices were established and each was assigned a medical officer of health, a public health inspector and dental, nursing and health education consultants. Regional offices were expected to encourage activities on the part of local boards, to offer

special consultative and other services, to administer applications from local boards for grants and to relay funds[25]. Originally these regions were not meant to be administrative units.

Having considered a report by the Ontario Council of Health, in 1969 the Minister announced that his Department intended to transform the character of the public health regions. Rather than remain bases for consultative services, regions would be developed into administrative areas governed by councils composed of health board members from the various health units and departments within the regional boundaries. The provincial field offices would continue to provide their services, in cooperation with the administrative councils.

At the same time, the Minister modified the existing pattern to create seven different regions, five of which were to cover southern Ontario and were centred around university health sciences centres located at London, Hamilton, Toronto, Kingston and Ottawa. However, while the new boundaries have been established, to date no machinary has been arranged for the transformation. Pending the adoption of appropriate regulations, the character of the regions remains unchanged[26].

For Hospitals

Shortly after its inception in 1957, the OHSC established regions to facilitate the planning and coordination of hospital

services. In an effort to organize groups of hospitals[27] within these regions, it also experimented with a programme which promoted the establishment of community councils.

Such councils were entirely voluntary; their formation was left to the initiative of single municipalities or groups of municipalities. They were composed of interested citizens, health professionals or laymen, and their function was to advise the Commission on the planning, coordination and capital financing of hospital programmes and facilities within their areas. If their proposals were accepted by the Commission, then the community councils might also attempt to enlist the cooperation of hospitals in the area[28].

When citizens took an active interest, community councils worked reasonably effectively. Some councils were able to set up cooperative arrangements among hospitals, to share laundry facilities and to establish central supply systems. However, they generally proved powerless when any one hospital felt it might lose from a sharing arrangement. For example, a hospital might be bitterly opposed to sharing the cost and use of an expensive piece of equipment which was to be located in another hospital. If a particular hospital was sufficiently influential, it could circumvent these advisory boards and approach the OHSC directly in an effort to realize its wishes[29].

Even with the elimination of the OHSC, some community councils have remained intact, but they still serve on a voluntary basis and therefore, constitute an informal system.

Under current plans for a formal regional system, municipalities would be required to contribute members to a regional council or to form community councils within the region.

Purposes of Regionalization

Health regionalization refers to the development of working relations among the various programmes and facilities within a defined geographical area. Scarcity, specialization and the pressure of rising costs are among the factors which have contributed to the need for regionalization.

Scarcity is a relative term applicable either to personnel or equipment and facilities. As it is difficult to define the "need" for medical services, the notion of scarcity suggests some general agreement as to what might reasonably be supplied in specific places at specific points in time. Proponents of regionalization have claimed that a regional council could plan and coordinate the services within its relatively small territory more effectively than a single central body which would preside over all the services in Ontario.

The growth of specialized health facilities and the specialization of health professionals has resulted in a fragmented network of services in Ontario. By establishing formal referral channels, proponents of regionalization claim that it poses one answer to the problem of fragmentation.

The costs of providing care are increasing at an unacceptable rate. There is a broad consensus in Ontario that every step consistent with quality care should be taken to control the rate of increase. Regionalization is supposed to help control costs through the avoidance of duplication, which should come from planning and coordinating services within a manageable area.[30]

Additionally, the adherents of regionalization claim that this form of organization also offers an opportunity for the community to become more involved in developing its own services.[31]

Departments of the provincial government in Ontario other than Health are experimenting with regionalization. These include Treasury and Economics, Education and perhaps most notably the Department of Municipal Affairs. Until recently there were approximately 900 local government units in the province, the majority of them small both in terms of population and physical size. The Department of Municipal Affiars is, however, currently reorganizing local government structure to create new regional government units. The regional government units generally consist of several former municipalities grouped together. On a representation by population basis, municipalities appoint some members and elect others to serve on the regional council. Individual municipalities continue to have their own councils to provide minor services, but regional councils become the

primary local government bodies[32]. According to the Province, regional government councils should be able to assume more important functions than the traditional smaller municipality councils have in the past[33]. It has been reasoned that regional government units will be large enough, both in terms of population and size, to serve as basic planning and coordinating areas for certain types of service. In terms of health care, for example, the regional government units might serve either as hospital regions or as further subdivisions of the regions, within which community councils could be formed. Regional government councils could assume a role in planning and coordinating such services, possibly serving as the community councils. With more important functions to perform, some political scientists believe that regional government should be able to attract better candidates than the old local municipality councils did and thus provide men and women capable of assuming such new responsibilities[34]. Whether authority would be decentralized to regional government councils and their committees or independent boards, the formalization of the OHSC's arrangement is being promoted in Ontario as an attempt to decentralize authority over hospitals.

There is some question as to whether regionalization can actually achieve such objectives. While it is not the specific concern of this study to judge the concept's merit, the likelihood for success will be briefly considered.

First, there is little concrete evidence to suggest

that regionalization equalizes the availability and the accessability of services or that it has effectively controlled costs. The appropriate "before-after" studies simply have not been undertaken[35]; this may be because of the obvious difficulties with evaluative research.

Second, regionalization does not necessarily result in decentralization of authority. Decentralization may be defined in several ways, but for the purposes of this discussion it will be defined as the degree to which authority is delegated to lower levels of the health council hierarchy. In a decentralized system, the authority to make decisions, to command resources and to demand results is localized as far down as possible. It implies the freedom of those at the lowest level to make decisions within clearly enunciated guidelines set at the top[36].

The hierarchy set up under a regional system may consist of a central body (a branch of the Health Department or independent commission like the OHSC was) and a set of regional councils or it may consist of two such tiers plus a third set of district councils. Regardless of the pattern of regionalization, either regional or district tiers would have to be more than advisory to the Province, if decentralization were to be accomplished.

Decentralization is more complicated than simply delegating authority to the lower tiers, however. To ensure the uniformity of decision and treatment which is deemed necessary, sound decentralization requires adequate

central control with a repeated and clear enunciation of general policy. Guidelines should be sufficiently specific to ensure that central aims are understood, but not so specific that they infringe more than necessary on the general manner in which the aims are achieved[37].

The regional system's actual design and the specific nature of central guidelines would have a bearing then on how much decentralization is implied by health regionalization.

Even if sound decentralization could be achieved, its value can be questioned. The computer now makes centralized planning much more feasible. Coordination is probably still more suited to a decentralized system, however, and many public administrators agree that the decentralization of authority prevents attrition of interest at the lower levels[38].

Varying Regional Designs: Their Implications for Government Involvement

The Province has not only traditionally shown an interest in minimizing direct provincial government control over health by decentralizing authority, but also by including health professionals, particularly physicians, on its policy making bodies and administrative councils. The OHSC, for example, included health professionals as did the OHSC's community councils. Local government has shown an interest in including health professionals on the boards of health[39].

A review of operating regional systems throughout the world indicates that six basic steps must be considered in setting up such a system. These six steps include:

(1) defining regional boundaries;

(2) choosing a size for the average region;

(3) deciding the composition of regional councils, and of district councils where the regions are subdivided;

(4) setting a method for selecting the council members;

(5) dividing authority between the central and lower tiers; and

(6) defining the relationship between public health and hospital services.

Different approaches can be taken to each component so that several variations of the conceptual framework may result.

Besides having implications for the degree of decentralization, the design of a regional system has implications for the degree of government power relative to the health professions.

Power in this context is defined according to French and Raven[40], as the maximum potential ability of government, one participant in regionalization's machinary, to influence health professionals, the other major participant. Government power is measured by its maximum possible influence, though it may often choose to exert less than full power for a variety of reasons.

The six components which make up a regional health system can be divided into two groups according to their relative importance for government power. The peripheral issues are those which determine the physical structure of the regional system: (1) the boundaries for regions and, where they exist,

districts: (2) the size of basic health units, either regions themselves or regions and their subdivisions; and (3) the relationship between public health and hospital services. The key issues are those which imply the allocation of power: (1) composition of the health councils, either regional or both regional and district; (2) control over selection of representatives; and (3) focus of power according to the allocation of authority.

In the following sections, possible alternative approaches to each of these components, with their varying implications for government power, are discussed. The implications of focus of power for the degree of decentralization should be obvious.

Alternative Approaches to the Peripheral Components of a Regional Design

These components are again: (1) boundaries; (2) size; and (3) the relationship between public health and hospital services.

Boundaries--- Regional boundaries have been set in one of two ways. Boundaries either correspond with local government boundaries or to informal consumer utilization patterns, which may not coincide with the boundaries of local government[41]. The Swedish system[42], for example, employs the former approach, while the original British regional system[43] employed the latter.

The first alternative is more likely to contribute to power for government. If boundaries were based on

consumer utilization patterns, then physicians would largely determine utilization boundaries and would have considerable influence over administrative decisions. The use of local government boundaries as health region boundaries implies some attempt to relate medical care services to the public health and welfare services provided by municipal governments. Consequently, administrative decisions regarding health would have to take into consideration the perspectives of other professionals, and the total needs of the community. Thus the health profession's power to influence could be diluted. In this case, government officials may become power brokers between the different groups; as mediators, government officials would have considerable power over decision making.

Size--- In terms of size, there are relatively large regions as the basic planning and coordination units or large regions subdivided into districts for use as the basic units. Regions in the United States, for example, may be as large as one or more states, serving perhaps several million people. The American regions are generally not subdivided into districts[44]. Both Sweden and the Soviet Union[45] subdivide their large regions into districts, which serve less than one million people on the average.

The size of the region is related to the number of services that have to be administered. Engel believes that the Swedish district councillors are in the best position to plan rationally and promote coordinated efforts, as they

have jurisdiction over a manageable number of services[46]. A frequent reason given by the health professions for majority representation on regional or district councils is that professionals have a better knowledge and understanding of the health care delivery system's operation than do government officials[47]. Government officials sitting on a regional council with jurisdiction over many and varied services might be inclined to rest on the expertise of the profession. Government officials on a district council should be less tempted to do so, as it should be relatively easy for them to become directly acquainted with the needs of the area.

Public health and hospital services--- Public health and hospital services might be planned and coordinated jointly or separately. In Sweden and the Soviet Union, public health and hospital services are the responsibility of common councils. Conversely under the original British system, these services have been administered separately. If services are administered separately, their encatchment areas tend to be of different sizes with different boundaries.

In Ontario, the joint planning and coordination of these two services is more likely to contribute to power for government, although the contribution would probably be termed indirect. Its main contribution would be to present an argument in favour of drawing the boundaries of health regions and districts to coincide with local government boundaries. Traditionally public health planning and coordination areas have respected local government boundaries.

Coterminous boundaries would avoid any necessity of disrupting the present public health patterns which are more stable than the informal boundaries of hospitals.

In reality, in each of the alternatives to the three peripheral issues the relative contributions to government power are tenuous at best. The use of alternatives which may appear to contribute to government power are more important in setting the stage for a truly meaningful increase in government power through the key issues.

Alternative Approaches to the Key Components of a Regional Design

To reiterate, the key components are: (1) council composition; (2) method of selecting members; and (3) focus of power according to the allocation of authority.

Council Composition--- There are three basic methods of composing the regional, and where they exist district, councils. First, councils may be entirely composed of government officials (either elected representatives or civil servants). In Sweden, the local government councils and their health committees are responsible for planning and coordinating services under their jurisdiction. The regional councils are composed of representatives from local governments encompassed by the region. There are similar arrangements in the Soviet Union and for public health in Saskatchewan[48]. Clearly the fact that under these three systems, regions are subdivided

into smaller districts which correspond to local government units facilitates the use of local government councils in planning and coordinating all health services jointly.

As an alternative, district and/or regional councils could be structured so as to balance the representation of government officials and health professionals. This is essentially the arrangement found in Britain.

Finally, such councils might be structured so that a majority of their seats are held by health professionals as in the case of the regional programmes in the United States, the Heart Disease, Cancer and Stroke programme and the Partnership for Health one[49].

Friedson argues that increased representation for health professionals on such organizing bodies enhances their power over the operation of the delivery system[50]. It is clear, that if health professionals hold the majority of seats on district and/or regional health councils, they can potentially dominate decision making by sheer force of members; this assumes block voting based either on a truly homogenious perspective or trade-offs for specific issues. Similarly, if government officials held all or the majority of seats, they could dominate. Government officials on such councils would probably take health professional advice into consideration, but final decisions would be theirs. Only when government officials were highly dependent on the advice of health professionals might their voting power be more apparent than real.

Where government officials are about equally balanced with health professionals on such councils, power would probably shift according to specific issues and the type of bargaining which disputed ones made possible.

Selection of Members--- Methods of selecting council members tend to vary according to the composition of the councils. In a country where a majority or all of the seats on health councils are held by government officials, the officials tend to be appointed by the appropriate level of government and without consulting the health professions. This is the procedure followed in Sweden and the Soviet Union.

In practice, where government officials and health professionals are balanced on such councils, government appoints its own representatives and consults with health professionals in choosing their representatives. Consultation frequently takes the form of asking for a list of nominees from which government might choose. This is essentially the British approach. Where health professionals hold a majority of seats on such councils, it is not uncommon for the groups represented to select their own representatives as under the major programmes in the United States.

When a government body appoints representatives to the district and/or regional health councils without consultation, government controls both initial appointment and tenure. Under the arrangement whereby government appoints health professional representatives from lists submitted by the groups in question, a potential stalemate may be created

between government and health professional power over these representatives. Government controls tenure and can refuse to reappoint members who repeatedly take a stand against government policies, while the professions can continue to nominate representatives whom they know will oppose government policies to which their groups are unsympathetic. Under the final alternative, of course, the health professions could control both initial appointment and tenure to their own satisfaction.

Focus of Power--- The World Health Organization (WHO) has classified regional systems according to the focus of power and has labeled systems as decentralized, partially decentralized and centralized[51].

In a decentralized system, authority is decentralized to the district level. The central government sets broad policy guidelines and the regional councils try to encourage cooperative planning and coordination. District councils are either allowed to collect taxes or are provided with a lump-sum unconditional grant by the central government to carry out their decisions, so that financial arrangements support the decentralization of authority. The systems of Sweden and the Soviet Union are so decentralized. In both cases, decentralization is to district (and regional) tiers composed entirely of government officials.

At the other end of the spectrum lies a centralized system. Final decisions rest with a central government

authority. Regional and district councils may either be balanced between health professionals and government officials or dominated by either. Final decisions on planning and coordination may rest with the central authority, but it is not uncommon for that authority to become highly dependent on advice from the lower tiers[52]. If these are dominated by health professionals, then in effect, the professions exercise considerable influence over the decisions which are taken. Further, if health professionals on the councils are more concerned about protecting the professions' interests than about implementing practices which might improve health care delivery in their areas, their advice to the central authority might be biased.

Alternatively, the central authority may be disinclined to follow a regional or district council's advice and prefer to make decisions on its own initiative. As the members of the central authority tend to have a limited knowledge of local needs in specific areas, their decisions may be as inappropriate as if they had been acting on biased advice from the lower tiers. This situation can develop regardless of the composition of the lower tiers and evidently has existed in Saskatchewan's public health system. Besides affecting government's ability to plan and coordinate services effectively, it tends to undermine its credibility and to strengthen an argument that more power should be placed in the hands of health professionals.

Saskatchewan's regional and district public health councils which are composed of local government representatives have been criticized in certain quarters for giving the Province poor advice and the suggestion has been made that health professionals be included on new councils. The Research and Planning Branch of the Health Department, however, blames the Province for ignoring advice from the regional and district councils. This practice has discouraged regional and district council members and they tend to spend less energy on devising careful recommendations, thereby leaving themselves open to even more criticism from those who claim that health professionals could do a better job[53].

In the partially decentralized system, authority is shared between the central authority and the regional body. The central authority may make final decisions on large capital expenditures, while the regional councils are given lump-sum unconditional grants to cover the minor capital and operating costs of services under their jurisdiction, thus wielding considerable influence over the programmes and facilities which are developed. Britain's is a partially decentralized system. The British system has apparently not been studied for the effects of such an arrangement on government power. In light of the developments which tend to occur under decentralization and centralization respectively, it may be reasonable to assume that partial decentralization would enhance government power over coordination, but threaten

to diminish its power over planning. Council composition and method of selection would no doubt have some bearing on the outcome of such an arrangement.

Combining Alternative Approaches into Three System Types

While the alternatives to each component can be combined to form a number of composite systems, in practice there are three basic variations of regionalization. In attempting to suggest a formal regional pattern for Ontario recently, the Ontario Council of Health identified the Soviet, the British and the American systems as representative of the basic patterns of regionalization[54]. These three specific systems appear to allow varying degrees of government power relative to the health professions.

The Soviet system allows health professionals the least power relative to government and, for purposes of comparison with the other types, might be broadly re-labeled a strong government system. Regions are subdivided into districts which correspond to local government units. Both public health and hospital services are planned and coordinated by a committee of the local government council in each district. Because of the council composition, it follows that members are essentially appointed by government. Authority is decentralized to the district level and local government councils are given lump-sum grants to cover the

cost of services under their jurisdiction.

The original British system might be referred to as one providing for moderate government involvment. Public health and hospital services are separately planned and coordinated. The hospital regions serve several million people generally, are not subdivided and do not respect local government boundaries. Non-teaching hospitals are the responsibility of the regional boards of health. Their membership is balanced between government and health professional representation, representatives of the latter being appointed by the Minister from lists of nominees. Authority is partially decentralized to the regional tier; the central government is responsible for major capital expenditures and the regional councils for the minor capital and operating expenditures of services under their jurisdiction. To carry out their decisions, the regional councils are awarded unconditional lump-sum grants.

The two major American programmes allow considerable power to health professionals and might be labeled weak government types. Their regions are large and not subdivided; neither do they respect local government boundaries. Public health and hospitals are separately planned and coordinated. Health professionals appointed by their own groups tend to dominate the regional councils. Authority is centralized under the Heart Disease, Cancer and Stroke plan and decentralized under the Partnership for Health one. Dominating the regional

councils, professionals have considerable power over the health care delivery system's operation in either case.

It might be noted that their degree of involvment in health regionalization parallels the general role assumed by each of these governments in solving social problems.

New Directions for Health Regionalization in Ontario

Originally the provincial government asked the Ontario Council of Health to recommend a formal regional health system for Ontario. Having published the Council's recommendations, the Ministry departed from them in an August, 1972 policy statement. Presently, the Province seems to have imposed a moratorium on the issue while reconcsidering carefully the whole concept as well as the actual system type which it should implement.

The Ontario Council of Health's Plan[55]

The Council of Health has suggested that health region and district boundaries should respect local government boundaries. Regions would be approximately one to two million people in size depending upon the major urban concentrations; districts would serve about 250,000 people and be approximately the size of a standard regional government unit.

The Council has also suggested that an unspecified number of local government representatives should be included

on regional and district health councils. Essentially the recommended composition would allow for a predominance of representatives for the health professions at both levels, however. One-third of the regional council membership would be representatives of the district councils. All appointments (regardless of tier) would be made by the Minister from lists of nominees presented by the groups involved.

Authority over planning and coordination would have been partially decentralized to the regional level under the Council of Health's plan. District councils would "pass judgment" on any proposal for new programmes or facilities, or modifications to existing ones which required provincial aid. The district councils would review proposals from agencies and institutions and refer them with recommendations to the regional council. The regional council would then either approve or reject the proposals and inform the Province of their decisions. According to the Council's plan, the provincial government's role should be to set broad policy guidelines for the regional and district councils. The Council suggested some complementary decentralization of financial responsibility to ensure the regional councils' authority, but did not suggest any specific arrangements.

Under the Council's scheme, all health services (preventive and curative) would have been planned and coordinated by the health hierarchy, since the Council felt that it would not be appropriate to organize hospital services separately from those of public health.

The Ministry of Health's Plan[56]

The Ministry of Health's plan for regionalization differs significantly from the Council's plan. Health region and district boundaries would not uniformly respect local government boundaries, but would be based on consumer utilization patterns. The recommended size of regions and districts, however, is similar to the Council of Health's.

Health interest groups would be substantially represented on district councils, probably holding a majority of the positions. The inclusion of local government representatives is suggested, but optional. The Minister would appoint all members from lists of nominees presented by groups to be represented.

There would be no regional councils, but instead an Area (or Regional) Planning Coordinator who would be a provincial civil servant. His responsibilities would include helping the district councils to develop master plans for the development of services under their jurisdiction and helping the councils to design methods of coordinating the efforts of those services. Essentially the district councils' plans for new services and the coordination of existant ones would take the form of recommendations to the Province; these councils would function in an advisory capacity only. Presumably, since there would be no decentralization of authority, there would be none for financial responsibility.

District councils will be responsible for curative services only, while local authorities retain their responsibility for public health.

Implications of the Two Plans for Government Involvement

The Council of Health's plan generally includes more of those alternatives to individual components which enhance government power than does the Ministry's.

The Council of Health has suggested that regions be divided into health districts which would correspond to local government units. The Ministry's plan does not specify this approach, but suggests the use of consumer utilization patterns as the criterion on which health region and district boundaries will be drawn.

Both have suggested smaller districts within the larger regions. The Council of Health appears to believe that lower tier councils should be responsible for planning and coordinating hospital and public health services with a proper administrative body to carry out their decisions. The Ministry's plan, on the other hand, implies at most ad hoc joint planning and coordination of these services with the local government councils maintaining prime responsibility for the public health field.

While both plans suggest the inclusion of some regional (or local) government representatives on lower tier independent boards, the Council's stipulates their inclusion, whereas the Minisry only suggests that they might be included. It would be possible under both for medical people to control the majority. Both plans have recommended appointment of representatives by the Minister from lists of nominees submitted by the groups in question.

The Council of Health's design has called for some decentralization of financial responsibility to complement partial decentralization of planning and coordination authority to a regional tier. The Ministry's plan implies an important advisory role for the district councils, with little actual power.

Clearly neither of these plans augers much power for government relative to the health professions; the Council of Health's, however, implies more than does the Ministry's. By virtue of the recommended focus of power and the composition of regional councils, the Council of Health's design also offers more decentralization.

Implications of Regionalization for the Medical Profession

Medicine and the State

As Friedson indicates, the foundation of analysis of a profession is based on its relationship to the state, the ultimate source of power and authority in modern society. The medical profession enjoys a virtual monopoly over practice. This monopoly operates through a system of licensing which allows the physician to hospitalize patients and to prescribe drugs and order laboratory tests which are otherwise all but inaccessible. It is the state, however, which grants this monopoly to the profession, the exact form of which may

vary among countries.

Through their professional associations, American doctors essentially have the power to control almost all conditions of the profession's work. In countries like Britain where a national health system has been established, representatives of the medical profession sit on both policy-making and administrative councils, negotiating with the state various proposals which could affect practice. In the Soviet Union's national health system, there are no truly private and independent representatives of the profession who can negotiate with the state, although advisory and administrative councils do include doctors.

A survey of such countries illustrates that the autonomy of the medical profession differs from country to country, depending on the bent of the state. While the profession in all countries may be able to control the content of its work, the extent to which the profession can control its terms of work varies[57].

Physicians in Ontario occupy a position between their American and British counterparts. As in Britain, the provincial and local governments have included physicians on policy-making boards and administrative councils whose duties may affect the practice of medicine. The scope of the Ontario government's involvment in health care is not as broad as the British government's; its scope is wider than the American's, however, as the Province operates a physicians' services insurance scheme which to some extent

limits the profession's economic freedom. More than any other health professional, physicians have the most to lose in terms of both professional and individual autonomy in the face of a programme like regionalization.

The Ideology of Medical Care in Canada

Hlishen describes how statements released by the Canadian Medical Association prior to the implementation of government health insurance clearly indicate that their central concern is the control over the profession's conditions of work by third parties, particularly government. This concern is closely followed by two others, and in order of importance, they are freedom of the physician and the patient and the quality of medical care. These three themes have received differing emphasis over the period from World War II[58].

The Profession's Primary Concern: Self-government

Self-government has traditionally been one of the rewards which Canadian society offers for the achievement of professional status. It is frequently granted in recognition that members have access to a highly technical body of knowledge whereby only the profession can judge the competence of its members. It is important to the profession that government continue to accept fully the claim that a doctor's ability can be determined only by his peers. The individual physician may chafe at the controls imposed on his professional behaviour by peers. However, the benefits of belonging to the medical association renders any strain, resulting from the possibility of professional sanctions, tolerable and encourages the same

physician to respect the professional body as his protector as well as his overseer. This side of self-government strengthens group loyalties, builds professional solidarity, and encourages respect for the organization's right to oversee practice. Thus it reinforces the professional body's influence in maintaining standards of practice. The medical profession guards its self-governing status jealously. No move by government which might undermine professional autonomy is welcome.

The profession is well aware, for example, that different methods of remuneration provide for more or less government interference in the practice of medicine. Under salary to government, a physician would be subject to much more interference than even under the present Medicare scheme. This is one of the reasons why the possibility of change in the organisation of medical care, which might lead to some method of paying the physician other than by the fee-for-service method, arouses anxiety[59].

A Secondary Concern: Freedom

As well as being protective of the profession's autonomy, physicians tend to be protective of their own individual freedom and the freedom of their patients. By stressing freedom as a value, the profession again legitimizes its autonomy.

The profession claims that a patient should be free to choose his own physician. There is some doubt, however,

as to how solidly physicians are behind this assertion. Patients who are known to "shop around", and therby invite comparisons as well as competition among doctors, may find themselves generally sanctioned by the profession.

Of their own freedom, practitioners emphasize freedom to choose the number and specific patients they wish, and type and location of their practice. The emphasis on freedom to choose his patients is related to difficulties many doctors face today in meeting the increasing demand for medical services under conditions of private practice. If the physician is unable to meet the increasing demand on his practice, he should be able to curtail it by selecting his patients, turning away those who seem to make excessive or unreasonable demands on his time, skill or resources.

Any threat to the freedom of choice of practice (private or public) arouses the concern of doctors. Public practice has usually been regarded as less prestigious and is generally less lucrative. For the physician who wants to practice privately, any arrangement which might threaten his right or opportunity to do so is unwelcome.

Because a variety of hospital and other medical services are available in urban centres while those located in rural areas are limited, many physicians would prefer city practice. Another advantage of city practice may be the greater demand for services which will keep a physician fully occupied and favour his income. Even overdoctored

centres attract some physicians by the amenities and lifestyle which they offer. Members of the profession who would prefer to practice in an urban centre fear any act which might be aimed at relieving the current maldistribution of physicians by restricting their freedom to locate where they wish and possibly directing some to underdoctored rural areas[60].

The Final Major Concern: Quality of Medical Care

The quality of medical care depends on a variety of factors including: the availability, accessability and competence of physicians; the medical facilities at their disposal; and, the effectiveness of coordination among health services. The medical profession recognizes that some areas of the province, particularly the rural, are underserviced. Physicians may recognize that even in adequately serviced areas, like the cities, medical care programmes and facilities are often not well coordinated, that much duplication may occur or that a patient's access to the maze and his progress through it may be difficulat. Still, they argue that any government proposal for solving such problems must be based on acceptance of the principles of medical practice, that is, professional autonomy and the freedom of both individual physician and patient.

The profession attempted, for example, to justify its resistance to Medicare by claiming that both the profession and the insured would suffer restrictions in the

terms of service provided under a publicly financed insurance scheme and therefore, the quality of care would be reduced[61].

Regionalization as a Threat to Ideological Principles

The nature and extent of impact on medical practice that regionalization would have in Ontario would depend at least partially on the specific functions to be performed by the organizing hierarchy (that is, the provincial, regional and district bodies). The functions assumed by such organizing hierarchies in regional systems throughout the world vary from country to country. In Britain, for example, the regional hospital boards (responsible specifically for non-teaching hospitals) have basically a two-fold purpose: the planning and coordination of treatment facilities and the organization of specialist services. As part of the latter responsibility, regional councils decide how many specialists of each kind are to be employed within the regions and how their number are to be deployed among the regions' facilities, as well as arranging for their payment[62].

Their counterpart, the Executive Councils, are similarly responsible for organizing general practitioners. Among other duties, these Councils administer payment, control the geographical distribution of general practitioners and promote community health centres as sources of primary care[63].

There has been no suggestion that the regional, or district, councils proposed for Ontario would either organize specialist services as the British regional hospital boards have or general practitioners along the lines of the British Executive Councils. It might be well to remember that such responsibilities could be added later.

For now, only the former purpose of British regional councils has been suggested for the organizing hierarchy of a regional health system in Ontario, planning and coordination. Both the Council of Health and the Ministry have suggested these functions in the broadest terms. The impact of such functions on medical practice must depend on their specifics. By examining regional systems in other countries, one can determine what type of specific duties Ontario's organizing hierarchy might perform under the general heading of planning and coordination. Descriptions of the concept and its purposes generally include some specific examples of how regionalization can achieve its goals of improved availability and accessability as well as controlled costs. In conceptual terms, the planning and coordinating functions imply administrative decisions infringing upon the freedom of the physician as well as causing disruption of the medical community's power structure and upsetting customary patterns of practice.

As part of its planning function, the organizing hierarchy of an Ontario system could stipulate the level of services which a particular hospital would be allowed

to offer[64]. For example, it might set up a hierarchy with smaller hospitals allowed to offer only the simplest procedures. Doctors in the smaller hospitals might then find themselves prohibited from performing services they had in the past. The profession might argue that the patient's welfare and his freedom would suffer. For example, the patient commonly depending upon a doctor in a small community to perform some procedure under hospitalization might find his doctor prohibited from continuing were the services of the local hospital restricted. Then the patient would have to seek a new doctor, perhaps travelling miles and suffering the upset of developing a relationship with some other practitioner. Particularly if his former doctor were competent, such a change might be not only inconvenient but traumatic for the patient.

In a variation of this type of planning decision, the organizing hierarchy could choose to provide funds to support a pediatric ward, for example, in only one of the general hospitals in a large city, where previously several hospitals had had such wards[65]. Certain dislocations in the professional community are inherent in this type of merger. At an informal level, the medical community is a complex structure of interaction, sponsorship and cooperation among doctors. At a more formalized level, it is a structure of status, power and influence that is articulated through not only medical associations but also through professional networks

in work organizations like the hospital. Merger has the potential to disrupt both the informal and formal structure of physicians involved. The centralization of clinical services, like pediatrics, in one hospital and the relocation of personnel would mean the breakdown of existing patterns and require the establishment of new ones. While undermining the existing power structure and possibly affecting some physicians' opportunities, this type of shift could cause a great deal of referral inconvenience for doctors not involved in the merger but trying to follow the changes. The formal structure is further threatened by the opening of new administrative positions and the elimination of others with a possible consequent loss of power and status for their former holders[66].

As part of its coordinating function, the organizing hierarchy could stipulate referral patterns[67]. Besides limiting a physicians' choice of specialists to whom he may refer, this could mean a change in patterns of referral. The profession might argue that with boundaries and restricted referral patterns the patient will also lose some of the leeway he has enjoyed; boundaries might interfere with his choice of a primary physician and referral restrictions might diminish his opportunities to be referred to the specialist or facilities his general practitioner might have chosen had the choice been unlimited.

Finally, since the system would be initiated by the provincial government to serve purposes of its own,

regionalization would undoubtedly involve an increase in government power, either at the provincial or local level, over health care delivery and pose a threat to professional self-government[68]. New forms of decision affecting medical practice would come under government scrutiny.

As has been pointed out, however, the degree of power government officials would have relative to health professionals, including physicians, under a regional system would depend on the system's actual design. In light of the impact which regionalization might have on the practice of medicine, the degree of government power implied by any plan suggested for Ontario may have some bearing on the acceptance it receives from the profession.

Importance of the Medical Profession's Acceptance to the Success of Regionalization

When the Ontario provincial government moves to implement a regional health system, it will undoubtedly wish to implement an effective one. It is difficult to decide which of the alternative approaches to regionalization would be most effective in Ontario, since many variables figure in effectiveness. One variable which seems to have had a bearing on the effectiveness of regionalization elsewhere is the degree of acceptance which the system has received from the medical profession[69], both in terms of the actual design implemented and the profession's general assessment of the merit of the concept.

The Saskatchewan doctors' strike illustrated how resistance to a new government programme introduced can seriously retard the programme's implementation and create bitter feelings[70]. Although strikes have never been a popular weapon for demonstrating the profession's opposition, more subtle tactics can threaten implementation and viability[71]. Negotiations prior to the implementation can be drawn out, or there may be attempts to organize public opposition. Similar tactics can interfere with its ability to achieve the goals of the programme once it has been implemented. If contrary to their preference, for example, physicians were given a very minor role on the lower tier councils of a regional health system, those few members of the profession on councils could impede council deliberations through filibustering, engineering antagonism among other different groups represented or pitting members of a single group against one another. With or without encouragement from their representatives on the lower tier health councils, physicians practising under a regional system might take any opportunity presenting itself to quietly sidestep regulations. Both leaders of the profession through publicity and "rank and file" members on a personal basis with patients might try to convince the consumer that this system is somehow detrimental to him and urge protest.

The evidence suggests, according to Grove, that the Ontario government has not always been open and cooperative

with doctors in developing new programmes[72]. In the past there appears to have been a curious reluctance on the part of the provincial government to have anything more than the essential minimum of consultations with the profession prior to implementing any new programmes, and then only when forced to do so[73]. In fact, says Grove, there is little doubt the Saskatchewan doctors' strike could have been averted, if that Province had had a better understanding of the nature and depth of its professional body's stand on Medicare. Similarly, he warns that, unless the Ontario government makes an effort to build more intimate working relationships between itself and its physicians, the result could be another violent confrontation over a programme such as regionalization[74].

Restatement of the Objectives

It appears that until now the Province has, rather than consulting doctors, more or less attempted to "guess at" what their reactions would be to any new programme like regionalization. The findings of this research should pinpoint how accurate the provincial government has been in estimating a regional health system that will be acceptable to Ontario's medical profession. As previously indicated, the primary purpose of the research is to determine Ontario physicians' opinions about alternative models for health regionalization which indicate varying degrees of government power and the implications of these opinions for possible

acceptance of that Province's plans for regionalization.

Secondary purposes are to determine: the reasons for doctors' preferences as to type of regional system; their general opinion of the concept's merit; and whether objective background characteristics, specifically official leadership status, work setting, type and location of practice and place of basic training, are related to the type of regional health system which any doctor preferred or to his view of the concept.

FOOTNOTES

[1]Ontario (Council of Health, Committee on the Regional Organization of Health Services), Report (Toronto: Dept. of Health), 1969, p. 21. This is a definition the Committee took before its first attempt to devise a design.

[2]Quebec (Commission of Inquiry on Health and Social Welfare), Health (Quebec City: Government of Quebec), 1970.

[3]Manitoba (Dept. of Health and Social Development), White Paper on Health Policy (Winnipeg: Dept. of Health and Social Development), 1971.

[4]Nova Scotia (Dept. of Health), Report on an Integrated System of Hospital Facilities and Related Services (Halifax: Dept. of Health), 1971.

[5]Canada (Royal Commission on Health Services), Report (Ottawa: Queen's Printer), 1965, Chaps. 7-9.

[6]Canada (Task Force on the Cost of Health Services in Canada), Report (Ottawa: Queen's Printer), 1970, pp. 31-40.

[7]Ontario (Committee on the Healing Arts), Report, I (Toronto: Queen's Printer), 1969, Chap. 3.

[8]This is actually a figure representing the average expenditures of all Canadian provinces taken from the Task Force on Cost, op. cit., p. 428. It is also for all health services, but by this date physicians' services insurance would not have been covered by most provinces. According to other tables in this series, public health probably accounts for less than one per cent.

[9]B. Blishen, Doctors and Doctrines (Toronto: U. of Toronto Press), 1969, p. 110.

[10]Ontario, Committee on Regional Organization, op. cit., pp. 24-25.

[11]Again an average estimate for the provinces. These are 1968 figures; many of the provinces would still not have been supporting physicians' services.

[12]Ontario (Ministry of Health), An Implementation Plan for the New Orientation and Structure of the Ministry of Health (Unpublished memorandum), 1972.

[13]Blishen, op. cit., p. 107.

[14]Canada, Yearbook (Ottawa: Queen's Printer), 1972, pp. 309-10.

[15]This has been speculation largely. Some attempts to determine whether these are actually causes and the extent of their effects are just beginning. See, for example: P. Enterline, et al, "Effects of 'Free' Medical Care on Medical Practice in Quebec", New England Journal of Medicine, 288: 1152-56, 1973.

[16]Medical Post article on the new controls, March 6, 1973, 1, 26.

[17]Medical Post article on joint OMA-government fees committee in Ontario, October 16, 1973, 1, 30.

[18]J.E.F. Hastings, Organized Community Health Services (Ottawa: Queen's Printer), 1964, pp. 12-31.

[19]Ibid., pp. 5-11.

[20]Personal communication, Dr. J.E.F. Hastings, Toronto, December 16, 1970.

[21]Ontario (Dept. of Health), Progress in the Formation of Health Units (Unpublished mimeo), 1967, pp. 2-3.

[22]Personal communication, Dr. J.E.F. Hastings, loc. cit.

[23]Ontario (Dept. of Health), Progress, loc. cit.

[24]Personal communication, Dr. J.E.F. Hastings, loc. cit.

[25]Ontario (Committee on the Healing Arts), Report, III, op. cit., pp. 24-25.

[26]Loc. cit.

[27]Mental institutions did not come under their jurisdiction, but under another branch of the Health Department. They are regionally organized in the sense that each has a large designated encatchment area. Ontario (Committee on Regional Organization), op. cit., pp. 35-36.

[28]Ontario (Committee on Regional Organization), op. cit., p. 38.

[29]Personal communication, Dr. J.E.F. Hastings, loc. cit.

[30]W.J. McNerney and D.C. Riedel, Regionalization and Rural Health Care (Ann Arbour: U. of Michigan Press), 1962, p. 148.

[31]Ontario (Smith Committee on Taxation), Report, II (Toronto: Queen's Printer), 1967, pp. 495-550. This committee suggested the use of regional government units as health regions and a role for regional government councils in hospital as well as public health planning and coordination.

[32]A description of the regional government programme and number of regional governments either implemented or planned may be found in E. Beecroft, Local Government in Canada (IULA conference address), 1971.

[33]Ontario (Office of the Prime Minister), Design for Development: Phase Two (Toronto: Dept. of Municipal Affairs), 1968.

[34]D.C. Rowat, The Canadian Municipal System: Essays on the Improvement of Local Government (Toronto: McClelland and Stewart, Ltd.), 1969, pp. 167-68.

[35]McNerney and Riedel's study, op. cit., was a small-scale one.

[36]A. Willms, "Administrative Decentralization". In A. Willms and W. Kernohan (Eds.), Public Administration in Canada: Selected Readings (Toronto: Methuen), 1971, p. 132.

[37]Ibid., pp. 133-34.

[38]Ibid., pp. 136-37.

[39]Personal communication, Dr. J.E.F. Hastings, loc. cit.

[40]J. French and B. Raven, "The Bases of Social Power". In D. Cartwright (Ed.), Studies in Social Power (Ann Arbour: U. of Michigan Press), 1959, pp. 152-53.

[41]Consumer utilization patterns may be based on a variety of factors including: positioning of health services, positioning services other than health, geographical barriers, transportation and communications networks, and so on.

[42]A complete description of the Swedish system can be found in A. Engel, "Regional Planning". In the American College of Hospital Administrators (Eds.), The Swedish Health System (Chicago: U. of Chicago Press), 1971, pp. 63-80.

[43]Descriptions of the British system can be found in several sources. For example: A. Linsey, Socialized Medicine in England and Wales: The National Health Service, 1948-1961 (Chapel Hill: U. of North Carolina Press), 1962.

[44]For a comprehensive description of the two major regional programmes in the US, see S.A. Warren, Regionalization of Health Services in Southern Ontario (Unpublished Master's Thesis), 1971.

[45]For a complete description of the Soviet system, see M.G. Field, Soviet Socialized Medicine (New York: The Free Press), 1967.

[46]Engel, op. cit., p. 65.

[47]E. Friedson, Professional Dominance: The Social Structure of Medical Care (New York: Atherton Press, Inc.), 1970. Friedson discusses the various "uses" of the profession's expertise claim.

[48]For a complete description of the Saskatchewan public health system, see Saskatchewan (Dept. of Public Health, Research and Planning Branch), Organization and Management of Preventive Health Services (Regina: Dept. of Public Health), 1966.

[49]According to legislation, consumers were supposed to dominate the regional councils of the Partnership for Health programme. In practice, however, health professionals dominate. United States (Dept. of Health, Education and Welfare),

Regional Medical Programmes: Fact Book (Washington: HEW), 1972, p. 12.

[50]Friedson, op. cit., pp. 83-84.

[51]World Health Organization, Technical Report Series 499 (Geneva: WHO), 1972, pp. 14-24.

[52]"Hill-Burton After Twenty Years", Modern Hospital, 107: 95-98, 1966. This early American programme demonstrated the effects of relying on community initiative.

[53]Saskatchewan (Dept. of Public Health, Research and Planning Branch), op. cit., pp.119-123.

[54]Ontario (Committee on Regional Organization), op. cit., pp. 41-46. Actually the Council identified four types of system, including the ad hoc type of arrangements which arise in developing countries.

[55]Ontario (Council of Health, Committee on Regional Organization of the Health Services), Supplementary Report (Toronto: Dept. of Health), 1971. After further consideration of recommendations made in its first report, the Council modified them and suggested the design described in its supplementary report.

[56]Ontario (Ministry of Health), Implementation Plan, loc. cit. A description of the intended regional system is included.

[57]Friedson, loc. cit.

[58]Hlishen, op. cit., pp. 150-52.

[59]Ibid., pp. 152-54.

[60]Ibid., pp. 155-57.

[61]Ibid., pp. 157-59.

[62]Linsey, op. cit., pp. 245-50.

[63]Ibid., pp. 83-85.

[64]This is done to some extent in all regional systems, chiefly through refusing funds to support certain services in particular hospitals.

[65]This type of move has already been taken by the Ministry of Health in Ontario and has not been a popular one.

[66]R. Rothman, et al, "Physicians' and a Hospital Merger: Patterns of Resistance to Organizational Change", J. of Health and Social Behaviour, 12: 51, 1971.

[67]This is an institutional arrangement more than one for individual doctors in operating regional systems. For example, in the Soviet Union where primary care doctors and specialists are grouped in health centres, it is customary for a primary care doctor to refer to specialists within the clinic.

[68]Rothman, op. cit., p. 47.

[69]Loc. cit.

[70]An account of this struggle can be found in R. Badgeley and S. Wolfe, Doctors' Strike (Toronto: MacMillan of Canada), 1967.

[71]The tactics of the AMA in trying to forestall Medicare illustrate. R. Harris, A Sacred Trust (New York: The New American Library), 1966.

[72]J.W. Grove, Organized Medicine in Ontario (Toronto: Queen's Printer), 1969, p. 293.

[73]The formation of a joint committee like the one for fees may indicate a change of heart in this respect.

[74]Grove, op. cit., pp. 293-94.

CHAPTER III: PREDICTING DOCTORS' OPINIONS REGARDING HEALTH REGIONALIZATION

Other Studies

Despite the widespread implementation of regional health systems, only one major attempt to quantitatively measure physicians' preferences as to system type and their opinion of the concept has been made. The medical profession's stand on regionalization has not received the attention of its stand on government health insurance and it may be difficult to predict which type of regional system physicians will prefer, their reasoning, opinion of the regional concept's merit, or any relationships between background characteristics and opinions on regionalization from the findings of studies which focus on other issues.

The one study of physicians' opinions on health regionalization whose findings might be applicable here was conducted in Britain. Shortly after the British government presented its White Paper of 1944[1] describing a total scheme for socialized medicine, the executive of the British Medical Association (BMA) drew up a questionnaire which was distributed to the entire doctor population asking its views of, among other issues, the government's proposed plan for health regionalization[2].

Because Britain is a country whose basic social, cultural and political values closely resemble those of Canada and of Ontario in particular, a study of the British profession's

opinions would be a logical start were one looking for a clue as to how Ontario doctors might react to health regionalization.

It must be acknowledged, however, that Canadians are also strongly influenced by the opinions of their American neighbours. A review of American medical journals reveals that statements periodically made by leaders of the American medical profession on health regionalization have roughly paralleled the consistent stand taken in the past and currently by the majority of the British medical profession[3]. It is probably reasonable to assume that, if Ontario doctors have taken their cue from opinions expressed recently by members of the British medical profession towards regionalization, any American influence brought to bear would only have reinforced an already implanted notion.

Because of the scarcity of studies in this specific area, predictions based on the British study alone, or on the results of similar studies centering on other issues of medical care organization, must be very tentative.

The Preferred System Type

Predictions as to the Ontario profession's response will be based mainly on British physicians' reactions to the first formal proposals for regionalization in that country.

Before World War II, British hospitals were not regionally organized. In fact, individual hospitals infrequently set up formal relations to, for example, share resources. Rural areas were then badly underserviced, and

might really have benefited from ties between their services and more adequately staffed and equipped ones in heavily populated areas nearby. Heavy casualties in the countryside around London during the war necessitated some arrangement through which the lack of services could be alleviated. London was divided into ten parts, each part linked with a rural section on the periphery, and these ten areas became the first hospital regions.

Under emergency conditions, rural doctors came to see how really deprived their areas were. City doctors, asked by the government to temporarily and in shifts transfer to rural areas, also became aware of the problem. The sharing of personnel and formal referral channels built up through this experiment with regionalization appeared one way to increase the range of services easily accessible to rural residents which might work in peacetime as well. Systematic planning within regions might also ensure that services in rural areas were expanded, rather than the constant improvement to more populated areas[4].

The British government suggested permanent formal organization immediately after World War II, as part of a general plan for its National Health Service (NHS).

In response to the British government's proposal for socialized medicine, the BMA conducted a survey of its membership to ascertain their opinions on various aspects of the proposed national health service, including the type of regional health system.

The Peripheral Issues

The British government's proposals, both in respect to the peripheral and key issues, were made in a 1944 White Paper. The boundaries of hospital regions were to respect local government boundaries, although specifically which local government units would be included in any region would depend on how consumer utilization patterns suggested they be grouped. Regions were to be large, serving one to four million people. The local authorities within these regions would be responsible for both public health and hospital services.

The British Medical Association's questionnaire did not ask the profession for its opinions of the suggested boundary criterion, of suggested average size for the regions or specifically of the proposal that public health and hospital services be jointly planned and coordinated. The executive itself argued that consumer utilization patterns did not exactly correspond to local government units and should not be unnaturally forced. Size was apparently not an issue, which may suggest that the government recommendation was essentially acceptable. The suggestion that local authorities assume responsibility for hospitals was not welcomed and, although the executive may have favoured joint planning and coordination of public health and hospital services by one set of councils, it would not favour this at the expense of allowing the local authorities to assume responsibility for both[5].

It might be noted here that there was also some controversy over whether the bodies responsible for hospitals should be responsible for both teaching and non-teaching facilities with some split on this issue within the profession. The issue was eventually resolved to create a separate system for teaching hospitals[6]. Since there has been no suggestion of such a separation in Ontario, the controversy will not be discussed.

The British government has recently proposed a re-organization of the hospital system. Hospital region boundaries will be redrawn to respect local government ones. Regions will be subdivided into areas or districts. Public health will be transferred from the local authorities to new comprehensive health councils also responsible for hospital facilities[7].

Current BMA leaders are not particularly pleased that the consumer utilization criterion for boundaries is being abandoned. They are apparently not, however, opposed to the subdivision of regions into districts. Many actually favour the coming change which will mean joint planning and coordination of public health and hospitals under one set of councils, as long as this means the transfer of public health from local authorities not vice versa[8].

In analyzing the British study, Eckstein concluded that official leaders of the profession essentially reflected its membership on the issues covered by the questionnaire. One might suppose that a majority of British doctors would also

have agreed with their leaders on the above issues and do so now. One might further predict that a majority of Ontario doctors would support these same stands.

The Key Issues

Of the key issues, only the matter of council composition received much attention on the BMA questionnaire. The British Ministry of Health had recommended that the national body, a council under the Health Ministry, be composed of central level government officials (elected representatives and civil servants). Asked their opinion of the government's proposal, only a slight majority, 51.0 per cent, of British doctors were opposed. Those who were opposed suggested a variety of alternatives which stressed an official role for doctors. The most popular alternative was a council of medical leaders elected by the profession.

The Ministry had suggested that councils composed of health professionals be established to advise local authorities. Approximately 78.0 per cent of doctors responding to the BMA questionnaire took the stand that lower tier councils should be established separate from the local authorities to plan and coordinate hospital services. A substantial majority, 80.0 per cent, felt that health professionals should be officially represented on such councils. This latter issue was apparently a contentious one and incidents surrounding its final resolution probably deserve some note[9].

At the time that regionalization was first proposed,

a Conservative government was in power. It accepted the medical profession's resistance to regional councils composed solely of local government representatives and abandoned its position in favour of boards on which health professionals would be represented. Shortly after the negotiated settlement was achieved, the Conservative government was defeated and a Labour government took office. Under Labour leadership, the Health Ministry reverted to the original plan of manning regional health councils solely with local government officials. Although its stand was evidently quite firm, only a few weeks later the Labour government reversed its policy abruptly and suggested that health professionals should indeed be represented on the hospital boards.

From the time of the British government's first moves to implement a national health service, the specialists were more receptive than the general practitioners and had expressed their support openly. The general practitioners were dissatisfied with several proposals originally related to them specifically, especially the hint that a "fixed element" in the form of a nominal salary would be introduced into the capitation system with which they were familiar. As negotiations drew on, their opposition intensified. Fearing a split in the profession, the specialist body became more hesitant about openly supporting "socialized medicine". With the general practitioners opposed and the specialists toning down their support, it appeared that plans for a

national health service would falter. About the same time, the Labour government reversed its stand on the composition of the regional boards and the specialists decided to renew their support for the plan in general. Forsyth believe this suggested a possible trade-off[10]. If the issue of regional council composition were used as a plum to draw the specialists back into the fold of support, there can be little doubt of how important health professional representation on hospital boards was to them. With the specialists' renewed support for a national health service and a few concessions directed especially at family doctors, the general practitioners were reluctantly drawn in.

The method of selection, on the other hand, was apparently not a major issue. There were no direct questions in the BMA survey about the method of selecting representatives for the boards. The government had suggested appointment by the Ministry after consultation with the appropriate groups. The most popular alternative to a government dominated national body was a council of health professionals elected by their peers. This may suggest a strong element of the medical profession, although not a majority would have favoured group selection of representatives.

The British government's White Paper did not detail specifically where real power would be focused, at the central or regional level. Possibly as a consequence, the BMA questionnaire did not ask doctors to comment on any preference. The executive has not, however, particularly

opposed the approach which gradually developed, that is, shared authority. The basic approach to each of these three components will not be changed in 1974, for which leaders of the profession are generally thankful[11].

At the time of the BMA study British doctors preferred that health professionals be well represented on health councils. Their leaders, at least, have continued this stand into the present. Likewise, their leaders continue to prefer a method of selection which gives the profession some control over exactly who sits. One might then predict that a majority of Ontario doctors would want at least adequate representation of the health professions on such councils in their province as well as some control over the exact members who sit on the councils. Just exactly how well represented they will want the professions to be is difficult to predict. The British leaders originally demanded that doctors alone constitute one-third of the members on regional councils and that to this representatives of the other health professions be added. Finally, the medical profession settled for one-quarter of the councils' membership to be doctors, but with the addition of representatives of the other health professions, present composition of these councils usually tends to be a see-saw balance between government and the professions.

Focus of power has never been much of an issue in Britain and the profession seems to see merit in any one of the three possible alternatives, decentralization,

partial decentralization or centralization. Generally, the current approach is acceptable. One might therefore predict that, while Ontario doctors may also be somewhat split over this issue, a majority will find it acceptable to leave some final decisions in the hands of a clearly government dominated level, probably the central one.

The Overview: Moderate Government Power System Type Preferred

Considering the peripheral and key issues together, one might predict that a majority of Ontario doctors would not accept a system which maximally involves government, but would opt for one which provides for moderate government power. A joint stand taken by the Ontario Medical Association (OMA) and the Ontario Hospital Association (OHA) in May, 1973 tended to support predictions made in the study's planning stage about what system type a majority of doctors would prefer[12].

The specific type of regional health system suggested as a basis for experiment closely resembles in spirit, the one originally implemented by the British. Although the policy statement submitted to Ontario's Minister of Health did not suggest an appropriate average size, it did express the opinion that health region boundaries should be based on consumer utilization patterns rather than regional government boundaries. The brief suggested the inclusion of a public health official on each district council, implying at least

ad hoc coordination of their services and other health services.

The brief suggested that councils should be composed of approximately 15 members: two from each of the ranks of district hospitals and doctors; four members from the general public; one each from local government, allied health professions, voluntary health agencies, social welfare agencies, medical officers of health, extended care and domiciliary institutions. Charles Boyd, President of the OHA, has frankly admitted that this structure would make it possible to load the council with hospital and medical people. The brief proposed the appointment of council members by the health minister from persons nominated by the groups which they would represent. The system proposed by the OMA and OHA would allow the prime responsibility for planning and coordinating health services to remain with the Province. District councils would be essentially advisory. However, Louis Harnick, then President of the OMA, has called it essential that the province take no decision regarding any district until its health council has been consulted and had an opportunity to comment. Harnick has suggested that the Province and district councils will have to work together to make sure the councils do not become "rubber stamps" for what the Ministry of Health wants to impose upon them.

A recent study in the United States by Engel[13] also tends to support the prediction that a majority of Ontario doctors may opt for a regional system which implies moderate, rather than either strong or weak, government power. Engel compared the perceived autonomy of physicians in three types of bureaucratic setting: solo practice; privately organized group practice; and government medical organizations. She labeled these respectively as non-bureaucratic, moderately bureaucratic and highly bureaucratic settings. Her data revealed that those physicians associated with the moederately bureaucratic setting were most likely, and those in the highly bureaucratic setting were least likely, to perceive themselves as autonomous within the client-professional relationship. Engel concluded that there is an optimal level of bureaucratic organization with respect to professional autonomy.

Engel recognizes that bureaucracy places certain restrictions on professional activities. In attempting to explain her findings, however, she argues that it is not bureaucracy per se but the degree of bureaucracy that can limit professional autonomy. Engel takes the position that bureaucracies need not be deprofessionalizing and are, in fact, becoming important vehicles for professional activities.

Alterations taking place within the profession itself have made it more compatible, in certain ways, with bureaucratic employment. The rapid and expansive increases in medical knowledge have made it increasingly difficult

that regionalization by itself helps to equalize the distribution of services, facilitates referral from primary care units to more sophisticated services, or ultimately improve the health level. Even in Britain, doctors who favoured regionalization may have been those involved in some way with the London regions and their commitment based on pure personal intuition. Leaders of the American profession and recently those of the Ontario medical profession[19] have expressed some doubt as to whether regional organization actually produces the rewards which the concept promises.

The second reason why doctors might be skeptical of regionalization is that it may imply to them an unnecessary encroachment by government, with all the attendant "evils" of bureaucracy including regimentation and red tape. Some may feel that such a system will interfere both with the profession's traditional autonomy and with their patients' freedom, without producing any of the benefits frequently promised of it.

Observing that reasons for preferring approaches which imply moderate government involvement are likely to be backed with arguments given in terms of patient freedom and quality of care, one might also predict that doubts or objections to regionalization will be given in these terms.

as Engel divided types of practice into non-bureaucratic, moderately bureaucratic and highly bureaucratic, types of regionalization can be classified as implying seak, moderate and strong government power. Hlishen has pointed out that the quality of care is an important ideological concern of physicians and that they are interested in methods of organization to improve delivery. If faced with a choice of regional systems which imply various degrees of government power, physicians may see moderate government involvement as contributory to the system's ability to improve delivery just as doctors in Engel's study perceived a moderately bureaucratic setting as contributory to their effectiveness. For example, Ontario physicians may regard politicians and civil servants as having had more managerial experience or understanding the Province's financial tolerance better and this might be their distinctive contribution to a regional health system. On the other hand, the profession may feel that government officials lack a sufficient knowledge of medical aspects which would also be important in developing a more effective delivery system under regionalization; this would account for their preferring some balance of government and professional power. Some power for the professional would also protect both his own and his organization's autonomy from more interference than necessary by government.

Possible Reasons for Rejecting a Strong Government Power System Type

Reasons why the Ontario medical profession might prefer a moderate government power system, but not be willing to accept a design for health regionalization implying strong government power, have been essentially discussed. They will not be reiterated in detail here. Briefly, the medical profession might consider that a system implying strong government power would:

(1) threaten the profession's traditional self-governing status more than necessary for successful regionalization;

(2) restrict the individual physician's freedom and the patient's more than necessary for a successful regional programme; and

(3) be less likely than a more moderate approach to improve, or at least maintain, the quality of care presently being delivered in Ontario.

Predicting the Foremost Reasons

During 1965, the last time period examined by Blishen, the latter two concerns had taken pre-eminance over the former in ideological statements from the medical profession on health insurance[14]. An indication that this trend may be continuing is the profession's recent attempt at examining itself through the Pickering Committee[15]. One stated purpose of the Committee's study was to suggest ways of avoiding a confrontation with government over such issues. The profession might be expected then to be attempting a more cooperative approach to considering proposals such as those for regionalization which could result in a muting of the self-government issue in its members' own minds. In the

past, the leadership has tended to regard cooperation with the Province in initially devising new programmes a foothold in the door of the profession's autonomy[16].

Opinions of the Regional Concept's Merit

The British government suggested permanent formal regional organization immediately after World War II when the climate among British doctors should have been most favourable. The War had demonstrated deficiencies in the hospital system which regionalization might coorect. Yet, when asked on the BMA questionnaire whther such a system should be implemented at all, only 63.0 per cent voted in its favour[17].

Based on the British experiment, one might then predict that Ontario doctors would not be ready to wholeheartedly support the implementation of such a system. In May, when the OMA and the OHA presented their policy statement to the Minister of Health, these associations asked that regionalization not be implemented across-the-board throughout Ontario, but that experiments be set up in a few areas and be evaluated[18]. Their policy statement tended to indicate that the prediction which had been made in the study's planning stage would be borned out.

Possible Reasons for any Skepticism

There are at least two possible reasons why the medical profession may be hesitant to back widespread implementation of a regional health system.

First, as previously noted, there is no real evidence

that regionalization by itself helps to equalize the distribution of services, facilitates referral from primary care units to more sophisticated services, or ultimately improve the health level. Even in Britain, doctors who favoured regionalization may have been those involved in some way with the London regions and their commitment based on pure personal intuition. Leaders of the American profession and recently those of the Ontario medical profession[19] have expressed some doubt as to whether regional organization actually produces the rewards which the concept promises.

The second reason why doctors might be skeptical of regionalization is that it may imply to them an unnecessary encroachment by government, with all the attendant "evils" of bureaucracy including regimentation and red tape. Some may feel that such a system will interfere both with the profession's traditional autonomy and with their patients' freedom, without producing any of the benefits frequently promised of it.

Observing that reasons for preferring approaches which imply moderate government involvement are likely to be backed with arguments given in terms of patient freedom and quality of care, one might also predict that doubts or objections to regionalization will be given in these terms.

Subgroup Characteristics as Related to Opinions

The type of regional health system preferred by the OMA and OHA has been documented, as one balancing government with health professional power. The hesitancy of these associations to support immediate widespread implementation has also been noted. However, as has already been pointed out, it is unlikely that their policies are supported unanimously by the province's more than 10,000 doctors. To assume such a unanimity of opinion would be to disregard the high degree of diversity among doctors.

A secondary objective of this research was to examine differences in the type of regional system preferred by Ontario doctors. The differences were examined not only in terms of leadership roles, but also in terms of several other objective characteristics including: type of practice (general or specialty); work setting (public or private practice); location of practice (urban or rural); and place of basic training (in Canada or another country).

Leaders vs. the "Rank and File"

In analyzing the results of the BMA questionnaire, Eckstein noted that the leaders of the British medical profession essentially reflected the opinions of the "rank and file" towards regionalization. This might seem surprising in light of varying background characteristics which might lead one to expect more conservatism from leaders; that is, they would be less willing to see professional influence over the

system's operation restricted. The agreement between leadership and "rank and file" may have been related to the issue itself, since leaders were generally less satisfied with the suggested payment scheme.

Eckstein felt that the differences in political attitude within the profession on the payment scheme were due to three factors: income; security of establishment; and familiarity with the impact of non-medical organization on medical practice. Unestablished doctors did not usually attend BMA representative meetings nor sit on the BMA council. Practitioners struggling with long lists of public patients from the working-class or medical officers of health loaded with committee work and routine administration were too busy to become involved in the Association. To exert influence in medical politics a doctor must have a certain amount of time and money. The income and workload of a medical class practice were well-suited to participation in medical politics. "Representative" medical bodies were therefore weighted in favour of affluence and private practice, those doctors who had the most to lose from any payment scheme which moved the health care delivery system closer to virtual government control [20].

It has not always been found, however, that doctors in potentially influential positions reflect the opinions of the "rank and file" on issues more similar to regionalization. Rothman et al studied doctors' reactions to a three-hospital merger; merger is often suggested as one method of cutting

duplication of facilities and optimizing the use and coordination of specialized personnel under a regional system. Rothman and his associates found that, while doctors who actually held office in local medical organizations did not differ in their opinions from the "rank and file", those who had achieved a moderate degree of "backstage" political success within the profession were less inclined to favour the merger. The researchers attributed this to their anticipating the development of new power bases, at the cost of existing structures, with the merger. As it turned out, these doctors were right in anticipating such changes. An examination of office holders in the community showed that a good deal of reshuffling of personnel in local medical organizations (and hence, no doubt, to some extent representatives at higher levels) did occur, with different doctors occupying medical society positions after the merger than before. If official positions shifted, one might assume that any informal power structure was also altered. Whether "backstage" leaders exercised their influence specifically through formal leaders of the medical profession or through other channels, their ability to influence was probably affected[21].

In this particular community, the "backstage" leaders evidently did not, for whatever reason, exercise influence through formal professional leaders, since their opinions differed. Conceivably in other communities, such as Ontario, "backstage" leaders might exercise influence through these

channels and if they were more conservative, the formal leadership might reflect this. On balance, however, the evidence tends to suggest that official leaders in Ontario will essentially reflect "rank and file" opinions on regionalization.

Work Setting

Eckstein noted that British doctors in public practice, (armed services doctors, those in educational institutions, medical officers of health and so on) were more willing to accept a stronger role for government in planning and coordinating hospital services than private practitioners. They had no vested interest in keeping the health care delivery system as clear of government involvement as possible and one can assume these doctors had relatively little distrust of public organization. In some cases, doctors who entered public practice freely may naturally have been less resistant to government involvement than those who entered private practice. Working in a public practice probably also had its effects. At that time many of the service doctors had been drafted to serve during the war. Their vote on these issues showed that they had not been disillusioned by corporate practice. Such doctors had had a full dose of organization, but had evidently decided that the doctors' clinical independence need not be threatened by non-medical organization[22].

In the United States, Lipset and Schwartz also report

that public practitioners tend to be more liberal about government involement in general[23].

The weight of evidence then suggests that in Ontario public practitioners will be willing to accept a system implying more government involvement than those in private practice.

Type of Practice

Eckstein noted that British specialists were no more willing than general practitioners to see doctors' influence on regional hospital boards restricted at the expense of increased government involvement[24]. Similarly Colombotos found no difference on the issue of Medicare in the United States[25]. Both researchers analyzed the differences between these groups in dichotomous terms, however; that is, either physicians were for or against the proposals which had been made by their governments. This study provides a spectrum of choices to Ontario doctors. The three types of regional system represent a range in which government influence is gradually increased and therefore, it may be possible to make a finer distinction between general practitioners and specialists according to the degree of government involvement implied by the system type favoured by each group.

If one were to speculate on a difference between the two groups, it might be that specialists would be more liberal, having been accustomed to organization through their association with hospitals. On the other hand, however, since regionalization by virtue of its nature is likely to

have a greater effect on specialty practice through its effects on the hospital network, one might predict that specialists will be less liberal than general practitioners. Theoretically, either seems possible.

On balance, however, the evidence tends to indicate that there will be no relationship between type of practice and system type preference for Ontario doctors.

Eckstein made no comment, in discussing differences of political attitude according to the above characteristics, on whether these characteristics might also be related to any doctor's estimation of the concept's merit. Because the fact of regionalization itself implies organization, one might speculate broadly that any group in Ontario which is less conservative in regards to system type will correspondingly be more ready to approve of the concept.

Location of Practice

Eckstein did not analyze the possible relationship between location of practice and opinions; and the British Medical Journal's 1945 account of the questionnaire findings did not include this variable. Nor have any other studies to determine whether location of practice is related to opinions about government involvement in health regionalization *per se* been conducted either in Britain or the United States.

There is some indication that urban doctors are likely to be less conservative than rural ones concerning government

involvement in other types of medical care organization, such as prepaid health insurance. Harris, for example, points out that in the early 1900's the American Medical Association (AMA) actually favoured Medicare, but in the twenties changes its stand largely in response to a flood of letters from rural doctors protesting government health care insurance. At that time, says Harris, urban doctors were far more favourably inclined towards such a programme than rural ones[26]. Rural doctors' opposition to Medicare may in part have been explained by a general tendency among rural residents to view less favourably any government attempts aimed at solving social welfare problems. With improved communications and the shortening of distance between town and country through better roads and more efficient transportation, however, the disparity between rural and urban residents on political views appears to be disappearing[27].

Colombotos found a difference between New York City and upstate physicians on government health insurance, with New York City physicians being more inclined to favour Medicare than upstate physicians. Colombotos, however, attributed the difference to region, rather than any urban/rural dichotomy, since upstate physicians practising in cities over 25,000 in population were no more likely than upstate physicians practising in rural areas to favour Medicare[28]. It may not be legitimate to make predictions, based on either Colombotos or Harris' examples, about how rural Ontario doctors will feel regarding regionalization, since the issue of payment

might have a different significance to doctors than regionalization. Indeed the literature suggests that these two issues, at least, do have a different significance to physicians. For example, while leaders of the British medical profession essentially reflected the "rank and file" on regionalization, there was a divergence of opinion between these two groups on certain aspects of the payment scheme, with leaders less favourably inclined towards the general arrangements suggested by the government. Similarly, while there was no difference between British general practitioners and specialists as to their opinions on health regionalization, there was again divergence of opinion over the payment scheme, with the general practitioners less favourably inclined towards the government's plan for them[29]. Moreover, there is no guarantee that rural doctors opposed to Medicare were simply not more vocal than their urban counterparts who opposed government health insurance.

In New York state, McNerney and Reidel found that doctors in urban areas were more favourably inclined towards regionalization that rural doctors. Urban doctors saw the hospital hierarchy inherent in a regional system as aggrandizing their position, while rural doctors felt that regionalization diminished theirs[30]. The study, however, included interviews with only seven doctors and this number is probably not sufficient from which to draw any but the most tentative conclusions.

The conflicting and sometimes inadequate evidence on

possible rural/urban differences makes a prediction for Ontario doctors difficult.

Place of Basic Training

While not intentionally studying a relationship, Colombotos noticed evidence in the context of other research to suggest that foreign-born doctors might be more likely than American-born ones to favour Medicare[31]. If governments in their places of origin participate extensively in solving social problems (and if these doctors have not left to escape government involvement), then foreign-born doctors may be more accustomed to state involvement and therefore, less wary of it.

Any prediction based on Colombotos' observation would have to assume that doctors have a general attitude towards government involvment which is not modified by the specific issue. This is an assumption which the literature suggests may not be justified. The lack of evidence again makes a prediction for Ontario doctors difficult.

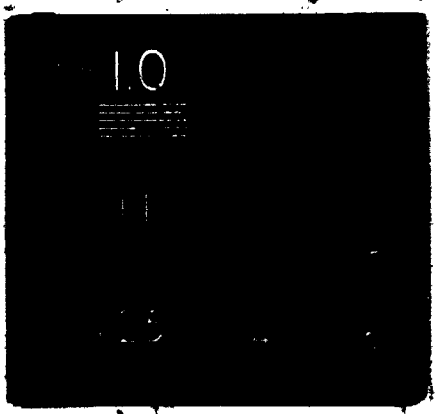
Summary of Predictions

The predictions might be summarized briefly:

(1) On balance, a majority of Ontario physicians will prefer a system type which implies moderate government influence and in spirit resembles more the design proposed by the Council of Health than by the Ministry.

(2) A majority of physicians will express concern for patient/physician freedom or for the quality of care which might result, rather than for protecting the

2 OF/DE 3



profession's autonomy, when giving reason for their system preferences..

(3) A substantial segment of the profession will be uncertain of, or deny, the concept's merit. These physicians will base their stand either on the lack of evidence that regionalization achieves the goals promised or on the belief that such a system will interfere with patient/physician freedom or professional autonomy more than justified by the improvement in care it is capable of. The latter reason will be predominant.

(4) Finally, with the possible exception of work setting, which is expected to be related, there is little real evidence to suggest that the other background characteristics in question will be related to physicians' opinions on regionalization. Doctors in public practice are expected to be more receptive to government involvement in regionalization and more inclined to see merit in the concept than private practitioners.

FOOTNOTES

[1] United Kingdom (Ministry of Health), A National Health Service (London: HMSO), 1944.

[2] The complete questionnaire and its results were published as: "BMA Questionary", BMAJ, II: 25, Supplement Aug. 5, 1944. The response rate was 48 per cent, actually quite high for doctors, and there was no reason to suspect that respondents differed from non-respondents on objective background characteristics such as sex, type of practice, work setting, etc. There was some difference on age (younger doctors more inclined to answer), but this was adjusted for. Because the reference population, in terms of these background characteristics, was known, it was possible to weight the results to be representative. The figures shown in Chapter II are the weighted ones.

[3] References can be found in a variety of articles, an example being: J. Cline, "The Physician's Point-of-View on Regional Organization of Hospitals", Cal. Med., 69: 12-15, 1948. A succinct description and has been repeated in scattered sources more recently.

[4] R. Stevens, Medical Practice in Modern England (New Haven: Yale University Press), 1966, pp. 66-70.

[5]Personal communication, Dr. D. Gullick, Undersecretary BMA, London, England, August, 1972.

[6]This controversy is described in G. Forsyth, Doctors and State Medicine (London: Pitman Medical Publishing Co., Ltd.), 1966, Chap. 6.

[7]These changes and others are described in: United Kingdom (Dept. of Health and Social Services), National Health Service Reorganization: England (London: HMSO), 1972.

[8]Personal communication, Dr. D. Gullick, loc. cit.

[9]BMA Questionary, op. cit., p. 26.

[10]Forsyth, loc. cit.

[11]Personal communication, Dr. D. Gullick, op. cit.

[12]London Free Press report of the OMA-OHA brief, May 7, 1973, p. 4.

[13]G. Engel, "The Effect of Bureaucracy on the Professional Autonomy of the Physician", J. of Health and Social Behaviour, 10: 30-41, 1969.

[14]B. Hlishen, Doctors and Doctrines (Toronto: U. of Toronto Press), 1969, p. 105.

[15]Pickering Committee, Report of the Special Study Regarding the Medical Profession in Ontario (Toronto: Ontario Medical Association), 1973. The new joint OMA-government fees committee also indicates a new willingness on the part of the profession to join with government in solving certain medical care problems.

[16]Medical Post article on the Pickering Committee, Oct. 26, 1973, pp. 1, 30.

[17]BMA Questionary, loc. cit.

[18]London Free Press report, loc. cit.

19 For US: Cline, op. cit., p. 12. For Ontario: London Free Press Report, op. cit.

20 H. Eckstein, The English Health System (Cambridge: Harvard University Press), 1964, pp. 156-8.

21 R. Rothman et al, "Physicians and a Hospital Merger: Patterns of Response to Organizational Change", J. of Health and Social Behaviour, 12: 47, 53, 1971.

22 Eckstein, op. cit., pp. 156-7.

23 S. Lipset and A. Schwartz, "The Politics of Professionals". In H. Vollmer and D. Mills (Eds.), Professionalization (Englewood Cliffs: Prentice-Hall), 1966, p. 304.

24 Eckstein, op. cit., p. 156.

25 J. Colombotos, "Physicians' Attitudes Toward Medicare", Medical Care, 6: 324, 1968. This is comparing all specialists to general practitioners. Within the specialty category, some specialties were more liberal than others, notably psychiatrists.

26 R. Harris, A Sacred Trust (New York: New American Library), 1966, pp. 6-7.

27 R.S. Friedman, "The Urban-Rural Conflict Revisited", Western Political Quarterly, 14: 481-95, 1961.

28 Colombotos, loc. cit.

29 Eckstein, op. cit., pp. 156-8.

30 W.J. McNerney and D.C. Riedel, Regionalization and Rural Health Care (Ann Arbour: U. of Michigan Press), 1962, p. 58.

31 Colombotos, loc. cit.

CHAPTER IV: MEASURING DOCTORS' OPINIONS

Sampling

Choice of a Locale

As already noted, for some years Ontario has been developing a regional pattern for organizing health services. The province was divided into hospital referral areas with services in each area focused around a health sciences centre. At the provincial level, the Ontario Hospital Services Commission, was set up to plan and coordinate hospital services within these regions. Communities were invited to establish, if they wished, councils to advise the OHSC on their communities' needs. With the recent reorganization of the Department of Health, the OHSC was disbanded and its functions were transferred to an appropriate branch of the new Ministry. Many of the community councils which were set up under the OHSC are still operating and they are channelling their advice to the new branch responsible. For several years, the province also has had public health regions with a regional medical officer in each serving as liaison between the central Health Department and local health authorities[1].

As plans for formal health regionalization progressed, tentative regions (coincident for public health and hospital services) were defined. The researcher chose to sample only doctors practising in the tentative southwestern Ontario region, as a personal collection of the questionnaire was planned and a survey of doctors practising only in that area

would be more practical in terms of time and money. The Regional Medical Officer of Health informed the researcher that the tentative southwestern Ontario region included the ten counties of: Bruce, Grey, Perth, Huron, Oxford, Middlesex, Elgin, Kent, Lambton, and Essex[2].

Sampling Frame

The basic sampling frame used was the 1972 Canadian Medical Directory (CMD). The CMD is suitable as the Health Manpower Planning Division of the National Department of Health and Welfare has found it is an accurate listing with an estimated measurement error of less than five per cent[3]. The Directory not only records the names of doctors practising in Ontario and their addresses, but also provides information on at least five background characteristics, including: for some doctors, executive positions which they might hold in any professional organizations, such as the OMA or OCPS; work setting (private or public practice); educational status (general practitioner or specialist); size of community in which the doctor practises (population); and place of basic training (university). This information allows taking a stratified sample. A stratified sample was preferable in this study because the number of doctors in leadership roles, public practice and foreign-trained were relatively few and a stratified sample would ensure their adequate representation.

Eckstein noted no difference between male and female

British doctors in the opinions they held on regionalization; however, to eliminate any possible effect of sex, only male doctors practising in southwestern Ontario were identified. The total number of male doctors identified as practising in the southwestern Ontario region was 1339.

Stratification by Background Characteristics

The names of all male doctors practising in southwestern Ontario were recorded on data processing cards along with information on the following characteristics.

Leadership Status

The simple dichotomy used was leader/not leader. Since the number of doctors listed by the CMD as holding leadership positions was few, its information had to be supplemented with other sources. From the Ontario Medical Review a list of 1972 OMA executives was used as well as the list of the Review's editorial staff. Similarly a list of OCPS executives was taken from a 1972 bulletin; and a list of Canadian Medical Association (CMA) executives as well as the editorial staff of the CMA Journal was taken from a 1972 issue of the periodical. Doctors practising in southwestern Ontario included in these lists were noted as leaders. Through the CMD, the researcher was also able to identify several doctors who during 1972 were leaders in other capacities: on the executive of local medical societies within the region; on the executive of several national specialty organizations;

as presidents of their medical staffs in hospital; on the board of directors for a professional foundation (such as PSI); in an important administrative position at the university (such as dean of medicine); on a provincial committee to study health matters (such as the Ontario Council of Health); or in political office. Undoubtedly not all persons who would fit into the leadership category under such categories were identified. If any bias were introduced as a result, it would likely be that those with a greater sense of leadership were overrepresented, since these were the ones who deemed it important to report such positions in the thumbnail sketches which they supplied to the CMD. Slightly less than 5 per cent (4.7 to be exact) of the doctors in southwestern Ontario were finally classified as leaders[4].

Work Setting

This was recorded as a private/public dichotomy. It was not always clear from the CMD whether a doctor should be placed in either the private or the public category, since some doctors appeared to work in a combination of settings. As a general rule those doctors whose mailing address appeared to be a private office or general hospital were classified as in private practice. Those doctors whose mailing address was a government hospital, health unit, industry, university or non-profit organization were classified as in public practice as were any doctors

specifically noted by the CMD as in full-time public practice, including medical officers of health, administrative personnel at the university, hospital administrators, and so on. The assumption was that most doctors would list as their mailing address the place where the majority of their time was spent. The proportion of doctors listed in private practice was 85.0 per cent, in public practice 15.0 per cent.

Type of Practice

This was recorded as a general/specialty practice dichotomy. It is not clear whether the fact of being a qualified specialist or the actual proportion of time spent practising a specialty should be used in considering the relationship of this characteristic to any specialist's opinions. Specialist qualification was used for this study because it was the information available in the CMD and doctors could be classified beforehand for sampling purposes. A doctor was classified as a specialist if he was certified by or a fellow of the Royal College of Physicians and Surgeons of Canada in the CMD. It seems probable that the majority of these would actually be spending much of their time in specialty practice. Doctors who had had specialty training in other countries (unless a reciprocal arrangement exists between Canada and their countries) were not classified as specialists, since theoretically they would not be allowed to practise their specialty in Canada. The proportion of doctors classified as in general practice was 50.6 per cent, in specialty practice 49.4 per cent.

Location of Practice

This was recorded as a rural/urban dichotomy. A doctor was classified as rural if practising in a town of less than 100,000 population and urban if practising in a city of more than 100,000 in population, that is, practising in London or Windsor. A dichotomy based on any other size grouping would not have allowed for approximately equal numbers in the rural/urban groups. This dichotomy is logical to the point that London and Windsor are major medical centres; they have a complete range of medical services and are major referral centres for their surrounding areas. Further, with the exception of one city of 50,000 people, all of the remaining towns classified as rural had less than 25,000 people. The proportion of doctors classified as practising in rural areas was 41.6 per cent, in urban areas 58.4 per cent.

Place of Basic Training

The place of basic training was defined as the country in which the doctor received his first medical degree. Place of basic training rather than the place of birth was used since this was the information available in the CMD. This may throw a slightly different light on the matter than did Colombotos' data (which was based on place of birth only), since the socialization process experienced in medical school would be combined with the social, cultural and political background from which the doctor originated[5].

The dichotomy was recorded as first degree received in

Canada/in some other country. Most countries from which "foreign" doctors originate, with the exception of the United States, are characterized by more government involvement in health care delivery than Ontario and would probably have been at the time these doctors left. According to CMD information, very few American-trained doctors come to Ontario; probably less than 2 per cent of the foreign-trained doctors practising in the province come from the United States. The proportion of doctors who received their basic medical training in Canada was 75.0 per cent, outside Canada 25.0 per cent.

Simple dichotomies were used because the researcher hoped to define several strata which would take into account at least some of the background characteristics at once. Finer distinctions might actually have produced more cells than there were doctors to fill them.

Occasionally a doctor listed in the CMD could not be classified on one of the characteristics, other than leadership or work setting, since the information was not listed. These doctors were excluded from the frame. Less than one per cent fell in this category since information on these characteristics in the CMD is very complete. Consequently it was felt that the numbers lost were small enough that the loss would not in any way bias the results.

Had strata taking into account the dichotomies of each

of these five categories at once been identified, some would have had virtually no members[6]. Consequently strata were created by the computer as follows.

Eight were based on the dichotomies of the three variables with the most equal proportions, type of practice, work setting and location of practice. These eight strata and the number of doctors identified in each are shown below.

Stratum	Number in the Frame
General practitioner, trained in Canada, practising in a city over 100,000 in population	184
General practitioner, trained outside Canada, practising in a city of over 100,000 in population	76
General practitioner, trained in Canada, practising in a town under 100,000 in population	246
General practitioner, trained outside Canada, practising in a town under 100,000 in population	54
Specialist, trained in Canada, practising in a city over 100,000 in population	301
Specialist, trained outside Canada, practising in a city over 100,000 in population	88
Specialist, trained in Canada, practising in a town under 100,000 in population	128
Specialist, trained outside Canada, practising in a town under 100,000 in population	78

The relationship of each of these three variables, at

least, with doctors' opinions on regionalization could then be examined separately in the analysis.

Sixty leaders and 122 doctors in public practice were identified to form strata nine and ten respectively.

The researcher hoped to finish with at least 30 respondents in each of these ten strata. This sample size, it was thought, would reduce the estimated error to a tolerable level. Since doctors are reputed to be incooperative when it comes to answering questionnaires (response rates usually range from 40 to 50 per cent), it was decided to oversample; approximately one-half of the doctors in southwestern Ontario would be included in the mailing. A random sample totalling 560 doctors was selected from the first eight strata, a variable sampling fraction used, such that the three variables were orthogonal. That is, 90 doctors were selected from each of the four largest strata and 50 were selected from each of the four smallest ones, the smallest strata consistently being those which accounted for foreign-trained doctors. Table 1 illustrates the orthogonal design.

Table 1: Orthogonal Design of Three Main Characteristics used in Stratifying the Sample

Type of Practice	First Training			
	Native		Foreign	
	Urban	Rural	Urban	Rural
General Practitioner	90	90	50	50
Specialist	90	90	50	50

Because their numbers were so few, all of the leaders were surveyed (60). A random sample of 62 doctors in public practice was selected. The total number of doctors in the sample was then 682.

Questionnaire Design

Format

A copy of the questionnaire used is included as Appendix A. The questionnaire was divided into four sections: (1) a basic description of regionalization; (2) questions on the components of a regional health system and the concept's merit; (3) questions on other issues of medical care organization; and (4) questions on characteristics which had been used in stratifying the population for sampling purposes.

Section 1

A review of professional journals showed that until 1972 there had been little formal discussion of the concept of

regionalization. Consequently the researcher felt that some doctors might be relatively unfamiliar with the term. In two short introductory paragraphs, the concept and its aims were described and, in addition, the six components of a regional health system (actual boundaries, size of regions, composition of health councils, method of selecting council members, focus of power and possible relationship between public health and hospital services) were noted.

The description was as objective as possible. There was no mention that various types of regional system implied different degrees of government power over their operation. No value judgment of the concept's merit was suggested. Thus every effort was made to guard against biasing the responses which a doctor subsequently made. Since discussion in professional journals had been minimal before the questionnaire was distributed and the data were fully collected prior to the OMA and OHA's joint policy statement, it seems reasonable to assume that respondents were not particularly parroting views which had been implanted by the profession's leaders.

Section 2

The second section asked doctors to choose among alternative approaches to the six components of a regional system. To reiterate, these include:

(1) actual health region boundaries;

(2) average size for the basic health unit, region or district;

(3) composition of health councils;

(4) method of selecting members to sit on the health councils;

(5) focus of power according to division of responsibility; and

(6) relationship between public health and hospital services.

The alternatives chosen by any one doctor to each of these six components could be pieced together into a design, implying various levels of government power over the system's operation. In this short questionnaire it would have been impossible to give the full range of approaches which conceivably could be taken to each of these components.

It was realized that some doctors might be aware of and prefer an approach which had not been listed; an "other" category was provided so that these doctors could express their particular preference. Theoretically any specific preference described by an individual doctor, including the preference that no such system be set up, would still fit into one of the three general categories according to the level of government influence it implied, as would any of the standard approaches which had been submitted for consideration in the questionnaire.

An opportunity for the doctors to express "no preference" was also provided, to prevent frustration among those who had no set opinion for one or more particular items.

Besides being interested in the type of system per se which a doctor preferred, the researcher was interested in determining what level of government power over the system's

operation was implied. Under each component at least one alternative approach implying strong, moderate or weak government power relative to the health professions was provided so that the doctor could choose among them.

Doctors were also asked to give reasons for their choices.

In addition to indicating the approach to each component which was preferred, doctors were also asked to state whether or not they felt that the government should implement such a system. Those doctors who were uncertain of the concept's merit or opposed the implementation of a regional health system were asked to indicate their reasons.

Section 3

This section was designed to determine the approach doctors felt that the government should take towards solving the following problems of medical care organization:

(1) high cost of the Medicare plan;

(2) unequal distribution of doctors throughout the province;

(3) oversupply of specialists as opposed to general practitioners;

(4) ineffective patterns of practice, for example, solo as opposed to group; and

(5) licensing.

These questions were included more as a point of interest than to achieve the purposes of the study as stated in Chapter I. As such their purposes and the findings are

not reported in the body of the thesis but are included as Appendix B. The original intent was to see if an index of opinions towards government could be constructed and to see if such an index might be related to regional preferences.

Section 4

To check the accuracy of classification based on CMD information, doctors were asked to self-classify their educational status, place of basic medical training, work setting and any leadership positions. Location of practice would more than likely be accurate if the questionnaire reached a doctor at the address used. In cases where the postmark on the return envelope did not correspond to the mailing address, the source of the discrepancy was checked by contacting the doctor's office. Most frequently the doctor had returned the questionnaire from his place of residence (which might, for example, be a small town on the outskirts of the large city where he practises) or while out of town for some reason.

The Pilot Test

The initial draft of the questionnaire was pilot tested, not in the usual manner by administering the questionnaire to a small sample of doctors similar in composition to the larger sample proposed. Instead it was administered to doctors on the research committee of the two Family Medical Centres in London which are teaching units for the Department of Family Medicine at the University of Western Ontario.

This approach was substituted because the researcher was assured of a good response. Further, since the doctors used in the pilot study were interested and experienced in research they could be expected to comment on the design of the questionnaire with some insight. Although not perhaps truly representative of the larger sample which was to be taken, those asked to cooperate in the pilot test would at least be similar to the larger sample by the very fact of being doctors.

Based on their criticisms, the questionnaire was revised to its final form. Brevity was stressed by the doctors in the pilot phase and the major change involved was some shortening of the schedule. For example, the section defining and explaining the purposes of regionalization was condensed and the alternatives to each of the six components of a regional system were stated in point form, rather than in a more extensive narrative.

Administration

In mid-November, those doctors included in the sample were each sent a copy of the questionnaire along with an introductory letter. A copy of the introductory letter is included as Appendix C.

The letter explained that the purpose of the questionnaire was to determine the type of regional health system a majority of doctors would prefer to see implemented in Ontario. Again the letter made no reference to the fact that three types of systems were represented in the

questionnaire or that these systems implied different levels of government involvement?

The letter assured doctors that their answers as individuals would be kept confidential so as to encourage response and frankness among those who did respond. It was pointed out that no doctor need sign the questionnaire he returned. Instead each questionnaire was numbered and a master sheet kept by the researcher matched each doctor with his code number. This sheet was available to no one but the researcher. Two reasons were given for using the code numbers. First, doctors were offered a copy of the results of the study, if they were interested. In returning the questionnaire those who wished the results were asked to indicate so at the top of the form. The code number on the form would tell the researcher who was requesting a copy. This offer was made in the hope that it would elicit a higher response by promising feedback. The second reason for the code number had to do with the method of returning the questionnaire. The doctor was offered two possibilities. If he had no questions about the study or the subject of regionalization itself, a doctor could simply return the questionnaire by mail using the self-addressed stamped envelope included and his name would be crossed off the master sheet. If, on the other hand, a doctor had questions, he could retain the questionnaire and the researcher would visit him to answer those questions and pick up the form personally. The code number would allow the researcher to

identify those doctors who had responded by mail and those who had not, presumably waiting for a personal call. It was hoped that the offer of a personal call would impress the doctors by the interest with which the researcher viewed their opinions.

The letter stated that, if the researcher had not received an answered questionnaire by December 1st, it would be assumed that the doctor had questions he wished to ask and the researcher would visit to pick up the form. By December 1st, 34.8 per cent (238) of the questionnaires had been completed and returned. Those doctors who had not returned their questionnaire were sent a reminder letter (included as Appendix D) and a second copy of the questionnaire with the same code number. The letter told doctors that, unless their answered questionnaire was received by a date specified in the letter, the researcher would visit their office on that date to pick up the form and answer their questions. A different date was set for each of the ten counties.

Another 26.7 per cent (183) of the questionnaire were completed and returned by the specified dates. As the dates arrived, the researcher phoned the office of each doctor who had not responded asking if the doctor wished to make an appointment convenient to himself to discuss the study or subject of regionalization. Only four doctors asked for a personal interview; three others held an extensive phone conversation with the researcher both asking questions and elaborating on the opinions they would express in the form.

The remainder either indicated that they did not wish to participate in the study, some giving a reason, or promised to mail in the questionnaire then. The response rate was increased by a further 4.0 per cent (26) following the phone calls to give a total rate of 65.5 per cent (447).

Prior to the phone procedure, four doctors had returned their questionnaires unanswered, stating that they did not wish to participate in the study, three giving their reasons. Of the remaining questionnaires returned all were usable as indicating the system preferred and preferences regarding other issues. Four doctors had destroyed their code numbers; four had refused to fill in the personal data, but left their code number on. Those who had destroyed their code numbers could be identified as rural/urban by the postmark on the return envelope.

Thirty-one letters were returned as wrongly addressed and four as person deceased. City directories, telephone books, and a list of doctors in the region kept by the Office of Continuing Education at the medical school were checked to determine a possible new address when appropriate. When a new address could be determined, a second effort was made to contact the doctor by mail. Efforts were usually futile, since a new address could not be found for many and new addresses found and tried for others proved still incorrect. Of the 31, only five could be traced.

Validity and Reliability

Validity

Internal Validity

The primary concerns in the construction of the questionnaire were: whether the questionnaire really measured the kind of opinions desired and whether it provided an adequate sample of those kinds of opinions. The responses of those who critically examined the content of the questionnaire (doctors in the pilot test) indicated that the instrument met these concerns. Consequently, it was believed that the questionnaire had face validity.

It was not possible to determine the construct validity of the questionnaire because of the lack of validated indices or schedules which might be used for the purposes of comparison. Therefore, the study is a test of the pragmatic utility of the questionnaire as well as an analysis of doctors' opinions concerning regionalization.

External Validity

The final response rate was 65.5 per cent (447), a comparatively high one for doctors. Table 2 shows that orthogonality of the three main background characteristics was reasonably well preserved.

Table 2: Degree to which Orthogonality of the Three Main Background Characteristics was Preserved After Allowing for Non-Response

Type of Practice	First Training							
	Native				Foreign			
	Urban		Rural		Urban		Rural	
	%	N	%	N	%	N	%	N
General	63.3	57	64.4	56	58.0	29	66.0	33
Specialty	64.4	56	64.4	56	60.0	30	74.0	37

There were at least 30 responses in each category except for foreign specialists practising in urban areas where there was 29. Conversely foreign specialists practising in rural areas had the highest response rate. The response rates for doctors in public practice and leaders respectively were 66.1 per cent (41) and 73.3 per cent (44).

The distribution of respondents was quite similar to the distribution of non-respondents on background characteristics (as Table 3 shows) and this suggests that there were no systematic biases in response patterns.

Table 3: Distribution of Respondents vs. Non-Respondents on Background Characteristics

Characteristic	Respondents %	Respondents N	Non-Respondents %	Non-Respondents N
Type of Practice				
General	48.8	218	49.8	117
Specialty	51.2	229	50.2	118
Total	100.0	447	100.0	235
Training				
Native	66.2	296	67.7	159
Foreign	33.8	151	32.3	76
Total	100.0	447	100.0	235
Practice Location				
Urban	51.2	229	54.0	127
Rural	48.8	218	46.0	108
Total	100.0	447	100.0	235
Work Setting				
Public	8.3	41	8.9	21
Private	91.7	406	91.1	214
Total	100.0	447	100.0	235
Leadership Status				
Not Leader	90.1	403	93.2	219
Leader	9.9	44	6.8	16
Total	100.0	447	100.0	235

Reliability

Extensive reliability checks were not considered feasible. Undoubtedly many doctors would consider their initial cooperation was cooperation enough. Since, however, the questionnaire had face validity, the researcher felt justified in assuming that the instrument was reliable and that doctors, had they been tested with the same instrument again at some subsequent time, would have expressed the same opinions in so far as their opinions were stable.

Summary of Methods

Using information recorded in the Canadian Medical Directory, doctors in southwestern Ontario were classified according to: official leadership status; work setting; type of practice; location of practice; and place of basic training. A stratified sample was taken.

A mailed questionnaire requested doctors to choose an approach to each of the six components of a regional system from several alternatives implying various levels of government involvement. To reiterate these components include:

(1) boundaries;
(2) size;
(3) council composition;
(4) method of selecting council members;
(5) focus of power according to the allocation of authority; and
(6) relationship between public health and hospital services.

Doctors were also asked to give reasons for their choices and

to indicate their opinions of the concept's merit. In addition, doctors were asked to indicate the general level of government involvement which they preferred in solving a variety of other health care delivery problems.

The two call-back procedure produced a final response rate of 65.5 per cent (447), with no apparent response bias.

FOOTNOTES

1 Committee on Regional Organization of the Health Services (Ontario Council of Health), Report (Toronto: Dept. of Health), 1969, pp. 35-39.

2 Personal communication, Dr. R. Aldis, Regional Medical Officer of Health (Southwestern Ontario), London, Ontario, September 1972.

3 Canada (National Dept. of Health and Welfare), Health Manpower Inventory (Ottawa: Dept. of Health and Welfare), 1972, p. 3.

4 No comparison data could be found in the literature.

5 It is recognized that a doctor might be trained in a country other than his birthplace.

6 Information given in the CMD would also have allowed the researcher to stratify according to age. When age was taken into account at once with the three main variables of type and location of practice and place of basic training, however, the number of doctors in a few of the resultant strata was reduced below twenty. Age as opposed to some other characteristic was eliminated from consideration for two reasons. First, Eckstein found that age had no bearing on British doctors' opinions on regionalization and Colombotos in the US found no relationship between age and a doctor's attitude toward government involvement in health insurance. Further, even if this study did show some relationship, age is not normally a characteristic by which

the profession is subdivided, for example, if government realized that general practitioners were less likely than specialists to see any merit in regionalization, it could easily arrange a series of meetings with the College of Family Practice to discuss the concept's merit or even contact individual general practitioners; however, if older doctors seemed less likely to see any merit in the concept, it would be difficult indeed to find a group of doctors who were naturally defined on the basis of age or classify individuals.

7

The Council of the Ontario Medical Association was contacted and asked if it would supply a short note, Xeroxed copies of which could be attached to the introductory letter, endorsing the project. It was felt that OMA support would improve chances for an adequate response rate. The Association, however, responded that as a matter of policy it did not endorse studies not initiated from within the profession.

CHAPTER V: ANALYZING THE MEDICAL PROFESSION'S OPINIONS

Uses for the Data

In line with the stated objectives of the project, it was hoped that the data gathered would allow the researcher to:

1. describe the approach to each of the six components of regionalization preferred by a majority of Ontario doctors, and the general system type most commonly preferred, with their implications for government power relative to the health professions;
2. describe the reasons which led doctors to choose the approaches to the six components of regionalization which they had;
3. describe the opinions of Ontario doctors regarding the concept's merit and the reasons given by those who doubted or denied its worth; and finally
4. identify subgroups of the profession which were more likely to choose a particular approach toward any individual component of regionalization or type of system as well as subgroups which were more likely to view the concept's merit in a particular way[1].

The Preferred System Type

First, the researcher derived a simple frequency distribution to determine which approaches to each of the six components of regionalization were preferred by a majority of Ontario doctors.

The Peripheral Issues

Ontario doctors responded to the peripheral issues much as predicted. Table 4 illustrates the proportion of doctors

who chose a particular approach to setting boundaries from the alternatives directly suggested in the questionnaire.

Table 4: Boundary Preferences

Preference Indicated	Doctors Expressing that Preference	
	%	N
The same as local government units	17.7	79
Based on consumer utilization patterns	73.8	330
"Other", e.g. variable according to local conditions or no system	3.1	14
No preference	4.5	20
Missing	.9	4
Total	100.0	447

By far a majority of doctors, 73.8 per cent, preferred that health region boundaries be "related to where people go for health services, irrespective of local government boundaries". Of those who described "other" alternatives, the majority preferred that no such system be implemented.

Table 5 illustrates the proportion of doctors who chose a particular approach to size from the alternatives directly suggested in the questionnaire.

Table 5: Size Preferences

Preference Indicated	Doctors Expressing that Preference	
	%	N
Large regions	20.1	90
Small regions	60.9	272
"Other", e.g., larger regions subdivided into districts or no system	13.4	60
No preference	4.3	19
Missing	1.3	6
Total	100.0	447

Again a rather clear majority, 60.9 per cent, favoured the designation of small regions. Of the rather considerable proportion, 13.4 per cent, who devised their own approach, more than half, 8.7 per cent, suggested larger regions subdivided into districts, an approach which also implies the use of small basic health units. A small percentage, 2.5 per cent, suggested again that no such system should be implemented.

Table 6 illustrates the proportion of doctors who chose a particular relationship for public health and hospital services from the alternatives directly suggested in the questionnaire.

Table 6: Preferences Regarding the Relationship of Public Health and Hospital Services

Preference Indicated	Doctors Expressing that Preference	
	%	N
Joint planning and coordination of these two types of service	79.2	354
Treatment services organized separately	12.1	54
"Other", e.g., no system	3.6	16
No preference	2.2	10
Missing	2.9	13
Total	100.0	447

A clear majority, 79.2 per cent, felt that public health and hospital services should be jointly planned and coordinated. Of those who suggested an "other" alternative, it was virtually always that no such system as regionalization be set up.

The Key Issues

Once again doctors responded to these issues much as predicted.

Table 7 illustrates the proportion of doctors who chose a particular approach to council composition from the alternatives directly suggested in the questionnaire.

Table 7: Council Composition Preferences

Preference Indicated	Doctors Expressing that Preference	
	%	N
Dominated by provincial government representatives	1.1	5
Dominated by local government representatives	0.0	0
Dominated by doctors	12.3	55
Dominated by health professionals (including doctors)	56.8	254
Dominated by consumers	1.6	7
"Other", e.g. no majority but a balance of all these types, or no system	25.5	114
No preference	1.8	8
Missing	.9	4
Total	100.0	447

A slight majority, 56.8 per cent, preferred that health councils be dominated by a diversified group of health professionals. Added to this, 12.3 per cent, preferred that doctors dominate the health councils, to make a total of 69.1 per cent, who favoured domination by health professionals of some kind as opposed to government or consumer representatives. Those who devised "other" approaches primarily suggested that no group should hold a majority, but that representatives from the various segments be balanced. A small percentage once again suggested that no such system be implemented.

Table 8 illustrates the proportion of doctors who chose a particular approach to method of selecting representatives from alternatives directly suggested in the questionnaire.

Table 8: Method of Selection Preferences

Preference Indicated	Doctors Expressing that Preference	
	%	N
Appointed by the provincial government (without consultation)	2.9	13
Appointed by the local governments (without consultation)	3.8	17
Selected by the groups they represent	70.2	314
Directly elected	3.4	15
"Other", e.g. nominated by groups, government appointed or no system	16.8	75
No preference	1.8	9
Missing	1.1	5
Total	100.0	447

A clear majority, 70.2 per cent, preferred that the groups to be represented choose their own representatives to serve on the health councils. Of the 16.8 per cent who suggested other alternatives, the most popular by far was the suggestion that government appoint group representatives from among lists of nominees submitted by those groups. As

before, a small percentage refused to support any such system.

Table 9 illustrates the proportion of doctors who chose a particular approach to dividing authority from the alternatives directly suggested in the questionnaire.

Table 9: Division of Authority Preferences

Preferences Indicated	Doctors Expressing that Preference	
	%	N
Centralized to the provincial level	15.2	68
Shared between the province and lower tier councils	58.6	262
Decentralized to local health councils	17.7	79
"Other", e.g. no such system	3.8	17
No preference	1.6	7
Missing	3.1	7
Total	100.0	447

A slight majority, 58.6 per cent, preferred that authority be shared by the province and lower tier health councils, while about equal proportions, 15.2 per cent and 17.7 per cent, preferred centralization or decentralization of authority respectively. Very few "other" approaches were suggested. A few doctors disapproved of any system, while

others favoured some form of decentralization other than the specific one suggested.

The Overview: Implications for Government Power

As a group then, doctors described the following type of system as preferred. A system in which:

(1) boundaries were drawn according to consumer utilization patterns;

(2) small basic health units were designated;

(3) all health services were jointly planned and coordinated by one set of councils;

(4) health professionals (a diversified group or doctors alone) would dominate the health councils;

(5) groups would select their own representatives; and

(6) authority would be shared between the Province and lower tier health councils (with then at least partial decentralization of executive authority).

On the balance, a majority of Ontario doctors (taken as a group) indicated that they prefer a system which implied moderate government power... a system more like the one suggested by the Ontario Council of Health than by the Ministry -- mainly by virtue of the preference for partially decentralized responsibility.

Another way of analyzing doctor preferences for any one type of system is to cross tabulate the approaches suggested to the six components of regionalization and to determine how many actual systems were described, what proportions would fall into each of the three general categories according to government power, and what proportion of doctors voted for a system falling into each of three categories.

To analyze the data in this way the researcher assigned a score for each component of regionalization according to the approach preferred — a score of 1 if the approach promised to contribute to a system implying strong government power, 2 if the approach implied moderate government power, 3 if the approach chosen promised to contribute to a system implying weak government power (0 given for no preference). The coding procedure used is included in Appendix E.

In all, 97 actual systems were described by the 377 doctors who described a complete system; 70 doctors who responded had left one or more of the six items unanswered. Each system was assigned an overall score for government power taking the mode score on the individual six items.

Table 10 illustrates the proportion of actual systems described falling into each of the three categories of government power and the proportion of doctors who described such a system.

Table 10: System Type Preferences (All Issues)

Government Power Implied	Systems Described		Doctors Describing that System	
	%	N	%	N
High	20.6	20	16.5	62
Moderate	57.8	57	66.5	251
Low	20.6	20	17.0	64
Total	100.0	20	100.0	377

A majority of doctors preferred a system which seems to imply moderate government power.

The mode score of the six items taken together, however, could be misleading, since doctors tended to be more liberal on the peripheral issues than on the key issues. Although a majority recommended consumer utilization patterns for use in defining boundaries, they did recommend small basic health units and the joint planning and coordination of public health and hospital services by one set of councils. If the three peripheral issues were disregarded and the key issues considered, a different picture emerges. While a majority did express a preference for share authority, doctors stressed that lower tier councils should be dominated by health professionals selected by the groups they were to represent. The former issue then is resolved with a moderate bent, while solutions to the latter two lean towards a weak government power system type.

In light of this possible distortion when all components were considered, the score for the three key issues (council composition, method of selection and division of authority) were considered separately. Table 11 shows the results. A total of 19 systems were described[3] by 408 respondents; 39 had left at least one of the three items blank.

Table 11: Preferred System Type (Key Issues Only)

System Type	Actual System Described		Doctors Describing Each	
	%	N	%	N
Strong government power	10.5	2	.9	4
Moderate government power	52.6	10	30.6	125
Weak government power	36.9	7	68.5	279
Total	100.0	19	100.0	408

The two approaches to analysis give different pictures. Probably the results of the first (when considering all six items) should be paid more attention when implications for government power are being considered. While the peripheral issues are not as important as the key issues in defining immediate government power, the approach taken to them has a great deal to do with setting the stage for change. For example, the government might eventually wish to give local government control over health services. If it starts by defining health regions which do not correspond to local government units, it will later not only have to transfer control to local government councils, but at the same time disrupt services by changing boundaries and this might have to be done in two stages to accustom doctors. If, on the other hand, health boundaries had always been the same as local government units only one step would be required. In

case the Ontario government should ever wish to evolve the province's regional health system into one implying strong government power, potential for change may be as important as the initial design in terms of the development of the system.

Inferring Doctors' Attitudes Toward Government from the Preferred System Type

However, if one were interested in inferring what level of government involvement a majority of doctors would prefer in the immediate system, the second approach to analysis (key issues only) might be more revealing. Certainly the implications for government power inherent in the alternative approaches offered for the issues of council composition and method of selection should be more clear to doctors than the implications of alternatives provided for the three peripheral issues. The clarity of focus of power would depend to a certain extent on how effectively any doctor could link his choice here to his choices on the other two issues. For example, decentralization enhances government power only when government officials control, or are at least balanced with health professionals, on the lower tier councils. If health professionals were in control, then decentralization would enhance their influence. Certainly the OMA-OHA policy statement indicates that the leadership of the medical profession is aware of focus of power implications as they relate to council composition and method of selection[4].

Since the researcher has no measure of construct validity, however, any conclusion about doctors' attitudes towards government involvement in regionalization based on the findings of this study would have to be very tentative. The conclusion would be, of course, that doctors prefer to minimize government power over the implemented regional system's operation for one reason or another.

Using the IALIK programme, an attempt was made to scale both the six items and the three key ones. The R for each attempt respectively was .29 and .07. The results of this test tend to indicate that there is no common dimension underlying doctors' preferences; that is, individual doctors did not appear to pick alternatives which implied a consistent level of government power. At least two reasons might be suggested to explain the absence of a common dimension.

First, while individual doctors might have a set attitude as to what level of government involvement in the health care delivery system is appropriate, they may not have understood the implications of the alternatives provided under each of the six components well enough to express that attitude consistently.

Second, individual doctors may judge each alternative to an item on its own merit according to such variable criteria as patient welfare, organizational effectiveness and professional autonomy rather than on the single criterion of how much government power <u>per se</u> over the health care delivery system's operation is in their own opinion appropriate.

The reasons which doctors gave tend to support this latter conclusion as did their responses to the other issues about which they were questioned (see Appendix B).

Reasoning Behind Doctors' Preferences

After analyzing the written reasons, it appeared that three categories closely resembling the three named by Blishen could indeed be used for classifying doctors' reasons for choosing a particular approach to any of the six components of regionalization. A segment of the physicians surveyed was clearly concerned with protecting the profession's autonomy from encroaching government power, and the reasons could be labeled accordingly. The other two categories, however, could not be directly related to Blishen's, remaining categories, individual freedom and quality of care. Slightly different headings seemed more appropriate.

Under freedom, Blishen discussed both patient and physician freedom. Many doctors in giving their reasons for certain choices stressed the importance of freedom of choice for the patient. Freedom for the physician was termed for the patient's benefit, not the doctor's. For example, an answer might include the assertion that the basic freedom of the patient would be interfered with were his doctor confined to specific referral channels. Physician's also seemed to be concerned for other aspects of the patient's welfare, for example, the importance to the patient of comprehensive care which would be enhanced by joint planning

and coordination of public health and treatment services. At first, such an answer might seem to be more appropriate under a quality category. It does mention the patient directly, however, whereas an apparent third set of reasons were concerned with quality of care in an indirect manner. Physicians would state, for example, that "small basic health units encompassing a manageable number of services would be easier to handle". Presumably, because the number of services would be less, planning and coordination would be more effective and indirectly patients would benefit. Such an argument does not directly mention the patient's welfare; rather it implies that the system which will "work best" would result in quality care for the patient.

The researcher decided to substitute Blishen's freedom category with a broader one called patient welfare. Any reason for a choice which directly stated that an alternative was in the patient's best interest was classified under this heading. These included any assertion of the patient's right to choose his own doctor or the facilities he would like to attend without restriction and any assertion that this basic freedom would be interfered with if the doctor were confined to set referral channels.

A third category was labeled organizational effectiveness. This label was suggested by the profession's repeated reference to the approach that would "work best" or "achieve the goals of regionalization". This category seemed to correspond relatively well to Blishen's quality category, with

the inherent assumption that one of the measures of organizational effectiveness would be the quality of care delivered under the system.

Approximately one-third, or 167 doctors, gave reasons for their choices for each of the six components. The distribution of preferred approaches to each of the six items was similar for both those who gave their reasons and those who did not. In terms of background characteristics, respondents who gave their reasons were similar to those who did not. Exact information on the comparisons is provided as Appendix F. These two comparisons suggest that the reasoning of these 167 doctors should represent the reasoning of all those surveyed.

The Peripheral Issues

Concern for patient welfare seemed to be the prime consideration when doctors were choosing approaches to any of the peripheral issues.

Regardless of their preference for boundaries, 71.0 per cent of the doctors who gave their reasons expressed a concern for patient welfare, 22.8 per cent a concern for organizational effectiveness and only 6.2 per cent an interest in protecting the profession's autonomy.

The reason for choosing consumer utilization patterns as the basis on which boundaries should be drawn was oriented towards a concern for the patient's freedom of choice, coupled with a belief that local government units do not

necessarily encompass the services which individuals customarily use. Of that minority of doctors who had stated a preference for local government boundaries, most did so out of a concern for organizational effectiveness, their reasons, included that: "some common area should be used for planning and coordinating all services and this is the most convenient"; "such an approach would facilitate the inclusion of local government officials who are more attuned to local needs than the province"; and "this approach would stimulate community interest and achieve the goodwill of local government".

As for size, the reasons for choosing either large or small basic health units were about equally related to the concern for patient welfare (41.3 per cent) and the concern for organizational effectiveness (51.8 per cent). With this item it became clear for the first time that two doctors could advocate different approaches and still base their choice on the same type of reason. For example, one doctor might choose to advocate large basic health units because this would "minimize duplication", whereas, another doctor might choose small basic units because they would be "easier to administer". Each doctor, therefore, would be expressing a concern for the system's effective operation, but each would regard his own choice as the most appropriate approach. A small percentage, 6.9 per cent, expressed a desire to protect the profession's autonomy in choosing one or the other approach.

Patient concern was by far the overriding reason where the possible relationship between public health and hospital services was confronted. A clear majority of doctors felt that the public health and hospital services should be jointly planned and coordinated, stressing the importance of comprehensive care to the patient's welfare. Regardless of preference, however, 73.8 per cent explained their choice in terms of a concern for patient welfare, while small percentages, 14.1 per cent and 12.1 per cent respectively, were concerned with organizational effectiveness and protecting professional autonomy.

The Key Issues

Concern for organizational effectiveness seemed to be the prime concern when doctors were choosing approaches to any of the key issues.

It was by far the prime concern with the issue of council composition, as 74.3 per cent of the doctors giving their reasons gave this reason, regardless of the alternative they chose. In one form or another, doctors repeatedly expressed the importance of using the approach which would "work best". Those who felt government officials should dominate recognized, for example, that "these representatives might have a better conception of financial realities than health professionals". Those who felt there should be no majority, but a balance of representatives from government and the professions, believed, for example, that this would

"promote a spirit of cooperation between the two groups represented" or would "ensure that depending upon the type of decision to be made, financial or service, there would be adequate representation from the group most suited to assess the problem". Other doctors who felt that health professionals should dominate believed, for example, that "health professionals would be better able to make decisions about planning and coordination, since they were intimately familiar with the system's internal network of programmes and facilities, by virtue of their day-to-day contact with it". A significant minority, 20.1 per cent, chose on the basis of a concern for professional autonomy ("too much government regimentation implied if officials control the councils" or "health professions have traditionally been the organizing force and should remain so"), while only 5.6 per cent backed their choice in terms of patient welfare.

Organizational effectiveness was by far the overriding consideration with the issue of selection as well. A clear majority had chosen the approach that groups select their own representatives. The reason usually given was that these groups were "in a better position than any one to judge the relative capabilities of possible representatives". Regardless of their preference, 87.5 per cent expressed a concern for organizational effectiveness, 8.2 per cent a concern to protect the profession's autonomy and 4.3 per cent for patient welfare.

Organizational effectiveness was again the prime concern

in relation to the issue of power focus. Although doctors were rather widely split on the approach that should be taken, most (95.5 per cent) backed their choice with a concern for organizational effectiveness. Those who felt decision making should be centralized believed, for example, that this would "ensure standardization across the province". Others who preferred partial decentralization felt, for example, that "this approach would ensure uniformity without emasculating the lower tier councils which were bound to know the needs of their areas better than the Province". Finally, doctors who advocated decentralization did so, for example, because this would "cut down the bureaucractic channels which specific decisions would have to go through" or "ensure that people who understood the area were in control". A slight 4.5 per cent backed their choice by expressing a concern to protect the profession's autonomy.

Doctors appear inclined to place concern for the patient and concern for organizational effectiveness over a concern to protect the profession from any loss of autonomy at the hands of government. While for each item some doctors chose an alternative limiting government power and cited their reason to be protection of the profession's traditional independence, their numbers were very few (usually less than 10 per cent). Noticeably, however, those alternatives which doctors were inclined to put forward as contributory to patient welfare and organizationally effective tend to include those which do not give full reign to government.

The question arises whether doctors are interested in protecting the profession's traditional independence from government encroachment, but are unwilling to blatantly express this protectionism and so disguise it behind reasons which ostensibly fit into other categories. This is, of course, a possibility. Two explanations for such a ruse might be fear of government repercussions or desire to avoid censure from the researcher.

It seems unlikely that any doctors responding were afraid of some repercussion from government if their reasons betrayed a concern for professional autonomy. Each doctor was promised that his answers as an individual would remain confidential. It was pointed out that the project was not government sponsored, but a private research project. Furthermore, doctors who might fear such repercussions certainly had either the option of not participating in the study at all or of leaving the open-ended questions on their reasons for any particular choice unanswered.

Some doctors might have felt slightly embarrassed to give reasons for their choices which the researcher could have judged as more "selfish". This too seems unlikely, since most neither knew, nor probably considered that they would ever encounter, the researcher.

There are at least three alternative possibilities why doctors might have backed their choices with arguments of patient welfare and organizational effectiveness. First, any doctor might not understand the underlying implications,

of the various approaches to each component, for government power and their possible consequent effects on the profession's status. Or members of the profession may honestly feel that the approaches which happen to imply maximum government power are not the most effective ones or in the best interests of the patient. Finally, it may be that this is a specific time when the three concerns are not in the overview order which Blishen calculated. Blishen did find that, from the Second World War on, these three concerns were given varying emphasis during clearly distinguishable time periods. During the last period which Blishen examined, that is, 1965, concerns for freedom and quality of care had both taken precedence over an expressed desire to protect the profession against encroaching government power.

The Concept's Merit

Doctors' Opinions

Table 12 shows the distribution of answers to the question: "Should the government attempt to organize the health care delivery system's operation through regionalization?"

Table 12: Opinions of the Concept's Merit

Opinion of the Government's Plan to Implement Health	Doctors Expressing that Opinion	
	%	N
Favour the plan	43.0	192
Uncertain as to whether the government should develop such a system	32.9	147
Opposed to the plan	23.3	104
Missing	.9	4
Total	100.0	447

As predicted, there was no overwhelming majority in favour and considerable uncertainty.

Reasons for Doctors' Opinions

As predicted, the reasons given by those who were uncertain about, or opposed to, the government's plan to implement health regionalization stressed either that there was no concrete evidence of the concept's merit or that it would unsatisfactorily involve government in the health care delivery system's operation.

Table 13 shows with what frequency doctors who were uncertain or opposed to regionalization gave each of these reasons.

Table 13: Reasons for Uncertainty or for Negative Opinions

Type of Reason Given	Doctors Expressing that Reason	
	%	N
Insufficient evidence that such a system would improve health care delivery	26.8	22
Unsatisfactory government involvement in the health care delivery system's operation	73.2	60
Total	100.0	82

Among those giving reasons, concern over unsatisfactory government involvement seemed pre-eminent. As might be expected, however, government involvement was accused of being detrimental either to the patient's welfare ("only health professionals are qualified to make, in the patient's best interest, the kind of decisions that would be involved"), or detrimental to the health care delivery system's effective operation, ("government involvement would make a bureaucratic nightmare out of this facet of the delivery system's operation"). A threat to professional autonomy was rarely mentioned. However, only 82 doctors gave reasons for their opinions so that any conclusion based on this evidence must be quite tentative.

Subgroup Characteristics

To determine how accurately doctors had been classified on background characteristics using the CMD classification system, the CMD classification for each characteristic was compared with self-classification. There was less than three per cent disagreement on the number of doctors who should have been classified one way or the other according to type of practice and place of basic training. According to self-classification, more doctors appeared in public practice than according to the CMD classification. Appendix G shows the comparison on these grounds. Internal agreement was also good on type of practice and place of basic training (comparisons are shown in Appendix H). As Table 14 shows, however, internal agreement was not particularly good for work setting. Many of those doctors who had been classified as private according to the CMD actually claimed to spend most of their time in public practice and vice versa. This was probably due to the inadequacy of the criterion (mailing address) used by the researcher to classify from the CMD[5].

Table 14: Internal Agreement on Work Setting (CMD vs. Self-classification)

CMD Classification	N / %	Self-classification	
		Private	Public
Private		364 91.0	36 9.0
Public		7 17.5	33 82.5

Table 15 shows that a considerably higher proportion of doctors classified themselves as leaders than the researcher had through the variety of sources used to pre-classify doctors on this characteristic.

Table 15: CMD vs. Self-classification on Leadership Status (Proportion classified as belonging to one or the other side of the dichotomy)

	CMD Classification		Self-Classification	
	%	N	%	N
Not leaders	90.1	403	50.6	224
Leaders	9.9	44	49.4	119
Total	100.0	447	100.0	443

Correspondingly, as Table 16 shows, internal consistency was disrupted.

Table 16: Internal Agreement on Leadership Status (CMD vs. Self-classification)

CMD Classification	N %	Self-classification	
		Not Leaders	Leaders
Not leaders		220 54.1	187 45.9
Leaders		5 13.5	32 86.5

The researcher had felt that the percentage pre-classified as leaders might be an underestimate of the

number of doctors who held leadership positions in any one year, because it had been impossible to identify all doctors who, according to the definition of leadership, held such a role. It seems unlikely, however, that the self-classification is anything but an overestimate. The overestimate is probably due to a fault in the questionnaire. The question on leadership read:

> "Check if in the last five years, you have: held any office in a professional organization; represented a hospital medical staff; sat on the board of governors of a hospital or medical foundation like PSI; been on a government committee studying medical care issues like the Ontario Council of Health; or held elected political office."

The five year limit was stipulated in the belief that such positions would not have a rapid turnover. Expecting some turnover, however, it was hoped that a time period of several years would catch those who might have been in office at the time when classified through the CMD or other sources, but subsequently retired. From the result one might conclude, however, that at least some of the positions stipulated have a rapid turnover. A better way to asking this question would probably have been: "In 1971-72, did you hold.....". Or, if there is not much turnover in any of these positions, one might alternatively conclude that the examples were given in too broad terms and that more doctors consider themselves to hold leadership positions than would actually have been so classified by the researcher. For example, "represented a hospital medical staff" was meant to be taken as chief-of-staff. Representatives on tissue

committees, etc., however, may have classified themselves as leaders on this broad category, whereas, the researcher was only interested in "politically" important positions.

In light of discrepancies, the question arose as to whether the CMD or the self-classification should be used in examining the relationship of subgroup characteristics to opinions. With the exception of leadership, the number of doctors who were classified one way or the other under each subgroup heading irregardless of CMD or self-classification was quite similar. Consequently, it was felt that, even if the self-classification was used in studying the relationships, it would still be possible to generalize with confidence to the reference population. Internal agreement was felt to be the more important issue and since the self-classification was likely to be more accurate, it was chosen for use in studying the relationship between the three characteristics, type of practice, work setting and place of basic training, and doctors' opinions. Since the self-classification on leadership might be a gross overestimate, if the high proportion of leaders could be traced to misinterpretation of the examples rather than rapid turnover, it was decided to use the pre-classification (CMD) for this characteristic.

Leadership vs. the "Rank and File"

Leaders of the profession were no more likely than "rank and file" members to:

1. prefer a particular type of regional health system, in terms of its implications for government power.
2. view the concept's merit in a particular way.

Leaders were no more likely than the "rank and file" to choose a particular approach to any of the six components of regionalization, except for their choice of an alternative approach to drawing boundaries (as shown in Table 17 below). Leaders were more inclined to emphasize using consumer utilization patterns as the basis for drawing regional boundaries then the "rank and file"[7]. If a concern to limit government power plays any role at all in a doctor's choice of alternatives, it may be that the Ontario leadership is more aware of the subtle implications of using local government boundaries.

Table 17: Association between Leadership Status and Boundary Preferences

Approach Chosen	Leader		Not Leader	
	%	N	%	N
Local government boundaries	5.6	2	18.9	77
Consumer utilization patterns	94.4	34	72.7	296
"Other", e.g., no such system	0.0	0	3.4	14
No preference	0.0	0	5.0	20
Total	100.0	36	100.0	387

$x^2 = 8.41$, 3 df, $P < .05$

One might then conclude that official leaders of the

Ontario medical profession essentially reflect the opinions of the "rank and file" on the issue of regionalization at least[8]. Either "backstage" leaders then are not more conservative than the profession's official ones or if "backstage" leaders are more conservative, they do not apparently attempt to exercise influence through the formal power structure of the medical community.

Work Setting

While doctors in public practice were no more likely than those in private practice to choose a particular approach to any of the six components of a regional health system, they were inclined to:

1. prefer a system type which gave greater power to government than were their counterparts in private practice (as Table 18 below shows); and
2. view the implementation of such a system more favourably than private practitioners (as Table 19 shows).

Table 18: Association between Work Setting and System Type Preferred

Approach Chosen (according to government power)	Public %	Public N	Private %	Private N
High	14.1	9	18.2	65
Moderate	78.1	50	63.0	225
Low	7.8	5	18.8	67
Total	100.0	64	100.0	357

$\chi^2 = 6.23$, 2 df, $P < .05$

Table 19: Association between Work Setting and Opinions of the Concept's Merit

Opinion of whether the government should implement such a system	Public %	Public N	Private %	Private N
Yes	69.7	46	39.0	145
Uncertain	25.8	17	34.0	126
No	4.5	3	27.0	100
Total	100.0	66	100.0	361

$x^2 = 25.10$, 2 df, $P < .01$

Thus, the prediction made in the second chapter that doctors in public practice would be less conservative than those in private practice was borne out[9].

Type of Practice

Specialists were no more likely than general practitioners to:

1. choose a particular approach to any of the six components of a regional health system;
2. prefer a particular type of regional system, in terms of its implications for government power; or
3. view the concept's merit in a particular way[10].

Location of Practice

Location of practice (urban/rural) appeared related to any doctor's opinions on health regionalization, when neither type of practice nor place of basic training were controlled for. While rural doctors were no more likely than urban

doctors to choose a particular approach to any of the individual components of a regional health system they appeared to:

1. prefer a system type implying more government power; and
2. regard regionalization less favourably.

When controlled for practice and training respectively, however, these relationships held only if a doctor were in general practice and native-trained. In light of the fact that neither practice nor training appeared themselves related to a doctor's opinions, it seems inconsistent that controlling for these characteristics should affect the relationship between location of practice and opinions. The finding though is consistent with the fact that, when a possible relationship between practice or training and opinions was examined controlling for the two remaining characteristics in each case, several such one-sided relationships were found. For example, specialists appeared to view the concept more favourably than general practitioners, but only if they were native-trained. The meaning of these several intricate, one-sided relationships was not immediately clear to the researcher.

It may be of interest to note that the relationship between location of practice and doctors' opinions of the concept's merit, when the other two variables were not controlled for, ran in the same direction as one might have predicted from the literature; on the other hand, the relationship between location of practice and level of

government involvement in regionalization implied by system preference ran in exactly the opposite direction.

Place of Basic Training

Foreign-trained doctors did not appear any more likely than native-trained ones to:

1. choose a particular approach to any of the six components of a regional health system;
2. prefer a particular type of regional system, in terms of its implications for government power; or
3. view the concept's merit in a particular way[11].

It might be noted again that nativity was not one of Colombotos' intentional variables and the study was not designed to test for a relationship between nativity and attitude towards Medicare. Further, it must be considered that the method of payment issue might have a different significance for doctors. In addition, Colombotos was comparing the attitudes of foreign-born doctors with those of American ones. American doctors may be more conservative than Canadian ones so that a study comparing foreign-trained and Canadian-trained doctors might not find such a dichotomy.

At any rate, findings of this study indicate that the steady flow of foreign-trained doctors into Ontario is neither likely to harm nor help any regional system's chances.

One might conclude from this study that leaders of the Ontario medical profession essentially reflect the opinions of the "rank and file" and with the exception of work setting,

doctors cannot be distinguished from one another according to such obvious subgroupings as type of practice, location of practice or place of training.

Generalizations

Any generalization to the medical profession of Ontario as a whole, as far as opinions on regionalization go, would have to be based on the assumption that the opinions of doctors in southwestern Ontario are typical of those in other areas of the province. It seems likely that this would be a reasonable assumption. The design preferred by a majority of doctors as sampled from southwestern Ontario in spirit parallels the one suggested by the OMA in conjunction with the OHA. An examination of the OMA executive reveals it to be representative of the province in terms of geographic origin of members. It seems rather unlikely then that the OMA council would accurately reflect the opinions of doctors in southwestern Ontario, but not the opinions of doctors in other areas of the province.

If the opinions can be generalized, then it seems logical to assume that the reasons given for those opinions by doctors in southwestern Ontario could be generalized as well. Similarly generalizations about the relationship between the background characteristics in question and opinions on regionalization should be possible.

FOOTNOTES

[1] All computations were done using university computer facilities. With the exception of one IALIK programme (Item Analysis and Total Correlation Analysis - Likert Scale), SPSS programmes (Statistical Package for the Social Sciences) were used in analyzing the data.

[2] From a possible total of 729 (six items with three alternatives each).

[3] Of a possible 27 (three alternatives with each of the three items).

[4] London Free Press report of the OMA-OHA policy statement, May 7, 1973, p. 4.

[5] It is interesting to note that at least one of the relationships between work setting and a doctor's opinions on regionalizations which was found, was found only using the self-classification. In regards to the other background variables, similar relationships were found regardless of the classification used.

[6] Four missing who destroyed their code numbers and, therefore, could not be matched with their CMD classifications.

[7] An attempt was made to determine whether it would be feasible to control this relationship for the remaining background characteristics. Cross-tabulations revealed, however, that under the "Leaders" category, the other dichotomies were too disproportionate, e.g., virtually all of the leaders were in practice privately as opposed to being in public practice.

[8] As noted, no different picture appeared using the self-classification.

[9] For the same reason as with leadership, these relationships could not be controlled for the remaining background characteristics. Using the CMD classification, no relationship appeared between work setting and type of system. However, the same relationship between work setting and opinion of the concept's merit was evident.

[10] As noted, no relationships appeared when CMD classification used.

[11] No relationships appeared when CMD classification used.

CHAPTER VI: SUMMARY AND CONCLUSIONS

Review of Objectives

The provincial government is currently considering the implementation of a regional health system in Ontario. Physicians can be expected to play a critical role in the implementation of regionalization, since their opposition could threaten the organization's viability. A primary source of the potential opposition is the increased role for government in health care delivery implicit in regionalization. Regionalization may imply more or less government power, however, depending on the system's actual design. Within a broad conceptual framework, the individual components of a regional health system can be altered to create variations in government power. The six individual components include:

(1) the actual boundaries to be used for regions;

(2) an average size for the regions;

(3) the composition of the regional councils, and district councils if the regions are to be subdivided;

(4) a method of selecting council members;

(5) an appropriate division of authority between central and lower tiers; and

(6) the relationship to be assumed between public health and hospital services.

The main purpose of this study was to determine Ontario physicians' opinions about alternative approaches to health regionalization which indicate varying degrees of government power. Secondary purposes were to determine the reasons for

their preferences, their general opinion of the concept's merit and whether several background characteristics, including official leadership status, work setting, type and location of practice and place of basic training, were related to physicians' opinions.

In the following sections, the findings are summarized and their implications for public policy discussed.

Review of the Findings

In this section, the Ontario medical profession's opinions on regionalization are reviewed.

The Preferred System Type

As a group, the majority of Ontario physicians preferred a regional health system in which:

(1) regional (and district) boundaries would be based on consumer utilization patterns;

(2) regions would either be small themselves or large but divided into districts;

(3) lower tier councils, like the regional and district ones, would be structured so that health professionals held a majority of seats;

(4) the groups involved would select their own representatives;

(5) authority would be partially decentralized; and

(6) public health and treatment services would be jointly planned and coordinated by this set of councils.

The concensus of opinion on each issue was noteworthy.

The majority of doctors preferred a regional system which, on balance, implies moderate government power relative to the health professions.

Reasons Behind Doctors' Preferences

In making their choices, doctors expressed three concerns, about the implications of various alternatives for:

(1) the patient's welfare, including his freedom to use the doctors and facilities he might prefer and his primary physician's freedom to refer him accordingly;

(2) the system's ability to improve the quality of health care by improving availability and accessability, or what the doctors loosely termed "organizational effectiveness"; and

(3) professional autonomy.

Concern for patient welfare seemed to be the prime consideration when doctors were choosing approaches to the peripheral issues (boundaries, size and relationship between public health and treatment services). On the other hand, concern for organizational effectiveness seemed to take precedence when doctors were choosing approaches to the key issues (council composition, method of selection and focus of power). Concern for professional autonomy was infrequently expressed.

The Concept's Merit

While a substantial segment, 43.0 per cent, of the doctors appeared to favour the government's plan to implement formal regionalization, there is considerable uncertainty about, and some opposition to, the concept. These doubts appear to be based on the suspicions that regionalization cannot actually achieve its goals and that it will reduce the health care delivery system to a bureaucratic nightmare.

Relationship Between Background Characteristics and Opinions

A review of pertinent literature tended to indicate that certain objective background characteristics, such as official leadership status, work setting, type and location of practice and place of basic training, might be related to the physician's opinions on regionalization. The findings generally did not bear this out, except that doctors in public practice were likely to prefer a system implying more government power and were more favourably disposed to the concept of regionalization than were doctors in private practice.

The degree of consensus in opinions suggests that the province will have to take the doctors' opinions into consideration, if a formal regional system is to be implemented. In the next section, the implications of the findings for government health policy are explored.

Implications of the Findings for Public Policy

First, the implications of the system preferred by physicians for possible acceptance of two plans which have been suggested for Ontario, will be considered. Second, possible approaches which the provincial government might take in negotiations with the medical profession will be discussed, taking into consideration concerns expressed by the medical profession. Third, possible steps which the government might take to improve the concept's image will be

suggested. Last, the implications of non-differing subgroup opinions for the provincial government's efforts to gain acceptance of the concept or a particular design will be considered.

Implications of the Preferred System for Acceptance of Provincial Plans

The actual system described by a majority of Ontario physicians more closely resembles the Council of Health's than the Ministry's, especially by virtue of its preference for shared responsibility. Although a majority felt that region and district boundaries should be based on consumer utilization patterns as the Ministry recommended, doctors generally approved the Council's idea of joint planning and coordination for all kinds of health service under one set of councils and agreed with the importance of at least partial decentralization of executive authority. As both the Council of Health and the Ministry had anticipated, a majority of doctors preferred health councils on which a majority of the positions would be held by health professionals whose organizations had had some say in who specifically would represent them. In addition, a majority preferred small basic health units.

The doctors responses are close in spirit to the views of the Ontario Medical Association and the Ontario Hospital Association which were recently expressed in a joint policy statement to the Minister.

In light of the findings of this study and the OMA-OHA policy statement, doctors in Ontario might be expected to approve implementation of the Council's scheme, once the possible differences over boundary criteria were resolved.

If the principle of health districts boundaries coinciding with municipal boundaries were abandoned, it would be difficult for the Council's plan to be implemented. First, the inclusion of local government representatives would be complicated. Second, there would be some disruption of public health services, if their boundaries had to be changed in accordance with the newly drawn health districts.

Doctors who chose consumer utilization patterns over municipal boundaries suggested that the two did not correspond and that consumers should not be expected to alter their patterns. The consumer patterns are most likely to coincide with municipal boundaries in the larger urban centres which offer a range of municipal services. The problem arises in the smaller centres which would have to be organized into a tiered system in order to have access to a full complement of services[1].

The new regional governments being formed by the Ontario government have had their boundaries based on studies of consumer utilization patterns[2]. There is some evidence to suggest that health utilization patterns tend to coincide with other patterns of consumer utilization, economic and social[3], so that health district boundaries could correspond to regional government boundaries with minimal difficulties.

The problem then is how to group the population in the smaller municipalities into districts and then regions with minimal disruption of consumer habits. It is recognized that informal regional systems for medical services have emerged in Ontario. For the most part the regions centre around the five university health sciences centres and tend to include whole counties [4].

With such evidence in hand it might be possible to persuade doctors to accept regions and districts based on municipal boundaries. The main problem would be satisfying doctors about the municipalities which might border two districts or regions, where the consumer may be inclined to go to two or more centres for specialized services. However, this would be a problem in either type of regional system.

Regions and districts might be devised on municipal boundaries with the proviso that individuals may cross over the boundaries when necessary or desirable. This proviso should answer the main concern of doctors who favour the consumer utilization patterns. The Council of Health's plan for regionalization should then be acceptable to a majority of physicians, even preferable to the Ministry's.

The acceptability of the Ministry's plan is probably also assured, providing the provincial government can persuade the medical profession that district councils on which health professionals are to be substantially represented will, although officially advisory, carry considerable weight in final decisions made at the provincial level. This

persuasion should be important whether it plays to a genuine concern for organizational effectiveness, as suggested by doctors' reasons for preferring some guarantee of such influence, or to a covert desire to protect the profession's autonomy. The Ministry's plan has the advantage of suggesting consumer utilization patterns as the basis on which boundaries should be drawn, ostensibly regardless of whether this would imply some municipal dissection. It also covers the relationship between public health and treatment services by recommending at least some form of ad hoc coordination of the two.

Choosing Between Two Acceptable Plans

Since both plans seem acceptable, a choice between them may rest on other factors. One factor which might be considered is the degree of decentralization offered by each. Under the Council's scheme authority would be partially decentralized to the regional tier, one-third of whose membership would be district tier councillors. According to the Ministry's plan, district councils would be only advisory and the regional tier would consist of an Area Coordinator, a provincial civil servant. For achieving decentralization then, the Council of Health's plan would probably be preferable to the Ministry's.

Another factor which might be considered is each design's potential to improve delivery while cutting costs. Apparently in an effort to learn from the successes and failures of

other countries, the Council of Health studied regional systems operating throughout the world. Unfortunately, it is nearly impossible to determine which regional system is "best" from this type of analysis. The limitations on such an analysis are:

(1) We lack sufficiently sensitive indicators to demonstrate the relative efficacy of varying regional programmes upon the health of a society. One cannot determine if a specific type of regional system leads to better health care than another system.

(2) The socio-political traditions of the health care system are different. Systems that emerge are frequently pragmatically structured, as they are the result of numerous compromises, and these cannot be duplicated.

(3) The socio-economic and demographic characteristics may vary.

Despite these limitations, hopefully something can be learned from the experiences of other systems[5].

The Council of Health relates how it rejected a system type like the one operating in the Soviet Union, because it reflects the general political bent of the country and would probably be unacceptable in this province. The Council notes that it studied both the British and American approaches. Having distinguished between them, the Council opted for the British approach incorporating proposals which have been made by the British government for its reorganization[6]. The Council does not give specific criterion for deciding that the British system has achieved more in the way of improving delivery and cutting costs.

The Ministry's proposal included no description of a similar background study, whether or not one was carried out,

or explanation of its reasons for modifying the design recommended by the Council of Health.

The Preferred System Type as an Indication of Doctors' Attitudes Towards Government

Besides an original interest in the implications of the physicians' preferred system for provincial policy on regionalization, the researcher also developed an interest in whether the preferred system might be translated into a general attitude towards government.

In choosing among alternative approaches to each of the six components of regionalization, however, neither as a group nor as individuals did physicians appear to pick those which implied a consistent level of government power. Since the questionnaire was not tested for construct validity, it may be that those surveyed simply did not recognize the implications of various alternatives to any one component. Or, if the profession did in fact recognize the implications, it may be that generally doctors have no fixed attitude towards government and judged the various approaches to each item on their own merit according to such variable criteria as patient welfare, organizational effectiveness and professional autonomy rather than on the single criterion of how much government power *per se* over the health care delivery system's operation is in their own opinion appropriate.

Persuading Doctors to Accept Particulars of the System

One product of this study is a broad indication of the type of regional health system a majority of Ontario doctors would prefer. Any number of details would have to be worked out by the provincial government within either the Council or the Ministry's proposal. The government will probably want to put these forward in such a way that they will be accepted by the profession.

When choosing among alternative approaches to health regionalization, doctors appeared to place concern for patient welfare and organizational effectiveness over a desire to protect the profession's autonomy. Thus, the profession appeared to attempt a rational evaluation of the problem. Such an approach on the part of the profession should make negotations with the provincial government easier[7].

Polishing the Concept's Image

Considering the skepticism with which physicians view regionalization, the government would probably be wise to retreat from general statements of what such a system is expected to achieve and to find some concrete evidence in the concept's favour.

This may pose a difficult problem considering the scarcity of studies, but if the government cannot find such evidence to publicize, then perhaps the demonstration model approach is one worth considering. The regional government

programme is itself only progressing in bits and pieces and if the provincial government should finally opt for the Council of Health's plan, these two experiments might progress simultaneously with experimental regional health systems set up around already existing regional government units. An experimental approach has been recommended by the OMA and OHA which are evidently more interested in proof than in theorizing.

Unless the medical profession and other health workers, not to mention the general public, can be persuaded of health regionalization's merits, even the most carefully designed and implemented system may fail simply to fulfil a prophecy.

Satisfying the Profession's Various Subgroups

Since objective background characteristics are in general apparently not related to the physician's opinions on health regionalization, any divergence of opinion within the profession should reflect individual differences rather than the views of readily identifiable groups within the profession. Practically speaking then, efforts to polish the concept's image could not be concentrated on particular subgroups which apparently doubt its merit or oppose the implementation of such a system, but would have to be aimed at the profession as a whole. Fortunately there appears to be a consensus of opinion as to which type of regional system should be implemented with only a very small minority likely to dissent.

Moreover, those doctors who hold official leadership positions with the medical community appear to essentially reflect the majority opinion among doctors which probably means that the government can negotiate in confidence with the OMA and other such organizations, assuming that a regional health system which appeals to the profession's formal leaders will also be acceptable to the doctors of Ontario.

Legitimacy of Predicting Behaviour from Doctors' Opinions

What is obtained from this study is a statement of opinion from a segment of the Ontario medical profession. Policy makers are not generally interested in opinions, but in overt behaviour. Recommendations which the researcher might make on the basis of this study must be based on the assumption that verbal responses reflect behavioural tendencies.

The inferential jump from verbal behaviour to overt behaviour appears tenuous under some conditions; this was demonstrated in a classic experiment designed by LaPiere in 1934[8] and others more recently[9]. Although the problem has been recognized by social scientists, not much effort has been made to determine under just which conditions people will act in accordance with their opinions.

In the case of this particular study, predictions of behaviour based on opinion may not be inappropriate. British

physicians were studied for their opinion of the concept's merit, the proposed plan for that country and possible subgroup differences which on the issue of system design actually turned out to be more subgroup similarities. In negotiations they apparently effectively bargained for a system resembling one a majority favoured -- there was a striking consensus of opinion on what shape the system should take. Evidence tends to indicate that British specialists, whom regionalization most affects, have tried to work towards the system's success and are reasonably satisfied with its achievements[10]. The opinions of Ontario doctors on health regionalization closely parallel those which were held, and apparently are still held by the British profession. To carry this further, one might speculate that the Ontario medical profession will, in fact, accept the model for health regionalization which it now says it will. The most pressing problem which the Ontario government may face is persuading doctors that any such system should be implemented.

As to the reasoning behind physicians' choice of a system and their opinion of the concept's merit, if these can be taken at face value[11] they may auger peaceful negotiations and a reasonably trouble-free implementation. First the Pickering Committee and most recently the Committee set up between the provincial government and the OMA to negotiate fee schedules tend to indicate that the profession is trying to avoid any confrontation with the Province over such issues even if this means easing its emphasis on professional autonomy.

FOOTNOTES

[1] This is an expression of Christaller's central place theory, first introduced to the English language by E. Ullman, "A Theory of Location for Cities", Amer. J. of Sociol., 46: 835-64, 1941.

[2] See local government reviews for further information on how regional government boundaries have been arrived at. For example: D. Steele, Hamilton-Burlington-Wentworth Local Government Review (Toronto: Department of Municipal Affairs), 1969 or T. Plunkett, Peel-Halton Local Government Review (Toronto: Department of Municipal Affairs), 1966.

[3] This was indicated by a study in the Ottawa area of D.M. Ray, "Urban Growth and the Concept of Functional Region". In N.H. Lithwick and G. Paquet (Eds.)., Urban Studies: A Canadian Perspective (Toronto: Methuen), 1968, 78-90.

[4] The most recently defined public health and hospital referral regions in Ontario both respect county boundaries. Personal communication, Dr. R. Aldis, Regional Medical Officer of Health, southwestern Ontario, London, 1972. Each of the southern Ontario regions includes one health sciences centre.

[5] Such limitations are discussed by Anderson in his book comparing the Swedish, British and American systems particularly. See: O. Anderson, Health Care: Can There be Equity? (New York: John Wiley and Sons), 1972.

[6] The council did not state that it was patterning its design after the new British system; however, the Council's approaches to each of the six components of a regional system are the same as those proposed for the British system's reorganization.

[7] It was not possible to distinguish between leaders and non-leaders on the type of reasons given, since not enough leaders responded to the open-ended questions. Nor had enough responded would it have been possible to control for other characteristics. The above statement to a certain extent assumes, because leaders essentially reflected the opinions of the "rank and file" on regionalization, that their reasoning would also be similar.

[8]R. LaPiere, "Attitudes vs. Actions", Social Forces, 13: 230-37, 1934.

[9]The list is quite lengthy, but is effectively summarized in S. Deutscher, "Words and Deeds: Social Science and Social Policy", Social Problems, 13: 245-46, 1966.

[10]Personal communication, Dr. D. Gullick, Undersecretary BMA, London, England, August 1972. Although among specialists at both the teaching and non-teaching hospitals, there is some feeling that these two should be merged under the new regional health boards rather than separated as they are now. This is also discussed in G. Forsyth, Doctors and State Medicine (London: Pitman Medical Publishing Co. Ltd.), 1966, Chap. 7. Specific reference to specialist approval of the principle of regionalization on p. 128.

[11]Providing that in general leaders with whom principal negotiations will be conducted can be assumed to have similar reasoning to the profession as a whole. The likelihood of this is suggested by the establishment of both the Pickering Committee and the OMA-government committee to negotiate the fee schedule.

APPENDIX A: Questionnaire

Health Regionalization Questionnaire

Although a loose form of health regionalization has existed in Ontario for some years, it has not gone far enough towards equalizing the distribution of health services. In an effort to achieve more from regionalization, the provincial government has decided to formalize the system. The aim of a more formalized system will be to improve care for rural and small town residents by facilitating their referral when necessary to skilled personnel and complicated facilities found only in more populous areas. Ontario would be divided into several geographical areas (regions) and, within each region, referral channels would be set up to link health centres to community hospitals and a regional hospital. Health councils would be set up to help establish and maintain these formal referral channels. In addition, these councils would be responsible for helping to build up the network of programmes and facilities, for example, where appropriate services were missing, the community would be given funds to provide them.

In setting up a new regional health system, the provincial government will have to make several decisions, including: (i) where the actual regional boundaries will be drawn; (ii) what size the regions will be; (iii) which group will hold a majority of seats on the health councils; (iv) how health council members will be selected; (v) whether the province or the regional health councils will make final decisions on planning and coordinating routines; and (vi) whether health councils will be responsible for both public health and treatment facilities or for treatment facilities alone:

Please check below the alternative you would prefer the government to choose in making each of the decisions which have been listed. On the lines provided after each question, please say why you prefer the alternative you have indicated.

1. Health region boundaries
   a) the same as local government units _____
   b) related to where people go for health services, irrespective of local government boundaries _____
   c) other (specify)_____ _____
   d) no preference _____

_____

_____

2. Size of regions
   a) large regions, 1 million to 1½ million people with health sciences centres serving as the regional centres, for example, the University of Western Ontario as the centre for Bruce, Grey, Perth, Huron, Oxford, Middlesex, Elgin, Lambton, Kent, and Essex counties _____
   b) smaller regions, about 250 thousand people, with cities, such as Windsor, Chatham and London serving as centres for the counties in their immediate vicinities _____
   c) other (specify)_____ _____
   d) no preference _____

3. Health councils with a majority of positions held by
   a) provincial government officials, for example, MPP's and civil servants _____
   b) local government officials _____
   c) physicians _____
   d) health professionals in general, for example, physicians, nurses, hospital administrators, pharmacists, dentists _____
   e) consumers _____
   f) other (specify)_____ _____
   g) no preference _____

4. Selection of the members for the health councils
   a) appointed by the provincial government _____
   b) appointed by local governments _____
   c) elected by the groups they represent _____
   d) elected directly by the people _____
   e) other (specify)_____ _____
   f) no preference _____

5. The responsibilities of health councils should be to
   a) recommend ways of planning and coordinating health services to the provincial government, with the Province making final decisions ____
   b) share final decision making with the Province, for example, the provincial government would supervise capital expenditures and give the councils lump-sum unconditional grants to look after operating expenditures ____
   c) have complete authority to make decisions on all planning and coordinating routines, collecting taxes to put these decisions into effect - the Province would only set broad guidelines to ensure minimum standards among the regions ____
   d) other (specify)_____ ____

   e) no preference ____

6. Health councils that would plan and coordinate
   a) both public health and treatment services ____
   b) treatment services only ____
   c) other (specify)_____ ____
   d) no preference ____

Please answer these few extra questions.

1. Should the provincial government move towards formalizing health regionalization?

   Yes __ Uncertain __ No __

   If not, why not? _____

2. Under what type of payment system do you think doctors should work?
   a) salary from the government ____
   b) capitation (payment by number of patients) ____
   c) direct billing of OHIP (Medicare) ____
   d) direct payment from the patient ____
   e) other (specify)_____ ____
   f) no preference ____

3. If the claim that doctors were unequally distributed throughout Ontario were substantiated, what do you think the government should do?
   a) restrict physicians from practising in "overdoctored" areas ____
   b) provide incentives for physicians to practise in "underdoctored" areas ____
   c) leave the medical profession to sort out a solution ____
   d) no preference ____

4. If it were shown that there was a need for a greater number of general practitioners, what do you think the government should do?
   a) strictly control the percentage of doctors allowed to specialize ____
   b) provide incentives for doctors to choose general practice ____
   c) leave the medical profession to find a solution ____
   d) no preference ____

5. If it were shown that practice in health centres would improve the quality of medicine a doctor practises, what do you think the government should do?
   a) require all doctors to practise in health centres ____
   b) provide incentives for doctors to work in health centres ____
   c) leave doctors alone to do as they wish ____
   d) no preference ____

6. How much influence do you think the government should have over licensing doctors?
   a) complete control ____
   b) moderate influence ____
   c) no influence ____
   d) no preference ____

7. Check, if in addition to your basic MD, you also have a specialist certificate. ____

8. Did you <u>first</u> complete your basic medical training (for example, graduate from medical school) in Canada ___ or in some other country? ___

9. Do you primarily work in a private practice (include yourself if you are on the staff of a general hospital) ___ or in public practice (for example, for a government hospital like the psychiatric and DVA hospitals, for the government in any other capacity like MOH, for an industry, teaching, in research, at administration)? _____

10. Check, if in the last five years, you have:
held any office in a professional organization;
represented a hospital medical staff; sat on the board of governors of a hospital or medical foundation like PSI;
been on a government committee studying medical care issues like the Ontario Council of Health; or held elected political office. _____

APPENDIX B: Other Issues

Regionalization of health services is frequently accompanied by the practice of putting specialists on salary and by an effort to group primary care doctors into health centre practices, putting them on salary or capitation. If this tight structure of providing services is developed and the number of positions fixed, government may want to see that appropriately qualified and only needed types of practitioners are produced to fit into that structure. Once health districts or regions have been defined, then under-doctored areas can be identified and some steps taken to supply them adequately.

Doctors were given their choice of three broad alternative approaches for the government, each again implying not only a general approach to problem solving but also a particular level of government involvement. The numeric code used in scoring doctors on their preferences appears as part of Appendix F.

The researcher was interested in determining what general approach to solving these problems a majority of doctors felt appropriate for government to take. The primary interest, however, lay in determining the implications for government power.

Approaches Preferred

Method of Payment

Table 20 shows the proportion of doctors who favoured a particular approach by government towards method of payment as directly suggested in the questionnaire, and including "other" suggestions in appropriate categories according to the level of government influence implied.

Table 20: Method of Payment Preferences

Approach Preferred	Doctors Expressing that Preference	
	%	N
Salary, capitation	6.3	28
OHIP and other typical combinations	65.8	294
Direct payment from the patient	24.6	105
No preference	5.3	20
Total	100.0	447

A slight majority, 54.4 per cent, had favoured the present Medicare system, but of the 11.4 per cent who devised their own approaches, all suggested some variation of the Medicare scheme, for example, Medicare for people below a certain income, bringing the total in this category to 65.8 per cent. A substantial minority, 24.6 per cent, favoured the return to direct payment.

No background characteristic seemed related to a particular preference as regards this issue when the CMD classification for leadership and self-classifications for other characteristics were used. When the possible alternative classifications were substituted, there appeared to be a relationship between leaders and preference, with leaders more likely to favour the return to direct payment (χ^2 =8.69, 2 df, P<.02).

Physician Distribution

Table 21 shows the proportion of doctors who favoured a particular approach by government towards solving the problem of their unequal distribution. Since the approaches were couched in very general terms, an "other" category was not provided, nor was an "other" category provided with the remaining issues.

Table 21: Physician Distribution Preferences

Approach Preferred	Doctors Expressing that Preference	
	%	N
Restrictions	5.6	25
Incentives	81.7	365
Laissez-faire	11.4	51
No preference	.7	3
Total	100.0	447

A substantial majority felt that it was acceptable for government to provide incentives aimed at attracting doctors to underserviced areas, choosing an approach which would imply moderate government power.

Type of practice appeared to make a difference as to whether any doctor preferred a particular approach here, with specialists inclined to favour more government influence regardless of classification (CMD - x^2 =9.46, 3 df, P<.02; Self - x^2 =19.59, 3 df, P<.01). When controlled for location and type of practice, the relationship held in both cases. When the self-classification was used, doctors in public practice also were inclined to favour an approach implying stronger government power than private practitioners (x^2 =9.35, 3 df, P<.05).

Supply of General Practitioners

Table 22 shows the proportion of doctors who favoured a particular approach by government toward solving the problem of an undersupply of general practitioners.

A substantial majority again felt that it was acceptable for government to provide incentives aimed at persuading doctors to choose general practice, preferring an approach which would imply moderate government power. No background characteristic, regardless of classification, seemed related to a particular preference here.

Table 22: Preferred Approach to Correcting the Undersupply of General Practitioners

Approach Preferred	Doctors Expressing that Preference	
	%	N
Restrictions	4.3	19
Incentives	77.6	347
Laissez-faire	15.4	69
No preference	.4	8
Total	100.0	447

Mode of Practice

Table 23 shows the proportion of doctors who favoured a particular approach by government to stimulate group practice.

Table 23: Preferred Approach to Encouraging Health Centre Practice

Approach Preferred	Doctors Expressing that Preference	
	%	N
Restrictions	3.1	14
Incentives	62.2	278
Laissez-faire	28.6	128
Total	100.0	447

A slight majority, 62.2 per cent, felt it acceptable for government to provide incentives aimed at persuading

doctors to enter health centre practice, choosing an approach which implies moderate government power.

Training appeared to make a difference in the particular approach which a doctor favoured only when the CMD classification was used. Native-trained doctors were more likely to choose an approach implying at least some government power than were foreign-trained doctors (x^2 =9.37, 3 df, P<.02). When controlled for type and location of practice, the relationship held only if a doctor was in general practice, but regardless of location.

Licensing

Table 24 shows the proportion of doctors who favoured a particular approach by government towards licensing.

As can be seen, a slight majority, 58.6 per cent, felt that government should leave control over licensing entirely to the profession, while a substantial minority felt that moderate control by government over licensing procedures would be acceptable. No background characteristic seemed related to a particular preference as regards this issue, regardless of classification.

Table 24: Licensing Control Preferences

Approach Preferred	Doctors Expressing that Preference %	N
Complete control for government	3.8	17
Moderate control for government	33.8	151
No influence for government	58.6	262
No preference	1.1	5
Missing	2.7	12
Total	100.0	447

Implications for a General Level of Government Influence over Health Care Delivery

Each doctor's score on these five items was correlated with a resultant R of only .29, so that no general level of government involvement in the health care delivery system is, therefore, implied. Once again because the researcher has no measure of construct validity, any conclusions about doctors' attitudes towards government involvement in the health care delivery system would have to be very tentative, although the implications of the alternatives provided for each issue seem to be quite clear. The conclusion would be that doctors have no general attitude towards government involvement, but rather differing attitudes depending upon the issue involved.

APPENDIX C: Introductory Letter

November 15, 1972

Dear Dr.

You are probably aware that the provincial government is preparing to formalize health regionalization in Ontario. In the past few months, we have been studying regional health systems which are already operating in other countries. One variable which seems to have a direct bearing on any type of regional health system's effectiveness is the degree of cooperation it elicits from the medical profession. We would now like to determine under which type of regional health system Ontario physicians would prefer to work.

We have selected a sample of several hundred physicians practising throughout southwestern Ontario and your name appeared among them. We would very much appreciate your help in completing our "Health Regionalization Project". Enclosed is a brief questionnaire; it should take no more than 15 minutes to fill in. It asks your opinion of the various approaches that could be taken towards regionalizing health services in Ontario. There are also a few questions asking your opinion of related medical care issues. You will notice that the questionnaire has been numbered in the top right hand corner of the first page. We have a master sheet which matches each doctor's name to a number so that we will know which doctors have returned the questionnaire. This master sheet will be kept strictly confidential, so that no one but the researchers could identify the person who completed any questionnaire.

We hope to publish the results of the study and to make them directly available to interested parties, including your professional organizations and the government. If you would like us to send you a personal copy, please indicate it on the top of the questionnaire you return.

..... /2.

Mrs. Warren will be at your office sometime after December 1st, to pick up the questionnaire. If you will not be in then, or if it is inconvenient for her to call on you, please use the enclosed stamped and addressed envelope to return the questionnaire. Thank you for your time.

Sincerely,

J.I. Williams, Ph.D.
Assistant Professor,
Department of Epidemiology
and Preventive Medicine.

Mrs. Sharon Warren
Graduate Student.

APPENDIX D: Follow-up Letter

December 2, 1972

Dear Dr.

Now that our health regionalization project is fully underway I can give you a more definite time for my visit. I will be in (name of city) on (date) and will drop by your office to pick up the questionnaire. Dr. Williams and I are arranging my visit specifically so that you may ask any questions about our project. If you do not have any such questions, or if you will not be in on the date I have mentioned, may I once again ask you to return the questionnaire by mail. If I have received it by the date above, I will know not to call at your office.

Our response by mail has been reasonably good, but there are still a substantial number of physicians who have not returned the questionnaire. We would very much appreciate your help in moving the project forward quickly. Because some time has passed since we first contacted you, I am enclosing a duplicate questionnaire in case you might have misplaced the first..

Thank you for your time and cooperation.

Yours truly,

Mrs. Sharon Warren

APPENDIX E: Numeric Code for Scoring on Government Power (Regionalization and Other Issues)

Regionalization

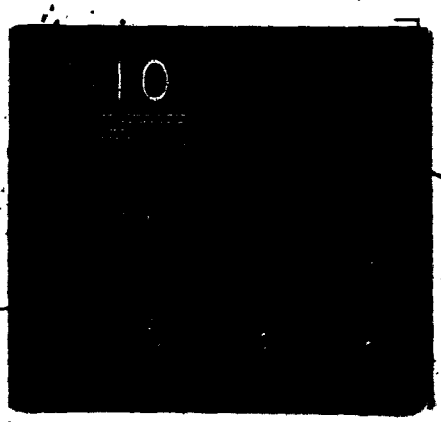
Item	Score	
1. Health region boundaries		
a) the same as local government units	1	
b) consumer utilization patterns	2	(since any type of organization implies some government involvement)
c) other	3	if no such system or some other score (1,2) depending upon implications for government power, for example, - county boundaries 1 - variable according to needs of area 2
d) no preference	0	
2. Size of regions		
a) large	2	(since any type of organization implies some government power)
b) small	1	
c) other	3	if no such system or some other score (1,2) depending upon implications for government power, for example, - large regions subdivided into districts 1
d) no preference		

3. Health Councils dominated by		
a) provincial government officials	1	
b) local government officials	1	
c) physicians	3	
d) health professionals	3	
e) consumers	2	(no affiliation, may be swayed either way)
f) other	3	if no such system or some other score (1,2) depending upon government power implied, for example, - balance including government 2 - some balance excluding government 3
g) no preference	0	
4. Method of Selection		
a) appointed by provincial government	1	
b) appointed by local government	1	
c) elected by groups they represent	3	if the doctor voted for domination of health councils by either physicians, health professionals or consumers.
	2	if any combination including government, or
	1	if for government domination of council membership
d) direct election	2	

e) other	3	if no such system or variable score (1,2) depending upon level of government power implied, for example, - appointed by government from lists nominated by the groups represented 2
f) no preference	0	
5. Division of Responsibility a) centralization	3	
b) shared	2	
c) decentralization	1	if doctor preferred health councils to be dominated by government officials, or
	3	if he preferred that councils be dominated by health professionals
d) other	3	if no such system or variable depending upon level of government involvement implied, for example, - decentralization, but with a lump-sum grant, not taxing authority - score reflecting council composition
e) no preference	0	
6. Relationship of Hospitals and Public Health a) joint planning and coordination	1	
b) treatment services only	2	(since any organization implies some government involvement)

3 3

OF/DE



c) other	3	if no such system or variable (1,2) depending upon the level of government power implied, for example, - ad hoc coordination 2
d) no preference	0	

Other Issues

1. Payment		
a) salary	1	
b) capitation	1	
c) Medicare	2	
d) direct billing	3	
e) other		variable according to level of government power implied
f) no preference	0	
2. Physician Distribution		
a) restrictions	1	
b) incentives	2	
c) laissez-faire	3	
d) no preference	0	
3. Undersupply of General Practitioners		
a) restrict specialization	1	
b) incentives for general practice	2	
c) laissez-faire	3	
d) no preference	0	

4. Health Centre Practice
   a) restrict solo practice 1
   b) provide incentives to health centre practice 2
   c) laissez-faire 3
   d) no preference 0

5. Government control over Licensing
   a) complete 1
   b) moderate 2
   c) none 3
   d) no preference 0

APPENDIX F: Comparison for Those who Did/Did Not Explain their Preferences for Regionalization

Table 25: Comparison on Background Characteristics* for Those who Did/Did Not Explain their Preferences

Background Characteristic	No Reason Given %	No Reason Given N	Reason Given %	Reason Given N
a) Location of Practice				
City over 100,000	49.6	139	46.1	77
Town under 100,000	50.4	141	53.9	90
Blank	0.0	0	0.0	0
Total	100.0	280	100.0	167
b) Type of Practice				
General Practice	48.6	131	44.9	75
Specialty	52.1	146	55.1	92
Blank	1.1	3	0.0	0
Total	100.0	280	100.0	167
c) Training				
Native	63.9	131	64.7	108
Foreign	34.3	94	34.7	58
Blank	1.8	5	.6	1
Total	100.0	280	100.0	167

*CMD classification used for location of practice, since doctors were not asked this and for leadership, since self-classification was regarded as possibly inaccurate; all others are based on self-classification.

Table 25 cont'd

Background Characteristic	No Reason Given %	No Reason Given N	Reason Given %	Reason Given N
d) Work Setting				
Private	86.4	242	78.9	131
Public	11.4	32	21.0	35
Blank	2.1	6	.6	1
Total	100.0	280	100.0	167
e) Leadership Status				
Leader	7.6	30	7.1	12
Not Leader	92.4	250	92.8	154
Missing	0.0	0	.6	1
Total	100.0	280	100.0	167

With the exception of doctors in public practice who were more likely to give their reasons than those in private practice, the distribution of those who explained and did not explain the reasoning behind their preference is quite similar.

Table 26: Comparison on Preferences for Those who Did/Did Not Explain

Preference	No Reason Given %	No Reason Given N	Reason Given %	Reason Given N
a) Boundaries				
Local government boundaries	15.4	43	21.6	36
Consumer utilization patterns	76.4	214	69.5	116
Other	2.5	7	4.2	7
No Preference	5.0	14	3.6	6
Missing	.7	2	1.2	2
Total	100.0	280	100.0	167
b) Size of Regions				
Large	20.0	56	20.4	34
Small	63.2	177	56.9	95
Other	10.0	28	19.2	32
No Preference	5.0	14	3.0	5
Missing	1.8	5	.6	1
Total	100.0	280	100.0	167

Table 26 cont'd

Preference	No Reason Given %	No Reason Given N	Reason Given %	Reason Given N
c) Council Composition (dominant group)				
Provincial Officials	1.1	3	1.2	2
Physicians	15.0	42	7.8	13
Health Professionals	57.1	160	58.0	94
Consumers	1.8	5	1.8	2
Other	21.4	60	21.7	54
No Preference	2.1	6	2.2	2
Missing	1.4	4	0.0	0
Total	100.0	280	100.0	167
d) Method of Selection				
Appointed by provincial government	2.5	7	3.6	6
Appointed by local governments	4.3	12	3.0	5
Selected by the bodies they represent	73.2	205	65.3	109
Direct election	2.9	8	4.2	7
Other	14.3	40	21.0	35
No Preference	1.4	4	2.3	4
Missing	1.4	4	.6	1
Total	100.0	280	100.0	167

Table 26 cont'd

Preference	No Reason Given %	No Reason Given N	Reason Given %	Reason Given N
e) Division of authority (according to focus of power)				
Provincial level dominant (centralized	16.4	46	13.2	22
Share authority (partial decentralization)	58.6	164	58.7	98
Local councils dominant (decentralization)	17.9	50	17.4	29
Other	2.1	6	6.6	11
No Preference	1.4	4	1.8	3
Missing	3.6	10	2.4	4
Total	100.0	280	100.0	167
f) Relationship between Public Health and Hospital Services				
Joint planning and coordination	80.7	226	76.6	128
Hospital services separate	11.1	31	13.8	23
Other	2.5	7	5.4	9
No Preference	2.1	6	2.4	4
Missing	3.6	10	1.8	3
Total	100.0	280	100.0	167

Table 26 cont'd

Preference	No Reason Given %	No Reason Given N	Reason Given %	Reason Given N
g) Concept's Merit (should regionalization be implemented?)				
Yes	41.1	115	46.1	77
Uncertain	37.1	104	25.7	43
No	21.1	59	26.9	45
Missing	.7	2	1.2	2
Total	100.0	280	100.0	167
h) System Type Preferred (in terms of government power)				
Strong government power	18.9	53	13.8	23
Moderate government power	60.4	169	64.7	108
Weak government power	16.4	46	16.2	27
Missing*	4.3	12	0.0	9
Total	100.0	280	100.0	167

On all issues those stating the reasons behind their preferences chose similarly to those who did not give their reasoning. The majority choice on the six items was without exception the same for both groups. Those who gave their reasoning, however, appeared slightly more likely to devise

*Too many items left blank to judge.

"other" reasons which probably accounts in part for differences between the two groups on alternatives suggested directly in the questionnaire. On the concept's merit, the majority category was again the same, although of those who gave reasons for their position considerably fewer were uncertain as to whether such a system should be implemented. As to preferred system type, those who had given their reasons for choosing any alternatives to the individual components appeared slightly more likely to favour a moderate government power type.

APPENDIX G: Consistency between the CMD Classification and Self-classification (on Background Characteristics according to the Proportion which belong in either one or the other side of the Dichotomies per Characteristic—Practice, Training, Work Setting)

Table 27: Proportion Consistencies between CMD and Self-classifications (for Type of Practice, Training and Work Setting)

Background Characteristic	CMD Classification		Self-Classification	
	%	N	%	N
a) Type of Practice				
General	49.1	216	46.6	205
Specialty	50.9	224	53.4	234
Total	100.0	440	100.0	440
b) Training				
Native	66.6	291	65.4	286
Foreign	33.4	146	34.6	151
Total	100.0	437	100.0	437
c) Work Setting				
Private	84.8	374	84.4	372
Public	15.2	67	15.6	69
Total	100.0	441	100.0	441

Agreement on the proportion which should fall into either one or the other side of each dichotomy is remarkably good on all three background characteristics between the CMD and self-classification.

APPENDIX H: Comparison of CMD and Self-classification on Internal Agreement (for Training and Practice Dichotomies)

Table 28: Comparison of CMD and Self-classification on Internal Agreement of Native/Foreign Dichotomy

CMD Classification	N %	Self-Classification	
		Native	Foreign
Native		283 97.3	8 2.7
Foreign		3 2.1	143 97.9

Table 29: Comparison of CMD and Self-classifications on Internal Agreement of General Practitioner/Specialist Dichotomy

CMD Classification	N %	Self-Classification	
		General Practitioner	Specialist
General		186 86.1	30 13.9
Specialist		19 8.5	205 91.5

The internal consistency of the native/foreign classification is almost ideal. There is some discrepancy in the general practitioner/specialist classification; however, there appeared to be no relationship between type of practice and any doctor's opinions regarding regionalization

and where there appeared to be a relationship between practice and opinions on physician distribution, the relationship appeared regardless of the classification used.

REFERENCES

American Medical Association. A National Programme to Conquer Heart Disease, Cancer and Stroke. JAMA, 1965, 192, 99-105.

Anderson, O.W. Health Care: Can There be Equity? New York: John Wiley and Sons, 1972.

Badgeley, R. and Wolfe, S. Doctors' Strike. Toronto: MacMillan of Canada, 1967.

Batistella, R.M. The Course of Regional Health Planning: A Review and Assessment of Recent Federal Legislation. Medical Care, 1966, 5, 150-60.

Beecroft, E. Community Planning in Canada. Notes for the Conference of the Progressive Conservative Association at Queen's University, August 22-24, 1969.

Blishen, B. Doctors and Doctrines. Toronto: University of Toronto Press, 1969.

BMA Questionary, BMAJ, August 5, 1944 Supplement, II: 24-28.

Burrow, J.G. AMA: Voice of American Medicine. Baltimore: Johns Hopkins Press, 1963.

Canada. National Department of Health and Welfare. Health Manpower Inventory. Ottawa: National Department of Health and Welfare, 1972.

Canada. Royal Commission on Health Services. Ottawa: Queen's Printer, 1964-65.

Canada. Task Force Reports on the Cost of Health Services in Canada. Ottawa: Department of National Health and Welfare, 1970.

Cline, J.W. The Physician's Point-of-View on Regional Organization of Hospitals. California Medicine, 1948, 69, 12-15.

Colombotos, J. Physicians' Attitudes Toward a County Health Department. AJPH, 1969, 59, 53-59.

Colombotos, J. Physicians' Attitudes Toward Medicare. Medical Care, 1968, 6, 320-31.

Colombotos, J. Physicians and Medicare: A Before-After Study of the Effects of Legislation on Attitudes. Amer. Sociol. Review, 1969, 34, 318-34.

Deutcher, I. Words and Deeds: Social Science and Social Policy. Social Problems, 1966, 13, 235-54.

Eckstein, H. The English Health Service. Cambridge: Harvard University Press, 1964.

Eckstein, H. Pressure Group Politics: The Case of the British Medical Association. London: Ruskin House, 1960.

Ellis, J.R. The Regionalization of Hospital Services. In L. Degroot (Ed.). Medical Care: Social and Organizational Aspects. Springfield: Charles C. Thomas, 1966, 338-47.

Engel, A. Regional Planning. In the American College of Hospital Administrators (Eds.). The Swedish Health System. Chicago: University of Chicago Press, 1971.

Engel, G.A. The Effect of Bureaucracy on the Professional Autonomy of the Physician. J. of Health and Social Behaviour, 1969, 10, 30-41.

Evang, K. Health Service, Society and Medicine. London: Oxford University Press, 1960.

Forsyth, G. Doctors and State Medicine: A Study of the British Health System. London: Pitman Medical Publishing Co., Ltd., 1966.

Field, M.G. Soviet Socialized Medicine. New York: The Free Press, 1967.

French, J. and Raven, B. The Bases of Social Power. In D. Cartwright (Ed.). Studies In Social Power. Ann Arbour: University of Michigan Press, 1959.

Friedman, R.S. The Urban-Rural Conflict Revisited. Western Political Quarterly, 1961, 14, 481-95.

Friedson, E. Professional Dominance: The Social Structure of Medical Care. New York: Atherton Press, Inc., 1970.

Fry, J. Medicine in Three Societies: A Comparison of Medical Care in the USSR, US and UK. London:

Grove, J.W. Organized Medicine in Ontario. Toronto: Queen's Printer, 1969.

Harris, R. A Sacred Trust. New York: The New American Library, 1966.

Hastings, J.E.F. Organized Community Health Services. Ottawa: Queen's Printer, 1969.

Hill-Burton After Twenty Years. Modern Hospital, 1966 107, 95-98.

LaPiere, R. Attitudes vs. Actions, Social Forces, 1934, 13, 230-37.

Linsey, A. Socialized Medicine in England and Wales: The National Health Service, 1948-61. Chapel Hill: University of North Carolina Press, 1962.

Lipset, S. and Schwartz, M.A. The Politics of Professionals. In H.M. Vollmer and D.L. Mills (Eds.). Professionalization. Englewood Cliffs: Prentice Hall, Inc., 302-11.

London Free Press. OMA-OHA Policy Statement on Health Regionalization, May 7, 1973, 4.

Manitoba. White Paper on Health Policy. Winnipeg: Department of Health, 1972.

McLachlan, G. (Ed.). Challenges for Change: Essays on the Next Ten Decades of the National Health Service.

McNerney, W.J. and Riedel, D.C. Regionalization and Rural Health Care. Ann Arbour: University of Michigan Press, 1962.

Marston, R. and Yordy, K. A Nation Starts a Programme. J. Med. Ed., 1965, 42, 17-23.

Medical Post. OMA-Government Joint Committee on Fees, Oct. 16, 1973, 1, 30.

Nova Scotia. Report on an Integrated System of Hospital Facilities and Related Services. Halifax: Department of Health, 1971.

Ontario. Committee on the Healing Arts. Report. Toronto: Queen's Printer, 1969.

Ontario. Committee on Regional Organization of the Health Services (Ontario Council of Health). Report. Toronto: Queen's Printer, 1969.

Ontario. Committee on Regional Organization of the Health Services (Ontario Council of Health). Supplementary Report. Toronto: Queen's Printer, 1970.

Ontario. Committee on Taxation. Report. Toronto: Queen's Printer, 1967.

Ontario. Department of Health. Progress in the Formation of Health Units. Unpublished mimeo, 1970.

Ontario. Ministry of Health. An Implementation Plan for the New Orientation and Structure of the Ministry of Health. Unpublished memorandum, August 1972, 307.

Ontario. Office of the Prime Minister. Design for Development: Phase Two. A statement by the Honourable W.D. McKeough, Minister of Municipal Affairs, Dec. 2, 1968.

Pickering Committee. Report of the Special Study regarding the Medical Profession in Ontario. Toronto: OMA, 1973.

Plunkett, T. Peel-Halton Local Government Review. Toronto: Department of Municipal Affairs, 1966.

Quebec. Commission of Inquiry on Health and Social Welfare - Health, Vol. IV. Quebec City: Government of Quebec, 1970.

Ray, D.M. Urban Growth and the Concept of Functional Region. In N.H. Lithwick and G. Paquet (Eds.). Urban Studies: A Canadian Perspective. Toronto: Methuen, 1968.

Replies to the Questionary. BMAJ, II, Supplement August 5, 1944, 25-8.

Richmond, J. Currents in American Medicine: A Developmental View of Medical Care and Education. Cambridge: Harvard University Press, 1969.

Rothman, R. et al. Physicians and a Hospital Merger: Patterns of Resistance to Organizational Change. J. of Health and Social Behaviour, 1971, 12, 46-55.

Rowat, D.C. The Canadian Municipal System: Essays on the Improvement of Local Government. Toronto: McLelland and Stewart, Ltd., 1969.

Saskatchewan. Department of Public Health, Research and Planning Branch. Organization and Management of the Public Health Services. Regina: Queen's Printer, 1966.

Saskatchewan. Report of the Advisory Planning Committee on Medical Care (Interim Report). Regina: Queen's Printer, 1962.

Steele, D.A. Hamilton-Burlington-Wentworth Local Government Review. Toronto: Department of Municipal Affairs, 1969.

Stevens, R. Medical Practice in Modern England. New Haven: Yale University Press, 1966.

Tindal, C.R. Regional Administration: A Study of Ontario Government Department Field Offices. Can. Pub. Admin., 1968, 11, 186-249.

United Kingdom. Ministry of Health. A National Health Service. London: HMSO, 1944.

United Kingdom. Ministry of Health. National Health Service Reorganization: England. London: HMSO, 1972.

United Kingdom. Royal Commission on Local Government in England. London: HMSO, 1969.

United States. Delegation on Health Services and Planning. Medical Care in the USSR. Washington: GPO, 1970.

United States. Department of Health, Education and Welfare, Division of Regional Medical Programmes, National Institutes of Health. Guidelines: Regional Medical Programmes. Washington: GPO, 1966.

Warren, S.A. Regionalization of Health Services in Southwestern Ontario. Unpublished Master's Thesis. University of Western Ontario, London, 1971.

Willard, W.M. Diverse Factors in Regional Medical Planning. AJPH, 1968, 58, 1026-31.

Willms, A.M. Administrative Decentralization. In A.M. Willms and W. Kernohan (Eds.). Public Administration in Canada: Selected Readings. Toronto: Methuen, 1971.

World Health Organization. Technical Report Series No. 491. Geneva: WHO, 1972.