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This era, the twentieth century, has been compared to the Golden Age of Greece. Since the turn of the century, the explosion in the discovery of new knowledge, technology, education, and social advances has been unprecedented. Who would have thought at the turn of the century and even into the fifties, that there would be men on the moon, the discovery of DNA, organ transplants, magnetic resonance imaging, jet travel, computers, and the eradication of diseases? The development of such advances and, more importantly, their almost universal availability has created a sense that everyone must have everything whether or not it is needed or whether or not it will improve their quality of life. Among the developments of this century, a real milestone is the availability of health care.

Guaranteed health care was first established in Canada by the Medical Care Act of 1966. In order for the provinces to receive financial support for the provision of such health care, they had to demonstrate that the health care plan was comprehensive, universal, portable, and publicly administered. One of these four premises that is in jeopardy today is the concept of universality. Universality represents the equal opportunity for health care for all people in Canada. Whenever the need for health care is felt, consumers want to be able to access the health care system quickly and directly. This demand for 'equality of care' is interpreted by most Canadians as a 'right' conferred by the Medical Care Act of 1966 and upheld in the Canada Health Act of 1984.

This equality of care leads most Canadians think that every other person in Canada receives identical or the same type of care. Equal opportunity means that everyone should have the same chance to receive health care. These two terms get confused when it comes to the provision of health care. Women in P.E.I. do not have the same opportunity for gynecological care as do women in Ontario. People in Northern Ontario do not have the same range of services as do people in Southern Ontario. For example, the access to care for mental illness is very limited in Northern Ontario. Locally, there are few mental health care services available for adolescents, especially adolescent males. Along with the limitations of services in various areas, is the added
aspect of the consolidation of services. Analysis of services in Windsor demonstrated that four hospitals offered duplicate services. In the new configuration, two hospitals have been allocated services for which they appear to have the more advanced facilities. System-wide cost-effectiveness of plant and services is the goal of contemporary health care programmes whether they are in the community or in institutions.

Today's economic situation is forcing the health care area to examine services, who provides care? who receives care? where is it provided? which services are required and why? Currently Windsor, Ontario is undergoing the process of reconfiguration of health care. A task force of local citizens chaired by Mary Jean Gallagher, under the aegis of the Essex County District Health Council, developed a report designed to remodel local health care delivery. The Essex County Win/Win Model — An Evolving Plan for Total Health System Reconfiguration — identified that from the consumers' and taxpayers' perspective, our local network of health and health-related social services is fragmented, uncoordinated, and wasteful. Among other problems mentioned is the observation that services do not reflect the community's needs. What is interesting about this health care development is the fact that, although people in Windsor and in the Province of Ontario feel that this taskforce was initiated by the government, the original impetus behind reconfiguration came from the administrators of the four hospitals in Windsor. These administrators demonstrated responsibility and accountability, recognizing the need to trim health care services, eliminate duplication, be cost effective, and still deliver universal, quality health care.

Health care providers and the consumers of health care have a unique opportunity at this time in Windsor to create a quality health care system that meets the needs of the consumer and matches the expertise of the various providers. While the goal seems ideal and inarguable, it is a risky venture as it places in question cherished beliefs and values about health care.

Questions of maintaining quality and access to all forms of services arise. It shakes the foundations of territoriality, the nature and retention of experts, and the ceilings to the cost of services. Our community seminar sought to stimulate dialogue on these and other aspects of health care delivery. We questioned and examined currently held ideas of health care. Who should administer health care? How and which

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services should be identified? Most importantly, we bonded together to HEAR and to LISTEN to the consumers. Patients and families want to be able to control what is or is not done to and for them in the name of health care.

Though technological advances assist people to live, as well as to live longer, loss of basic humanness and compassion occurs, more frequently than health care providers like to admit, when technology dominates care. Competition for technologies amongst hospitals for purposes of economic survival has created the need for every hospital to have the most modern equipment in order to be at the forefront of health care. This competition leads to several problems. First, the patient is neglected in terms of what she/he thinks should happen. Second, hospitals in the same city attempt to have the latest and the best technology. Third, the cost of providing this standard of health care escalates. Finally, the notion that the only place to receive the best care is in the hospital dominates the health care delivery system.

Change is occurring in spite of this thinking. A sign of this change is noted in the Ontario Health Survey conducted in 1990. The Province of Ontario established the following goals:

1. Shift the emphasis to health promotion and disease prevention;
2. Foster strong and supportive families and communities;
3. Ensure a safe, high quality physical environment;
4. Increase the number of years of good health for Ontarians by reducing illness, disability, and premature death;
5. Provide accessible, affordable, appropriate health services for all.

These goals reflect the ideas established by previous Federal Ministers of Health, Marc Lalonde and Jake Epp. Both of these ministers recommended that health care focus on the promotion of health and the prevention of illness. Mr Lalonde, in his address for the Boland Memorial Lecture, stated that the improvement of the social and physical environment and the modification of certain living habits influence the level of health and fitness. Health promotion and prevention of illness are more important than ‘curing.’

A health promotion concept places the emphasis on the person to


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care for him/herself appropriately and for the health care provider to teach the patient how to do this. It re-introduces personal accountability and common sense into the equation of health care provision. This 'common sense' aspect of health care recognizes that the consumer/patient/client has input into the what, when, where, and how services are needed for maintaining and promoting her/his health.

This community seminar, "Expanding Health Care Perspectives: Policy Making for the Year 2000," is also asking local health care providers to recognize the role of the consumer in determining what services are needed locally and how people interpret health care information and attention.

Interestingly, this is not the first time that the University of Windsor community initiated discussion on health care. In 1976, under the auspices of the Canadian American Seminar, a conference on *Health Care Delivery Systems in North America: The Changing Concepts*, was held. That conference, reflecting the thinking of 1976, focused on the problem of having a sufficient numbers of physicians "functioning in a delivery system to bind the wounds and treat the ills of all North Americans." Although the focus in the 90s is different, local health care providers in 1976 did suggest today's direction. Dr S Olesiuk of Windsor stated,

I appreciate the people that you have here. You have a lot of high level people speaking and there is very little input from the real individuals who deliver health care. I think that if you are going to have solution to the problems, you have to come down to the local community, . . . I think that if you have to cut down on costs, you have to put the onus and the responsibility on the individual patient and the practicing physician,\(^5\)

and I would add, the practicing nurse. Another participant, Ms Ada E McEwen, National Director of VON, commented that "health teaching has always been an important aspect of all programs with emphasis on encouraging individual and family independence." She continued:

the VON has always been convinced that the home is a 'good' place to provide care to people, not because it is cheaper, although that is an important consideration, but because it allows people to be cared for in familiar surroundings which are conducive to recovery and to rehabilitation. There the services can be adjusted to the patient rather

\(^4\)Murray, *Delivery Systems*, i.

\(^5\)Ibid., 118-19.
than the patient adjusting to the rules and regulations of an institution.  

This is the crux of the present volume how to adjust the rules and regulations of local health care providers to meet the needs of the health care consumer in the reconfiguration of health care in Windsor. "The current system does not acknowledge the importance that should be placed on the views of the consumer, direct service providers, and support staff."  

In a recent segment on Peter Gzowski's *Morningside* a group of health care experts discussed the changing provision of health care across Canada. These experts recognized the need for community involvement and recommended the importance of having health care meet the needs of the population of the area. Dr Ron Stewart, Minister of Health of Nova Scotia, stated that one way to improve the quality of care and the costs of services is to return decision making to the community. He stated that services must go to underserviced areas and the "best sources in terms of what services are needed are the people on the ground." Jane Fulton, another guest, remarked that health care services should reflect local populations. Not all services will look the same everywhere in Canada. If the area has an aging population then services should reflect that population.  

The adequacy of the client to identify health care needs has been well demonstrated by patients with AIDS and their families. Through their lobbying, the AIDS movement has received money for research and treatment with experimental drugs. Patients with AIDS and their families have identified the kind of care needed for themselves and others and have insisted that, that type and quality of care be given. Education and health promotion issues have also been addressed in preventing AIDS. Interested citizens have developed focus groups to deal with the needs of clients who are mentally ill, chronically ill, homeless, developmentally delayed, or addicted. In an effort to help people die in a dignified manner, with reduced pain, Hospice groups have initiated the use of palliative care regimens such as therapeutic touch, aromatherapy, massage therapy, and in-home support to reduce the stress of caring for a dying family member. More and more people are recognizing the efficacy of being treated at home. For example, an

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6Murray, *Delivery Systems*, 142.  
7Win Win Model, 76.  
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at-home intravenous antibiotic therapy programme, administered by a nurse, introduced in Alberta (1993) saved $99,540 in costs, in one year alone.\(^9\)

Innovation, risk taking, letting go of health care provider control over decision making, developing a health care contract with the client, encouraging health care decisions by the client and by the community will revitalize health care in Windsor. Do we, do you, have the courage to be different, to lead, to create, to provide, and to receive health care in new ways? Reconfiguration of the health care services in Windsor is an opportunity for all participants in the health care continuum (consumers, providers, agencies) to grow and to effect change by developing health care that meets the demands of our local populations whether in the social, cultural, physical, psychological, or spiritual domains.

The plenary speakers Dr M Muldoon, Dr A Sears and Dr A Forrest provided the group with various concepts surrounding health care and health.

During the discussions that followed the plenary sessions, many interesting ideas and approaches to health care evolved from the presentations by the plenary speakers. Dr Muldoon’s case history stimulated the participants to identify that health care needs to move toward a more people centred wholistic model. Health is more than the absence of disease. The determinants of health include ourselves, and other factors such as a clean environment, housing, income, employment, and nutrition. It is the concept of wholeness, wellness, and the integration of body, mind, and spirit. Recognition of the importance of traditional self-care models is necessary to meet the needs of different ethnic groups. Other cultures encourage the use of home remedies and the use of practices that result in effective health care.

Empowerment of patients was another concept generated by all three plenary speakers. This concept encourages patients to be an active participant in decisions about their health care. As well, it allows patients to ask questions and to advocate for themselves. Dr Forrest’s discussion of breast cancer reinforced strongly the issue of empowering women to make decisions about their health care. As well, the groups felt that it is an adjunct to care to be aware of the psychological and sociological effect that the diagnosis of breast cancer has not only on the woman herself but also on her significant others (family, friends, employer/employee).

\(^9\)Canadian Nurses Association, *IV Antibotic Treatment At Home* (Ottawa: Canadian Nurses Association, 1994).
Dr Sears's discussion of AIDS emphasized the relevance of community development and mobilization. His talk demonstrated the power of a consumer driven approach to AIDS and its effect on the health care establishment. The AIDS movement has demonstrated how things can be done and that we really can learn how to get our own health needs met, whatever they maybe.

The role of economics within the health care system was also recognized by the groups. A major concern expressed was that a balance in health care be available. An equal opportunity to receive the health care that the patient needs, and defines as what is needed, must be ensured. With reconfiguration health care providers must be open to change. We cannot continue to provide services as we have been doing. Through rethinking the process we will be able to provide health care that the individual has chosen and that gives the individual control in the health system and recognizes the role of the community in developing appropriate health care resources.

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