



# Import

## A WEEKLY REVIEW OF DEVELOPMENTS IN HEALTH AND HUMAN SERVICES

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*Welcome to this edition of Import. In it you will find summaries of new and interesting issues and developments in health and human services, as well as "In My Humble Opinion," a short analytical article by an Agora Group affiliate. Please feel free to visit The Agora Group's web site, which can be accessed by pressing the "our affiliates" button on the Consultant Network web site: [consultant-network.ca](http://consultant-network.ca).*

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### ONTARIO RELEASES HOSPITAL PERFORMANCE RESULTS

On January 26 Ontario's Ministry of Health and Long-Term Care and the Ontario Hospital Association released five reports on hospital care across the province – including reports on acute care, emergency department care, complex continuing care and rehabilitation. A fifth report provides implications for each of the province's six hospital regions. Each report focuses on evaluating four key areas – patient satisfaction, patient care, keeping up with change, and financial performance. These reports are part of an ongoing series of such reports issued annually. All five reports can be accessed at <http://www.hospitalreport.ca>.

Among the interesting findings:

- Small hospitals tend to fare less well on a number of quality measurements (particularly information analysis) than larger community and teaching hospitals. For example, 92% of teaching hospitals shared data relating to in-hospital mortality internally across specialties at least one per quarter, compared with 74% of community hospitals and 44% of small hospitals. Also, 92% of teaching hospitals compared data relating to unplanned readmissions to the same hospital internally across specialties at least one per quarter, while only 65% of community hospitals and 30% of small hospitals did so.



- However, patients in small hospitals generally show higher rates of satisfaction with their care.
- Hospitals tend to share patient and staff satisfaction data within their own organization, but are much less likely to compare their own satisfaction data (particularly staff satisfaction data) with data from other organizations. The majority of Ontario hospitals (83%) shared patient satisfaction data and results from *Hospital Report 2002: Acute Care* in some way within their organizations, and 77% of hospitals did the same with employee satisfaction data. However, 69% of hospitals said that they did not engage in the external benchmarking practice of comparing employee and physician satisfaction data across two or more organizations. Of the 31% of hospitals who did engage in external benchmarking practices concerning physician and hospital staff, only 24% reported sharing nursing satisfaction data with two or more organizations. In addition, 18% of hospitals reported sharing data related to the satisfaction of other regulated health professionals and other hospital staff with other organizations.
- Women indicate somewhat lower satisfaction rates than men do.
- About 88% of hospitals indicate nursing staff shortages. Small hospitals are less likely than larger hospitals to indicate nursing staff shortages (all teaching hospitals and 91% of community hospitals reported nursing shortages).

### **ONTARIO INTRODUCES LONG-TERM CARE SAFEGUARDS**

As a down payment on its promised strategy in response to media reports of long-term care deficiencies, on January 22 Ontario's Minister of Health and Long-Term Care announced measures to safeguard residents in long-term care facilities, including:

- unannounced annual inspections of facilities by ministry investigators (as of January 1, 2004)
- a toll-free phone service for residents and the public. The number, 1(866) 434-0144, will give people one access point to get information or register a complaint about a long-term care facility. This number will be available after hours and on weekends and will be staffed by trained agents fluent in various languages. Registered nurse compliance officers will be available to assist with urgent problems.
- posters for prominent display in long-term care facilities, to promote the toll-free phone service to residents and their families and caregivers.

A media release on the initiatives is at

<http://ogov.newswire.ca/ontario/GPOE/2004/01/22/c2284.html?lmatch=&lang=e.html>.

### **ONTARIO ANNOUNCES MOBILE EMERGENCY TEAM**

On January 23 Ontario announced creation of Canada's first-ever Emergency Medical Assistance Team (EMAT), which will allow a special unit of health professionals to act quickly in the event of an infectious disease outbreak. EMAT can be sent to the aid of communities anywhere in Ontario within 24 hours of an infectious disease outbreak, health emergency or other disaster.



EMAT is a mobile acute-care field unit consisting of 20 negative-pressure tents staffed by a team of healthcare professionals. The self-sufficient unit includes medical equipment and supplies, a communications centre and its own supply of electricity and water. A media release on EMAT is at <http://ogov.newswire.ca/ontario/GPOE/2004/01/23/c2670.html?lmatch=&lang=e.html>.

### **ONTARIO: SMITHERMAN PROMISES MORE FOR PUBLIC HEALTH**

According to a January 26 *Globe and Mail* article, Ontario's Minister of Health and Long-Term Care George Smitherman has promised a substantial increase in funding for public health. Said Smitherman:

*"We need to refocus precious resources to the prevention side of health care. What we need to do is rebrand public health and make it about health promotion and prevention, to talk about it in terms of what it can do for us as individuals, and that is to keep us healthier."*

Says the *Globe and Mail* commentary on Smitherman's remarks:

*"Mr. Smitherman's emphasis on shifting taxpayer dollars puts him on course to battle the established interests in health care: the doctors who want more money, the hospitals that say they are underfunded and the drug firms that take a rapidly escalating share of tax dollars."*

Smitherman's recent appointment of Dr. Sheela Basrur, formerly Toronto's Medical Officer of Health, to the position of Ontario's Chief Medical Officer of Health, is widely seen as a sign of the Ontario Government's renewed interest in public health. Basrur will conduct a review of public health services and programs to strengthen the province's capacity to respond to infectious disease outbreaks and other health emergencies.

### **NOVA SCOTIA: INFORMATION OFFICER WANTS MORE HEALTH INFO ACCESS**

Nova Scotia's freedom of information officer Darce Fardy recently called on the province's government to close a loophole that allows hospitals to deny information to patients and their families. According to Fardy, the province currently gives hospitals the right to deny information requests if the requested reports are subject to peer review. Fardy has encountered several instances where hospitals, worried about the threat of lawsuits, denied information by claiming the information is part of a peer review process.

The issue surfaced after the IWK Health Centre denied information to the parents of a child who died at the hospital.

Nova Scotia's government has a spotted record in terms of freedom of information. In May 2003, the Canadian Association of Journalists gave the Nova Scotia government its annual Code of Silence Award (a plaque featuring a padlock hanging from chains) as the most secretive government in Canada. The award was given in part because Nova Scotia had instituted the highest fees in the country for access to information requests, resulting in a sharp decrease in the number of requests under the Freedom of Information Act. As well, in 2002 the government denied a freedom of information request for background material on why cabinet decided to cut some programs and keep others – a request that Nova Scotia Justice Minister Michael Baker described rather tactlessly as "information rape". The government's decision was later overturned by the courts.



## **MANITOBA REPORT CALLS FOR INFECTIOUS DISEASE CENTRE**

On January 26 the governments of Canada and Manitoba released the report of their joint Centre for Infectious Diseases Task Force, entitled *Fighting Disease - Fostering Innovation*. The report recommends creation of an International Centre for Infectious Diseases in Winnipeg, and the establishment of a special development zone, BioMed City, in Winnipeg. BioMed City would be an area where research laboratories and academic resources can provide "synergies for new research, product development, commercialization and company start-ups. It will also attract companies seeking to develop in proximity to others in the infectious disease field".

The report is a 53 page PDF file at [http://www.gov.mb.ca/est/pdfs/fighting\\_disease.pdf](http://www.gov.mb.ca/est/pdfs/fighting_disease.pdf).

## **SASKATCHEWAN RELEASES WOMEN'S LEGAL GUIDE**

On January 17 the Province of Saskatchewan released a guide to legal issues for Saskatchewan women. The Public Legal Education Association of Saskatchewan produced the Guide with funding from Saskatchewan Labour's Status of Women Office. Said Deb Higgins, Minister Responsible for the Status of Women, "Many women who experience relationship violence, workplace harassment or financial difficulties do not get the information they need because of privacy or safety concerns for themselves or their families. *A Guide to the Law for Saskatchewan Women allows women to get the knowledge they require without harassment or victimization.*" The Guide is available as a 196 page PDF file at <http://www.plea.org/freepubs/guide.pdf>.

The Guide complements Saskatchewan's *Action Plan for Women* issued in October 2003. The *Action Plan* is available as a 44 page PDF file at [http://www.swo.gov.sk.ca/Action\\_Plan.pdf](http://www.swo.gov.sk.ca/Action_Plan.pdf).

## **FEDS MAY UP HEALTH FUNDS TO NUNAVUT, BUT BATTLE FIRST NATIONS**

Federal Minister of Health Pierre Pettigrew, in a recent visit to Nunavut's capital Iqaluit, indicated the Federal Government may increase funding for health provided to Nunavut through its Non-Insured Health Benefits (NIHB) program. Said Pettigrew, "The particular challenges that you have...(are) the extra costs that don't exist in the south. The government of Canada has its responsibility".

NIHB covers extra health care services such as medical travel and prescriptions for aboriginal people that are not included in regular provincial and territorial health coverage. Nunavut receives \$37 million a year in NIHB payments for Nunavut's Inuit, who comprise 85% of the territory's population.

Nunavut has complained that the funding rules for NIHB do not reflect true costs in the territory. For instance, NIHB will cover \$250 for airline tickets to travel for medically necessary care, when the actual cost of such trips is often well over \$1,000. Nunavut officials claim the cost to the territory of covering such expenses hampers the ability of Nunavut to invest in other areas of wellbeing for its population.

Meanwhile, a Health Canada initiative to introduce a new consent form for Aboriginal people receiving NIHB benefits continues to founder in the face of opposition from Aboriginal groups who say the form requires Aboriginal people to allow government access to their medical records, in violation of the Charter of Rights and Freedoms. Federal officials claim the consent is necessary to ensure appropriate services are provided through NIHB. The new consent form was introduced by the Federal Government in late



2002, but failure to sign it entailed no penalty until September 1 2003, subsequently extended to March 2004 (although some Aboriginal Canadians have complained they had been pressured to sign the forms). After the cut-off date, Aboriginal people using NIHB would be required to pay "up front" for services and seek reimbursement thereafter from the government. To date, 79% of the 746,266 people who qualify for full medical coverage under NIHB have not signed the consent form, despite Federal expenditure of over \$3 million to persuade Aboriginal people to sign. Health Canada claims it has secured the consent of about 33% of those who actually used NIHB benefits in 2001-02.

Says the Assembly of First Nations (AFN):

*"First Nation Leaders from across Canada have expressed serious concern that First Nations people will not be able to access NIHB benefits due to their opposition to Health Canada's Program Consent Initiative. Health Canada has made it clear that if First Nations people do not sign NIHB Program Consent Forms, the NIHB Program will not pay for benefits such as a prescription medication or dental service. First Nations view that the NIHB program is a fiduciary obligation resulting from an inherent Treaty and First Nations right to health."*

AFN has indicated a willingness to help develop an alternative consent form, to include statements affirming basic treaty rights, clarification of individual entitlements under the NIHB Program, and affirmation of the individual's right to refuse without penalty. The alternative consent form would allow Health Canada to collect only the minimal field of information necessary for remuneration and auditing provider abuse.

Whether the Federal Government is willing to negotiate its way out of the impasse may be one of the first tests of Prime Minister Paul Martin's commitment to a renewed emphasis on Aboriginal issues.

### **AVIAN FLU POSES THREAT**

Concern continues to spread globally as the number of avian flu cases found in humans in Asia, and the number of Asian countries in which the cases have occurred, continue to increase. At last count human cases have been found in Vietnam, Thailand, Cambodia and possibly Myanmar, spread in all likelihood by migratory birds. It appears that officials in Thailand delayed announcing the presence of avian flu in the country, so that its extensive poultry exports would not be affected until the last moment.

Avian flu has also spread to Pakistan, Indonesia, South Korea, Laos, Japan and possibly China, although no human deaths have been reported in these countries. Klaus Stöhr, a senior virologist at the World Health Organization, pointed to the magnitude of the spread of avian flu this year, saying, "*Never in history have we seen such outbreaks of highly pathogenic avian influenza over such a wide area, simultaneously*".

At present avian flu can spread from birds to humans, but not from one human to another. All human cases so far are believed to be from contact with chickens or their waste, not from eating birds or their eggs. What worries epidemiologists and virologists most, however, is the possibility of a change in the avian flu virus that could make it transmissible from one human to another.

This could initially occur in a person infected simultaneously with "human" flu and avian flu. Under such conditions, it is possible that a "reassortment" of the DNA in the two viruses can occur, turning avian flu in to a virus that incorporates properties from human flu, thereby making it possible for avian flu to pass from human to human. This could prove much more disastrous than the SARS epidemic, which was limited in



part because SARS could be spread from one human to another only through fairly large airborne droplets of fluid. Most flu viruses can spread in airborne form through much smaller droplets. Avian flu has so far produced high mortality rates among humans infected with it, and is resistant to the less costly of the two main classes of drugs used to fight influenza viruses. Laboratories in the World Health Organization network are using new techniques to try to develop a human vaccine against avian flu.

The only feasible response to avian flu at present is the slaughter of infected birds under controlled conditions that protect workers who slaughter the birds – a difficult task in parts of Asia, where many chickens are raised in unidentified “backyard” bird coops. Infected birds can shed large amounts of the virus in their feces. The virus can survive for long periods in the tissues and feces of diseased birds and in water, especially when temperatures are low. In water the virus can survive for up to thirty days at water’s freezing point, and survives in frozen material indefinitely.

### **UK: HOUSE OF LORDS TO CONSIDER EUTHANASIA**

On January 14 the British House of Lords took an unprecedented step by appointing a committee to investigate a Bill to legalize assisted suicide. The Private Member’s Bill was first presented to the House last summer by Lord Joffe, a former human rights lawyer, who claims that 80% of British citizens support the legalization of euthanasia. However, a May 2003 UK Right To Life organization report states that 74% of doctors surveyed would refuse to perform assisted suicide if it were legalized. A clear majority (56%) of the surveyed doctors consider it impossible to set safe bounds to euthanasia.

Britons who support and who oppose euthanasia will likely refer to experience in the Netherlands as they attempt to influence the Lords committee. A year and a half after the Netherlands became the first country to legalize euthanasia and doctor-assisted suicide, up to 3,000 lives have ended through euthanasia (the exact figure is open to dispute), and the law seems to have wide popular support. Some critics argue that a number of doctors are participating in euthanasia without reporting their acts, making it impossible to monitor the practice.

Meanwhile, in a US development, Wisconsin Catholic Archbishop Raymond Burke has formally notified Catholic lawmakers in his La Crosse Diocese that they cannot receive Communion if they continue to support procured abortion or euthanasia, saying, “*Catholic legislators... are not to be admitted to holy Communion, should they present themselves, until such time as they publicly renounce their support of these most unjust practices.*” The notification followed media reports that Archbishop Burke had sent letters to three Catholic legislators in the diocese, warning them of the spiritual dangers of their votes “against human life”. Burke said none of the lawmakers to whom he wrote accepted his invitation for a private meeting to discuss their voting records, and in letters to the bishop, the legislators said they were not open to changing their positions. Burke said many Catholics misunderstand the concept of separation of church and state, taking it to mean that church teachings have no application to political life. Burke affirms that Catholics are obliged to form their political judgments from church teachings.



### **AUSTRALIA: ADDICTION HELP BY MAIL?**

A groundbreaking new program called the "Controlled Drinking by Correspondence Program" has been launched by the Government of the Australian state of New South Wales to help people not severely dependent on alcohol, but who are problem drinkers. The program, targeted to women and rural residents, showed some success in its pilot phase. According to Steve Whan, a New South Wales legislator:

*"You simply phone up, and they send you an eight-week program tailored specifically to your needs. You will also receive a credit card sized self-monitoring package that helps you keep track of your progress and contains reminders of important tips whenever you become tempted. A major benefit of the program is that around 50% of its participants are women. Unlike traditional face to face alcohol treatment programs where only 7-14% of the participants are women."*

The program attempts help people to find ways to reduce their alcohol consumption, even in social situations, so that they are not at risk of alcoholism. People can make initial contact with the program by calling a toll free number.

The program's 12 month trial period showed significant reductions in participants' alcohol-related problems and overall reductions in drinking of more than 50%.

Information on the program, which is operated by the Australian Centre for Addiction Research, is at <http://www.wmi.usyd.edu.au/aboutus/acar/page10.html>.

### **VENEZUELA: NEW TWIST ON THEFT LAWS?**

According to comments made by Venezuela's Supreme Court Judge Alejandro Angulo Fontiveros on January 14, proposed legal changes in the county will include a proposal that people charged with non-violent theft of food, medicine or inexpensive items will not be punished if the theft is motivated by extreme hunger or need. Fontiveros, in charge of drafting the proposed legal changes, says, "*This is a guide for judges to avoid injustice. They lock up for years a poor person who lives in atrocious misery and what they need is medicine.*"

Critics say the initiative will fuel crime, but supporters argue such a change in law is necessary in a country where two thirds of its 25 million people are poor, and at least one third of those cannot afford their basic food needs, despite the nation's huge but poorly distributed oil wealth.

The penal reforms spearheaded by Fontiveros may also propose decriminalization of abortion and voluntary euthanasia for the terminally ill.

### **US MILITARY MEDICINE: GOOD NEWS/BAD NEWS**

Occasionally in our meanderings in the health field we find articles that contain good news overlaying bad news. This was the case recently when we read a November 2003 media release on the US Army's military medicine web site.

The good news first. US Army Staff Sergeant Adam R. Irby, assigned to the 28th Combat Support Hospital in Iraq, is not a trained medical technologist – but when a problem arose, he solved it with a low technology invention. The hospital deals with a number of severely wounded US soldiers, and it needed a



device to raise the body temperature of soldiers who had lost large amounts of blood, as a way to help with the clotting problem. With blood loss a patient's temperature starts to drop, and with this drop in temperature the patient loses the ability to stop the internal bleeding.

Irby designed a simple box-like structure that encloses a patient (except for the head) lying on a hospital bed. Made of cloth-covered cardboard and dubbed "the Chief Cuddler", the box has a hole in it into which a hairdryer can be inserted to gradually increase a patient's body heat. The Chief Cuddler has helped save over 20 lives. These lives are documented on the outside cover of the Cuddler with each patient's number, and the date and time it was used. Before Irby's invention, the hospital used conventional methods of warming a patient with many blankets and lamps. "*This was not a timely or effective method,*" Irby said.

Now the bad news. According to the media release:

*"Under normal conditions, doctors and surgeons would use a 'Bear Hugger' blanket, which incorporates small ventilation pipes distributing warm air around the patient, said [Doctor Tracy] Lyon. She said the hospital has been waiting four months for the arrival of the blankets, which cost more than \$900 each. In the mean time, the 'Chief Cuddler' has been working hard to save lives."*

Why – with all the famed logistical support the US provides to its military forces in Iraq – and despite its ability to fly President Bush into Baghdad for a turkey photo op – does it take more than four months for blankets to arrive that will save the lives of soldiers?

The media release is at <http://www.defendamerica.mil/articles/nov2003/a111903h.html>.

## **US GOVERNMENT SUED OVER VETERANS' SERVICES**

In a bizarre development at a time when US officials take every opportunity to praise their men and women in uniform, US Congressman Ted Strickland (a Democrat from Ohio) on January 22 joined the Vietnam Veterans of America in filing suit against the US Department of Veterans' Affairs (VA) charging that the Secretary of Veterans' Affairs failed to "*comply with its statutory duty to provide veterans and their families with 'outreach' regarding health care benefits and services.*"

The suit stems from a July 18 2002 memo from a Veterans' Affairs Deputy Secretary to all VA Network Directors ordering them to "*ensure that no marketing activities to enroll new veterans occur within your networks.... Even though some sites might have local capacity...all facilities are expected to abide by this policy.*"

Said Strickland, "*This lawsuit is a last resort. I wish there had been some other way to deal with this situation. But the Administration has been unwilling to lift this shameful policy. And despite the Secretary's claim that the gag order was temporary, it's still in place a year-and-a-half later.*"

The US Congress requires VA to discharge "*the affirmative duty of seeking out eligible veterans and eligible dependents*" so they can apply for federal benefits and services – a mandate VA has neglected, according to the lawsuit.



## OUR READERS SAY.....

In response to last week's editorial about "trailer trash" media depictions of the disadvantaged, one reader wrote:

*"Your editorial reflects largely one half of the equation. While people in distress or who are disadvantaged have every right to be protected from stereotyping, we also need a way to ensure people in need exercise responsibilities as well as availing themselves of rights."*

Another reader wrote:

*"North American generally pride themselves on being a society without social classes, but we all have a perverse need to have someone to look down on. If we didn't have classes, we would invent them anyway."*

In response to a reader's description in last week's *Import* of his denial of drug coverage because of his wife's salary (even though his drug costs exceeded her salary), another reader wrote:

*"This would be easier to accept if it were straight malice. Unfortunately it is an example of the dehumanization that often comes with rules. 'When in doubt, always follow the book' is no way to run a human and humane service system."*

**Editor's update:** The reader who experienced the problem has since informed us that he has been granted a one-month extension of his drug coverage by the Ontario Disability Support Program. The extension expires on January 31. He was also informed that he would be sent a card to use for the one-month extension – and that it would be sent to him at the end of January, thereby rendering it useless. Said the reader, *"I can hardly wait to see what surprises they have in store for us in February as they will only have 29 days in which to screw up the works"*.

## IN MY HUMBLE OPINION: ABSORPTIVE CAPACITY

A fairly recent buzz phrase – absorptive capacity – will likely become more widespread in the near future. The meaning and implications of the phrase are worth examining, since the concept may become a useful tool in human services.

Absorptive capacity, first defined as the ability of an organization to recognize the value of new, external information, to assimilate it and to apply it to organizational ends, became part of the lexicon in 1990 – more specifically through the influential article *Absorptive Capacity: A New Perspective on Learning and Innovation* written by W.M. Cohen and D. A. Levinthal and published in *Administrative Science Quarterly* 35: 128-152. Since then its meaning has broadened to include the ability of an organization to absorb anything that might affect its future.

One face of absorptive capacity looks outward, scanning the environment for information or other phenomena the organization should know about. The other face is inward: it is the ability of an organization to actually incorporate new phenomena within itself.



Two other dimensions of absorptive capacity are also worth mentioning:

- the **technical ability** of an organization to identify and incorporate new information and resources
- the organization's **motivation** to identify and incorporate new information and resources.

The concept of absorptive capacity has been bandied about in the sphere of international development for the last few years. As governments in the developed world continue to provide resources to developing nations, often for health initiatives to combat HIV/AIDS, tuberculosis and malaria, some analysts question the absorptive capacity of developing nations to actually apply the funds to the purposes for which the funds were designated. A country that receives \$50 million for grass-roots AIDS prevention, for instance, but that doesn't have the community infrastructures to deliver preventive services, can be said to lack absorptive capacity.

Some champions of international development worry that a focus on absorptive capacity may be used as a blanket pretext for not investing in the developing world – *"Why bother giving them money? They wouldn't be able to use it properly anyway"*.

On the other hand, a sober approach to absorptive capacity has led some international donors to funnel their money not to third world governments (whose absorptive capacity may be limited by corruption, internal political conflicts or just plain incompetence), but to non-government organizations in those countries that exhibit greater absorptive capacity because they have fewer internally competitive agendas.

But absorptive capacity can be applied much closer to home. Ontario's recently released hospital scorecards, for instance, indicate that for a number of dimensions of information acquisition, sharing and application, small hospitals may not do as well as larger hospitals. One possible explanation of this finding is that smaller hospitals have less technical absorptive capacity: they may have the motivation to gather, share and apply information, but they may not have the specialized personnel and knowledge to absorb and use information as well as they would like.

While similar annual scorecards are not commonly found among community-based health and social service agencies, these are the very agencies that may face the biggest challenges in terms of absorptive capacity. They are usually small organizations, without specialized knowledge management staff and with harried managers who are forced to concentrate on today's problems rather than tomorrow's solutions. As one such manager once put it to me, *"It is tomorrow's solutions that are most important, but it is today's crises that will kill me. Guess which gets most of my attention?"*

And just as developing countries may have problems absorbing and applying new resources, so smaller agencies in our country may have difficulty properly using new resources unless they are allowed to invest some of those resources in improving their absorptive capacity.

In Ontario for well over a decade, for instance, organizations have occasionally benefited from spurts of new funding from government (often to solve a public relations crisis faced by the government). Very often the funding comes with a proviso attached – all of the money must be used for direct service, and none for growth in administrative infrastructure. I know of one instance in which an organization's budget has more than doubled, but its administrative budget line has remained constant.



Can such organizations really do a consistently good job of spending money wisely and strategically when their absorptive capacity has not increased? I doubt it, despite the best efforts of managers in these organizations. And whether an organization has received new direct service funding or not, its manager and its board are now peppered with increasing requirements to show “accountability” to funders and to emulate best practices, without an allowable increase in funding to help the manager demonstrate – much less guarantee – accountability, or to uncover and introduce best practices.

The solutions to the problems of strengthening absorptive capacity are not easy ones, but two are worth pursuing:

- convincing funding sources (most often governments) that an investment in absorptive capacity is just as necessary as an investment in direct service. This may well be a “hard sell” since government employees often face their own problems of absorptive capacity – the gutting of government staff complements to create leaner bureaucracies – a phenomenon that helped create the inspection crisis that underlay the Walkerton tainted water scandal.
- finding multi-agency ways to improve absorptive capacity. For instance, one little agency may not be able to invest much in knowledge management, but ten similar little agencies, working together, may be able to put together a central knowledge management team to serve all ten. There are many examples of agencies investing in such collaborative enterprises of their own volition – but sometimes agencies have been their own worst enemies, refusing to cooperate in such joint endeavours for fear of losing control (even when the choice is between partial control of something, and total control of nothing).

So the concept of absorptive capacity will be with us for a while, globally and locally. We can dismiss it as the latest techno-babble – or we can use it as a pragmatic tool to increase our capacity to deal with information and other resources in the human service system.

John Butler, The Agora Group

#### **FROM THE QUOTES VAULT**

*“When everyone has to reinvent the wheel, many people invent square wheels.”*

Jakob Nielsen, The End of Homemade Websites, Oct. 14 2000