S/A 4071: Social/Cultural Aspects of Health and Illness:
Class 18: Medical Practitioners, Medicare & The State

* Today we will look at issues surrounding the history, organization & delivery of health care in Canada

Early Canadian Medical Organizations:

* Aboriginal peoples: various cultural definitions & practices (e.g. botanical remedies, Shamans, etc.)

* Early settlers faced many threats to health (e.g. epidemics, poor sanitation, cold, short growing periods, poor diets, childbirth). Relied on folk remedies, midwives, & traveling medical salespeople)

Origins of the Contemporary Medical Care System:

* 19th century: a variety of practitioners offering services (e.g. midwives, lay healers, folk remedies, medicine shows, lots of opium & alcohol)

* Barbers served in capacity as apothercaries/ external surgeons

* Army surgeons active

* Homeopathic doctors worked alongside emerging allopathic practitioners

* First medical school: 1824 (not scientifically based)

* First government involvement 1832: quarantine & sanitation provisions as a result of impending epidemics

* Late 1800's: Public Health; Food & Drug; Narcotic Control Acts

Efforts of Early Allopathic Physicians to Organize:

* As far back as 1795, high status allopathic practitioners attempted to have legislation passed to give them a professional monopoly on medical practice

* Allopathic practitioners complained they were under-rewarded & under-esteemed due to competition from “quacks” & disorganized state of medical education

* Nevertheless, alternative healers exhibited considerable education, strength & organizational skills (aided by divisions among allopaths)

* Surprisingly, in 1869 College of Physicians & Surgeons of Ontario formed to include both groups. A similar body formed in Quebec in 1847, albeit with French-English tensions

* Competition & infighting between varying practitioners largely subsided by WW1

* 1912: Canada Medical Act passed: went hand in hand with US Flexner Report to standardize licencing procedures & favor allopathic medicine

* By the 1920's the medical scientific, technological, centralized hospital treatment that we know today was in place

* Allopathic medicine & its schools were hit hard: fell most heavily on women & Blacks: favored White, mid to upper class males

A Brief History of Universal Medical Insurance in Canada:

* This idea was proposed in 1919 & 1945, but rejected by the provinces

* Tommy Douglas in Saskatchewan: first provincial medicare program: influential on Federal government

* In 1957 the government proposed paying 50% of the average provincial costs for certain hospital& testing services

* 1961: Royal Commission recommended universal health care

*1968: Medical Care Act. Objectives:

(1) Universality
(2) Portability
(3) Comprehensive Coverage
(4) Administration (non-profit)

* 1984: Canada Health Act: added accessibility to these principles

* Subsequent growth of health care costs: dispute between federal government, provinces & medical associations over "extra billing"

* Conflict continues in different forms today: doctors dissatisfied vs. public support for medicare

Factors in the Development of Medicare in Canada:

* The development of medicare in Canada over past half century was influenced by:

(1) Western nations' move toward rational, bureaucratic social organization & monopoly capitalism
(2) The spread of social welfare legislation in other areas/countries
(3) Benefits to the medical profession

(4) Interests of the medical & health insurance industries in maintaining market share/profitability
(5) Interests of the drug, medical & hospital supply companies to develop their increasingly profitable markets
(6) Interests of urban unions & farm cooperatives in obtaining social welfare benefits for members
(7) Charismatic leadership & dedication of key individuals in positions of power at opportune times

The Impact of Medicare on the Health of Canadians:

* Despite introduction of universal medicare, health continues to vary by class: obviously more going on than unequal access to medical care

* Much of Canada's health care is still private (service delivery: 30% of health funding, incentives for doctors to operate private for-fee clinics to cover procedures not paid by medicare, preferential access to treatment, many prescriptions not covered for working poor)

The Impact of Medicare on Medical Practice:

* Medicare boosted doctors' incomes & attracted more people to medicine as a career

* Some areas have an oversupply of doctors (lowering salaries); others too few (boosting salaries, but having side effects on accessability & workload)

* Changes in the work of doctors resulting from medicare:

(1) In working conditions
(2) In control over patients & other occupations in field

(3) Re: self-regulation in education, licensing & discipline
(4) In the actual content of the work

* Charles (1976) Medicare resulted in increased administrative, economic, political & social constraints & stresses

* Buckley & Harasim (1999): rank order of stresses facing doctors:

(1) Lack of time for a personal life
(2) Oral & written examinations
(3) Information overload
(4) Time demands of research
(5) Sleep deprivation
(6) Financial hardship
(7) Fear of being incompetent
(8) Time demands of being on night call
(9) The hospital computer system
(10)Uncooperative hospital staff
(11) Insecurity over future career opportunities
(12) Resident & staff conflicts

The Impact of Medicare on Health Care Costs:

* Health care costs as a % of GDP have increased since 1960. In 2002 this amounted to about $3300/person.

* Private expenditures add another $1357/person (2000 figures). Especially among those with higher incomes

* The Federal government has been gradually cutting back its share of health expenditures amid great conflict with the provinces & recommendations for wider federal programs (e.g. Pharmacare)

* Many commissions have studied this issue & made recommendations (e.g. Romanow), amid a patchwork of provincial coverage

* Compared to US, Canadians are more likely to visit a doctor, but there are no significant differences in hospital admission rates or length of stay.

* Yet greater class differences exist in the US. There, the poor visit less often, but, once engaged, tend to have longer stays

* Medical care in both the US & Canada more expensive than other OECD countries

* Highest levels of expenditure are on the hospital sector, physicians & drugs. Pharmaceuticals moving into second place over time

* Federal cutbacks of "earmarked" funds for health care in return for more provincial freedom has resulted in hospital & bed closures across Canada

* Shorter hospital stays result in higher rate of readmissions (e.g. births)

* Health care is now a major political football, but must be studied in its wider political economic context.

* Burke & Stevenson (1993): Many government studies may be criticized due to: (1) therapeutic nihlism; (2) healthism; & (3) the discourse of health promotion.

* Varying proposals for cutting costs include:

(1) user fees, extra billing, co-insurance & deductibles
(2) controls over the number of physicians & hospitals

(3) recognition of the increase in alternative models of health care, alternate physician payment schemes, capitation, salary & health promotion education, & publicly funded competition between types of health-care practitioners

* Only time will tell how this situation will evolve, & the impact on health & health care in this country