S/A 4071: Social/Cultural Aspects of Health and Illness:
Class 19: Medical Practitioners, Medicare & The State 2

* Today we look at the social development of the Canadian health care system, & its relation to those of other capitalist countries (Torrance)

* "Convergence" theory: most advanced industrial societies have followed a broadly similar path in both dealing with disease & death, as well as in the evolution of health systems

* As morbidity & mortality declined in 19th century for various reasons, a unified medical profession was emerging, attaining professional autonomy & achieving dominance over competing healers due to social background, connections, state backing, & promotion of curative effects in select areas

* The emergence of modern state systems of health insurance to facilitate accessibility resulted from the interactive efforts of the medical profession, social elites, labor movements, politicians, bureaucrats & the state (with varying degrees of influence/strategies in different countries)

* Outcome: health care systems with:

- a heavy emphasis on curative medicine in hospitals
- little attention to socio-economic sources of illness, prevention, public health or rehabilitation
- complex & expensive medical technology
- growth of specialization vs. primary care
- a rigid division of labor
- creating new sources of corporate profits/professional wealth from state subsidized care
- the intrusion of the medical industry into problems previously considered outside its jurisdiction

* New phase: conflict over containing burgeoning health costs: burden falling most heavily on those least powerful, organized, active, & vocal

* Despite similarities with other countries, however, the development of the Canadian health care system has two topics worthy of special consideration:

(1) the emergence of professional dominance 1818-1912
(2) the emergence of nationwide health insurance 1919-72

(1) The emergence of medical dominance 1818-1912

* Canada's medical system developed in a more controlled fashion than the US, with an elitist character & closer relationship to the state

* Aboriginal practices wiped out by European epidemics, etc.

* "Toiler society" of early to mid 19th century: health system shaped by settler populations, diseases, beliefs, & various healing practices they brought with them. Little connection with science (e.g. brandy, opium, "home remedies," herbs & army surgeons)

* Mid-1800's: no cohesive medical profession despite emerging medical schools: competitive market & difficulty on part of elites to pass/enforce licensing laws against "irregulars" (though these attempts preceded US)

* Impediments to professionalization: convincing eligible people to *become* licensed & devising ways to *exclude* those considered "ineligible" despite public opposition. Strategies:

- incorporating homeopaths as "representatives" (i.e."coopting")
- establishing university medical schools & upgrading training
- controlling/narrowing channels of entry

- subordination, limitation & exclusion of associated/competing occupations (e.g. pharmacy, nursing, midwifery). Mostly those with previous independence or largely female members
- new associated professions emerge under medical control (e.g. X-ray techs, physiotherapists)
- 1912: passage of the Canada Medical Act standardizing medical licensing across Canada
-1912: Flexner Report: spillover effects in Canada: "scientizing" & legitimating laboratory medicine (though already well under way)

* This all went on against the backdrop of terrible living, working, & health conditions resulting from mass immigration, urbanization & industrialization

(2) The emergence of nationwide health insurance 1919-72:

* Canada trailed behind many Western countries in the development of public health insurance, as in other social welfare legislation (it took until 1968)

* While this idea emerged in Germany in the 1880's & was followed up by European countries, in North America social forces prevented the rapid adoption of such models:

- uneven development of industrialization
- lack of political alliance between farmers & industrial workers
- shortage of practitioners & facilities
- doctors' professional fears of lay control/losing autonomy
- the relative weakness/divisions in the Canadian Medical Association until the 1920's, thereafter becoming focused
- close connections between the medical profession & government/bureaucratic elites

- free market ideology/ general disdain for state intervention
- constitutional division of powers: health a provincial matter
- doctrinal opposition to “socialist” policies by the church
- the interests of the health insurance industry & others

* Factors leading to introduction of health insurance:

- slowly building political pressure compared to elsewhere, complicated by divisions among groups
- the great depression, poverty, worsening health & political radicalism (esp. in the West)
- a CMA report endorsing health insurance so long as they maintained autonomy & dominance
- growing labor unrest/ radicalism
- planning for reconstruction after WWII: Heagerty Commision & breakdown of Federal-Provincial Conference
- increasingly prosperous, populous, urban, educated middle class
- growth of the medical-industrial complex, research funding & technological treatments, with successes promoted through the mass-media
- CCF provincial government in Saskatchewan: provincial hospital insurance program 1947
- Federal Health Grants 1948
- National Hospital Insurance program 1957
- Saskatchewan medical care insurance 1962
- Royal Commission on Health 1964
- struggle to pass federal legislation until 1968 (territories included in 1972)
- less historical opposition to government intervention than in US
- long term interests of capital (i.e. workers “healthy enough” to be productive, opportunities for profits, obfuscation through “shell game” of government as “middleman” taking the blame for costs)

* In the end, the introduction of this government health insurance:

- reduced, but did not completely eliminate disparities between regions & income groups in access to medical services
- institutionalized the status quo (winners/losers)
- increased the difficulty of introducing structural changes needed to make health care more responsive to society