S/A 4071: Social/Cultural Aspects of Health and Illness: Class 20: Medical Practitioners, Medicare & The State 3

* Canadian health policy oscillates between preventative & curative approaches, with treatment & cure being generally dominant

* Shifts in emphasis tend to go hand in hand with shifts in power in the health care system

* Today we look at the organization of the health care system & current reform initiatives in this light

Health Care & Health Care Policy in Canada:

* Canada's constitution makes health a provincial matter: the federal government can only influence health policy through fiscal mechanisms & political influence on the public

* This is one reason, among others, that we have already noted universal medical insurance took so long to develop in Canada. Others include:

- doctors' desire for professional autonomy
- the private insurance industry
- fear of "creeping socialism"
- working class agitation
- the need for healthy labor
- provincial initiatives

* Ultimately universal health care was introduced under a fee for service scheme (a concession to doctors autonomy & a clear inflationary factor)

Medical & Cost Containment:

* By 1972 all provinces/territories were covered by medicare.

* Characterized by 5 principles: -Universality of eligibility
  - Comprehensiveness of coverage
  - Portability between provinces
  - Accessibility/prepayment through tax
  - Public nonprofit administration (50:50 cost sharing between Feds & provinces)

* Only services by physicians (in or out patient) covered. Discouraged provincial alternatives to doctor/hospital services/ encouraged cost control strategies:

- reducing number & duration of contacts with health care system
- removing direct 1:1 link between provincial/federal costs (neither happy)
- <u>Fed-Prov Arrangements & Established Programs Funding Act</u>:

  $20/person incentive for provincial community care
  Federal contribution reduced to 25%
  Uncoupling federal from provincial expenditures
  Capped federal funding increases at rate of growth of GNP
  Transferred tax points to provinces to help raise own funds

- 1980's & 1990's: further cost cutting to federal transfers (allowed to increase at rates below growth of GNP). Still health spending grew during this period
- Federal reductions in transfer payments initiated a series of cost cutting measures by provinces:

Budget reductions
Closing beds
Controls on fee increases
De-insuring certain services
Limits on # of particular services billed
Increased monitoring & disciplinary power for regulators
Reduction of hospital services
Increased community-home care services

- Doctors replied with strikes/ user fees / extra billing in face of widespread public opposition & political agitation
- Crowded waiting rooms & long waiting lists raise suspicions that reforms a strategy to "dismantle medicare by stealth"
- Politicians have responded by reasserting commitment to medicare
- Canada Health Act (1984) banned extra billing: many doctors replied by lobbying for privatization
- Since 1997, most governments have reaffirmed commitments to medicare & thrown more & more money at the problem (e.g. Canada health & social transfer, more tax points)
- The system is now far different than in the early 1970's, & is frequently perceived as inadequate

The Determinants of Health & Health Promotion:

* Health promotion has also become increasingly prominent over time (originally, health promotion was narrowly identified with better access to health care, but, in 1970's Lalonde argued it also included biology, self-imposed lifestyle risks, & environment: the "health field" concept)

* Responses varied: Some thought this would empower/integrate the marginalized & democratize health institutions

* Critics pointed out:

-victim blaming tendencies
- precursor to outreach/ screening programs that monitor & control people with drugs
- potential for expansion of individualistic, professionally dominated, clinical approach
- the powerful would twist this to their own interests
- there was increased potential for iatrogenic illness/unnecessary, ineffective & dangerous interventions
- diminishing returns in health despite high expenditures /health field concept could serve as a rationale to dismantle medicare

* Proponents countered by refining/refocusing the health field concept to one that "complements & strengthens the existing system"

* This controversy has raised important issues:

- "universal" access hasn't eliminated inequalities in health status
- prevention programs focus on injuries/illnesses that differentially characterize social groups
- changes in the health care needs of the population (not so much curing infectious diseases as managing incurable chronic illnesses, particularly among aging population)

* The adoption of the determinants of health policy framework has resulted in many changes to the nature & organization of health care

Regionalization: From Institutional to Community Care:

* Most recent & dramatic health reform is "regionalization" of the health care system: shift from centralized professional/occupational/

government control to community/consumer “control” in planning & service delivery

* Goals: to control costs, improve health outcomes, increase responsiveness, improve flexibility in delivery, better integrate & coordinate services, & provide better citizen awareness of, & participation in, health care planning & delivery

* Some see this as a move away from bureaucracy/ others as a form of corporatism (i.e. are the new “regional health authorities” the allies or the “fall guys” for more powerful players struggling to maintain professional control / contain costs?)

* Key point: no government has given RHA’s control over medical care or pharmaceutical budgets, nor would the medical profession allow this threat to their autonomy to go unchallenged

* Bureaucratic rationalization/ streamlining go hand in hand with this regionalization in incremental government strategies to keep the upper hand. Public perceptions/response is key to whether strategy succeeds

* Meanwhile, proponents of privatization promote their views, & political denials simply feed suspicion about eventual reprivatization

* Governments are attempting to limit medical autonomy/dominance in health policy/services, despite neither being as significant threats to medicare as a proliferation of private community clinics & service providers other than doctors (*de facto* privatization)

* Also pressuring for privatization are doctors, private sector health corporations, conservative provincial governments, aided by free trade

* It is unknown where this struggle for control will end. Privatization?