S/A 4071: Social/Cultural Aspects of Health and Illness:
Class 24: The Medical Care System: Critical Issues 1

* Today we begin to look at a variety of critical issues facing the Canadian medical care system. We will review:

(1) Issues surrounding the dominance of the medical model
(2) The changing balance between public & private funding
(3) The distribution of physicians across the country
(4) Mental health policy

* Next class we will turn to address the issue of sexism in medicine

(1) Issues surrounding the dominance of the medical model:

* Medical/allopathic model can be contrasted with the social/environmental & the lifestyle models. Each has value, but the medical/allopathic model is dominant in funding/support. Problems:

- increasing incidence of chronic diseases not amenable to cure
- prolonging life: issue of quantity vs. quality

* Demedicalization: medical model losing support (e.g. "Health promotion" framework emphasizing genetics, self care, mutual aid & developing healthy environments). Implemented through funding, health education, health advocacy & community development

* Trend further fostered by bureaucratization of health services & increased diversity of practitioners. Other important contributors to demedicalization include:

- the women's movement

- a changing disease profile (increased % of chronic illnesses, going hand in hand with an aging population)
- growing awareness of the importance of prevention
- focus on cost containment of growing health care costs
- the move toward a “risk society”
- a growing awareness of sexism in medicine

(2) The changing balance between public & private funding:

* Despite Canadians’ cherished public health care, it is under threat as public funding is down & private funding up

* We already live in a “publicly funded private system” where doctors & hospitals are largely private & work for profit (minimizing public control & maximizing control of professionals)

* Between 1991-97, private expenditures grew 30% while public expenditure decreased 1.6%

* Much public cost savings due to shorter hospital stays (less staff needed), private expenditures on home care, & popularity of some cost-cutting governments/re-election (though with consequences in time of crisis)

(3) The distribution of physicians across the country

* Inadequacy of public funded private system: problem in attracting retaining “entrepreneurial” doctors in rural areas (or towns under 10,000 population)

* Reflected in inequities in service delivery such as hospital admissions & home care (health outcomes?)

* Substantial aspects of health care have been moved out of hospitals, clinics & doctors' offices to home care. Fueled by:

- cost-cutting/ downloading of routine tasks
- deinstitutionalization of mentally disordered
- hospital & bed closures
- disproportion of doctors & specialists across the country
- new drugs
- aging population
- increasing chronic disorders

* Romanow Report: Home care will increase. Issues:

- new medications/technology will make more feasible
- new models/health professionals will develop in this respect
- more elderly people will prefer to stay at home
- stress & strain on families caregivers will be alleviated
- trends toward early hospital discharge will encourage
- home care will probably be cheaper

* Unfortunately, provincial jurisdiction over health makes for a current patchwork of home care services across Canada

(4) Mental health policy:

* Canada's "illness care system" may help deal with acute illnesses & injuries, but is relatively ineffective in dealing with increasingly long-term, chronic & degenerative health problems such as mental disorders

* Estimate: 20% of the population suffers from a mental health problem (2% from severe mental disorder). Treatment has increased, though settings have changed (i.e. fewer mental hospitals, more psychiatric beds in general hospitals)

* Many people never admitted to hospitals for treatment, but dealt with in private settings (either by family doctors or in homes). Many never seek help

* The total societal cost of mental health problems (direct & indirect) is hard to estimate, but is likely substantial

* The mental health care system is overwhelmed & incapable of dealing effectively with these problems

* Any definition of the solution to the problem depends largely on how the problem is defined in the first place:

- medical definitions result in medical "treatments" (first confinement in "asylums," later drug treatment in community)
- explanation for shift: "march of science" & "humanitarianism" vs. replacing one form of social control with another under economic & political imperatives
- challenges to psychiatry: "treatment" as coercive social control:

Szasz: patients really have "psychosocial problems in living"
Laing: patients respond rationally to an insane social reality
Patients' rights movement: legal rights to empower patients
Consumerism: choice of treatments/ variety of practitioners (limited by potential conflict between "mental health consumers," advocacy groups for families, & professional interests)
Mental patients' liberation movement: professional mental health services=oppressive forms of social control
Sociological critiques (e.g. diagnosis differences by class & gender, social causation vs. social drift arguments, etc.)
Scheff: labeling theory: mental disorder as residual deviance reinforced/stabilized by social reaction

* In the end, three competing groups emerge:

(1) medical professionals emphasizing mental illness as real, & treatment as the solution
(2) non-medical professionals maintaining issue is psychosocial & that sufferers require assistance
(3) psychiatric consumers-survivors who claim, whatever the nature of the problem, they should be responsible for its definition & solution

* Research findings also ambiguous, providing support for each position in some way. Hence: policy efforts often strive to accommodate all while keeping costs contained

* Current provincial policy proposals/developments ("health promotion framework"). Characteristics:

(1) increased emphasis on mental health promotion & prevention of mental disorders
(2) the protection of human rights & freedoms
(3) care for the coordination of service planning & delivery

* Mental health promotion/prevention of mental disorders:

- Officially vague definition of mental health, not defined as absence of mental illness, promotes "continuum" view where absence of symptoms does not=mental health
- Promotion of mental health the same for all, regardless of whether they suffer a disorder (i.e. "Overcoming obstacles")
- Prevention analytically distinct, though often intersects
- Despite emerging consensus that multiple factors cause mental disorders, little being done in terms of primary prevention
- Secondary prevention (i.e. of relapse) primarily pharmacological

- Most attention focused on “tertiary prevention” (i.e. minimizing disabilities / the need for expensive in-patient care)
- Stakeholders divided between exclusive reliance on medical treatment technologies vs. anti-professionalism/ volunteer initiative
- Having groups at loggerheads like this prevents common definitions, cooperation & effective practice: problem “papered over”

* Protecting human rights & freedoms:

- traditional delegation of power to designate mental “illness” to medical vs. legal professions (alternate emphases on “expertise” vs. need to protect society & individual rights)
- recent ascendancy of legal profession results from problems of diagnosis, mental health consumers, & the anti-psychiatry movement
- *Canadian Charter of Rights & Freedoms* also significant
- Contradiction between consumer empowerment & involuntary care: must strike a balance between individual & collective rights
- Introduction of mandatory community treatment orders to avoid “revolving door syndrome” & reduce cost: challenged as “leash laws”

* Community care:

-community care emphasized to balance institutional & community based supports
- goes hand in hand with deinstitutionalization/ provision of a range of alternatives for people with various levels of need
- consumers are supposed to have input
- cost-savings may be a big part of this movement
- further reducing in-patient services may not be without conflict

* Coordination of service planning & delivery:

- accurate identification of needs is necessary for rational planning & resource allocation/ individual treatment plans
- increasingly emphasized due to shortsightedness/ problems arising after first phase of deinstitutionalization (e.g. ghettoization, transinstitutionalization to the CJS)
- decentralization & regionalization proposed as policy alternatives
- advantages: -closer to the local problems
  -transfer of some power / more democratic
- problems: -difficult & divisive resource allocation decisions dumped on communities/ intensifying struggle
  -varying degrees of autonomy/real control
  - vested interests not willing to give up control/ fighting for control with no consensus on problem or solutions
  - a way of passing the buck

* Ultimately: - lack of consensus about the nature of mental health problems contributes to the institutionalization of contradictions at the level of service delivery
- this may not so much solve the problem as create new ones