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