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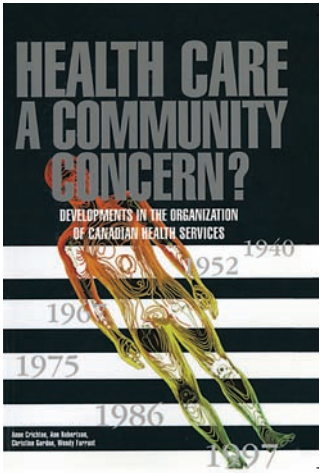

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 4

The Redistribution of Power Away from Local Communities and the Prospects for Its Return

Canada was settled mainly by farmers and fishermen who lived in scattered rural communities. In order to survive the rigours of life in a harsh climate, they helped one another in times of need. In Quebec mutual aid was always strengthened by the parish church; when the prairies were settled in the twentieth century, by cooperative action; and in the mining towns, by union activities.

Desrosiers (1979) has explained how, on the farms, family members of all ages were expected to earn their keep and to help each other with their tasks. Gradually with industrialization young adults moved into the cities to set up their own families and to look for paid employment. But then there was only one breadwinner for each family and if he were ill, disabled or out of work there was no extended family to fall back on. Neighbours continued to help one another as much as they were able, but their resources were insufficient to deal with all the problems which arose.

In the cities philanthropists established charity agencies to help the poor and the sick, and when these were unable to provide enough support, the municipalities would offer relief to the poor. Professionals often gave free services to those who could not afford to pay.

On the prairies farmers were influenced by the cooperative movement (which had started in Great Britain). They worked together to solve marketing problems and used their elected municipal governments to establish programs to support educational, health and social welfare services in their communities.

Changing Social Structures

With industrialization, social organization was changing in another way. The development of science and technology was creating a demand for experts in business and service provision. From the late nineteenth century onwards the numbers of professional persons began to grow as their expertise was seen to be valuable. There were, of course, many different kinds of professional skills which countries wanted to have and Canada encouraged immigrants with these skills to come in as settlers before it was able to produce a supply of its own. At the top of the hierarchy of professionals are medical doctors and they were much sought after. People no longer wanted doctors to provide pastoral care only (as they had done for some years in the more settled parts of Canada): they wanted to consult trained professionals who had learned about scientific diagnosis and treatment and who could be expected to cure, not just comfort their patients. Small communities tried to find ways of bringing these and other experts into their midst.

Canada's adjustment to these scientific and technological changes was interrupted by the First World War and then the Great Depression of the 1930s. The federal government and some provincial reformers (particularly on the prairies[1]) wanted to set up a publicly financed social safety net to ensure free health care for all who needed it and to improve educational provision.

The previous chapter has described the evolution of the welfare state in Canada. This new form of social organization put power over social programs into the hands of elected representatives of the communities. They were sent off to sit in legislative chambers in the federal and provincial capitals. Governments were expected to work closely with the growing bureaucracies to set up these new social programs. This decision by the federal government to take over new powers of funding health, education and welfare services took some time to work through, but it meant that most of the financial power was removed from the local communities and placed in the hands of a few people who were not always readily accessible.

Some provinces maintained strong municipalities (Manga and Muckle 1987) but others removed authority for many social programs to the provincial level. In either case the old established authorities had to learn new ways of relating to higher levels of organization and how to conform to new rules.

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1 In 1933, a group of reformers, the Cooperative Commonwealth Federation (CCF), published the Regina Manifesto proposing collectivist changes in social organization and social services, but it was not until the CCF was elected to power in Saskatchewan in 1944 that changes could be brought in.

After the major welfare state programs were brought in in the 1960s, the charitable organizations found they were less able than before to raise money to provide services, and they often became partially dependent on higher-level governments for contracts or subsidies. Board members of philanthropic organizations in the larger cities, following American examples, usually formed Community Chests or United Way organizations to try to rationalize the remaining charitable activities and to dovetail them in with the government-funded services. But not all of them agreed to cooperate in this way, some preferring to raise their own funds. Major cities set up voluntary planning councils to determine local priorities for charitable efforts in their communities (Canadian Council on Social Development 1972). However, Govan (1966) noted that as the welfare state was put in place, the old style charitable voluntary organizations for health care were often being replaced by mutual aid organizations (such as disease groups helping one another to cope). The meaning of non-governmental community involvement became less clear to the ordinary citizen.

As well, the new welfare state programs were using professional experts to provide services. These professional experts were not prepared to give up total control over their practices and so they bargained with the provincial governments' representatives on terms and conditions of service. Thus community members were now given little opportunity to contribute to policy making. They could talk to their elected representatives, use complaint mechanisms (where these existed) or sue through the courts, but as consumers they were put into a position of dependency to the formal authorities and experts.

Power in the Welfare State

Robert Dubin (1974) analysed the distribution of power within industrial organizations but his analysis can be applied to the new welfare state organization in Canada. He discussed four types of power: technical, formal (i.e., legal authority), non-formal (i.e., knowing "how to work the system") and informal (i.e., using one's social connections in society generally to bring influence to bear).

The medical professional groups had been given the authority to select their own recruits to membership early in the nineteenth century on the grounds that no one else could judge competence. This had given them a monopoly and when the governments decided to fund hospital and medical services, it put them into a strong collective bargaining position. Taylor (1978) and Badgley and Wolfe (1967) have discussed how the Saskatchewan doctors (who were hostile to the provincial government's reform plans) formed "a separate government" with their own agenda of resistance to

change. They found considerable support from the public when there was a doctors' strike in 1962 because people were concerned that many doctors would leave the province and there would be a shortage of those with enough technical knowledge to care for them.

The provincial politicians had previously been very part-time workers with little authority. Now they were given new responsibilities which they had to learn how to handle. It took many years for the cabinets to become reasonably competent at policy making and administration.

And of course there have always been grumblings about the insensitivity of bureaucrats in interpreting the rules, and as there were more bureaucrats and more rules, there was more grumbling.

Some Challenges to Professionals

Gradually, however, some challenges built up to counter the doctors' claims for overriding technical power. The concept of reviewing "consumer power" to combat the activities of "disabling professionals" was brought over the border from the United States in the late 1960s (Illich 1974). The idea was taken up by many groups — for example, by radical youth, by the Quiet Revolutionaries in Quebec and by some lawyers and economists in Ontario (Slayton and Trebilcock 1978).

Efforts to reform professional regulation in Quebec (Quebec 1970–72), and Ontario (Ontario 1970) failed to dislodge the experts from their dominant position or to increase their concern for consumer interests at that time. There were a number of superficial or temporary solutions to this surge of radicalism — the federal Local Initiative Projects and other schemes for involving young people in community activities, changes in medical school admission policies to give recognition to the demand for more female and ethnic doctors, or the recruitment of lay members to boards of professional associations to represent consumer interests.[2] But radicalism decreased and finances grew tighter in the mid seventies and this demand for reform faded away. Much of the discussion then moved towards establishing patients' rights (Rosovsky 1980), increasing risk management in hospitals and improving complaints procedures.

It was perhaps in "the disabled community" or among its advocates that the challenge to medical professionals grew most strongly. The CELDIC Report (Commission on Emotional and Learning Disorders in Children 1970) argued that psychiatrists would be unable to tackle the adjustment problems of *One Million Children*. Paraplegics and polio victims began to assert

2 But in the seven top professional organizations they found it difficult to compete with expert opinions.

their need for independent living (Hahn 1985). More broadly, the limits of medical power were set out by a bureaucratic task group in *A New Perspective on the Health of Canadians* (Canada 1974a), but it took some time for a response to develop.

A Learning Time for Politicians and Bureaucrats

It is perhaps not surprising that there was resistance to consumer involvement by politicians and bureaucrats who were having to adapt to the new terms and conditions of working in the 1970s, for they must have been unsure of themselves as they struggled to cope with the new demands upon them. Because the politicians saw themselves as the formally elected representatives of their constituents, they did not seem to be willing, during this learning period, to let community groups into the power structures. For example, a report on increasing community inputs (Saskatchewan 1973) was taken no further once the MLAs decided they did not want to move on it. However, other discussions on community inputs into health policy decision making did result in the development of District Health Councils in Ontario from 1973, and in the establishment of management boards of Centres locaux des services communautaires (CLSCs), Centres d'accueil and Conseils régionaux de la santé et des services sociaux (CRSSS) in Quebec, in 1971, but in both provinces the powers of these local forms of health care organizations were somewhat limited at first.

Other Forms of Power

We shall not discuss non-formal and informal power here but we should give recognition to other ways of influencing persons in formal power positions. Until the provincial governments' Cabinets really learned how to take charge, back-benchers were very responsive to their constituents and they brought nonformal and informal power to bear on cabinet policy makers. The plans developed in the National Health Grant programs were seldom followed through because of back-bench interventions.

Changes in Welfare State and Health Policies

In the previous chapter, we discussed how the emphasis on financial redistribution in the early years of the welfare state had changed, and how the human rights initiatives in the 1970s and 1980s made people more conscious of the meaning of citizenship and the need for general and professional attitude change towards disadvantaged groups. The importance of inter-personal relationships began to be reinstated after the years of impersonal financial redistribution.

In health care the health promotion movement focussed on the need for increasing personal responsibility for healthy living and the importance of physical and social environment. There were strong reactions against professionals who treated consumers disrespectfully and against other members of the community who stigmatized persons with disabilities. Support grew for the healthy cities and healthy communities movements, wellness groups and other community-based organizations, concerned not only with better lifestyles and better community networking, but also with an improved health systems' organization which should take into account consumers' views.

The provincial reviews of health services which were carried out in the late 1980s recommended that community involvement should be increased. This increased involvement will be discussed in later chapters.