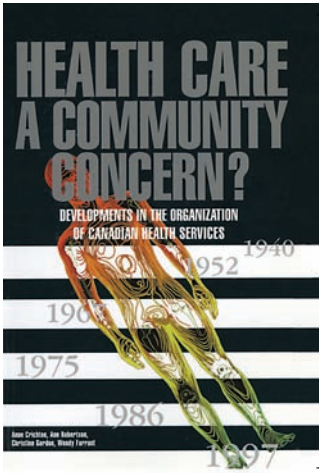
University of Calgary Press
www.uofcpress.com



HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
ISBN 978-1-55238-572-2

THIS BOOK IS AN OPEN ACCESS E-BOOK. It is an electronic version of a book that can be purchased in physical form through any bookseller or on-line retailer, or from our distributors. Please support this open access publication by requesting that your university purchase a print copy of this book, or by purchasing a copy yourself. If you have any questions, please contact us at ucpress@ucalgary.ca

Cover Art: The artwork on the cover of this book is not open access and falls under traditional copyright provisions; it cannot be reproduced in any way without written permission of the artists and their agents. The cover can be displayed as a complete cover image for the purposes of publicizing this work, but the artwork cannot be extracted from the context of the cover of this specific work without breaching the artist's copyright.

PART IV

Service Delivery Systems and their Response to the Need for Change to a Collective Care Organization

CHAPTER 9

Care in the Doctor's Office

When national health insurance legislation was enacted by the federal government in 1957 and 1966 there was already a medical care delivery system in place. The purpose of the health insurance legislation was to provide more adequate and better distributed funding to support this system of care. It was not until the whole new funding system was in place that questions began to be raised about the health outcomes of this subsidized traditional structure of organization (Le Clair 1975), for until then, the main thrust of government policies had been towards improving universal access of individuals to hospitals and physicians' services.

The Model Is Established: Regional Hierarchies of Organization

The medical model of health care was firmly established in Canada in the nineteenth century. Desrosiers (1979) associated its rise with industrialization in Quebec, but elsewhere demand for medical services was not confined to the cities. When the prairies were settled early in the twentieth century, one of the principal objectives of the farmers' cooperatives' policies was to encourage well qualified physicians to serve rural communities (Badgley and Wolfe 1967).

In 1910 Flexner reviewed the work of medical schools in North America and made it clear that they should provide teaching based on scientific research in laboratories and teaching hospitals. The effect of this study was to put medical schools at the top of a pyramid — a "regional hierarchy" (Fox 1987) — with quaternary care specialists working in university health science centres at the peak, tertiary specialists providing service in metropolitan areas, secondary specialists working in hospitals in the larger population centres in the middle (although often these secondary centres in the provinces are known as regional centres) and primary care giving general practi-

tioners at the bottom. The influence of the biomedical scientific paradigm as the predominating concept of medical care led to the diminishing valuation of magical, religious or pastoral care (Field 1973).

Competitors,[1] such as chiropractors or midwives, were excluded from this hierarchy. They were able to continue in practice only where public support was very strong. Other health professional groups, such as nurses, therapists and technicians, usually were employed in hospitals working under medical direction.

Reversing the Pyramid? Putting Primary Care First?

Early health planners concerned with the health of the population generally (e.g., in Great Britain 1920) wanted to turn this pyramid around, to establish the importance of primary care (Saward 1976) as the entry point to the system of care. They were unsuccessful in doing so for a number of reasons, but mainly for lack of public and medical professional support. By the end of the second decade of the twentieth century, the medical profession had convinced the public that doctors were able to prolong life, decrease disease incidence and reduce discomfort, and that their system of medical care organization was the most appropriate structure to achieve good health.

When Canada first turned to governmental planning for health in Saskatchewan in 1944 the Cooperative Commonwealth Federation (CCF) party accepted the introduction of hospital insurance as a priority rather than state-funded primary care services, as advised by their public health officers (Taylor 1978). This set the pattern for all other provinces except Quebec (Desrosiers 1987).

Payment Systems as a Conservative Influence

Changes from direct payment by patients to third party insurance schemes began to be introduced just before the Second World War. Hospital insurance took priority, but in the early 1950s doctor-sponsored third party prepayment schemes became available all across Canada (Shillington 1972). The Saskatchewan CCF government (1944–62) had made government-sponsored health insurance the major thrust of its policies. Having introduced publicly financed hospital insurance in 1946, it was ready to bring in medical care insurance after 1957 when it received federal grants to support hospital insurance and had enough resources to embark on its next initiative. The en-

1 Medical Health Officers in the public health service were not expected to treat the sick but to prevent disease outbreaks. There were conflicts over immunization and maternity care, and sometimes school health activities, as these were not clearly in clinical or preventive territories.

actment of provincial legislation in 1962 resulted in a doctors' strike. A provincial Medicare scheme was finally brought in, although concessions were made by the government regarding policing of the doctors' billings. As well, the community clinics in the province, which had adopted an alternative form of practice organization with consumer advisory boards, were forced to reduce their connection with these boards to a landlord/tenant relationship (Badgley and Wolfe 1967).

The Canadian Medical Association, anticipating that other provinces might follow Saskatchewan's example, had asked that a Royal Commission on Health Services be appointed in 1961. This commission (Canada 1964), recommended the introduction of federal funding to support Canada-wide provincial medical care insurance. The Medical Care Insurance Act (Medicare) was passed in 1966 and medical plans to administer the scheme were established in all provinces between 1968 and 1970. Before attempting to legislate its provincial program, the Saskatchewan government had recognized that the doctors would not accept salaries or capitation methods of payment and had decided to negotiate fee-for-service payment methods).[2] Blishen (1969), the research director of the royal commission, confirmed that this was a necessary condition for professional cooperation in implementing Medicare, but since then, governments have been searching for other ways of making payments. These alternatives will be reviewed in discussions of different forms of organization of medical services in Chapter 11.

In setting up the medical plans it was not made clear, except in Quebec, whether the doctors were in contract with governments or were subsidized entrepreneurs. At the beginning the medical associations' bargainers were able to establish generous and well accepted fee schedules (Evans 1984), but as time went on and inflation eroded income levels, dissatisfaction grew. Some provinces (e.g., British Columbia) negotiated large increases in the early 1980s with the condition that no additional charges be made. Others permitted the practice of "extra-billing" to creep in. At about this time the doctors in certain parts of Ontario, in particular specialists (Heiber and Deber 1987), began to bill their patients over and above the provincial rates. This practice appeared to open the door to "two tier" medicine and created visible opposition groups. The federal government decided to put a stop to extra-billing by passing the Canada Health Act (1984). This gave the provincial governments three years to decide whether to eliminate all additional charges (extra-billing and hospital user fees) or to forego grant aid from the

2 The defeat of two regional referenda in 1951 had resulted in the government abandoning further attempts to introduce a salaried regional medical service responsible to consumer representatives.

federal government dollar for dollar on an assessment of these charges.[3] All provinces had conformed by 1987 to eliminating all fees, though the Ontario doctors had staged a prolonged protest strike against the Ontario Health Care Accessibility Act (1986), which ended "extra-billing" (Heiber and Deber 1987; Tuohy 1986).

The medical professional organizations are usually separated into two bodies with different functions: the Colleges of Physicians and Surgeons which regulate admission and professional conduct (e.g., ethical relationships with patients, professionals' substance abuse), and the medical associations which are interest or lobbying groups. In Saskatchewan before 1962 these were combined into one body which led to continuing strife between the doctors and the elected government.[4] Since then the two functions have been separated in all provinces and it is the associations which appoint committees from their membership to bargain with the governments on fees. Quebec is the exception, being the only province which has permitted self-regulating professionals to form unions. In that province there are two separate unions for specialists and general practitioners (Gerzina 1976).

Reform of the Professions?

In the late 1960s to early 1970s strong critiques of the use/abuse of medical power were put forward in the United States. This radical movement affected Canadian attitudes and investigative committees were set up in Quebec and Ontario (Quebec 1970–72; Ontario 1970). Quebec established new structures for professional control and greater protection of the consumers' interest and Ontario set up a standing review committee. Consumers began to be appointed to these regulatory boards and there were a number of studies of patients' rights (e.g., Saskatchewan 1973). However, these investigations made a very minor impact on traditional behaviours (Slayton and Trebilcock 1978).

---

3 In early 1990 the Conservative federal government indicated it might have to retreat from enforcing the Canada Health Act sanctions because it was no longer able to provide the amounts of funding required by the provinces to ensure common standards across the country. However, it later affirmed a commitment to the act in *Building Partnerships* (Canada 1991a). The Liberal government which took office in 1993 has indicated that it wishes to preserve Medicare but some provincial governments (e.g., Alberta) have shown willingness to permit some degree of privatization, i.e., two tiers for some aspects of medical care.

4 Taylor (1978) and Badgley and Wolfe (1967) have discussed the way in which the combination of the college function of registering doctors with the association function of collective bargaining led to the formation of a "separate government" which could oppose the wishes of the elected political party in power.

Coburn, Torrance and Kaufert (1983) have argued that the medical profession dominated the health care delivery system until 1962, but since the settlement of the doctors' strike in Saskatchewan, this dominance has been eroded (see also Milbank 1988). On the other hand Tuohy (1986), comparing the Canadian and American medical professions, has argued that the terms agreed between doctors and governments on the introduction of health insurance in Canada has enabled doctors there to maintain greater clinical autonomy *vis-à-vis* administrators rather than doctors in the United States, and clinical autonomy is at the core of their professional power. Coburn, Torrance and Kaufert (1983) thought that another aspect of power — their control over service organization — was gradually being removed. While this may be happening in hospitals it has certainly not touched office practice yet. In fact, Tuohy (1982) perceived struggles with hospital administrators over budget crunches and fee battles "as attempts to keep a technologically outmoded system working" (p. 190). Her comments would suggest that medical dominance is not yet ended. Yet the profession is not monolithic. Apart from divisions between generalists and specialists, Marsden (1972) identified a growing rift between academic physicians and practising clinicians while others have noted struggles between reformists and conservatives in collective bargaining and in setting policy directions generally.

Physician Supply

The decision to recommend the introduction of universal medical care insurance led the Royal Commission on Health Services, 1961–64, to inquire into the supply and distribution of physicians available to provide services to patients (Judek 1964). Shortages were identified and steps were taken to increase the supply of doctors through encouraging immigration and increasing the numbers of medical schools and places within existing schools. The new medical schools were expected to emphasize training of family practitioners who would take up practice in underserviced rural areas. All schools moved to establish specialty training in family practice.

It is not possible within the scope of this review to provide a detailed discussion of planning physician supply. Efforts were made throughout the 1970s to determine the numbers of specialists and general practitioners which would be required to provide a universal service to the Canadian people but there were major miscalculations about population growth (Evans, Barer and Marmor 1994). The planners were unable to keep control of the supply which soon became excessive. The medical schools are part of provincial education services, not their health services, and the policies of health and education departments may differ markedly. The federal government was able to intervene in only two areas — control of immigration and control of

postgraduate residencies — but admissions to medical schools remained in the power of universities funded by provincial governments. They were not willing to cut back on medical school admissions. Nor have efforts at physician substitution succeeded. Even with successful demonstrations of the work of nurse practitioners, Spitzer (1984) failed to convince medical practitioners that they should continue to delegate when special pilot program grants ended, for the fee-for-service system does not usually pay for nurse practitioners' services. Contandriopoulos, Laurier and Trottier (1986) did not foresee a willingness of Canadian general practitioners to change their attitudes, though in the United States, there appeared to be growing interest in "collaborative practice."

Inglehart (1986) reviewing the Canadian health care system, said that "medical manpower planning" was its greatest problem. About this time, Canadian health economists began to take a strong stand. Barer and Evans (1990) demonstrated how capital investment in equipment leads to further capital investment in personnel and that there were no effective controls on either. Lomas and Barer (1986) suggested that reforms in physician supply policy were necessary in the public interest, but the politicians were not yet ready to listen. However, in 1990, Barer and Stoddart (1991) were asked to prepare a report for the Council of Health Ministers. The health ministers then decided to act in January, 1992 and medical schools were asked to cut admission by ten percent.

Medical Education

The courses in the medical schools themselves are still developed by faculty, assessed through peer review and restricted by tight time schedules. Consequently in eleven of the old established Canadian schools, there have been no major changes in curriculum emphasis after the federal decision to introduce collectivist policies, although at McMaster University and four new foundations established in the 1960s following royal commission recommendations, more room was made for experiment.

The new foundations were expected to put more emphasis on primary care, to ensure that more physicians geared to family practice in rural as well as urban areas were produced in the system. The traditional schools then made some modifications to their first and second year curricula. Later the Council of Universities of Ontario held a national conference with representatives present from all Canadian medical schools to consider future directions for health science centres (Squires 1982) and to discuss the changing structure of the health care system in Canada and new issues brought forward since the introduction of the last health insurance program. The emphasis was put on the social model of health care (i.e., population health,

inequalities in health, the determinants of health, pressures of funding and regulation of the health care system, ethical matters).

It is not easy to change the curriculum in medical schools where there is a heavy emphasis on biomedical technology and a general lack of concern for issues such as better management of health services or "the social responsibilities of practitioners" (Murray 1990). White and Connelly (1991) have suggested that medical schools, worldwide, lost public trust and confidence by failing to recognize the social problems surrounding them. They said they needed to reset their goals, re-planning curricula to those designed to meet the public's needs and renegotiating their contracts with society.

There have been some adjustments, particularly in teaching methods (pioneered by McMaster University) but there is still a need for development of greater understanding of health service organization. In 1991 the Association of Canadian Medical Colleges endeavoured to help its members to refocus the mission of the schools to prepare physicians to deal with new challenges by adopting community oriented approaches (already adopted by McMaster University, University of Calgary, and Université de Sherbrooke) and to take an integrated view of health care. Valberg et al. (1994) have proposed new ways of planning academic medical centres to meet changing needs.

The Specialty of Family Practice

The sixteen medical schools in Canada have all embarked on providing postgraduate residencies in family practice since 1970. One of the first needs of the new practice units was to define the scope of their activities. Wolfe and Badgley (1972) set out a model based on the work of family doctors in a community clinic practice in Saskatchewan. Others (e.g., McWhinney 1975; MacDonald 1981) have also stressed the commitment "to the whole persons" of the patients — to a group of people rather than to a body of knowledge. Because of this the family practitioners want to keep close links with the hospitals when their patients are admitted (Vancouver Hospitals Department of Family Practice 1990; Hennen 1990). McWhinney (1989) has now produced the standard textbook for Canadian family practitioners and Dean (1990), reviewing the new specialty, listed the following concepts as its special concerns: family dynamics, continuity of care, comprehensive care, humanistic care, health maintenance, preventive medicine, lifestyle changes and health promotion.

At first the new family practice units had difficulties in establishing teaching and research activities[5] which could be taken seriously by their academic

5 A research network has now been established among family practitioners in British Columbia. Within the College of Family Practice a national research committee has also been formed.

colleagues steeped in the Flexner scientific tradition.[6] They remained at the bottom of the totem pole in the hospital teaching centres and the older medical schools. However, efforts are now being made to escape this position by setting up teaching units in rural regional centres (e.g., University of British Columbia Department of Family Practice 1989; Longhurst 1987). These units are struggling to train competent generalists for practice in more outlying areas[7] but they have difficulties in getting the specialist teachers to provide basic courses in obstetrics, general surgery, etc., sufficient to enable the family practitioners to cope with emergencies but certain to ensure referrals when possible and necessary.

Practice Variations

While there may be improvements in theoretical approaches and in the work situation there are wide variations in the way medicine — primary, secondary and tertiary care — is practised. These variations have been reviewed by Wolfson, Tuohy and Shah (1978), Battista, Spasoff and Spitzer (1986), Sheps, Scrivens and Gait (1990), and MacLean and Richman (1989) who concluded that across Canada "practice decisions are closely connected to resources" (p. 370). How can this situation be better managed? Evans (1989a), who examined the prospects of greater public involvement, increasing pressure on overall health resources, and the effects of organizational restructuring, concluded that: "Unless and until research and researchers on practice variations begin to offer ways of relieving the endless pressure for more health spending" (p. 54) little will change, because the providers will always argue the necessity to give the best quality of care to their patients. Consequently more resources will be used as more diagnostic tests become available, more drugs are marketed and more manpower is introduced into the system. Many attempts have been made to stop this escalation of spending even though the final crunch between governments and service providers has not yet come. However, some controls over overall health care spending have been introduced into Saskatchewan and Alberta and they are forcing reductions in the numbers of consultations with patients. There has been considerable interest in the Oregon study of clinical priorities which lists medical services in order of necessity.

---

6 Carol Herbert, personal communication, 1990.

7 See also discussion on rural health care in Chapter 14. The new emphasis on preparing family practitioners for rural areas has sparked some concern for urban family practice training (Gruson and Bates 1990).

Quality Assurance Issues

What then of the quality of primary medical care? While the royal commission was sitting, Clute (1963) had carried out a survey of the work of general practitioners. The researchers thought that only sixty percent of Ontario physicians surveyed and forty percent of those in Nova Scotia (the two provinces in the study) were practising at a satisfactory level. There was in their view inadequate continuing education to maintain standards. This study led to the establishment of a College of Family Practice with certification examinations (along the lines of the specialists' Royal Colleges), increased activity by universities and medical associations in providing continuing education courses and the establishment of hospital libraries for lending books, journals and teaching tapes. Since almost all Canadian physicians had hospital privileges, the hospital libraries and doctors' coffee rooms became local centres of informal continuing education.

Quality control over office practice is minimal. By tradition control is left to the professional ethics of the individual physician or to malpractice suits in the courts. It is recognized that there is some economic fraud (Wilson, Lincoln and Chappell 1986) which is, in theory, kept under control by the professional colleges (or associations) when these are provided with information by the medical plans about billing practices (Tuohy 1982). But the controls over volume of practice permit two standard deviations from the norm and the norms continue to change as more technology becomes available and intensity of servicing increases.[8]

Professional activities conducted in the hospitals are subject to peer chart review but this technique has not been introduced into office practice in Canada. The College of Physicians and Surgeons of Ontario conducted a peer survey of physicians' work in 1984, finding 30 of the 255 practitioners to be deficient (McAuley and Henderson 1984). Follow-up assessments showed that recommendations for improvements had been followed through in most cases.

At a national quality assurance conference in Toronto, Fletcher (Ontario 1989f) proposed a new funding model for primary care with knowledge-based information systems to support it: "Likened ... to an ongoing clinical trial, this would provide us with the opportunity to evaluate outcome information on a large scale and even permit an on-the-spot assessment of the most appropriate treatment, based on information already retrieved" (p. 40).

---

8 The medical plans of Saskatchewan, Alberta and British Columbia have imposed cuts on high-level service providers in the number of consultations with patients.

The Ontario Medical Association appointed a strategy group to consider the concept of establishing guidelines for practice. Linton and Peachey (1990) believed that these should be set by appropriate panels which would make "a synthesis of existing scientific data ideally obtained from randomized controlled trials. However, at present, we may have to rely on less satisfactory data and the views of experts in the field" (p. 629).

One effort to change clinical practice has been the work of the Task Force on the Periodic Health Examination (Canada 1979) which set out guidelines for patient examinations. As Morgan suggested in this report, this should have improved the focussing and targeting of preventive advice, but it is dubious whether this proposed change in practice activity has been widely implemented (Abelson and Lomas 1989).

Practice Organization: Implications for Cost and Quality

At one time it was thought that encouragement of group practice organization (Canadian Medical Association 1967) would result in greater sharing of information between practitioners and thus, improved quality of service, but the development of more rental premises and the introduction of computerized billings led many to engage in looser forms of association — agreements to share overhead costs rather than entering into partnership arrangements where clinical work is conducted on the same premises (Taylor, Stevenson and Williams 1984).

Williams et al. (1990) developed a typology of medical practice organization in Canada from a national survey of 2,014 physicians in 1986–87. Their typology identified six different types of practice. Their practice type criteria are reproduced in Chart 9.1. They found that almost half were in fee-for-service solo and group practices but a substantial proportion were in partnership practices involving income and expense sharing arrangements without shared arrangements for patient care.[9] They said that "increasing attention has been directed towards establishing and assessing alternative modes of practice organization, which may produce cost-efficiencies in health service delivery while ensuring a high standard of care ... there have been fewer incentives in Canada to explore alternatives to traditional solo practice than exist in the competitive medical marketplace of the United States" (p. 996).

---

9 This typology is concerned with doctors' relationships. Different forms of organization for dealing with doctor-patient relationships are discussed in Chapter 11.

Chart 9.1

Professional Characteristics of Physicians by Practice Type[1]

Practice Type	Percent Income from Fee-for-Service[2]			Sex[2]		Year Graduated[2]				Number of Physicians
	0–33% (%)	34–65% (%)	66–100% (%)	Female (%)	Male (%)	25–55 (%)	56–65 (%)	66–75 (%)	76–84 (%)	
Private										
Solo	2.4	.8	96.9	7.2	92.8	29.3	25.6	33.3	11.8	516
Group	3.1	1.3	95.6	15.5	84.5	20.7	25.7	34.1	19.5	390
Partnership	3.1	2.2	94.7	15.2	84.8	17.5	23.7	34.7	24.2	323
Institutional										
Hospital	31.8	17.8	50.4	10.9	89.1	21.5	28.0	36.1	14.4	368
CHC/HSO/CLSC	72.0	8.0	20.0	19.6	80.4	6.0	24.0	28.0	42.0	51
Mixed	21.7	13.7	64.7	10.7	89.3	21.9	28.7	32.8	16.7	366
Chi-square			600.9[3]		20.3[3]				65.9[3]	
Percent of Physicians	13.2	6.7	80.2	11.7	88.3	22.2	26.2	34.0	17.5	2014

Source: A.P. Williams, E. Vayda, H. Stevenson, M. Burke, and K.D. Pierre, "A Typology of Medical Practice Organization in Canada," *Medical Care* 28, no. 11 (1990). Reprinted with permission.

1. Figures exclude physicians working fewer than 30 hours per week.
2. Cell entries are row percents.
3. Significant at 0.01.

Resistance to Change

In 1986 Hastings and Vayda said:

> Medical and health care services are largely fragmented and uncoordinated. ... Fragmentation has persisted despite repeated exhortations for coordination. ... The rhetoric calls for a pluralistic system with multiple models[10] but, to date, the reality has been that the political, social, economic and legislative structures in Canada have, in effect, bolstered the prevailing system based on independent fee-for-service practice. In other words, we have public payments for a private system. Coordination and integration, when they have occurred, have been *ad hoc*. The political, economic and social pressures have not yet reached a critical level and there have been relatively weak incentives for the present system to change." (pp. 348 and 358)

International studies by social scientists (e.g., Marmor and Thomas 1971) have made it very clear that the medical profession everywhere is still in control of payment and physician distribution systems.

In some provinces the medical associations are reviewing other payment systems such as capitation. The changes in Ontario's payment system are discussed in the following chapters but as yet shifts in practice organization are minor.

There is, and will continue to be, conflict between the medical profession and the governments over all of these issues of autonomy and control outlined above. While Stevenson, Williams and Vayda (1988) suggest that efforts should be made to break out of the institutionalized forms of conflict which have "characterized the relations between governments and organized medicine thus far" (p. 99), Evans (1990), comparing Canadian and American medicine, saw the institutionalized conflict as a positive development, for it provided a framework for the two interdependent parties in the continuing struggle to continue to discuss their demands/needs with one another.

Two Variations of Office Practice

Student Health Services

In addition to the services provided by general practitioners, there are two other primary care services which should be considered. These are associated with work situations but they differ in kind from one another. Student

---

10 By this they mean alternative models such as community health centres, Comprehensive Health Organizations and other alternative models to be discussed in Chapter 11.

health services are a variant on doctors' office services. The doctors are salaried but they bill for their activities and the universities are remunerated by the provincial medical plans. To the earned fees, the university adds twenty percent to cover additional services such as inoculations, coordination with vocational counselling services, recreation and fitness, and disability support programs. Outreach is regarded as high priority. Dr. Farquhar of the University of British Columbia[11] pointed out that specific student health service reviews had been conducted over the past twenty years and amendments had been made, but as yet no general assessment has been published.

Occupational Medical Services[12]

With the growth of interest in environmental health, there has been a growth of interest in occupational health services. Guidotti and Fredona (1987) reviewed the scene:

> There is a consensus that there is a shortage of facilities and trained practitioners capable of providing services beyond the most rudimentary. This shortage is felt in all metropolitan areas and many rural parts of the country. It is particularly reflected in the scarcity of services, beyond acute medical care for injuries, that are available to small business. ... Employer sponsored health and safety or medical departments are not feasible for small businesses with limited resources. Labour-sponsored clinics are few in Canada and may not be acceptable to all employers. Health care facilities serving several employers are the most obvious solution. ... While publicly-supported or sponsored occupational health clinics have their merits, it is difficult to imagine governments committing to this model in times of fiscal constraint. ... One alternative is for provincial governments to adopt a policy encouraging the private sector to meet this need." (p. 26)

Guidotti and Fredona (1987) thought there could be development of hospital-based occupational health clinics, multi-specialty group medical practices and industrial medical clinics, as in the United States, which would ensure better care.

There would appear to be considerable concern in occupational health units about disability prevention and rehabilitation after injury in the larger companies. Gibson (1990) explained the policy at a large steel works:

> [We] try to keep people at work, not simply to avoid compensation claims but because it has been our feeling that they get better faster. ... As soon as you get ... a reported injury things fall apart.

11 Dr. Donald Farquhar, personal communication, 1990.

12 Occupational safety and disease prevention services are discussed in Chapter 15.

> ... In [a] time lost injury study we counted a minimum of 12 other individuals or agencies that became involved. So life for the worker becomes very complicated. ... There is a fear of rejection by peers ... if it becomes a compensation claim. [And there is] a fear of the job itself. ... Supervisors are genuinely concerned about re-injury. ... Coworkers will have to work harder ... [and] if this goes on and on ... then this becomes a very silent problem." (pp. 405–6)

Gibson (1990) also described how the medical officers tried to combat psychological depression which was, perhaps even more troublesome than the physical injuries. Nevertheless, when Walters (1984) reviewed the activities of some company doctors working in Ontario, her report began: "Company doctors do not enjoy a positive image." She added: "Two themes run through these negative images. One is that company doctors are biased because they are employed by companies. ... The other is that doctors are less than competent" (p. 811). Her sample consisted of full-time doctors in large companies and part-timers on contract, mainly with small companies.

This image does not seem to have improved over the years, and trying to make cost savings during hard economic times, a number of companies have shut down their industrial medical services.[13]

Summary

Biomedical care had replaced magical, religious and pastoral care early in the twentieth century and was confirmed as the best model of health care by Flexner who was appointed to inspect existing American and Canadian medical schools in 1910. The growth of medical specialization which followed the adoption of this model led to regional hierarchies with specialists in teaching hospitals at the top and practitioners in primary care at the bottom.

Although health planners concerned with population health wanted to establish the importance of primary care as the entry point to the system, the public and the medical profession preferred that doctors should treat individuals needing crisis care. Thus when health insurance was introduced into Canada, hospital insurance was given priority and then medical care insurance was brought in.

Payment was based on fee-for-service and at first it was not made clear whether the doctors were in contract with governments or were subsidized entrepreneurs. The development of "extra billing" (or charges to patients on top of insurance rates) led in due course to the Canada Health Act, 1984, which stopped this practice by imposing penalties on provincial governments which permitted any user charges for acute hospital or medical care.

---

13 C. Hertzman, personal communication, 1995.

The medical profession has been self-governing since the mid nineteenth century. In the late 1960s there were radical challenges to its monopoly power. Commissions of inquiry in some provinces suggested more consumer appointments to professional regulatory boards but these have had little real effect. However, Coburn thought that the introduction of publicly financed medical care insurance marked the beginning of a reduction in medical power.

The supply of physicians in Canada was increased by the expansion of medical schools in the 1960s. However, it was not until 1990 that governments were prepared to accept that there was an oversupply and that medical school entries should be reduced.

The curricula in the established medical schools emphasized specialist skills. New schools were expected to promote more interest in primary care. Gradually, departments of family practice have been opened up; however, there are great variations in medical practice activities across Canada.

Since the mid 1960s efforts have been made to improve quality of care in office practice but there is as yet no standard method of reviewing medical work outside the hospitals.

Practice organization has hardly changed since publicly financed care was introduced. At one time there were moves towards group practice but computerization of billings and availability of rental accommodation have enabled physicians to keep their own patients while negotiating with others to share overheads.

International studies have made it clear that the medical profession everywhere is still in control of payment and physician distribution systems despite public financing.

The chapter ends with two brief reviews of student health and occupational medical services.