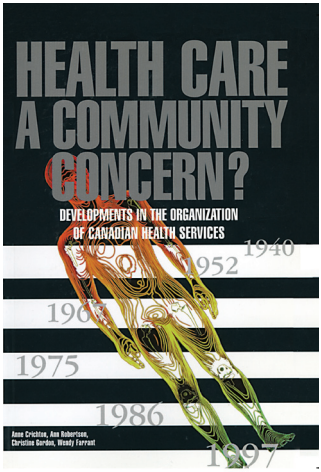
University of Calgary Press
www.uofcpress.com



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.

Making a difference.
Making you think.

Acknowledgement: *We acknowledge the wording around open access used by Australian publisher,* **re.press**, *and thank them for giving us permission to adapt their wording to our policy* http://www.re-press.org/content/view/17/33/

CHAPTER 30

Where Do We Go From Here?

It has taken a long time for Canadians to recognize that when they took on a commitment to collectivism in the 1940s it was a complicated and difficult move. They had a simplistic view of what sharing meant in those days and they had underestimated how difficult it would be to organize a collectivist society.

Commitment to Collectivism

In earlier chapters an attempt has been made to trace the way in which ideas about sharing resources changed from focussing only on financial redistribution, to considering how to enhance the citizenship rights of disadvantaged Canadians. Before that, however, in considering financial redistribution policies, the changes in the political salience of the different social divisions of welfare was also explored — how much weight to put on social minimum, universal or revenue foregone policies. And there was some discussion of Canada's attempts to adjust to changes in the global economic situation by shifting resources away from basic income support to job creation and job retraining programs.[1]

The increasing complexity of ideas about the purposes of a welfare state (or welfare society) has, it would appear, reduced commitment to sharing in some provincial jurisdictions though there have always been differences across provinces in that commitment. Alberta and Ontario are anxious to privatize a number of services in the previously accepted public areas of universal medical and hospital care and post-secondary education, and these two provinces have reduced income support programs as far as they possibly

1 However, as of March 16, 1996, Canada was ranked seventeenth only in its ability to compete in the global market today.

can. (However, they both have a history of conservatism compared with the other provinces.)

Marchak (1975) and others have pointed out democratic socialism was a counter-culture in Canada; its ideas about sharing were accepted in the postwar reconstruction years, but may no longer be so acceptable.

Should Canada continue to defend its modified welfare state? Or should it abandon it, as Krauthammer (1995) has suggested because "it has been a primary cause of the decline of society's mediating institutions" (such as the family)? It would seem that Canada is not likely to go so far to the right of the political spectrum as this, if it can only find a way to manage its deficit/debt problems. Canada is a centralist society, a nation which tries to make accommodations and find moderate solutions.

When the Liberals were elected to power in 1993 they found that the deficit was bigger than they had thought, and as this was the main concern of the public, they had to respond to it. Although they had campaigned for reconsideration of the financing of social programs during the election, they have been caught in the deficit web and forced to consider further cutbacks. Their more right-wing predecessors, the Progressive Conservatives, were not prepared to cut out social programs either. In 1991 Prime Minister Brian Mulroney himself opened up the division within the Department of the Secretary of State which was to be concerned with advancing the status of disabled persons.

What then is the likely future of collectivist sharing in Canada today?

As Djao (1983) pointed out, any analysis of social welfare programs is about values, and values continue to change. And as Boudreau (1987a,b,c) has said, there are conflicting ideologies at every level of the system. The social model of care varies from province to province and, within provinces, from one government to the next. While from 1940 to 1966 the importance of establishing a social minimum seemed to have equal weight with the establishing of universal programs, and helping businesses was less important, from 1975 onward the politicians began to emphasize the necessity for stimulating private enterprise to a much greater extent in order to make Canada a successful market competitor and to raise the revenues necessary to meet the costs of social programs. But then in the 1980s "harmonization" with other North American Free Trade Agreement (NAFTA) businessmen began to seem more important than Canadian social program funding.

The federal government backed off from its earlier commitments to financial redistribution because of the growth of Canada's national debt since 1981. During the 1980s the global trade situation changed dramatically. Canada's natural resources had been run down and the nation was finding it difficult to compete in world markets, so it reduced taxes on companies. It

eagerly embraced the corporate model of decision making and the NAFTA model of free trade. But this has not brought in sufficient revenues to cope with the deficit and has resulted in increasing social differences between rich and poor.

On the other hand there is a major change in Canada's acceptance of minority groups. While it is recognized that this emphasis on attitude change establishes a new way of looking at social relationships, it may have detracted from concerns about poverty and the social minimum. Advocates for the "disabled community" have tried to keep both issues before the public, because persons with disabilities are often poor as well as handicapped, but the emphasis in "the welfare society" is less about money and more about acceptance of others. "Equality of consideration" seems to have taken over from "equality of condition" or concern about the social minimum.

Another shift in the perception of goals of the collectivist welfare state particularly affects health policies. The emphasis in the first stages of development was on access to medical and hospital care, but in the 1970s there was a move towards giving greater consideration to outcomes. Although it was made clear in the Lalonde report (Canada 1974a) and the Epp report (Canada 1986c) that biomedical care was likely to make a relatively minor difference to health outcomes and that good health was more dependent on good lifestyle and on good physical and supportive social environments, the Canadian public has had some difficulty in linking health goals to the broader goals of the welfare state. Thus, although a number of analyses have shown the relationship of health status differences to income (Manga 1981; Wilkins and Adams 1983; Schwartz 1987; Badgley and Charles 1987; Canada 1990m,n) and the *Active Health Survey* (Canada 1985c) identified the people in lower income groups as likely to be living less healthy lifestyles, it has not made the public willing to focus on minimum income support except in negative ways.

So what should be done to improve the living conditions of Canadians caught up in these complex situations? The public's emotions have been linked to the deficit, the difficulties of competing in global markets and in finding and keeping jobs. Most Canadians who have achieved the goal of access to medical and hospital care are not particularly interested in counteracting the bad determinants of health if it is going to cost them more. They do not want to engage in improving financial redistribution to an even wider group now that helping those with human rights needs have been recognized.

The early simplistic ways of seeing how to improve sharing in the welfare state are no longer viable and the Canadian governments are still struggling with the concept of collective security in a more complex world. The country is divided and confused.

Is the commitment to collectivism likely to continue in these circumstances? There is no doubt that the poorer provinces have found it important to have a financial redistribution even if this has now diminished and they would like to continue with collectivist sharing. Some of the richer provinces are less certain, but they are unlikely to want to separate from Canada as Quebec has threatened to do. The problem for the middle range and richer provinces is the complexity of the choices which they now have to make in supporting collectivism Perhaps one answer is better formal organization of the welfare state/society.

Organizational Restructuring

As we have seen in Chapter 27, Canada has a poor record in social program organization. It seems clear that this is the first place where changes should be brought in. By bringing service organization "closer to home" and focussing upon better communication between the present divisions of care in order to improve organizational efficiency, it may be possible to solve the country's problems without exposing poor or less competent citizens to the miseries of an out and out capitalist society.

It would appear that the Canadian provincial governments want to seek reasonable solutions, namely to involve local community members in reducing costs by finding better ways of organizing social programs — first by improving communication between service providers and the public; then by identifying the important local issues, setting priorities and working on streamlining the systems of care. An overview of the current system is provided in the Canadian College of Health Service Executives' latest report (1995).

It is clear that there was only one jurisdiction in Canada where the necessity for a planned restructuring of services was understood when the proposals for introducing a welfare state were first put forward, but Saskatchewan had no money of its own to implement such a program. Nor was it understood that there would be powerful resistances to the introduction of these new structures. For when Quebec later came up with a rational plan for reforming its health and welfare services, it was no more successful in achieving acceptance of the changes than the other provinces. This is not to say that other welfare states internationally have been much more successful in their organizational structuring. It would seem that the concept of collectivist sharing in Canada was too large to comprehend properly and the processes of decision making about the introduction of new legislation too incremental to deal with the whole situation.[2]

2 Tuohy (1994) has discussed the complexities of moving towards a new model of social *distribution* because of *constitutional* barriers and other resistances.

So where do we go from here?

It is clear that there has been a swing away from centralized decision making towards empowering people at local levels to make their own choices. This swing is being resisted by the poorer provinces, which are anxious to maintain financial redistribution across the nation. Elsewhere, however, there has been strong support for decentralization of power to regions by consumers excluded from policy discussions until now.

Will encouraging community members to become more involved in public decision making help? Canada still prides itself on its close-knit social organization, its acceptance of citizens of all colours and creeds. The annual report of the Canadian Policy Research Network (1995) said:

> Governments, corporations and citizens are all groping for new ways to enhance productivity and generate wealth.
>
> At the same time, we are beginning to understand that our capacity to generate wealth depends critically on the quality of social interaction — the trust and reciprocity that are woven into the social fabric. They are needed to sustain citizens' commitment to the rule of law and the legitimacy of democratic institutions in times of hardship. 'Social cohesion involves building shared values and communities of interpretation, reducing disparities in wealth and income and generally enabling people to have a sense that they are engaged in a common enterprise, and that they are members of the same community'. (p. 4)

As yet, however, regional structures and involvement of local communities are still in the process of development, and it is far from clear whether provincial governments are ready to devolve much of their power to these new authorities (except in Saskatchewan where the province was forced to take some action because of impending bankruptcy). The regions in Alberta and Nova Scotia are tightly controlled from the top down and limited in what they can do. And while British Columbia has said it wants to develop a consumer controlled system of health planning and management, the provincial Health Department has not been altogether willing to let go. (The board of the Capital Regional District was recently dismissed [Thomson 1995, 1995–96].)

It is still much too early to predict whether policy making at the regionalized level will become more successful than the centralized policy making of the federal government. There is no doubt that centralized welfare state programs of the last fifty years have helped to make Canada into a leading first world country with a healthy, well educated population.

Yet it seems that the unit of collectivist sharing — the nation as a whole — has been too big for most people to understand. Even the idea of sharing across a province is not easy to envision in such a vast country. It may be

that by breaking the units of decision making down to the regional level, we can increase such understanding. In a city like Vancouver, the west side residents, who are comparatively well off people, have difficulties in visualizing what surviving means for others who live in the downtown east side of the city, on the streets, or in hotels with few facilities or in temporary shelters. Nor is there a great understanding by seniors of the pressures on adolescents who are concerned about finding jobs, relating to the other sex in contemporary ways and perhaps trying out drugs and alcohol. In addition, seniors have their own problems of degeneration into dependency and denial of the need for planning to meet it.

There is no doubt that allocating control over budgets to regional authorities will help to break down the divisions between service providers which have been allowed to grow up under federal and provincial jurisdictions, and should enable these authorities to move finances across to community services, underfunded in the past. It may even be possible, in time, to address issues of social inequities and their implications for health outcomes rather than continuing to stress access to health care, if health and social service agencies can be brought together under one authority.

Perhaps the emphasis on deficits and debts has its positive side, for it has forced Canadians to reconsider their basic values about sharing their resources. It has encouraged governments to go ahead with plans for reform and restructuring of their welfare state programs and to reconsider ways of letting community members have more say in decision making for their local areas. This may be the next way of getting renewed commitment to collectivist sharing.