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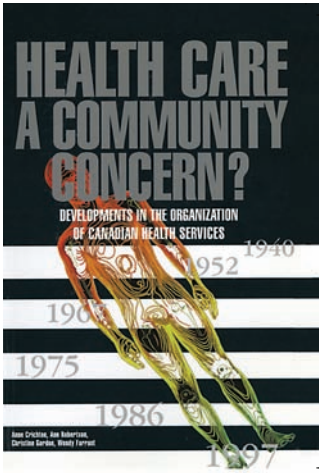

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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CHAPTER 2

Canada's Publicly Financed Health Care System

Canada's health care system is a matter of pride for the majority of Canadians, for while it is not at the very top of the national morbidity and mortality indicators, it is not far off and it provides satisfying care for most citizens (Blendon et al. 1990). In the last ten years, however, the system has come under scrutiny in almost all provinces (Angus 1991; British Columbia 1991) and all governments have been concerned with the need for reform and restructuring.

In the first half of the twentieth century the growth of scientific medicine changed perceptions about the new importance of doctors' expertise in providing diagnosis and treatment for illness and this resulted in major changes in the organization of doctors' offices and hospital practice. Small communities in rural areas struggled to attract doctors to provide care and many worked out ingenious solutions (such as the Municipal Doctor Schemes on the prairies). Charity hospitals, which had often been a refuge for indigents in the nineteenth century, gradually separated out fee-paying patients from those who sought free care and became important treatment centres after they had managed to cope with infection control (Andrews 1979).

Most hospitals were in the cities, where they had often been set up as charitable foundations, though there were municipal hospitals in some rural areas and mission stations, usually on Indian reserves. By 1933 there were 589 public hospitals with 45,000 beds and approximately 300 private proprietary hospitals.[1]

1 The term public hospital includes charitable foundations as well as municipal hospitals. Most of these public hospitals were subsidized by taxes. There was little development of hospitals during the depression so this is a reasonable

In addition, there were two publicly financed health care services – asylums for those who were mentally ill or mentally handicapped or for those who had offended society in some way, such as mothers of illegitimate children, or vagrants;[2] and public health departments which had begun as infection control agencies but which later had taken responsibility for the health education of high-risk groups in the community, such as pregnant women and mothers with young children, as well as providing school health services.

In the first half of this century individual patients were expected to choose their own doctors, to pay them directly for their services and, when admitted to a hospital, to pay hospital fees as well (Shortt 1981). In the 1930s the main difficulties for Canadians seeking care were payment problems. The standards of medical practice were satisfactory by international criteria but the costs of care were rising steadily as new technologies were introduced. Agnew (1974) has suggested that those who had the greatest difficulties in paying were the middle classes using proprietary hospitals, for the poor could usually get help from their doctors, charity hospitals or the local municipalities if they needed it.

Private prepayment schemes for both hospital and medical care had begun to be offered in the early twentieth century (Shillington 1972). However, if the payors had to make a choice of prepayment schemes, hospital insurance took priority because breadwinners feared the effects which a serious illness might have on their families.

During the Great Depression of the 1930s, even middle-class patients found it difficult to pay doctors' bills and hospital fees. Now the idea of prepayment began to catch on and, particularly after the Second World War, there was a universal demand for prepaid insurance.

In 1935 the British Columbia government had tried to introduce a provincial publicly financed insurance scheme but the act, although passed by the legislature, was never proclaimed because of the resistance of doctors and businessmen. However, the idea of publicly financed insurance, as a means of improving the health of Canadians by making medical care services

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indication of available services in 1948 when National Health Grants provided funding for a review of hospital and health services and led to major construction projects in the 1950s.

2 By the mid 1960s a strong movement had grown up to decrease the numbers of persons in institutions and, if at all possible, to treat those with mental illnesses in the regular health care system. Most provinces had moved the care of persons with mental handicaps over to their social service departments by the early 1970s and the care of many persons with mental illnesses over to the regular hospital and medical care insurance programs. By 1996 almost all persons who had been institutionalized resided in the community.

available to all, was taken up by the Saskatchewan and federal governments which were anxious to reform health care in the 1940s.

Saskatchewan's socialist government provided models of health planning and service delivery for the rest of the country. It was the first jurisdiction to introduce a hospital insurance program, in 1946, and a medical care insurance scheme, in 1962. The federal government had been anxious to provide conditional matching grants to the provinces for improvements in health and post secondary education services, rather than giving them higher unconditional equalization grants (which were traditional). It had become aware of the needs for improving services across Canada, on the one hand through the report of an investigation of the impact of the depression on the provinces (Canada 1940) and, on the other, through reports on the health and educational levels of recruits to the armed services in the Second World War. It was thought that conditional grants would force the provinces to increase provision of social programs and bring about greater standardization across the country. But the federal government was held back by Ontario and Quebec at the Dominion-Provincial Conference on Social Reconstruction in 1945–46 on the grounds that it did not have the constitutional rights to interfere in social affairs which were a provincial matter (Taylor 1978).

Because of these constitutional challenges the federal government was unable to introduce its proposed health insurance schemes in 1945–46. However, it was able to offer National Health Grants in 1948 so that the provinces could develop health care and hospital plans, begin hospital construction to fill gaps and set up demonstration programs in mental and public health.

There were no trained health planners at that time except in Saskatchewan; the other provinces used consultants to develop plans, but they were seldom able to stick to the plans because back-benchers lobbied for hospitals to be built in their own constituencies – for at that time hospitals were a major symbol of caring and they brought jobs to an area. Overbuilding of hospitals and, in some provinces, naiveté in copying Saskatchewan's hospital insurance scheme (Detwiller 1985) led to great financial difficulties in maintaining hospital services without federal help. So in 1957 Ontario was persuaded to join the eight smaller provinces to get the federal government to pass the Hospital Insurance and Diagnostic Services Act which provided matching grants for operating costs. (Quebec finally accepted federal hospital insurance grants in 1961.)

In 1962, after settling a doctors' strike, Saskatchewan introduced a provincial medical care insurance scheme. Seeing that other provinces might want to follow, the Canadian Medical Association had asked the federal government to set up a public inquiry. A Royal Commission on Health Ser-

vices, 1961–64 (Canada 1964) recommended that the federal government introduce a national medical care insurance scheme. This was enacted in 1966 and instituted in all provinces by 1970, but not without some resistance on the part of the medical profession (Taylor 1978).

Although the federal government was aware that other countries had introduced a wider range of free health care schemes, which included, for example, dental services[3] and prescription drugs, it was decided to leave any further program development after 1970 to the provincial governments alone. Most provinces brought in Pharmacare schemes for disabled and elderly persons, and some provinces provided dental care programs for children. All provinces started to bring in long-term care programs which later developed into continuing care schemes bridging institutional and community care for frail elderly and disabled persons.

The regional hierarchies of the medical profession's organization[4] have been challenged since 1920 by government medical advisers who did not see this form of organization to be in the general interest (Saward 1976). When collectivist health care systems were to be introduced into Saskatchewan to replace individualistic health care, public health service advisers pointed out that any government involvement in the funding of health services should focus on primary care which might help consumers avoid specialist services and hospital care if they followed preventive advice.

However, few governments were able to listen to these advisers on collectivist service organization who were bucking the trend toward greater and greater specialization and ever-increasing support for the scientific hierarchical model. As well they were backed up by the consumers of care who regarded preventive medicine by primary caregivers as less important to them than crisis medical care provided by specialists.

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3 For further information about dental services see Stamm et al. (1986).

4 The technical power of the doctors and other health professionals had been growing since a commitment to scientific medicine was made by the western world in the mid-nineteenth century. In 1910, Abraham Flexner, who had been engaged by the Carnegie Foundation, reported on the quality of medical schools in North America (Flexner 1910). He assessed their worth by their commitment to biomedical research and development. His report was extremely influential for it ensured that university medical schools became the high status centres. The number of medical specialists grew and the pastoral care of general practitioners became less important than their biomedical skills in diagnosing and treating disease. As in other more developed countries, the medical profession was structured into "regional hierarchies" (Fox 1987). Primary care physicians (general practitioners) who were placed at the bottom of the pyramid were expected to refer their more difficult cases on to secondary or tertiary care specialists in hospitals in the larger towns.

As a result of welfare state legislation all provinces had by 1970:

1. accepted National Health Grants for health service planning, contributions to hospital construction and limited support for existing public and mental health services
2. agreed to implement the Hospital Insurance and Diagnostic Services Act, 1957, which provided payment for care of patients in acute care hospitals. This act was based on the principles of universality, comprehensiveness, portability and public administration
3. agreed to set up medical plans following the Medical Care Insurance Act, 1966, which was based on similar principles and authorized the payment of doctors' fees. (Taylor 1978)

It will be recognized that these programs were all concerned with improving access to medical services through providing more treatment facilities and ensuring ability of consumers to get free care.

A new federal Deputy Minister of Health, Dr. Maurice Le Clair, appointed in 1968, took office just as the medical care insurance provisions were being brought in. He was not convinced that increased access to medical care and hospital services was going to result in better health outcomes for Canada so he introduced a number of inquiries into the system of care. Some of these questioned management efficiencies — such as the study of health care costs (Canada 1970b) (mainly focussing on hospital operational activities) and the matching grants method of funding — but others questioned goals and objectives.

In 1977 conditional matching grants were withdrawn in favour of block grants for health and higher education under the Established Programs Financing Act (EPF). These federal-provincial transfers were to be reviewed every five years. Some systems research (as well as biomedical research) was funded, and some financial consultants were seconded to help the provinces to manage their funds better.

As mentioned above, *A New Perspective* (Canada 1974a) argued that medical care was less important than lifestyle, a good physical and social environment, and biological risk factors in determining health outcomes. Le Clair thought that there needed to be more research on health care systems, not only on biomedical matters. *A New Perspective* took a long time to make an impact. Canadians were still determined to ensure universal, comprehensive and equitable *access* and it was not until after the Canada Health Act, 1984, was passed to stiffen up previous legislation that they were prepared to look further at *outcomes*.

The Alma Ata Conference on Primary Health Care called by the World Health Organization (WHO) in 1978 shifted the emphasis in that organization from promoting scientific medicine to examining basic social organiza-

tion issues. Canadian civil servants began to work closely with WHO on concepts of health promotion based on a broader concept of health as a function of good social organization (rather than focussing on medical care alone). As mentioned in the previous chapter, Canada called the first conference on health promotion in 1986 and presented a changed set of goals in its policy statement *Achieving Heath for All: A Framework for Health Promotion* (Canada 1986c). This set out the health challenges as reducing inequities, increasing prevention and enhancing coping, thereby laying out a health agenda based on a social model of health care.

In deciding to make a commitment to collectivist health care in 1945–46, the Canadian federal government did not at first recognize what collectivism meant.[5] In the postwar reconstruction period the federal government saw itself solely as a redistributor of funding across the provinces and it relied on the professional experts to develop the best system of health care for Canadians. What it did not realize was that the medical experts with their scientific training could not see further than improving and expanding the scope of the biomedical model of care. As well, as a group, these professional experts, mainly doctors, did not wish to become employees of the state, preferring to remain as individualistic subsidized entrepreneurs rather than working together with governments to develop an optimal collectivist health care organization. This resistance to change has continued over the years.

There are many reasons for the less than optimal organization and management of the system of health service delivery in Canada. Politicians were unsophisticated and provincial bureaucracies had to be built up gradually to administer Canada's social programs. Mistakes were made. Programs were introduced incrementally, and this led to an imbalance between acute care and community care. At the start, the emphasis was put on gap filling for crisis care rather than the coordination and balancing of crisis care with primary care. The need for greater attention to this has now been recognized because a greater appreciation of the social determinants of health has developed.

5 See Appendix A for definitions.