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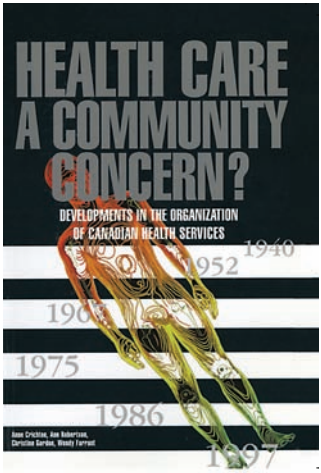

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
ISBN 978-1-55238-572-2

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CHAPTER 15

Four Preventive Care Programs

Four issues have been chosen to show the scattered approaches to prevention outside the structures of the traditional health care system. In Chapter 17 the problems of horizontal and vertical coordination within the health service organizations will be considered. This material is presented to raise the issues of lack of coordination between different departments of the provincial governments and with non-governmental organizations in the preventive sector of health care.

Monitoring Accidents

Statistics Canada collects data about accident mortality rates which include suicides and homicides (Canada Statistics Catalogue, annual). These rates vary enormously between the provinces and, furthermore, considerable variation can be found from one year to the next. Fluctuations are particularly evident in provinces with small populations. These data may be used to justify the introduction of preventive programs (Canada 1990f). Accidents (including suicides and homicides) are the primary cause of death among young people above the perinatal age in Canada and the reason that many are impaired, disabled and handicapped. Consequently provincial governments are anxious to prevent accidents as much as they can.

A New Perspective on the Health of Canadians (Canada 1974a) identified health status risks as being related to lifestyle, environment and biological risk, but the health departments themselves can do little in these areas except to provide educational programs. Most of the preventive work is done by others who have a special interest in a particular area. Quite often this interest is related to the question "who pays for the results of accidents?" Insurance companies providing income support to the injured would prefer to reduce demands upon their funds.

The first two examples chosen — safety policies in occupational health and prevention of motor vehicle accidents — bring up problems of individual protection within an insurance context. The second two examples — prevention of substance abuse and prevention of suicides — raise different questions about the limits of choice of lifestyle in Canadian society.

The Interest of Insurance Companies in Prevention

Occupational Health and Safety

In the past the main focus of attention on health care lay in the work situation, for when Canada industrialized, families tended to rely on one breadwinner only (instead of all members of the family) and his ability to continue to work was of the greatest importance. Following the example of other western countries, Canada's provinces set up Workers' Compensation Boards (WCBs) in the decade following 1907. Employers were assessed according to the hazards of their work situation, using insurance principles. Guest (1980) has described the differences between these boards which used a range of European models of organization.

At first attention was given to the matter of income support for the families of injured or dead workers, but it was soon recognized that prevention of accidents could profit both employer and employee. It has long been recognized that prevention is better than having to compensate and rehabilitate those with occupational injuries, but since 1972 more questions have been asked about the adequacy of preventive activity in work situations. This is now the responsibility of the Minister of Health in Quebec, the Ministry of Labour in other provinces and the WCB in British Columbia. Most provinces have rewritten their occupational health and safety legislation[1] fairly recently or revised their workers' compensation laws (Nash 1983). The general thrust of these changes has been to ensure the rights of workers to have information on the hazards of particular jobs and to refuse unsafe work. Joint labour management committees on health and safety have been set up. They are expected to determine safe standards for work performance and working conditions and, subject to a review by a government appointed inspector, establish rules governing safe working conditions. More often, however, they are used to mediate complaints.[2] Despite these reforms, Sass (1989) did not think that there had been meaningful changes in workplace health and

1 The Ontario Ministry of Labour has developed a bibliography on occupational safety.

2 Clyde Hertzman, personal communication, 1991.

safety. He wanted to see more involvement of workers in the overall policy decisions of their employing bodies.

Despite efforts to improve safety at work, the number of claims has risen in recent years. Some of this is due to persons with industrial diseases beginning to make claims, but these are only a small proportion (about six percent) of the whole number of claimants [Ison 1989]). Some (e.g., Maynard 1993; Schulze 1993) have suggested that while workers' compensation was appropriate to earlier forms of industrialization, it is not serving "the information society" well. Yet others believe that WCBs are in trouble because of poor management (Geary and Buchanan 1990; Alberta 1990d).

Quebec takes a different approach to occupational health and safety from the other provinces. New legislation introduced in 1979 linked the preventive activities of the old Workers' Compensation Board into the restructured public health care system. Preventive care was to be provided through activities of the Départements de santé communautaire (DSCs) and Centres locaux des services communautaires (CLSCs). Problems in integrating various sectors of the reformed occupational health care programs were discussed by White and Renaud (1987) in a report to the Rochon commission (Quebec 1988) which was reviewing provincial health services. White and Renaud explained that

> the system that was created by the Act provided for a purely supportive role for the [occupational health] network: the identification of health risks and the preparation and application of specific health programs for each enterprise ('secondary prevention'). 'Primary prevention,' that is the establishment of specific mechanisms to prevent illness and accidents, is the responsibility of the private sector. There is an interdependence between the two which should ultimately be ensured through the role of the health and safety committees in a work place. (p. 189)

But in the first eight years of restructuring, the tensions in Quebec were so great that a number of occupational health experts left the field, and power struggles between various interest groups delayed progress in establishing pivotal elements of the system. The researchers presented their analysis of the difficulties in bringing together Workers' Compensation Boards and public health organizational cultures and examined five possible models for modifying current problems. Their recommendations were concerned with improvement of linkages between different sectors of the system through appointment of liaison officers.

This approach has not been taken by the other provinces which have not seen occupational safety as a health service issue. But the whole area of occupational risks has become a matter of greater public concern. Much more

research is now going on than even a decade ago. WCB structures are under pressure to bring in reforms.

Prevention of Motor Vehicle Accidents

Four provinces have taken over motor insurance as provincial responsibility — British Columbia, Saskatchewan, Manitoba and Quebec. These provincial motor insurance companies are strongly committed to prevention. For example, the Traffic Safety Education Department of the Insurance Corporation of British Columbia (ICBC) claims to have been involved in community development for several years. This five-stage process of community development is outlined in a paper by Coté and Cooper (1990) as: community profile development, community contact development, committee formation, planning and implementation, and review and evaluation. ICBC's community programs are particularly concerned with educating school children in bicycle safety and pedestrian safety and improving adult drivers' behaviour. Use of seat-belts has greatly improved, although it was said that the drunk-driving Counter-Attack Program was not yet having much impact.[3] It is recognized that there are insufficient recreational alternatives in small towns and this leaves room for drug and alcohol abuse to creep in. ICBC traffic safety staff have produced a series of booklets on aspects of drivers' behaviours in relation to specific kinds of accidents (Rothe 1986, 1987a,b, 1990; Rothe and Cooper 1987a,b). Similarly, Saskatchewan has produced studies of night-time drivers (Hieatt 1989), a seat-belt use program (Landry 1988; Medgyesi 1990) and senior drivers.

This does not mean that the other provinces are not concerned about motor vehicle safety, but they have decided to leave insurance to private companies. One of the larger issues for all companies is the discussion around the introduction of no-fault insurance which means that cases are settled out of court (as in workers' compensation). It is recognized that taking cases to court delays the start of the rehabilitation process as it is important to demonstrate the extent of injuries in order to increase the amount which may be awarded in a settlement. No-fault insurance is likely to reduce the total cost to the insurance companies and thus to the persons taking out insurance. Canada has investigated the possibility of following New Zealand's example (New Zealand 1967) and introducing a no-fault scheme for all accidents (Ison 1989; ICBC 1990), but in spite of considerable interest (Canada 1983–86), a national scheme has not yet found sufficient support from the experts or the public.

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3 This is a program of the Department of the Solicitor General, responsible for the police and their activities in the province. Bill Hubbard, personal communication, 1991.

Helping Those with Problems to Adjust to Mainstream Canadian Society

In a rapidly changing world moving towards a global economy, just coping with daily life and fitting into the mainstream of Canadian society is not easy for everyone. Some people find that meeting day-to-day demands is very difficult, and they are tempted to use drugs and alcohol to escape their responsibilities. Others go even further and decide to commit suicide rather than go on living. Canada struggles to help these people through preventive and/or rehabilitative programs.

Prevention of Alcohol and Drug Abuse

The issue of drug and alcohol abuse came to wider public attention with the radical social movement of the late 1960s, when young people started to leave home, to trek across Canada and to explore the world. Unlike their parents, who used alcohol as their drug of relaxation, young people tried out a range of other drugs such as marijuana and heroin, shocking the establishment and creating a political furore. The response of the federal government was to set up a royal commission (Canada 1973) to explore the magnitude of the problem and to suggest solutions. The commission was divided in its response, reflecting the divisions in the community. However, the result was the establishment of provincial Alcohol and Drug Commissions where these did not already exist, with mandates to research the problems, advise on policies and administer programs for addicts.

Many of the problems were common to all provinces though there were some differences. For example, British Columbia had to cope with the highest number of heroin users. The political salience of drug abuse has decreased since that time, leading some provinces to change the organizational structures for dealing with substance abuse. British Columbia, for example, abolished its commission and put drug counteraction programs under its Department of Labour, though these programs have now been brought back into the Department of Health. Alberta has reorganized its commission, creating a simplified structure (Kearns 1984), and has moved into social marketing of programs to adolescents (Kearns 1986).

A national survey provided information on the need for services (Canada 1990g). How the problems were being dealt with at the provincial level depended very much on the success of the bureaucratic authorities in developing relations with local communities. For example, the Nova Scotia Drug and Alcohol Commission, which reports to the Minister of Health, set up five community-oriented regional advisory boards and established a number of strong program divisions: the employee assistance program division,

which works with large companies; the documentation, evaluation and research division; the prevention and community education division; school services; the staff training and development division; library and media services; the treatment and rehabilitation division; and an employee assistance program (Nova Scotia 1988). However, as a result of recommendations by the provincial Royal Commission on Health Services (Nova Scotia 1990a), further restructuring to improve Nova Scotia's substance abuse rehabilitation services has been considered.

This list of activities in Nova Scotia gives some indication of the common policy problems. These were laid out by the government of Canada (1988a) in an action agenda — that is, counter-attack on drug abuse affecting driving, work performance, schooling, family life, native peoples, and efforts to moderate the cost to the nation in terms of law enforcement and medical services. Advisory pamphlets have been produced to help families with parenting (Canada 1990b,d,e), to help community groups to curb impaired driving (Canada 1990f) to help school children to work with peer groups (Canada Health and Welfare 1990a,b,c,d,e) and to give to those who want it general information about drugs (Canada 1990g).[4] One other area of concern has been the overuse of prescription and over-the-counter drugs by elderly persons.

It has become clear that the counter-attack against drugs will not be successful without community support. Considerable efforts are being made to work with local communities on drunk driving,[5] with industrial workers on alcohol use (McLatchie, Grey and Johns 1981), with school children and youth groups, with families at risk of violence and with native peoples (Hodgson n.d.). The Ontario Advisory Committee on Addictions (Ontario 1989a) has developed guidelines for establishing community action groups.

The emphasis on developing treatment programs was given greater priority in the mid 1970s. Underwood (1990) has argued that there are too few treatment programs in Canada and that addicts are having to go to the United States for care if they are desperate and can afford it. Most service providers would agree that more needs to be done in the area of rehabilitation (e.g., Nova Scotia 1987a).

As for long-term care, that can be successful only with community support. Alcoholics Anonymous, a self-help group (Maxwell 1964; Gallant 1987), assists large numbers of addicts in retaining their sobriety.

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4 Drug information telephone lines have also been set up and are much used.

5 Studies are beginning to be undertaken on alcohol related admissions to British Columbia hospitals. It has not been possible to access this evidence because it is not yet in the public domain.

The emphasis on improved coordination of services, which is a major thrust of the new regional authorities, seems likely to result in amalgamation of separately funded and structured community services being brought together under one management. Thus, for example, discussions are going on in Vancouver about combining, in 1995, public health, mental health and drug and alcohol services to form six restructured community service networks. Since these networks will have close links to community representatives who have the responsibility for planning and policy, it is hoped that more effective drug and alcohol programs will be developed.

Prevention of Suicides

Voluntary organizations often move in first when a social problem is recognized. In Canada the Samaritans set up a telephone service to counsel those who needed support for their depression problems. Most provinces still count on this service to meet these needs.

Alberta appointed a provincial suicidologist in 1978. The purpose of the appointment was, and is, to reduce self-destructive and suicidal behaviour and to reduce the impact of suicides and suicidal behaviour on individuals, families and communities. The reason for this appointment was the rapid increase in the 1970s in the number of suicides by young persons. The program was evaluated in 1987–89 after reviewing the existing situation and the general literature (Alberta 1989b) and it was recommended that it be strengthened by providing more time for contributions of the provincial expert and by increasing involvement of trained volunteers from the community.

However, the whole issue of suicide seems to be difficult for the policy makers to tackle. At the other end of the scale from the suicides of young people are the requests of those with incurable diseases for assistance to die. So far Parliament has not been ready to address this issue, despite growing concerns in the Canadian community. The response is much like that of the Le Dain committee, a division of opinion abut the rights of the individual to make individual choices of lifestyle and when to die.

Summary

This chapter has reviewed four preventive programs carried out by organizations other than the traditional provincial health departments. The first two of these, workers' compensation and motor vehicle insurance organizations, are spurred on to take safety measures by the costs of providing insurance to injured people. The second two, prevention of substance abuse and prevention of suicides, raise different problems about individuals' adjustment to Canadian society and the demands of society upon them.

This material has been presented in order to raise the issues of lack of coordination between different departments of provincial governments and with non-governmental organizations in the preventive sector of health care.