The personal is political: health care in Canada

Lesley Cooper and Richard Freeland, Kitchener/Ontario (Canada)

The personal is political. This statement is an activist imperative, used by 1970s feminists to explain the influence of race, class and gender on the exclusion of women from decision making. Prior to this, from a completely different perspective, Mills (1959) made the observation that private pains are the manifestations of public issues. Many of the choices we make are not about our personal feelings, experiences or preferences but are strongly defined by the broader social and political context. Exclusion from decision making and services is a public matter.

If the personal is political, let's begin by talking about the personal. Last year I migrated to Ontario, Canada from Australia. The very first question I was asked by colleagues and friends was "Have you found a doctor?" I answered in the negative and was bewildered as to why this was an issue. As I understood that Canada has a national health system, I had understood that as in Australia, I could call any doctor and obtain an appointment within hours.

I quickly came up against the difficulties facing people seeking to obtain health care in the province of Ontario. In order to receive health care, I needed to register for a health care card, an administrative process requiring my being photographed and the provision of other personal details. I also had to demonstrate that I was legitimately residing in Canada and not a freeloader from Canada's near neighbour, the USA, which does not provide its citizens ready or easily affordable access to quality health care. Certainly Ontario appeared to go to extreme lengths to prevent "refugees" from the US privatized health care system using their services.

When I first attempted to make a medical appointment for a minor ailment, I discovered that doctors' patient lists are closed, i.e., that new patients are not accepted. The only recourse to obtain minor treatment was to join a queue of over 20 people waiting outside an "Urgent Care Clinic" before the clinic had opened. Whilst no appointment was necessary at this clinic there was no provision for anyone to actually make an appointment. The queue that I joined comprised people without the benefits of having their own doctor as well as many who did have their "own doctor" but were not able to make an appointment within fewer than several days. The health care services I eventually received were free but quite detached from any treatment as an individual person. The system appeared equally capable of excluding both the wealthy, middle class and the poor.

I began the process of enlisting help in finding a doctor from local colleagues. My provost gave me a web address listing doctors in the region who were accepting patients. When I checked, the list comprised only two names, both psychiatrists. This was not what was immediately needed. Others advised me to make contact with the local general hospital which had similar lists. I could leave my name and when a vacancy occurred in a practice, I could make contact with the relevant doctor. The vet who assisted my cat, offered to write to his doctor asking for him to include our family. Finally, after much helpful advice, I meet a social worker whose husband was a doctor and through her good will, we were provided with the name of local GP. There is no real choice of doctor in such a system.

From this personal experience I will extrapolate a broad picture of the Canadian health care system and then attempt to provide a picture of how this situation has developed.

One unintended consequence of a public health system with an excess of demand and insufficient physicians is the rationing of services through long waiting lists and a process of excluding broad groups of people. It is emotional rather than evidence based. Migrants and refugees coming to Canada are excluded. Internal migrants are not assisted. The Indigenous population has poor access, this being a particular problem in their settlements. There are particular difficulties in rural and remote areas.

Canada has a national health system where all Canadians have access to doctors, specialists and hospital care. Canadians pay taxes so this service can be provided equitably to all. Canada does not have a dual health care system of private care for the wealthy and public services for the poor, as does its near neighbour, the United States. I discovered at first hand the experience of being excluded from a nationally funded health care system. What factors contribute to the breakdown of this national system and how are policy makers considering remedying this situation?

The Canadian national health care system which is funded from general taxation revenue and known as medicare has been in place for over forty years. The health care system grew out of concerns over financial barriers to accessing health care and was developed on the basis of a set of core values, including universal coverage for all citizens. The scheme is publicly administered on a not for profit basis with a system of cost sharing between the federal and provincial governments. Whilst it provides a comprehensive approach to provision of necessary hospital and physical services, dental health care and pharmaceutical services are not included. Citizens may obtain these services through private health insurance. As this is generally provided through employers, this poses difficulties for those on contract work, for the unemployed and for people who have retired. Even those with access to insurance to dental and pharmaceutical services, may find significant differences in levels of reimbursement depending on their employer's insurance arrangements. A unique feature of this universal Canadian health care system is the absence of private hospitals.

The different provinces have constitutional responsibility for health care whilst the Federal government raises and holds the bulk of revenue achieved through the taxation system. Despite decentralisation of health care being a subject of debate health service delivery has remained a responsibility of the provinces (Burke and Silver 2006). Despite these debates over the virtues of central or provincial systems, the current mixed model involving both federal and provincial authorities creates administrative duplication, provincial variations and potential inefficiencies. Whilst there is legislative provision for portability of entitlement across provinces, services available and services provided may well vary from province to province.

Canadians are immensely proud of their national health care system and the value of this scheme for all citizens. It is clear however that the main basis of this public perception is through comparison with that of their nearest neighbour (the USA), rather than with other OCED countries. This most visible comparison is not necessarily the best. This pride is evidenced in a public and transparent review of the system in 2002 (Romanov 2002) where the aim was to renew the health care system and establish a new collective vision for the future sustainability of universal health care for all Canadians. The commission's intent was to affirm and tinker with the existing system rather than change it.
This Romanov Commission, however recommended many changes including increased targeted funding to enhance rural and remote access to services, establishment of a diagnostic services, funds to improve wait times for such things as CT scans, MRIs and other technologically advanced procedures, greater emphasis on primary health care and provision of home care. A key recommendation was to set up a "catastrophic drug transfer" program to provide pharmaceutical treatment in cases where patients are unable to afford necessary drugs. Of particular relevance to social work were recommendations for the integration of

home care services in mental health, case management, palliative care and post-acute hospital care in the home environment. As a result of this home care provision, academic policy analysts are concerned over any possible transfer of care and responsibility from the public to the private and/or family sphere.
As a way of fostering inter-government collaboration and monitoring and reporting on the progress of the health care renewal, the government established the Health Council of Canada. In recent days, the Interim Chair of this Council has announced that 'Canada fails to measure up'. The Chair has stated that the various Federal and provincial government agencies have not provided any data essential to knowing whether care is getting better, safer and more timely (Toronto Star February 1 2007, page A21). Whilst Governments continue to move ahead with some changes, development of impact and outcome measurement is being neglected.

Some evidence is currently available about the overall performance of the health care system. Using OECD figures, the Fraser Institute, an organization committed to market solutions to health care, has stated that Canada does spent a large percentage of its GDP on health and that on adjusted figures this proportional expenditure is second only to Iceland (Esmail 2006). Money, they argue is not at issue. Given their commitment to a market driven system, the Institute argues for a market driven system or a model that combines government and private services. This is a diametrically opposed view to that of the Romanov review which strongly opposed private provisions and argued for maintenance of universal provision.

Access to timely diagnostic services, waiting times for access to surgery and specialists, shortages of physicians and an increasing expectation that family and friends will provide home care as an alternative to hospital care are regarded by Burke and Silver (2006) as major issues. There is ample evidence of problems in all these areas. Schoen et al (2005) report that when investigating the experiences of sicker adults across six nations (Australia, New Zealand, United Kingdom, Canada, the United States and Germany), Canadians waited longer in emergency rooms, had difficulties in getting a same day appointment with a doctor, have the longest wait for specialist appointments and wait the longest for elective surgery. This evidence supports the belief of many Canadians that their system requires fundamental changes. It also indicates that the general public perception of the Canadian health care system compared to that of the USA may be misplaced.

The question remains, what does access to health care actually mean in Canada? In the early development of the universal health care system in Canada, access meant that financial barriers imposed by poverty should not preclude obtaining medical and hospital care. More recently access in the Romanov Commission Report (2002) refers to the need for Canadians to have care when and where it is needed. The defacto measures of access have changed from financial barriers to ones that include waiting times for diagnostic procedures, specialists and surgical procedures. Despite the difficulties inherent in determining waiting times and lack of consensus about when these waits begin, Canadians who find themselves on waiting lists have at least got access to a general practitioner and specialist health care but little clarity of when they may receive the specialist services they have been referred to. Nor can they be confident of the level of assistance they may receive towards cost of pharmaceuticals. Clearly there are other hidden barriers to access. These barriers are also associated with the social inequities surrounding particular underserved populations including Aboriginal communities, rural and remote areas, visible minorities and immigrants and refugees.

It appears that the Canadian health care system does not make a clear distinction between utilization of services and access to services.

Rather than addressing access difficulties a 2000 Health Canada report referred to concepts of underservice and underserved populations. Underservice means people will experience

difficulty in obtaining care when and where they need it. They may receive no care, less care, a lower standard of care or access to services that do not met their health needs. The underserved populations are not necessarily the poor or those on a low income. Some consumers may have low status because of their mental illness or addictions. They may have persistent language and cultural barriers that prevent care at many levels. Some people are subject to overt discrimination because of their religious beliefs or sexual preferences. Many groups of Canadians through lack of information or education may lack awareness of availability of many basic services. Or they just may not live in an area where the required services are available. Underservice may also happen to people like me, or you.

References

Besner, J. (2007) 'Canada Fails to Measure Up', Toronto Star, Thursday February 1, 2007, A21.

Burke, M. and Silver, S. (2006) 'Universal Health Care: Normative Legacies Adrift' in Westhues, A. Canadian Social Policy: Issues and Perspectives, Wilfrid Laurier Press, Waterloo, Canada.

Esmail, N. (2006) How Good in Canadian Health Care? An International Comparison of Health

http://www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=877

Health Canada (2000) "Certain Circumstances: Issues in Equity and Responsiveness in Access to Health Care in Canada"

http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acces/part1-doc1-sec3_e.html

Mills, C. Wright (1959). The Sociological Imagination, Oxford University Press, New York.

Romanov, R. J. (2002) Final Report: Building on Values, the Future of Health Care in Canada, Commission on the Future of Health Care in Canada, Saskatoon.

Schoen, C. Osborn, R. Huynh, P.T. Doty, M. Zapert, K. Peugh, J. and Davis, K. (2005) 'Taking the Pulse of Health Care System: Experiences of Patients with Health Problems in Six Countries,' Health Affairs. http://content.healthaffairs.org

Lesley Cooper is dean at the Lyle S. Hallman Faculty of Social Work at Wilfrid Laurier University, Ontario.

Tags: Canada, health-care, inequality, welfare reform

-