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The Evolution of Health Care in Canada: Toward Community or Corporate Control?

Harley D. Dickinson and B. Singh Bolaria

Health policy in Canada oscillates between preventative and curative approaches. In general, prevention and promotion are subordinate to treatment and cure, but the balance is historically variable. Policy shifts in one direction or the other are accompanied by shifts in the nature of control over, and the distribution of power within, the health care system. In the late nineteenth century, for example, we saw the professionalization, scientization, and institutionalization of the curative approach in health care. More recently, in the last decades of the twentieth century, we have begun to see a reassertion of preventative approaches and various other challenges to the dominance of modern medicine.

In this chapter we outline key dimensions of the nature and organization of the Canadian health care system. We review the literature on the introduction of state hospitalization and medical care insurance programs (Medicare). We then look at current reforms initiatives and argue that they are manifestations of the struggle both for, and against, medical dominance.

Health Care and Health Care Policy in Canada

Canada does not have a single health care system. Under the Canadian constitution health is an area of provincial jurisdiction. As a result, there are ten provincial and three territorial health care systems. The main policy tools available to the Federal government, to influence health care policy and service delivery, are rather blunt fiscal and budgetary mechanisms combined with whatever influence it can exert on the formation of public opinion.

The federal – provincial jurisdictional split has meant, historically, that health care reforms occur at the provincial or sub-provincial levels of government. Examples include the Saskatchewan Municipal Doctor Plans, Union Hospital arrang-

ements, regionalized forms of health policy planning and service delivery, community clinics, as well as various hospital and medical care insurance plans (Douglas 1946; Mott 1947; Roth and Defries 1958; Wolfe 1964; Mombourquette 1991).

Health care insurance was an issue that was variously on and off the national and provincial political agendas. By the 1940s, failure of the market to ensure adequate access to necessary medical and hospital care, combined with limitations of the various locally developed collectivist solutions, had generated renewed interest in state medical care and hospitalization insurance. This was given added impetus by experiences with war time military and industrial recruitment where it was discovered that an alarming proportion of recruits were too sickly for military or industrial service (Fuller 1998: 27). As a result of this experience, and other statistics that demonstrated the poor health status of the Canadian population, health insurance was firmly established as a key component in government plans for postwar reconstruction.

Thus, in 1945, the Federal government put forward a plan for a universal health care insurance program cost shared by the federal and provincial governments. The general rationale for state intervention in this area was the belief that improved access to hospital and physician services would result in improved health status. This in turn was seen to translate directly into increased productivity and national prosperity. A more particular motivation for proposing a state financed, universal, and comprehensive health insurance program was concern that the proposed alternatives were inadequate.

By the end of the war there was a political consensus that health care could not be left to the market. Beyond that, however, there was little agreement. The medical profession favored a hospital and medical care insurance system that was based on voluntary participation in physician-sponsored or commercial insurance plans. The state's role would be limited to providing coverage on a means-tested basis to the medically indigent. The private insurance industry was in favor of a similar arrangement. Business organizations in general also favoured such an arrangement because of concerns about creeping socialism, as were several provincial governments. Even the organized trade-union movement was somewhat ambivalent about universal, compulsory state health insurance because they had largely secured coverage for their membership through various voluntary, private plans (Walters 1982). Among the strongest supporters of state insurance were the various farmer organizations, especially in western Canada. It is not surprising then that the first compulsory, universal, state financed and administered hospitalization insurance plan was introduced in Saskatchewan by a newly elected political party dominated by farmer interests (Dickinson 1993).

The federal government was convinced of the necessity to introduce a similar plan on a national scale for the reasons cited above. Thus, in 1945, at the Federal-Provincial Conference on Reconstruction, it introduced draft legislation. Key features of the legislation were the establishment of health regions, patient registration with physicians, a capitation mode of payment, additional financial incentives for physicians who adopted preventative approaches, and the administration of the system by commissions consisting of both physicians and consumers (Taylor 1978; Vayda and Deber 1992: 126).

The proposed plan was not implemented, however, because of provincial government concerns about Federal incursion into areas of provincial jurisdiction, and failure to reach agreement on taxation issues (Taylor 1960). As federal–provincial discussions bogged down and the prospects of implementation receded into the future, a new consensus emerged around the adoption of an incremental approach to the introduction of state health insurance.

The first major step in this regard was taken at the provincial level by the government of Saskatchewan when, in 1946, it introduced the country's first universal, comprehensive system of tax-paid hospitalization insurance. For its part the Federal government contented itself with introducing the National Health Grants program in 1948. This program was uncontentious from the perspective of the provinces and the organized medical profession because its main purpose was to increase hospital bed capacity across the country. The rationale behind this was that increased and equalized hospital bed capacity would result in increased access to needed hospital services and, as a result of that, equalized health status and increased productivity and economic prosperity. From a purely political perspective the National Health Grants program was seen as an important dimension of national building.

The 1946 Saskatchewan hospitalization insurance program was designed to be eligible for federal cost-sharing once agreement was reached between the rest of the provinces and the Federal government. Before that happened, however, four more provinces introduced hospitalization insurance plans. These five provinces increased pressure on the Federal government to introduce the long-promised cost-sharing arrangements. This was done in 1956 with passage of the Hospital Insurance and Diagnostic Services (HIDS) Act. By 1961, the remaining five provinces had introduced hospitalization insurance plans. The medical profession, although wary of this development, were not opposed to it, largely because it served to increase their incomes and posed no real threat to their autonomy.

Hospitalization insurance encouraged both physicians and patients to think of hospitalization as a treatment of first resort. This ensured high occupancy rates and rising costs. This inflationary feature of hospitalization insurance plans was reproduced and amplified in the medical care insurance plans that followed.

Although the introduction of state hospitalization was largely uncontentious, the introduction of medical care insurance was accompanied by bitter struggles. Analytical approaches to understanding the nature and consequences of those struggles vary (Tollefson 1963; Thompson 1964; Badgley and Wolfe 1967; Taylor 1978; Naylor 1986). A common theme, however, is medical autonomy and dominance, and its consequences for the nature and organization of health care delivery (Taylor 1960; Blishen 1969; Swartz 1977; Walters 1982; Coburn, Torrance, and Kaufert 1983; White 1984; Tuohy 1994;).

Walters (1982), for example, analyzes the introduction of Medicare in terms of the state's contribution to capital accumulation and political legitimation. Relative to capital accumulation, she sees Medicare as an attempt by the state to ensure the reproduction of a healthy and productive working class. Access to health care services, particularly hospital and physician services, is assumed to result in improved health status among the working population. The prevailing decentralized system of hospital and physician services was seen to be in need of

rationalization and reform. Medical autonomy and the self-interest of the private insurance industry were seen as inadequate foundations for national health policy. From this perspective medical autonomy and professional monopoly were seen as barriers both to the rationalization of the health care system and to improved population health status.

Swartz (1977), in contrast to Walters, argues that the introduction of Medicare is best understood as a concession wrung from the capitalist class and its state through the struggles of a militant working class and its political allies. He maintains that Medicare was part of an effort to appease the working class by increasing the social wage. Swartz's analysis draws attention to the ways in which the resistance of the medical profession resulted in modifications to the form and content of the original proposals for socialized medicine. These concessions had the effect of entrenching the interests and dominance of the medical profession (Weller and Manga 1983; Naylor 1986).

Coburn, Torrance, and Kaufert (1983) argue that the introduction of Medicare is best understood both as a response to working class agitation, and as an attempt to supply the capitalist class with adequate quantities of healthy labor. In contrast to Swartz (1977) and others, however, they argue that the introduction of Medicare marked the beginning of the end of medical autonomy and dominance, not its entrenchment.

Thus, debate over whether Medicare entrenched or undermined medical autonomy and dominance continues, and the evidence is contradictory. What is clear, however, is that the organized medical profession was afraid for its autonomy (Badgley and Wolfe 1967). Although the organized medical profession was unable to thwart the introduction of Medicare they were able to force the governments of the day to make significant compromises.

The main compromises made by the government of Saskatchewan, which eventually came to characterize medical care insurance programs throughout all of Canada, were retention of the fee-for-service system of remuneration and professional control over fee setting. From the perspective of the profession, fee-for-service, as opposed to the alternatives of a salaried physician service or a capitation scheme, was seen as a bulwark against even greater erosion of their professional autonomy. It was well known that a consequence of this compromise would be rising medical care and hospital costs.

At the time there was an awareness of the fiscal effects of these decisions. This, however, was not seen to be a particular problem. Partly because fee-for-service remuneration was seen as a necessary compromise with the profession, and partly because it was still widely held that unrestricted access to physician and hospital services was the major factor in improving population health status. This assumption quickly came to be challenged. At the same time various cost-containment strategies were deployed.

Medicare and Cost Containment

Following the lead of Saskatchewan, and the recommendations of the 1964 Royal Commission on Health Services, the Federal government introduced

Medicare in 1966. By 1972 all provinces and territories had opted into the program. The five principles upon which Medicare was founded are universality of eligibility, comprehensiveness of coverage, portability between provinces, accessibility achieved by prepayment through taxation, and public administration on a non-profit basis. Provinces that established medical care insurance programs in accordance with these principles were eligible for a fifty-fifty cost sharing arrangement with the Federal government.

A core structural feature of the federal–provincial cost-sharing agreement established in 1966 was that only physician provided services, either outpatient or inpatient, were included. This discouraged the provinces from developing non-physician, non-hospital services because they were not eligible for federal funds. It did, however, encourage the provinces to try various cost-control strategies (Dickinson 1994).

In this regard efforts were made to reduce the number and duration of contacts with the health care system during an episode of illness, and to reduce the cost per contact. Even these efforts were discouraged, however, because each dollar in savings achieved by provincial governments resulted in a one dollar reduction in federal government transfers. Not surprisingly, the provincial governments quickly came to be dissatisfied with this funding arrangement. The Federal government was also dissatisfied because its health care expenditures were determined directly by the level of provincial expenditures. Consequently, it had no control over the level of its expenditures. Thus, both federal and provincial governments were interested in changing the terms and conditions of the cost-sharing arrangement (Soderstrom 1978).

This was done in 1977 with enactment of the Federal – Provincial Arrangements and Established Programs Financing Act (EPF) by the Federal government. The EPF had a number of effects: it provided a $20 per capita incentive for provinces to put more of its resources into community care; it reduced the Federal government's share of Medicare cost from approximately 50 percent to approximately 25 percent; it uncoupled federal costs from provincial expenditures; and it limited the growth in direct federal government increases to the rate of growth of the gross national product (GNP). Provincial health care expenditures above that were ineligible for federal cost sharing (Vayda, Evans, and Mindell 1979; Crichton, Robertson, Gordon, and Farrant 1997). The motivation for the provinces to accept the terms of the EPF was an increased capacity to tax incomes as a means to offset reduced federal cash transfers.

The ascendancy of fiscal conservatism in the 1980s resulted in further federal cost cutting initiatives. In the mid-1980s federal transfers to the provinces were reduced to 2 percent *below* the rate of growth in the GNP. In the early 1990s further reductions in federal government transfers to the provinces were introduced. Under that formula federal transfers were frozen for a period of two years at 1989–90 levels. In 1992–3 they were allowed to increase at a rate 3 percent *less* than the rate of increase in the GNP.

These changes resulted in decreased total health expenditures expressed as a proportion of GDP. In 1994, for example, they were 9.7 percent of GDP, down from 10.1 percent in both 1992 and 1993. Despite this proportional decrease total health spending increased to $72.5 billion in 1994, up from $71.8 billion

the previous year. This represented a 1 percent rate of increase for 1994, down from 2.5 percent in 1993 and 5.6 percent in 1992 (Health Canada 1996: 3).

Federal government reductions in transfer payments initiated a series of cost-cutting measures at the provincial level. These included budget reductions, reductions in the number of hospital beds, efforts to control medical services fee increases, the deinsuring of some types of services, limits on the number of certain types of services for which physicians could bill, and increased monitoring and disciplinary powers for regulatory bodies (Vayda et al. 1979: 226; ACPH 1996).

Government cost-cutting efforts were also associated with changes in the types and location of health care services – a reduction in hospital services and an increase in various community-based and home care services – and an increased use of drug and alternative therapies. In addition, these developments corresponded to increased private expenditure on health care services (Health Canada 1996).

Not surprisingly, physicians, and other health care providers, responded critically, and in some cases militantly, to these initiatives. There were, throughout the 1980s, a number of nurses and doctor's strikes, as well as increases in the use of user fees and extra-billing to offset the effects of various cost-control initiatives (Northcott 1994).

Thus, cost control and various reforms were not popular with health care providers. Nor were they popular with health care service users. Reforms are generally claimed to have resulted in crowded hospital emergency rooms, and longer waiting lists for various diagnostic and therapeutic services. This has resulted in growing concerns that contemporary health reforms are really a strategy to dismantle Medicare by stealth. To counter these concerns, and to deflect the political consequences of being seen to violate a sacred political trust, politicians at all levels of government have reasserted their commitment to the five principles of Medicare.

The first retaking of vows came in the form of the Canada Health Act (CHA) in 1984. The CHA effectively banned extra-billing by physicians by imposing dollar-for-dollar reductions in federal transfers to the provinces for each dollar in extra-billing or user fees they allowed. One response of the organized medical profession and its political allies was to mobilize for the reprivatization of health care in Canada (Weller and Manga 1983; Stevenson, Williams, and Vayda 1988; Armstrong 1997; Fuller 1998).

In 1997, all levels of government reaffirmed their commitment to the principles of Medicare in the form of a joint statement. This was accompanied by a $1.5 billion increase (from $11 to $12.5 billion) in federal cash transfers to the provinces for health care. In 1999, the federal budget announced a further increase in health care funding through the Canada Health and Social Transfer (CHST). This amounts to an additional $11.5 billion targeted specifically for health care to be distributed to the provinces and territories on an equal per capita basis over the next three years. In addition to the increased cash transfer, the 1999 Federal budget announced increased tax transfers to the provinces with the understanding that new revenues will be used for health care.

The nature and organization of the contemporary health care system is much different than it was when Medicare was first introduced. It is also the case that

Medicare increasingly is seen as an inadequate response to the health needs of Canadians.

The Determinants of Health and Health Promotion

In addition to the general efforts to directly control costs in the health care system discussed above, efforts in the area of health promotion have also increased since the early 1970s. In particular, thinking about the relationship between enhanced access to hospital and medical care services and improved population health status changed dramatically. In the immediate post-World War II period, as we have seen, the primary goal of health policy was to optimize access to medical and hospital services. That is, health policy was really health care policy narrowly conceived. There was, however, widespread optimism that this in itself would have a substantial impact on the health status of the population. By the early 1970s, however, this optimism already had faded. The first official indication of this was the publication of a White Paper by the Federal Minister of National Health and Welfare, Marc Lalonde, entitled *A New Perspective on the Health of Canadians*.

This document put forward the Health Field Concept. This concept expressed the idea that health status is the result of several determinants, not simply, or even primarily, access to medical and hospital services. The main determinants of population health were identified as human biology, self-imposed risks associated with individual lifestyle choices, environmental factors, and health care services. The Lalonde report noted that "there is little doubt that improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology" (Lalonde 1974: 18). There is no mention here of increased access to medical services as a means to increase population health status.

Reaction to, and assessment of, this initial statement of the determinants of health framework was mixed. Some, like Renaud (n.d.: 230), saw it as nothing but a few broad statements of little policy significance. Others saw the health field concept, particularly its emphasis on individual lifestyle choices, as a potentially harmful form of victim-blaming and potential abandonment of the sick (Bolaria 1988).

Evans and Stoddart (1998: 561), on the other hand, suggested that the health field concept, or the determinants of health framework, results in a proliferation of outreach and screening programs in which increased numbers of people are placed on continuing regimes of drug therapies and regular monitoring. Thus, the determinants of health policy framework, given its focus on individual lifestyle choices, was seen by some to perpetuate and expand the individually oriented, professionally dominated, clinical approach to health care and injury and illness prevention (Evans and Stoddart 1998).

Others saw in the determinants of health /health promotion framework opportunities for the empowerment of the marginalized and the democratization of a wide array of social institutions (Dickinson 1996; VanderPlaat 1998). This optimism was tempered by a healthy dose of realism. Simply because a potential

exists for health promotion to contribute to greater equality of health status through democratic empowerment there is no guarantee that potential will be realized. There are powerful vested interests who may actively or passively resist the sweeping changes in power associated with health promotion. The history of health care reform is replete with such struggles.

At about the same time that the determinants of health/health promotion framework was being articulated, others were arguing that modern, scientific medicine had a direct, negative impact on health (Illich 1976). The notion of iatrogenic disease was quite influential in critical social science circles. This notion was given increased credence with the publication of empirical studies which showed that some proportion of physicians' services – from drug prescriptions to surgical procedures – were medically unjustified (Swartz 1987).

Concerns about the iatrogenic effects of medicine, and mounting evidence showing that many health care services were unnecessary, motivated a movement to assess the effectiveness of clinical interventions known as Evidence-based Medicine (EBM). The EBM movement can be understood as having two contradictory origins. On the one hand, it is part of an effort to rationalize medical and hospital care. As such, it is part of contemporary efforts to micromanage the practice of medicine and to erode medical autonomy and dominance in determining the form and content of the health care system (Naylor 1993). On the other hand, it is part of the response of the organized medical profession, particularly university-based researchers, to bolster claims that the clinical practice of medicine is more science than art. These contradictory origins of EBM are reflected in the contradictory responses to it by practicing physicians (Dickinson 1998).

In their analysis of the Health Field Concept, Vayda, Evans, and Mindell (1979: 226) noted that if medical and hospital services contributed only a small and decreasing amount toward increased population health status, there was no justification for continually increasing health care expenditures. Given this, several analysts saw the determinants of health policy framework as the first serious effort to dismantle Medicare (Swartz 1987; Armstrong 1997).

Proponents of the determinants of health framework responded to criticisms of it by refining and refocusing the health field concept (Epp 1986; Mustard and Frank 1991; ACPH 1994; Evans, Barer, and Marmor 1994; Hamilton and Bhatti 1996; Report of the Roundtable 1996; Evans and Stoddart 1998). In an effort to allay these fears, and to clarify the concept of health promotion, an influential Federal government policy paper stated that it was "an approach that complements and strengthens the existing system of health care" (Epp 1986: 2).

Despite the controversy over the effects it has had for Medicare, the determinants of health/health promotion policy framework has focused attention on a number of important issues. First, it highlights the fact that access to medical and hospital services has not eliminated inequalities in health status. Disadvantaged groups are consistently shown to have lower life expectancy, poorer health, and a higher prevalence of disability than others (Epp 1986; Bolaria 1994; Frideres 1994; D'Arcy 1998; Wilkins and Sherman 1998; ACPH 1994). It has also been shown that this health effect is on a gradient within all socioeconomic groups

(Marmot, Rose, Shipley, and Hamilton 1978; Hertzman, Frank, and Evans 1998).

Second, the injury and illness prevention dimension of health promotion has focused attention on a wide array of preventable injuries and illnesses that differentially characterize social groups. These include, *inter alia*, youth suicide, disease associated with tobacco use, sexually-transmitted diseases, and injuries associated with impaired driving.

Third, the health care needs of the population are changing. Whereas it used to be the case that the main sources of morbidity and mortality were infectious diseases, currently chronic conditions and disabilities predominate. This has significant implications for the nature of health care needs and, consequently, for the nature and organization of health care services.

Many chronic conditions currently are not amenable to medical or hospital treatment. Modern medicine has no cures for chronic conditions like arthritis or diabetes. The aging of the Canadian population has added urgency to efforts to find appropriate and affordable means to deal with a wide range of chronic conditions that are often associated with the elderly. What is required is long-term support in the management of these conditions. Although medicine often has a role to play in the management of many chronic conditions, it need not always be a dominant role.

Adoption of the determinants of health/health promotion policy framework, along with various cost-control strategies, has been accompanied by a variety of changes in the nature and organization of health care services. Not since the introduction of Medicare itself have such dramatic changes occurred.

Regionalization: From Institutional to Community Care

The most recent and dramatic reform of the health care system has been regionalization. Regionalization emerged in the late 1980s and early 1990s as a means to accomplish several health policy objectives, including cost control, improved health outcomes, increased responsiveness to health care needs, flexibility in care delivery, better integration and coordination of services, and greater citizen awareness of, and participation in, health care planning and service delivery (Angus 1991; Angus, Auer, Cloutier, and Albert 1995; Crichton et al. 1997; Lomas 1996; Lomas, Woods, and Veenstra 1997; Lewis 1997; Mhatre and Deber 1998).

How are we to understand these changes and their consequences? There is general agreement that regionalization marks an important shift in the model of health care governance and service delivery. The main direction of the change is away from collegial control and medical domination of health policy-making and service delivery toward either some form of communal or corporatist control.

Blishen (1991: 145), for example, sees regionalization as the emergence of a system of control in which "a community, or a community organization such as a consumer's group, rather than an occupational group, such as physicians, or a

third party such as the government, seeks to define the needs of members and the manner in which they are satisfied." He is cautious in his early assessment of regionalization. Although he recognizes that it has redefined the relations between the state, the medical profession, and consumers in the direction of increased consumer control, there currently is no evidence to show that it is a more effective way to organize and deliver health care.

Crichton et al. (1997) also see regionalization as a shift in the nature and organization of health care planning and service delivery. Unlike Blishen, however, they see it as a manifestation of neo-corporatism which, following Pleiger (1990), they term emergence of the Welfare Society. The key features of the Welfare Society are the decentralization and involvement of key stakeholders in partnerships as a means of reaching policy consensus. This is distinct from the centralized, bureaucratic and professionally dominated mode of decision-making associated with the Welfare State. As Crichton et al. (1997: 40) observe, in a Welfare Society, "the former power holders have to share their power with other groups of corporate decision makers."

Enthusiasm for a corporatist model of policy-making emerged from a 1980 OECD conference. At that conference it was argued that a corporatist model of policy-making was more likely to enable policy makers "to contain the bargaining power of physicians and other provider groups and thereby move the system toward real health outputs" (Wilensky 1981: 194). Britain, Canada, and the US were identified as countries that were least likely to accomplish this because of the nature of their policy-making processes. The Canadian Federal government did, however, over the 1980s, adopt more of a corporatist approach to policy-making (Crichton et al. 1997).

Picking up on this theme Lomas (1997) sees the new Regional Health Authorities (RHAs) as both allies and fall-guys for provincial governments in their struggle for control of the health care system. As allies the RHAs are intended to increase community participation and empowerment relative to policy-making and health system governance. The putative goal is to generate the critical mass of political power needed to break the so-called Medicare Pact. That is, the particular structural features of Medicare that entrenched medical dominance, inflationary cost increases, and a curative approach to health problems. As fall-guys, he suggests, the new RHAs are intended to deflect criticism from provincial governments as budgets are cut and the health care system is rationalized.

At this time it seems unlikely that regional health authorities are designed to break the "Medicare Pact." No provincial government has given the RHAs control over medical care or pharmaceutical budgets. Without such control RHAs have no capacity to adopt a "command and control strategy" relative to non-hospital medical care services. The exclusion of control over medical care and pharmaceutical budgets is not an oversight. Medical resistance to any organizational reform seen as a threat to professional autonomy and collegial control is fierce. Indeed, the profession effectively scuttled earlier attempts at regionalization because of the threat to medical autonomy (Taylor 1978).

Like earlier health reform initiatives provincial governments have taken an incrementalist approach. The first step is the rationalization of institutional, particularly hospital, services; the second is the vertical and horizontal coordina-

tion and integration of institutional and community services. The provinces have differential priorities in this regard. Some, like Saskatchewan and New Brunswick, rationalized hospital services prior to regionalization. In Saskatchewan, for example, this entailed closing or converting to community health centers 53 small rural hospitals. Other provincial governments left this task to the newly created RHAs.

The consequences of these differing strategies relative to the goal of creating new political allies remains to be seen. In part it will depend both on how various interest groups respond to the boards and how the boards themselves respond to the provincial governments. If local citizenry perceive the boards as empowering them and giving them effective control over the best way to satisfy local health needs, particularly their health care needs, then the regionalization might be considered a successful experiment in democratic corporatism.

On the other hand, if RHAs join forces with disgruntled citizens and health care providers against provincial government cutbacks, then it might also be seen as a successful experiment in community empowerment, but a failure as a means to wrest control over health policy and health care service delivery from providers. Aware of this possibility, some provinces have prohibited health care providers from serving on RHAs. Others that had announced intentions to institute elected boards have backed away from that commitment.

If this second scenario comes to pass it will likely herald the end of the regionalization experiment, and the beginning of a search for a new means to break the "Medicare Pact." The coalition for the privatization of health care is ever ready to extol the virtues of the market and modern management techniques as a panacea for all that ails a public health care system like Medicare.

Despite repeated assurances to the contrary, concerns remain that current health reforms are simply paving the way for the reprivatization of health care (Tsalikis 1989; Armstrong 1997; Fuller 1998; O'Neill, 1998). In one sense, as we have just seen, this is the case. Government is trying to limit medical autonomy and dominance relative both to health policy and health care services. In itself, reduced medical autonomy and dominance is not a threat to Medicare.

There is, however, a more serious threat to Medicare related to its structure. Currently, medical and hospital based services are covered by Medicare. Other services, in general, are not. As the system shifts the locus of treatment from hospital to community, and as service providers other than medically trained physicians come to play a larger role in health care delivery, there also is occurring a *de facto* privatization of health care.

Pressures also are mounting for privatization of the medical and hospital care sector of the health care system. Leading the charge in this regard is the medical profession, private sector health care corporations, many of which are US-based, and provincial governments ideologically committed to the market as a social policy tool. Pressure to adopt market solutions to social policy problems is given added impetus through various trade liberalization agreements and organizations.

CONCLUSION

In this chapter we have examined the changing goals of health policy and their relationship to the changing nature and organization of the health care system. A central theme in analyses of health care in Canada has been, and is, the nature and locus of control. More specifically, health care policy and service delivery has been greatly influenced, if not dominated, by the medical profession. We have argued that current reform initiatives, including the adoption of the determinants of health policy framework and the regionalization of health care decision-making and service delivery, is the most recent manifestation of the struggle to control the health care sector and improve population health status.

We have also shown that the outcome of these efforts is, at this time, indeterminant. It is not certain what the future holds. There is a potential for a more needs-based, publicly funded, and democratically controlled health care system to emerge. There is evidence to suggest that this possibility is real. There is also, however, the potential for an increasingly privatized, corporate controlled health care system to develop. There is, perhaps, even more evidence to suggest that this is the future of health care in Canada.

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