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HYGEIA VS. PANAKEIA:

THE COMMUNITY HEALTH CENTRE IN CANADA

by

Judith E. Wood, B.A.

A thesis submitted to the Faculty of Graduate
Studies and Research in partial fulfillment
of the requirements for the degree of
Master of Arts

Department of Sociology and Anthropology

Carleton University

Ottawa, Ontario

September, 1986

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HYGEIA VS PANAKEIA:

THE COMMUNITY HEALTH CENTRE IN CANADA

submitted by Judith E. Wood, B.A.
in partial fulfilment of the requirements for
the degree of Master of Arts

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September, 1986

ABSTRACT

This thesis examines the community health centre as an alternative form of primary health care in Canada. It provides an historical overview of the social and economic factors contributing to the adoption and maintenance of the conventional primary health care system. Two bodies of theory - elitist and neo-marxist - are examined as conceptual tools to aid in addressing the community health centre's relative lack of success as a challenging alternative in Canada.

The thesis demonstrates the necessity of developing a wider theory to address the lack of change in the health sector. The state's economic and political considerations are shown to be very important in its interest in the community health centre alternative. Yet, the more specific factor of the Canadian medical establishment, and its dominance of the health sector, cannot be ignored.

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The author wishes to express her appreciation to her thesis supervisors, Professors Dennis Olsen and John Myles, for their invaluable comments and guidance. Many thanks are also extended to Maija Kagi, whose assistance in the research process and enthusiasm for the Community Health Centre phenomenon were great assets to the author. Finally, gratitude must also be expressed to all those who have over the years given of their time and energy to pursue the Community Health Centre alternative; without them, this alternative form of primary health care would have remained an ideal.

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CHAPTER I

THE HISTORICAL CONTEXT

1.1---The Community Health Centre:--A Definition

The Introduction briefly described the community Health centre and the movement behind it. Before giving a more detailed definition of this phenomenon, it is useful to introduce the reader to the nature of the primary health care sector and how it is organized in Canada. This will be helpful in introducing the changes being sought by advocates of the CHC.

Primary health care has not been homogeneous in its organization in the Western world - it has varied over time and space. There are several dimensions along which the organization of primary health care may vary. These include the sponsorship of the organization, the model of health emphasized, the scope of services offered, the decision-making structure employed, and the specific method of funding adopted or desired by the organization.

On the first point, primary health care organizations have for the most part been sponsored by physicians, and more recently, by groups of physicians. Members of the medical profession have historically been responsible for deciding where medical facilities would be located, and for actually setting them up. However, this fact has not precluded the establishment of health care organizations sponsored by other groups, agencies,

criticized for being excessively expensive. Its efficacy and productiveness have been questioned, for health insurance has not demonstrated the expected increase in the level of health of the population (1). In the social and political spheres, it has been criticized for not making significant changes in the way services are delivered and for not addressing the inequalities of health based on factors such as geographical location, socio-economic class, and ethnicity (2).

One such example of the latter type of criticism comes from a social movement calling for the implementation of the ~~community~~ health centre as the first point of access in the primary health care sector (3). The community health centre (CHC) movement advocates the establishment of ~~consumer-sponsored~~, multidisciplinary health centres, emphasizing ~~preventive~~ medicine and health promotion, as well as ~~community~~ control of the organization. As will be seen, it has emanated partly from a concern that traditional medical care has not addressed the inequalities in health, and partly as one aspect of a larger movement occurring in western societies that has challenged the lack of individual control in important aspects of life. The questioning of professional dominance, of the lack of preventive care, and of the lack of consumer participation or input makes the CHC movement an important topic for sociological study. Furthermore, the claim made by CHC proponents, and studies done on CHC cost effectiveness showing that it could significantly reduce health care costs, adds to its importance in any

discussion of health care and health care costs.

In this thesis, we will be investigating the CHC concept and the social movement behind it. We will be taking an exploratory look at the CHC, tracing the roots of the social movement, its place within the health care system, and the reasons behind its eventual lack of success as a challenging alternative to the present system. The central question of this study asks what factors prompted state interest in the CHC in the late 1960s and early 1970s, and conversely, what caused this interest to wane during the mid-1970's? Two theoretical paradigms will be presented as conceptual tools to aid in reaching an understanding. These theories - the elitist and the neo-marxist - both provide very different insights into the question at hand. The first argues that the strengths and weaknesses of "structural interest groups" explain the nature of the state's interest, while the second argues that economic concerns and the interests of the capitalist class underlie the state's actions.

The evidence for this study was collected in three ways. First, a number of historical accounts of community health centre development were utilized. These accounts, either focussing on the CHC or dealing with it as one aspect of the history of the health system, provided important information on the community health centre concept and movement. Second, much of the information was collected from unpublished documents written about or by CHCs, newspaper and journal articles, briefs to

government task forces and commissions of inquiry, two federal inventories of community health centres in Canada, and other government studies and reports on the health care system. Finally, information was also gathered through interviews with a number of "key informants" - persons involved in community health centres and their development.

✓ The thesis is arranged as follows: Chapter I provides an overall view of the CHC alternative and the ways in which it differs from the conventional model of health. The historical context in which the movement developed will be outlined, demonstrating the social and economic roots of the movement and the political constraints under which it developed. Finally, the theoretical approaches mentioned above will be presented. Chapters II, III, and IV present the history of the community health centre and its successes and failures. Each chapter covers one of three chronological periods. Chapter II covers the late 1950s to the implementation of universal health insurance in 1967, when the earliest examples of community-sponsored health care were emerging alongside health insurance plans and other health arrangements. Chapter III covers the period of 1968 to 1973, when interest in the CHC alternative reached its zenith and many community health centres were funded by provincial governments. Chapter IV deals with the period of 1974 to the present, with a special focus on the province of Ontario. It investigates the decline of interest in the CHC, and its outcome as a "second class" aberrance within a relatively unchanged

health care system.

In each chapter, the roles played by the social movement, the medical profession, and the state will be examined. The constraints of the present health care system, the impacts of government involvement in health insurance, the economic concerns of the 1970s, and the impacts of social activism (and its decline) will be investigated.

The thesis will conclude by discussing the difficulties involved with pinpointing a causal understanding of the community health centre's lack of success. Neither of the theoretical paradigms presented in Chapter I is sufficient in and of itself to explain the outcome of CHC development. A more comprehensive view of the phenomenon must be taken into account, including the historical constraints, the economic factors, and the social and political forces important in shaping the state's policies on health.

ENDNOTES

(1) Numerous government and private analyses of the health care system in Canada have criticized its costs and effectiveness in maintaining health. See Canada, Task Force Reports on the Costs of Health Services in Canada (1969), the Ontario Report of the Committee on the Healing Arts (1970), Ontario's Report of the Health Planning Task Force (1974). See also Evans (1975), Bennett and Krasney (1977), Renaud (1975).

(2) Although the evidence is no means clear, numerous studies have pointed to a positive relationship between amount or quality of health care and socioeconomic and geographical factors. See Beck (1973, 1974), Beck and Horne (1976), Badgley et al (1967), Badgley and Wolfe (1981), Enterline et al (1973) and Manga (1978). See also Manitoba's White Paper on Health Policy (1972), and Charles' (1976) account of the Ontario government's attempt in 1969 to redress geographical inequality through its underserved areas doctor program.

(3) Primary health care is taken to mean those services that are provided "at the first contact between the patient and the health professional", including "the responsibility for promotion and maintenance of health and for complete and continuous care of the individual, including referral when required" (Task Force to Review Primary Health Care, 1982).

CHAPTER I

THE HISTORICAL CONTEXT

1.1---The Community Health Centre:--A Definition

The Introduction briefly described the community health centre and the movement behind it. Before giving a more detailed definition of this phenomenon, it is useful to introduce the reader to the nature of the primary health care sector and how it is organized in Canada. This will be helpful in introducing the changes being sought by advocates of the CHC.

Primary health care has not been homogeneous in its organization in the Western world - it has varied over time and space. There are several dimensions along which the organization of primary health care may vary. These include the sponsorship of the organization, the model of health emphasized, the scope of services offered, the decision-making structure employed, and the specific method of funding adopted or desired by the organization.

On the first point, primary health care organizations have for the most part been sponsored by physicians, and more recently, by groups of physicians. Members of the medical profession have historically been responsible for deciding where medical facilities would be located, and for actually setting them up. However, this fact has not precluded the establishment of health care organizations sponsored by other groups, agencies,

or institutions such as universities, industries, unions, or governments.

Second, the model of health emphasized in the health care organization is a dimension along which great variation may occur. Section 1.2 deals with conceptual models of illness and health in more depth; here the models will simply be identified in order to provide the reader with an overall picture of primary health care. Traditional physician-sponsored care has emphasized the medical, or curative, model of health. In this model illness is the main focus and the primary goal is to intervene medically in order to restore health. Alternatively, the holistic, or preventive, model has gained popularity. According to this model, health care workers seek to maintain health through various means of health promotion, involving the whole individual and his or her environment.

In reality, these underlying models of health care should not be seen as mutually exclusive. Obviously, primary care based on the holistic model does not exclude medical intervention. Nor does care administered from a medical model exclude prevention. In between, then, the reality of primary health care covers a wide range of "grey area".

Related to these models, primary health care also differs widely in the scope of services offered. Traditional primary care, with a limited emphasis on factors other than strictly physiologic or pathogenic ones, offers more limited services that

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stress cure of the illness. On the other end of the spectrum, primary care emphasizing the holistic model, and thus stressing the social and psychological aspects of health, attempts to integrate care by including social services, health promotion programs, and other extra-medical services.

The decision-making structure of primary health care organizations may also differ according to the sponsorship of the organization and the model of care underlying it. On the one hand, physicians may completely dominate the organization, deciding what kinds of services are needed or will be offered and where, to whom, and when they will be offered. On the other hand, these kinds of decisions may be made by non-medical boards of directors, or consumer or community organizations sponsoring health centres. In these latter cases, the physician may simply be an employee of the organization, and may dominate only insofar as he or she is responsible for making medical decisions. In between these two extremes are various arrangements where physicians, consumers and other actors share in decision-making on the activities, emphases, and policies of the organization.

Finally, primary health care organizations may differ in the way they are funded, or in the type of funding they desire. As the following chapters will show, the fee-for-service method of remuneration goes hand-in-hand with solo practice - a relationship reinforced historically by the private physician charging fees to private patients. In Canada, with the adoption

of government health insurance, this fee-for-service arrangement has been for the most part retained. However, other possibilities have been, or are, in existence. These include direct payment of physicians by salary, per capita funding arrangements (capitation), where a set fee is paid to physicians by either private citizens or government for all services required by enrolled patients, and global funding arrangements, where government pays for the operation of a health care organization and from the global funds salaries are paid to health care workers. These alternatives offer the possibility of providing funded extra-medical services, whereas fees-for-services must adhere to a fee schedule that is very curative in nature.

As will be seen in the thesis, these last three dimensions - funding, decision-making, and scope of services - are closely related to the model of health care emphasized, and perhaps less closely related to the type of sponsorship of the organization. However, it needs to be stressed again that although these dimensions map out typologies of health care organization, they are not intended to help construct two opposing models of health care organization. One can easily conceptualize the two models: on the one hand the practice of a solo practitioner offering only curative care on a fee-for-service basis with no formal avenues of consumer participation or input, and on the other hand the consumer-sponsored health and social service centre, emphasizing the holistic approach, funded globally and run by the community.

itself. As the thesis will demonstrate, the area in between is one which contains many variants of primary care organizations, differing along the dimensions discussed above.

For the most part, however, it must be acknowledged that primary care in Canada is physician-sponsored and dominated, and is delivered via a fee-for-service funding arrangement which covers mainly curative procedures. The CHC movement has been an important alternative movement challenging the status quo.

The community health centre is a concept that is not easily defined - it has been used to identify numerous organizational forms of health care in different historical and social contexts. It is thus imperative to define the CHC more clearly within the present Canadian context before delving into its history.

The report of the Community Health Centre Project (the "Hastings Report"), a federally appointed task force that in 1972 studied the existing CHC's in Canada and elsewhere, defined the CHC as an organization which has a number of distinguishing characteristics. First, it offers a comprehensive range of both health and social services. It stresses the holistic approach to health, which implies concern about the whole patient and his or her environment and the concern with continuing care. Second, it places strong emphasis on primary prevention and health promotion, rather than simply curative care. Surveillance, maintenance, and restoration are stressed, along with conventional diagnosis and treatment, in a program of continuing

care. Important here are the objectives of keeping people out of hospital by preventing illness, and treating them in ambulatory care settings. Third, the CHC employs multidisciplinary teams of health professionals and social service workers. Thus, "teamwork" is considered essential to the effective administration of holistic care, with teams made up of a mix of family practitioners, specialists, other health care workers, and social service personnel. Fourth, the CHC is under the direction or administrative control of a community-based board of directors. The board is responsible for detailed planning and priority setting, while the staff is responsible for the dispensing of care. And fifth, the CHC employs alternative funding methods to simple fee-for-service remuneration, which is deemed inappropriate for multiservice community health and social service centers as it does not allow flexibility in pursuing holistic care. Other methods, such as global budget funding, capitation, and a mix of these and fee-for-service payment for the medical component of care can be utilized in funding the CHC.

The above defines an ideal type of CHC. As will be seen in the following chapters, development of CHCs in their different forms did not necessarily correspond to this ideal. Some stress prevention, some community control, and some combinations of the above criteria. Sponsorship has also been diverse. Unions, public agencies, universities, physicians, neighborhood groups, and communities have all been important in sponsoring the CHC alternative. However, this ideal type definition is perhaps the

most comprehensive and most often used in Canada, and although actual developments do not necessarily match up, this definition is useful in outlining the ideal towards which many proponents of the CHC have moved.

1.2-----The Historical Context of Medicine and Health Care in Canada

A brief look at the history of the medical sector and of the prevailing understanding of health can help to further illuminate the changes being sought by the community health centre movement. CHCs have had to fight an uphill battle against the bastions of the medical establishment. However, it is important to clarify that the status quo in medicine is not a given; it has been attained quite recently and as a result of vigorous lobbying by the medical profession for state intervention.

In Canada the health care system did not become dominated by a well-organized "professional" group until quite late in comparison with other countries. Crichton (1980: 247) argues that the late development of a professionally-dominated health care system was a result of the slow pace of Canada's economic and social development. The early administrators of health care in Canada, until the mid to late 1800s, were to a large degree lay healers, such as midwives, patent medicine peddlars, eclectics (or root doctors), and homeopaths. Physicians, though still unorganized, were important, especially in more urban areas, and had begun even as early as the beginning of the

nineteenth century to spread across the country (1).

As in most other countries, it was in the interests of Canadian physicians to regard lay healers as "quacks". Physicians were anxious to attain a professional status. They were actively attempting to secure a monopoly over health care and medical education, because, as Swartz documents:

...the market was highly competitive and not particularly lucrative.... One physician expressed the problem in a letter to his local newspaper; "Believe me Mr. Editor, you, or your city compeers can form no conception of our position... Under my nose lives neighbour B. who bleeds and extracts teeth at exactly half the professional charge (Swartz, 1977: 327).

Canadian universities had already established four medical schools by the early 1900s and Canada was on its way to producing an indigenous supply of physicians. Professionalization would only be achieved if competing practitioners were subordinated or eliminated, and if the supply and education of physicians was controlled.

Between the late 1800s and the turn of the century the Canadian provinces passed the provincial Medical Acts granting an economic monopoly over medical practice and its definition to the fledgling medical "profession". In 1909 the Canadian Medical Association was chartered, and in 1912 the Canada Medical Act was passed. The provincial acts continue to provide the basis for physician dominance over all health care and medical practice, and over all other health professionals. The federal act of 1912 further strengthened this dominance by giving the Canadian

Medical Association the sole right to license physicians and to approve medical schools. It also gave to the medical profession the responsibility of monitoring its members and meting out reprimands or penalties. Thus, as of 1912 physicians in Canada had achieved a legal and economic monopoly over health and medical care, and the status of a self-regulating profession.

In the secondary health care sector (the hospital sector) physicians also managed to establish and maintain control through provincial hospital acts. As Swartz outlines:

In Ontario, which is representative of the situation generally in Canada (and the United States), the physicians of a given hospital must be organized into a self-governing body. These physicians annually recommend to the board of directors (on which physicians hold by law at least five seats if there are a hundred beds or more) which physicians shall have the "privilege" of admitting and treating their patients (that is, to be able to use the hospital without charge to earn fees from medical practice). The board may reject the physicians' recommendations but cannot appoint physicians directly. These self-selected physicians thus effectively control the hospital since they alone can admit and specify care to patients and hence determine the hospital's revenues and expenditures (Swartz, 1977:328).

As we shall see in the next chapter, this dominance of the hospital sector was an important factor in the struggle to establish the community health centre.

Concomitant with the achievement of a monopoly situation for the medical profession, there was also in Canada, as elsewhere, the adoption of a specific understanding or model of health and illness and of a particular type of medical practice.

Health care has embraced over time two different (though not by necessity mutually exclusive) approaches to healing and health. Dubos (1965:321) outlines these two approaches through the use of Greek mythology. On the one hand there exists the goddess of health achieved through appropriate living - Hygeia. This goddess exemplifies what is known as the holistic model of health care, emphasizing the social environment, hygiene, nutrition, emotional well-being, and the like. On the other hand is her sister, Panakeia, the goddess of medicine and healing. Translated as "Cure-All", this goddess exemplifies the medical model of health care, "...a cult still alive today in the universal search for a panacea" (Dubos, 1965: 321). In this model, good health is achieved and maintained through intervention in illness by special healers trained in curative care.

Hayes-Bautista and Harveston (1977) provide a history of the adoption of these models in Europe, England and the U.S. As Canada's history of medicine has been so heavily influenced by these countries (MacDermott, 1967; Crichton, 1980; Gidney and Millar, 1984), this discussion is helpful in outlining the importance of these models in this country as well.

The authors first define these models by pointing to the understanding of "pathogenic location" of disease and the underlying assumptions of the two models. The pathogenic location "...refers to where one places the ultimate origin of health and illness between two end points of a continuum: the

location inside the individual at a microbiological level, and the location outside the individual in the ecosphere" (Hayes-Bautista and Harveston, 1977: 7).

The medical model, the most recent of the two, has become by far the most widespread and accepted. Also known as the curative model, it sees the pathogenic location of illness inside the individual at the microbiological level. Hence, this is the site of treatment and cure. The underlying assumptions of the medical model are as follows:

- 1) An illness has an organic base;
- 2) The organic base is the result of discrete causal elements;
- 3) The illness is the involuntary result of an invasion of the host by an overwhelming quantity of the causal element;
- 4) The appropriate treatment for an illness is an agent which will directly counterattack the causal element and neutralize it;
- 5) Such an agent can be prescribed and administered only by a technically competent specialist;
- 6) The knowledge held by the specialist is inaccessible to the layperson, hence the patient must submit to the ministrations of the specialist without interference (Hayes-Bautista and Harveston, 1977: 7).

In contrast to the medical model, the holistic model identifies the pathogenic location as existing ultimately outside the individual, within the social, the political, the economic, and the psychological environments. Because all are at the root of illness, all must be addressed in the cure and prevention of illness and the maintenance of health. The following assumptions

underlie the holistic model of health:

1) Individual illness is a reflection of societal illness;

2) Illness is a product of multiple interacting elements or conditions found both internal (microbiological) and external (environmental) to the individual;

3) Given the multiple nature of causation, intervention must address both the internal and the external causes simultaneously;

4) Curative care is ultimately insufficient. It is useless to attempt to cure the individual on the internal level when his or her external conditions have not been dealt with;

5) Once a state of health is achieved, it requires active effort to be maintained;

6) Social restructuring is necessary to effectively achieve and maintain an acceptable level of health (from Hayes-Bautista and Harveston, 1977: 8-9).

According to the authors, it is possible to examine health care systems and classify them according to the above models. However, they caution against seeing these models as absolutes; the models are ideal types and should be treated as such.

Before Louis Pasteur's work on the germ theory in the 1850s and 60s, it was by necessity the holistic model that underlay much of health care. Without the germ theory at hand, and thus without a single, identifiable causal agent, it was the social milieu in general that had to be addressed. Public health care along the lines of the holistic model was thus very important. Accounts of early health care in Britain (Chadwick, 1842), the U.S. (Shattuck, 1948) and Canada (Heagerty, 1934; Hastings and Mosley, 1964; MacDermott, 1967) show that a great deal of health

care consisted of public health care. Many of those involved in health care worked towards laws for social reform in housing, sanitation, education, and the like in order to maintain health. MacDermott's study of the medical profession in Canada documents this emphasis by physicians in the 1800s:

The early records of the Canadian Medical Association are filled with discussions and resolutions which urged such fundamental services in preventive medicine as a system for the collection of vital statistics, the provision of pure water and adequate sewage services, pure food supplies, and the pasteurization of milk (MacDermott, 1967: 81).

Early physicians noted the correlation between illness and such factors as the above, and more generally the correlation between illness and poverty (see Rosen, 1974; Kroeger, 1937; Chadwick, 1842). And despite the lack of the germ theory, they called for the establishment of temporary boards of health to deal with infectious disease, epidemics and quarantine.

In spite of his discovery of the germ theory, Pasteur himself continued to emphasize the importance of viewing health and illness in a manner that considered the whole person in relation to his or her environment (Dubos, 1980; Hayes-Bautista and Harveston, 1977: 10). However, the medical model that developed from the germ theory almost totally replaced the holistic model in Europe, and somewhat later in North America. Medical schools in the U.S. and in Canada were greatly influenced by Flexner's Medical Education in the United States and Canada (1910), which urged adoption of the medical model. Medical schools either did so or lost their accreditation. As the development of

microbiological research advanced, "...medicine came to be the province of a small group of specialists whose attention was focussed on subhuman elements" (Hayes-Bautista and Harveston, 1977: 11).

As many have argued for the U.S., (Ehrenreich and Ehrenreich, 1970; Wohl, 1984), the dominance of the medical model has resulted in a medical, political, and industrial complex of interests tied to curative health care. They argue that not only have accreditations and licences been granted on the basis of this model, but also medical insurance (both private and public), payment schedules, the emphasis on drug therapy, and most day-to-day primary health care are largely based upon the search for health at the micro-organismic level. Instead of supplementing the holistic model, the medical model has supplanted it.

For the most part, Canada's health care system has also developed into a curatively-based medical-industrial complex (2). Most physicians in Canada work through the provincial health insurance plans, which reimburse physicians for medical procedures but not for basic health promotion. In Ontario, for instance, in the fiscal year 1981/82, 65.4 per cent of the Ministry of Health's expenditures went to institutional services (i.e. hospitals) and 30.2 per cent went to the health insurance program (FIGURE 1.1). Only 3.3 per cent (\$3 million) of the budget was spent on alternative arrangements, such as community health services, which emphasize health promotion (3).¹

FIGURE 1.1
ONTARIO MINISTRY OF HEALTH EXPENDITURES
BY MAJOR PROGRAM, 1981/82

(SOURCE: Ontario Council of Health, 1983: 17)

It is obvious from the above discussion that the community health centre movement is very much at odds with the model of health embraced by the present health care system. The movement has presented a challenge to the medical profession and its understanding of health and illness. It has also presented a challenge to governments and their support of the present system.

In the following chapters the community health centre concept and movement will be investigated. The history of this alternative form of health care, and of the movement behind it, will be documented, and government policy on CHCs will be analyzed. A special focus on Ontario will be undertaken, providing a more intensive look at the dynamics underlying the process of development in one province. This historical approach will be undertaken with the aim of addressing the central question of why this alternative has been generally unsuccessful in the health care system in Canada? What factors have been important in inhibiting the adoption and proliferation of the CHC concept?

A number of theories have been forwarded to explain the lack of success of alternative forms of health care delivery. Some point to the strength of the medical profession, others point to the entrenched nature of the curative model of health care and the force of technological advances in medicine. Still others see the modern capitalist system as ultimately responsible. The central argument of this thesis is that three factors must be considered in the explanation of the lack of success of the CHC; first, the role of the medical profession in thwarting change, second, the role of the CHC movement itself, and third, the state's role in intervening in the struggle and establishing policy on CHCs. Throughout the thesis, we will attempt to develop an argument explaining the state's role; how and why does it intervene, and what have been the implications of the state's

intervention?

We will conclude this chapter by reviewing several theoretical explanations for the lack of change in the health sector. Before doing so, however, a clarification of the key concepts being considered in the thesis is in order. First, the thesis will be looking at the CHC "movement". It, like other social movements, is a broadly based form of "collective behaviour" aimed at bringing about social change (Theodorson and Theodorson, 1969: 390). Because participation in social movements is not necessarily a formalized procedure (Piven and Cloward, 1977: 4), the exact nature of the social movement is not always determinable. In the case of the CHC movement, the social movement is taken to mean all those individuals and groups both formally and informally supporting and initiating the CHC concept.

Furthermore, the social movement should be distinguished from government policies, programs, and interest in the CHC concept. The two must be separated, as they have very different expectations, interests, and policies on CHC development and organization. However, it must not be assumed that their separateness precludes a mutual influence. The effects of the social movement on government policy, and vice versa, should not be overlooked.

Finally, a note of clarification on the use of the concept "degree of success". The central question of the thesis concerns

the degree of success of the CHC alternative. However, it would seem that success or failure must somehow be compared against a point of reference, or a benchmark of some sort. In this thesis success will not be measured against a quantifiable goal, for instance, of having X number of community health centres established by year Y. Community health centre development, as we shall see, has been an exploratory or evolutionary phenomenon, without specific long range goals for implementation set by provincial governments. Success or failure has to be indicated through less precise means. Success will be indicated by the ease with which community groups have been, and are able to establish new health centres, the ability of existing CHCs to remain viable within the context and confines of the conventional health care system, and the degree to which the principles of the CHC concept can be followed.

1.3-----Theoretical Considerations

A number of explanations have been put forth in an attempt to explain the persistent and unyielding nature of the health care system. One body of theory points to the nature of the health care system and those controlling it, and conversely to the nature of those challenging it, as instrumental in maintaining the status quo. Two somewhat similar explanations - the pluralist and the elitist - will be considered from this perspective. A second body of theory goes beyond the nature of the medical sector per se, and looks to the nature of the

capitalist society in particular as instrumental in conserving the curative health care system. This explanation comes from the neo-marxist school of thought.

It is important to note that it is not the integrity or acceptability of any of these theoretical explanations that is at issue here. They are not being put to the test in order to declare one correct and one inappropriate. Instead, they are being used as conceptual tools in an attempt to understand the nature of the health care system in Canada.

1.3.1-----Pluralist and Elitist Theories

Numerous health and social scientists have examined the pervasive and entrenched mode of health care delivery in western societies by looking to the actors, interest groups, or "elites" involved in making and influencing health care policy. It is important to look at this body of theory, for despite a number of difficulties inherent in this approach, it has much to offer in the analysis of the CHC movement.

In addressing the question of health policy, a simple pluralist approach to health care would identify interest groups which have somewhat equal access to the neutral decision-making apparatus of the state. All groups have the opportunity to compete and to influence policy in their direction (4). The pluralist approach, though helpful in providing detail on the policy-making process, is ultimately too simplistic, and thus

will not be given much emphasis in this thesis. The elitist approach is a more sophisticated variant of the pluralism. It recognizes that certain interest groups exercise much more power than others in influencing the state, often to the extent of actually dominating certain sectors of the state. Several elitist theories will be outlined here, but emphasis will be placed on the work of Robert Alford (1975). Alford's analysis of the American health care system looks beyond equal interest groups to the "structural interests" involved in the policy-making process. He identifies three major structural interests: the "dominant interests", which seek to maintain their acquired position of dominance; the "challenging interests", which seek to attain dominance through reorganization of social structures, and the "repressed interests", the unorganized and weak whose interests are not really dealt with by those who carry out policy-making. In Alford's application of this analysis to the health system and health centres in New York, the dominant structural interests are identified as the professional monopolists - the medical profession and hospital administrations - which seek to retain their position of strength. By nature, they do not have to strive too hard to do so, as they are coming from a strong and well-organized position. The challenging structural interests Alford identifies as the "bureaucratic rationalizers" - for instance health bureaucrats - which seek dominance over the irrational and illogical health care system presently controlled by the medical profession, and

attempt, through raising the cry of "crisis", to have changes implemented in their favour. The repressed structural interests are those in social movements advocating consumer control, equality of access to health, and other significant changes in the health care system.

According to Alford, there is a constant battle in the health care sector between the dominant and challenging interests, which seek to maintain or attain control. However, neither desires any real change in the system. Obviously the dominant interests call for no real change, but less obvious is the fact that the challenging interests desire only to modify the system to make it more rational and less costly, and in the process, to gain control over the "medical establishment".

The repressed structural interests are not very successful in influencing policy in the health care system, due to their lack of resources, power, and political know-how. For the most part these interest groups are not privileged to the channels of influence that other interests enjoy. In this sense, Alford acknowledges that not all interest groups are equal and have equal access and impact on the policy-making process. However, occasional changes are brought about to the benefit of repressed structural interests. And these changes, and the organizations fighting for them, are often encouraged and supported by those in power. As Piven and Cloward state:

Ordinarily ... elites do not support efforts to form organizations of lower-class people. But when insurgency wells up, apparently uncontrollable, elites

respond. And one of their responses is to cultivate those lower-class organizations which begin to emerge in such periods, for they have little to fear from organizations which have come to depend on them for support. Thus, however unwittingly, leaders and organizers of the lower classes act in the end to facilitate the efforts of elites to channel the insurgent masses into normal politics.... When the tumult is over, these organizations usually fade, no longer useful to those who provided the resources necessary to their survival. Or the organization persists by becoming increasingly subservient to those on whom it depends (1977: xii).

Attempts at change towards community-based health centres in New York, for instance, ultimately met with failure, or very limited success. Sponsored by the Office for Economic Opportunity (OEO) as part of the American war on poverty and as a redress aimed at the welfare rights movement of the mid-1960s, this project aimed at establishing Neighborhood Health Centres (NHCs) failed as the social movement was co-opted and as more powerful structural interests were able to influence the development in their favour (Alford, 1975, chapter 6).

An interesting and increasingly accepted variant of the elitist approach sees the real power elite in the health sector as being the technocratic and bureaucratic medical establishment. The best known proponent of this thesis, Ivan Illich (1975, 1976) argues that the process of industrialization has changed western society in such a way that health care, and most other areas of life, is increasingly removed from the hands of the people and placed in the hands of a technocratic elite, which possesses the skills and esoteric knowledge needed to operate medical bureaucracies. Thus, Illich argues that it is now the medical

bureaucrats who can control and manipulate medical resources and medical ideology. The medical bureaucracy, according to this theory, has perpetuated its power, not necessarily through the channels of government influence, but by creating an addiction to medical and technological care. Medical care itself is seen as being perverse, in the sense that over-medicalization is causing iatrogenic (doctor-caused) disease and dependency on medicine rather than on self-care, self-reliance, and less bureaucratized forms of health care.

For theorists of the variants of elitism, then, the failure of more preventive and community based health care can be seen in the increasing power of the medical elites or dominant structural interests. If, in fact, a change in the balance of power in influencing health care policy could be achieved, a much more rationalized and equalized health care system could be attained. Community control, for instance, could change the focus of health care to a much more preventive one, and could allow responsiveness to the needs of certain populations that have been repressed in the health care system.

These theories, and others which look at the power of certain groups or elites in the health care sector, are important in the study of the topic at hand. For indeed, through their research, these theorists point to very important empirical facts in the structure of the health care system and in the way policy is made. However, a second body of theory argues that this type of

lines, but also the existence of other economic interests in the present health care sector follow class lines. Because corporate capital has invaded all spheres of the economy and private life, including medicine, there has developed an increasingly profitable health industry, based on the commodification of medical care. Its profitability in the U.S., for example, is evidenced by the fact that stock in the health sector is a highly remunerative item. According to Wohl (1985), it is one of the surest ways to realize profits; the demand for medical care is endless in capitalist society.

Second, state spending on health care serves valuable legitimization functions, in that the heroic nature of medicine deflects criticism and obscures the true causes of illness in capitalist societies. The nature of the system in its inexorable drive toward accumulation requires that the health and well-being of individuals be sacrificed to the profit motive. The laws of the capitalist state protect the property rights of the capitalist class, while the right to health of the individual - in the workplace, in the environment, and as a consumer - are secondary.

Relations of production in capitalist society are not primarily created with the health and safety of the working class in mind. Occupational diseases and stress - caused by the alienation that is experienced by increasingly powerless and uncreative workers - are part of the "diswelfare" phenomenon accompanying modern capitalism. Rampant consumerism exacerbates

medical sector in Britain and the U.S. includes an examination of the functions of the state, its inescapable tendency toward fiscal crisis, and the implications of this fiscal crisis. His work builds on that of marxist theorists such as O'Connor (1973), Miliband (1970), and many others in their analyses of the state in capitalist societies.

Briefly, the marxist approach sees the growth of the state and its expenditures in western societies as being necessitated by, and supported by, the growth of monopoly capitalism. The state's expansion signifies a growing socialization of costs of production, both through its maintenance of conditions for the accumulation of capital and through assurance of legitimation of the relations of production and the capitalist system. Because of the exorbitant costs associated with maintaining conditions favourable to private profit, while at the same time maintaining a legitimacy of the capitalist state through social programs, education, health care, and the like, the capitalist state cannot help but be in a constant state of crisis.

According to Navarro (1976: 452-453), the state must attempt to address this fiscal "imbalance", and does so through a number of mechanisms. First of all, it attempts to cut the social costs of accumulation and legitimation by decreasing social programs and by instituting cutbacks in spending. In effect, the least productive of the state's social costs are targeted for cutbacks; welfare services, programs for the elderly, health care programs,

and day care must make sacrifices so that the "economy can be put back on its feet", a stated aim synonymous with the desire to boost capital accumulation. Numerous strategies are utilized to legitimate these cutbacks. In the health care field, as in all major institutions of society, an ideology of individualism is proffered in order to shift the blame for illness and the responsibility for health to the individual.

Second, the state increasingly centralizes its bureaucratic apparatuses and institutes a system of regionalization, of regional councils, for example, over which a centralized body is responsible. This regionalization is important in that it bypasses local levels of government and in that it provides a buffer zone between the centralized authority and the different components of the system.

Third, the state calls increasingly for a rationalization of the system in order to decrease unnecessary waste and pare down the costs of administering and providing social programs. In the health sector, this rationalization drive includes utilization of cheaper forms of health care delivery, as well as less expensive medical personnel, both of which are important as they pertain to reduction of costs. It also involves cutting back the wages of health workers.

These, according to Navarro, are the mechanisms employed by the state in the face of increasing fiscal crises. However, within the capitalist state there are contradictions which

strictly limit the alternatives and the strategies which can be employed successfully.

State spending in the health sector serves two often contradictory functions. First, it serves a direct accumulation function. In Navarro's terminology, the state provides for the capitalist class the "...infrastructure of production, i.e., the development of those goods and services that are the preconditions for the working of the capitalist system" (1976: 443). This includes, among other things, programs to maintain a healthy labour force. As Chapter II will show, economic considerations of this sort underlay the creation of Canada's "Medicare" program. In this sense, despite pressures to cut back on social programs, it is in the direct interest of capital for the state to maintain spending on social programs.

In addition, the class nature of the medical sector and of society itself is an important hindrance to any change the state might want to implement for reasons of rationalization. "...[R]eforms must take place within the set of class relations prevalent in capitalist societies" (Navarro, 1976: 448). Reforms in the health sector cannot challenge the basic free-market ideology underlying capitalism (5). For the medical profession, and for wider capitalist interests, class relations cannot be too drastically disturbed without the state appearing far too interventionist. Furthermore, Navarro points out that not only is professional dominance in the medical sector based along class

lines, but also the existence of other economic interests in the present health care sector follow class lines. Because corporate capital has invaded all spheres of the economy and private life, including medicine, there has developed an increasingly profitable health industry, based on the commodification of medical care. Its profitability in the U.S., for example, is evidenced by the fact that stock in the health sector is a highly remunerative item. According to Wohl (1985), it is one of the surest ways to realize profits; the demand for medical care is endless in capitalist society.

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Relations of production in capitalist society are not primarily created with the health and safety of the working class in mind. Occupational diseases and stress - caused by the alienation that is experienced by increasingly powerless and uncreative workers - are part of the "diswelfare" phenomenon accompanying modern capitalism. Rampant consumerism exacerbates

the problem, creating much illness through the marketing of unsafe and harmful products. Furthermore, the ravages to the physical environment caused by industrialized development are major contributors to the level of illness. According to Navarro, and to many others, the large majority of illness is collectively caused by capitalist development, while an ideology of individualism is perpetuated by medicine in order to conceal the true nature of health and illness.

In summary, then, a number of characteristics of the capitalist state and the class structure gravitate against change and against the success of alternative forms of health care. The fiscal crisis of the state dictates that cutbacks be made in areas such as health care, which prompts the state to look to alternatives in health care delivery that are more rational and cost efficient. At the same time, however, the medical sector of the capitalist state, and the needs of the capitalist class, exert pressure for maintenance of the status quo, with respect to the role of the state in dealing with the harmful products and byproducts of capitalism, with its role in maintaining a healthy labour force, and with its role of maintaining capital accumulation in the medical sector itself.

Furthermore, the state must maintain the legitimacy of the capitalist system, and in that sense the role of medicine is crucial:

...medicine is indeed socially useful to the degree that the majority of people believe and accept the proposition that what are actually politically caused

conditions can be individually solved by medical intervention (Navarro, 1976: 447).

A prevalent response to this contradictory dilemma, as faced by capitalist state caught in the fiscal squeeze, is the perpetuation and support of individual alternatives to health care. Because the individual has been blamed for creating his own illness, the individual is urged to modify his behaviour and maintain his own health.

As we have seen, the aim of capitalist medicine is to reduce a collective phenomenon to an individual one. In this respect ... the present self-care strategies, far from conflicting with the ideology of medicine, are strengthening that ideology so long as they remain at the level of individual responses (Navarro, 1976: 448, my emphasis).

1.4-----Summary

The following chapters will examine the development of the community health centre alternative in Canada, and more specifically, in the province of Ontario. Three chronological periods will be examined: the pre-medicare period of 1960 to 1967, in which alternatives were free to develop before government involvement with a universal insurance plan; the period of 1968 to 1973, in which much activity was present and was in some ways encouraged by provincial governments; and the period of 1974 to the present, in which for the most part the CHC alternative would seem to have been stifled in most provinces of Canada (6).

Because the theoretical explanations point to a number of

important forces influencing health policy, each chapter will investigate the state, the social movement, and the established medical interests, and the roles each has played in success or failure of the CHC alternative.

ENDNOTES

(1) See, for instance, Gidney and Millar (1984), Brown (1979), and Torrance (1981).

(2) Obviously, when compared with the American health care system, there is less private profit in the Canadian system. Hospitals, which claim a large proportion of the government expenditures on health, are almost all non-profit organizations. However, the medical supply industry, the pharmaceutical industry, private care institutions, the industries supplying over-the-counter personal care products, and day-to-day medical care are all supported by the curative model and continue to reap benefits from product consumption for curative care.

(3) From Ontario Council of Health (1983: 17). Of course, these statistics must be viewed with caution, for they do not measure the amount of unpaid health promotion that takes place in conventional primary care.

(4) See, for example, Anderson, 1972.

(5) A clarification of the term "free-market", as it is used in this thesis, is in order here. "Free-market ideology" and "free-market setting" are not meant to imply a health sector that does not experience any appreciable government interference, as might be argued for the American health sector. Rather, they are used to describe a situation where the state has interfered to fund health care, but seeks to maintain, at least at the level of appearances, a situation where medical entrepreneurs are free to decide the overall content of medical care and the way in which it will be practiced.

(6) It should be noted that these three periods are not completely distinguishable; some overlapping of chronological periods is unavoidable.

CHAPTER II

EARLY YEARS OF THE CHC MOVEMENT: 1960-1967

2.1-----Pressures for Government Intervention

In this chapter we will investigate the early roots of the community health centre in Canada. Although various forms of health centres, emphasizing to different degrees the integration of preventive and curative care and the role of the community, have existed in North America and Europe since the early 1900s (1), it was not until the 1960s that Canada saw the emergence of community-sponsored health centres. The grassroots movement advocating such an approach to health care, though by no means of homogeneous origin, would seem to have had in common the desire for an alternative form of health care delivery and alternative methods for financing, criteria for development, and rules for evaluating their alternatives. In short, it has attempted to shift the focus of the health care system to a more holistic one.

It is important to emphasize that the early health centre movement in Canada was but one facet of the more general movement demanding increased access to health care. As will be demonstrated in the following pages, the call for an alternative form of health care delivery has surfaced in the 20th century alongside the less drastic demands made by labour and the western population in general for simple insurance to cover the costs of conventional medical practice. The difficulties involved in getting governments interested in the provision of equal access

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to health care, coupled with the intransigencies of the medical profession as it attempted to prevent any change in the status quo, helped to propel the CHC alternative into existence. Before exploring the history of the CHC movement in Canada, a look at the state's reaction to calls for health insurance, and the way in which it was finally adopted, will first be provided.

The constitutional arrangements agreed upon by the federal and provincial governments in the British North America Act have not been at all conducive to the development of a system of health care or welfare in Canada (2). Because the provinces were designated responsibility for matters of a local nature, including health and other social matters, while most powers of taxation were granted to the federal level, the development of programs with a national scope requires complicated arrangements between the two levels of government. Surrender of jurisdictional rights to the federal level has been seen as undesirable for certain provinces, which prefer to retain control over programs and tax fields themselves (3). Thus, nationwide programs, or standards in areas such as health care, have been very difficult to achieve in Canada.

As outlined in the Chapter I, Canada's health care in the early decades of this century could best be described as curative solo practice on a fee-for-service basis. The individual (in all but charity cases) was responsible for medical costs, whether from his own pocket or through one of the existing private

insurance plans. However, signs of discontent with this arrangement appeared very early, with labour and the western agrarian movement voicing their discontent and desire for some kind of insurance against illness even before the economic depression of the 1930's (Torrance: 1981: 22-23). Employers in many areas of Canada, in an effort to attract labourers to remote areas and to fight worker discontent, set up their own health plans or facilities (Lomas, 1985: 16-18; Swartz, 1977: 316). In Saskatchewan as early as 1914, municipalities pooled their resources through taxation to ensure access to medical care; thus the ~~the~~ relative proliferation of municipal doctor plans throughout rural Saskatchewan and other prairie provinces.

In 1919 the idea of national health insurance, most likely adopted from Britain's National Insurance Act of 1911, was first endorsed by a political party in Canada at the Liberal Party convention that year. Numerous provincial governments also toyed with the idea fairly early on - British Columbia, for instance, where labour unrest was very high, had had two Royal Commissions on the topic by 1932. The government of that province actually passed but never implemented health insurance legislation in 1935, under pressure of growing discontent and support for the left wing Cooperative Commonwealth Federation in B.C. (Robin, 1972; 1973; Swartz, 1977: 316).

Throughout the depression and into the second World War, discontent became increasingly evident. The early 1940's saw numerous militant strikes, and in the political realm the C.C.F.

posed a very real threat in the Ontario elections and federal by-elections in 1945 (Swartz, 1977: 320). It became clear that the issue of social security, including health and accessibility to medical care, was becoming an important one, especially given the expected recession following the end of World War II. Granatstein's historical account of the period documents the shift of public opinion towards development of social security. Not only did the general public expect better conditions after the war (4), but also those in government and business feared the consequences if changes were not brought about. The choice was perceived to be either a capitalist welfare state or a socialist state. For example, J.R. Beattie of the Bank of Canada, in a paper delivered to the Canadian Political Science Association in 1944, stated that "[b]usiness has an overwhelming interest in accepting social security and helping to make it work, in view of the practical alternatives" (Granatstein, 1975: 276). It is not surprising, then, that most political parties in the 1945 federal election endorsed the ideal of health insurance.

In light of this political climate, the post-war reconstruction period witnessed the appointment of a number of committees to study social security plans, one of which was the Advisory Committee on Health Insurance, struck in 1942. Dr. J. Heagerty, its chairman, presented his report in 1943 (*Report of the Advisory Committee on Health Insurance*). The report was far-sighted in its emphasis on prevention and health promotion, and provided a blueprint for a comprehensive and universal health

insurance system, much like the one being discussed in Britain in the Beyeridge Report of 1942. From it was developed a very detailed model bill which was presented and discussed at the 1945 Dominion-Provincial Conference on post-war reconstruction, a bill which outlined a system for patient registration with family physicians in health regions. Under this system the physicians would be responsible for their patient rosters and would be paid on a capitation basis. In addition, they would also be paid to provide preventive services as medical health officers. The health centre would be the point of access to primary care under this plan, which would be administered in each province under the direction of a commission representing both health consumers and professionals.

This model bill was discussed but never implemented, despite the support in principle by the medical profession, which feared post-war conditions would not be in its economic favour (Crichton, 1978: 4). Several provincial governments, especially Ontario, were vehemently opposed to what they viewed as federal incursions into their provincial jurisdictions (Taylor, 1978: 48-60). Furthermore, the Liberal government of MacKenzie King was not really committed to the program, despite its rhetoric (Tsalikis, 1982a: 129; Swartz, 1977: 321; Granatstein, 1975: 275). It had already committed itself to funding Unemployment Insurance (1940), and Family Allowance (1944), and had also introduced collective bargaining legislation in 1944. To introduce another costly social program would be going too far.

for the business community (Swartz, 1977: 321) and for the more conservative in the Liberal party ranks (Granatstein, 1975, chap. 7).

In contrast with the British government, which passed the National Health Service Act in 1946, the Canadian government stepped back from the issue of health insurance, and shelved the blueprint provided by Heagerty for the development of an integrated and preventive health care system. The discussions that took place at the Dominion-Provincial conference made basic alterations to the model bill, alterations that fundamentally, and perhaps irrevocably, negated the possibility of developing an integrated or holistic health care system.

Basically, these changes involved a shift to hospital and diagnostic services development. A new emphasis was placed on hospital construction, which the federal government was to help finance through loans to the provinces. Laboratory and diagnostic services, which Heagerty envisioned as being developed in the second stage of his plan, became a first priority, replacing an emphasis on development of public health and prevention which included a visiting health nurse program. Furthermore, the two year deadline Heagerty proposed for development of first stage services was deleted; no specific deadlines or target dates would be set and discretion would be given to the provinces to develop services when they saw fit (Shillington, 1972: 33).

It must be argued that this path of development served the economic interests of the private sector, specifically the construction industry and the medical supply industries, as large amounts of money were provided by governments to build hospitals and to equip them with the increasingly expensive "necessary" diagnostic equipment. At the same time, provisions had not been made to fund these hospitals after construction. As the 1950s progressed, it became obvious that many hospitals were experiencing great financial difficulties as patients were not able to afford the increasingly expensive hospital-based care (5).

Thus, in 1957, under pressure from Saskatchewan, B.C., and Ontario, the federal government furthered its ad hoc approach and introduced a second program, the federal-provincial Hospital Insurance and Diagnostic Services program. With its introduction, the costs of the health care system began to rise dramatically. Evans (1975: 141) reports increases in hospital expenditures in 1959 and 1960 of almost 18 percent per year (see TABLE 2.1). Although hospital costs levelled off somewhat in the next few years, the share of health care expenditures going to the hospital sector rose from 60.5 percent in 1958 to 69.4 percent in 1968, an increase of almost nine per cent upon implementation of the hospital insurance program (Evans, 1975: 141).

TABLE 2.1
EXPENDITURE ON GENERAL AND ALLIED SPECIAL HOSPITALS
IN CANADA 1953-1965

Year	Expenditure (\$ Million)	Annual % Change
1953	280.4	----
1954	314.0	11.9
1955	342.4	9.0
1956	380.8	11.2
1957	422.9	11.1
1958	462.3	9.3
1959	543.7	17.6
1960	640.6	17.8
1961	722.1	12.7
1962	811.8	12.4
1963	909.8	12.1
1964	1015.1	11.6
1965	1144.5	12.7

(Source: Taken from Evans, 1965: 138)

It has been argued that by introducing hospital insurance in absence of primary care insurance, "...Canadians first became accustomed to using hospitals wherever possible because to both consumers and physicians the hospital had a relative cost advantage" (Van Loon, 1980: 345). Although this may be a rather simplistic analysis of the rising costs (Evans, for example, argues that it was not increased utilization per se, but a combination of factors, including wage gains for hospital workers in an open ended payment process, a change in the definition of necessary procedure, and overall increases in real resources used per patient day), it is important to note that the proliferation of hospital facilities and the implementation of hospital insurance had a dramatic effect on the amount of the nation's resources spent on health care.

Universal insurance for primary care, or "medicare" was not extended until the late 1960s in most of Canada. The Report of the Royal Commission on Health Services (1964) was clear in its support of the extension of the insurance principle to cover primary medical care. Although one cannot rule out the importance of humanitarian concern in the provision of "comprehensive" care, it is clear that the commissioners and the politicians in the 1960s had definite economic interests in mind. The Royal Commission's report (the Hall Report) demonstrated these economic concerns when it pointed out the rejection rates of armed service recruits during World War II due to health reasons, the loss of productive capacity, and the drain on the social budget due to illness. "[T]he economic capacity of citizens to be productive depends upon their health and vigour as much as upon their educational attainment" (1964:4). Furthermore,

...not all, or even the greater part of expenditures on health services are consumption; they are not solely a cost to the individual or society since they may yield substantial economic benefits; they are investment expenditures.... Expenditures for health care can generate a larger productive labour force in two ways: by extending the length of working life and by ensuring that individuals are able to work more regularly during their productive years (Royal Commission on Health Services, 1964: 501).

As Walters (1982: 167) argues, this belief in a corresponding level of health accompanying increasing expenditures on health insurance was also adopted by the government when it set the wheels rolling for a comprehensive medicare plan. It was not until 1969, however, that all the provinces were persuaded or

coerced into joining the federal-provincial program. Until that time, the individual still had to make his or her own arrangements for the most basic of primary care. In the meantime, unions fought to meet this need for their members. Insurance plans, especially in Ontario, the most industrialized province, had become a somewhat standard part of the welfare package won by unions in the collective bargaining process. The medical profession itself had attempted to address the need for primary health insurance, through a number of provincial prepaid plans organized by physicians, later amalgamated in 1951 under the umbrella of Trans Canada Medical Plans. As of 1951, approximately 900,000 persons were enrolled in the member plans comprising T.C.M.P. (Shillington, 1972: 109). As Shillington documents, these plans first started flourishing on the prairies, under the direct threat of consumer-sponsored health insurance plans, or compps, one of which in Saskatoon in the early 1940's, for instance, was "...flirting with the idea of establishing its own clinics and equipping them with its own salaried doctors..." (1972: 53). As seen in a report of the Manitoba Medical Services (a physician-sponsored plan) in 1957, the medical profession's interest in prepaid, physician-sponsored plans was basically a defensive one - a desire, in the face of consumer organizations and the hint of government health insurance, to offset and prevent any loss of professional autonomy and status;

The objectives were three in number:

- 1.) To establish the medical profession as the custodian of medical care for the people of Manitoba.
- 2.) To secure and preserve for the doctors the

privilege of practising medicine according to local custom, tradition, and practice.

3.) To prove to our citizens and governments that the medical profession could do this more economically and efficiently than could any government or commercial agency (quoted in Shillington, 1972: 59).

These private, physician-sponsored, and industry-sponsored plans were not without their difficulties. Although some areas and industries might have acquired adequate coverage, this was by no means universal. Many plans did not reimburse a very comprehensive range of services, co-payment charges were often involved, and costs varied immensely (Leclair, 1975). As will be seen in the following section, dissatisfaction with these diverse plans was a factor that contributed to the rise of the CHC movement.

2.2.2. Early CHC Development: Sault Ste. Marie and Saskatchewan

The late 1950's and early 1960's witnessed a growing movement in North America advocating an alternative approach to primary health care, to that practiced under commercial and physician-sponsored insurance plans and also under consumer plans for conventional medical care insurance. Two important social phenomena broke the ground for CHC development in Canada, one in Ontario and the other in Saskatchewan. The interest and activity by a number of Canadian locals of international unions in the union-sponsored health centres in the United States was one catalyst. These unions saw an opportunity to move beyond private health insurance plans, and their limitations, and set up a

totally different form of health care organization. At about the same time, a social movement sprang up in Saskatchewan in reaction to that province's infamous doctor's strike against medicare. In these early attempts lie the first visible roots of a CHC movement. Their struggles and their experiences provided a precedent that was studied and emulated by later community health centre advocates (6).

The Sault Ste. Marie health centre was the first Canadian example of alternative medical care organized and administered by a consumer group for its own use (7). This is in contrast to other union health plans, such as those in Sudbury, Kirkland Lake, and Timmins in the 1940s, where plans were instituted for, but not by, the union members themselves. It is also in contrast to a number of consumer-sponsored health insurance plans, sponsored by both communities and co-operatives. These plans, especially prevalent in Ontario and Saskatchewan (Shillington, 1972), demonstrate the roots of consumer organization for provision of care. However, they were not organizations which provided an alternative form of care, or an alternative philosophy of medicine. They simply contracted with conventional medical services to ensure access to medical care.

The initiative in Sault Ste. Marie was very much part of a North American union interest in the provision of alternative health care. In 1957, several members of the Sault Ste. Marie local of the United Steelworkers of America, and also members

from a Hamilton union, went to Philadelphia to study prepaid group health centres run by building trades and garment workers unions (Lomas, 1985). Impressed by these plans, and others such as the Health Insurance Plan of Greater New York and the Kaiser Foundation plan in California, and likewise dissatisfied with the quality of care, high costs, and lack of accessibility of medical care in Sault Ste. Marie under a commercial insurance plan set up by the union and Algoma Steel (8), these union members began planning for their own prepaid group health centre (Lomas, 1985).

A more widespread union movement toward alternative health care had been developing in the U.S.A. at that time. A 1961 account of the phenomenon describes the kind of focus this union movement had taken:

The earliest union health centre was organized in 1913 but this was the sole union venture in the field for some thirty years... the introduction of a "hold the line" order on wages by the U.S. government as an anti-inflation measure ... permitted voluntary welfare agreements between employers and the unions for the provision of fringe benefits.... The costs of such benefits were not classified as wage increases.... This in turn led to the preoccupation of unions with ... health centre activities. There are now some sixty of these in operation ... such centres have become relatively prominent during the past ten to twenty years.

They collect premiums ... and frequently enter into contracts with organized groups of physicians to provide medical care to subscribers.... Perhaps the two best known examples of the community type are the Health Insurance Plan of Greater New York (H.I.P.) and the Kaiser Foundation Plan in California.... A considerable number of union members and their dependents have comprehensive health benefits through contracts with such plans. These usually combine group practice with prepayment The emphasis is on preventive medicine... [and] on specialists rather than on general practice. This may have something to do with the fact that ... most plans stress the importance

of complete examination and early treatment

Most plans have a Board of Directors or Trustees ... the Boards are controlled numerically by consumer representatives. Thus there is a lay domination and any interference in medical matters which might result therefrom is counteracted only by the general desirability of unions to maintain the favour of the profession and their respect for the doctors' abilities in professional matters (Allison and Gillies, 1961).

This description, taken from the Ontario Medical Review, demonstrates the rather novel direction being pursued by consumer groups, and more specifically, by unions, in the U.S. No longer would these consumers be passive recipients of medical care in the form chosen by the medical profession. Instead, a very active role had been assumed, in that the nature of health care was to a large degree being determined by those sponsoring it.

The U.S. phenomenon was having a considerable impact on the Canadian scene. Indeed, the Canadian Steelworker Research Department was involved in the founding of the Group Health Association of America (GHAA) in 1957 - 1959, an association formed through the amalgamation of the Group Health Federation of America and the American Labour Health Association (Lomas: 1985). The GHAA provided a focal point for approaches to alternative health care, both in the U.S. and in Canada, as will be seen later. It was through the connections with the GHAA that the Sault Ste. Marie union, and also the steelworkers union local in Hamilton, Ontario first studied the health centres in the Philadelphia area. In addition to these early beginnings, there was a union movement in Toronto that had begun to study the possibility of establishing a health centre there (Lomas, 1985:

22). Fifty-five labour groups were involved in this project, which got as far as co-ordinating a one year research project. Despite its failure to materialize, this phenomenon shows the magnitude of interest in establishing alternative modes of delivery of health care, a definite step forward from simple health insurance provisions for conventional medical care.

According to Lomas, a more holistic and preventive approach to health had already developed in Sault Ste. Marie even before formal steps were taken.

The union was concerned with fully comprehensive care, regardless of cost, as was exemplified by two actions in the late 1950's. First, a suggestion that the welfare plan's financial difficulties be solved by using co-payment or user fees for each service, rather than by raising premiums, was rejected by the members because of the possibility that it might have further discouraged people from seeking care when it was needed. Second, under its own auspices, the union initiated a massive tuberculin immunization program in 1957 and stressed the value of the preventive approach to health (Lomas, 1985: 14).

The Sault Ste. Marie and District Group Health Association opened its doors in early 1963, despite intense resistance and outright warfare by the established medical society in Sault Ste. Marie and despite initial problems of attracting staff and obtaining the necessary funds through a \$135 subscription fee and a union checkoff system (Vayda, 1977; Lomas, 1985). The centre began operating with over sixty percent of the union members enrolled - a patient population of 12,000 - 15,000 people, including dependents. Also included were numerous subscribers from other locals of the United Steelworkers of America in Sault

Ste. Marie. Twelve doctors were hired on a salary basis to provide curative and preventive care. Other medical personnel were also hired, and space was available in the centre for expansion of facilities, such as dental, ophthalmological, and pharmaceutical services. According to Lomas's account, enthusiasm on the part of the union membership was high, with a commitment to establishing the kind of health centre that would practice health promotion and would attempt to meet the needs of the population, in terms of hours of operation, special programs for certain groups, and so on. Although initially for union members and their families, the centre would expand in the following few years to include fee-for-service patients and other subscribers from throughout the city of Sault Ste. Marie.

A brief description of the Saskatchewan phenomenon provides further insight into the early roots of health centre development. As in Sault Ste. Marie, the impetus for change towards alternative health care came from dissatisfaction with existing primary health care arrangements. In this case, however, it was not a slowly building dissatisfaction, but a very urgent one, precipitated by the physicians' threat to withdraw all but emergency medical services if their demands were not met.

The proliferation of the co-operative movement in Saskatchewan and the election of the Co-operative Commonwealth Federation in 1944 held promises of change in the medical sector. The newly elected C.C.F. government commissioned a study by a

British health expert, Dr. H. Sigerist. His report in 1945 recommended a complete reorganization of Saskatchewan's health sector into a three-tiered system in which the community health centre would be the base, or point of access. The government established an experimental system in the Swift Current region in 1946, based on Sigerist's plan. However, in the absence of federal funds, and in the face of considerable professional opposition, the experiment was not carried any further (Lipset, 1968: 294). As stated by Swartz:

...the CCF's electoral victory in 1944 laid the basis for the first effective state health insurance program in North America. Yet this victory was a distinctly limited one. Although the CCF leaders saw 'socialized medicine' as their most important reform (which they conceived to be a system of salaried physicians under the control of the government), in the face of opposition from the doctors they backed down (Swartz, 1977: 323).

Although hospital insurance was brought into effect in 1947, control over the medical sector was left as the domain of the medical profession. The pressure and lobbying carried out by the medical profession in the province ensured that the status quo would not be upset. The plans of the CCF to implement sweeping changes - including health promotion and prevention, carried out in the community health centre - were left by the wayside. As Lipset documents, one physician summed up the change in emphasis by saying that the government now stood for "...health insurance rather than state medicine" (Lipset, 1968: 293).

As would be the case in the rest of Canada, the CCF proceeded along an ad hoc path of development, beginning first

with a Hospital Insurance program in 1947. In doing so, it disregarded the comprehensive model put forth by Sigerist. This disjointed approach was reinforced by the introduction of "...unlinked Federal programs from 1949 onwards..." (Crichton, 1978: 5).

In 1962, once again considerably earlier than the rest of Canada, the New Democratic Party (the newly renamed CCF) in Saskatchewan was pioneering in the primary care insurance sector. Its medicare plan evoked the withdrawal of most physicians services. However, a grassroots movement had been preparing for the planned withdrawal, and across the province, and especially in rural areas where withdrawal of services would be most keenly felt, community associations sprang up to take the provision of health services into their own hands. These community associations set out to attract doctors sympathetic to medicare and to the concept of community health. A number of British doctors were recruited, and a handful of Saskatchewan doctors broke with the profession and joined sides with the community associations. Some thirty associations were formed across the province. A provincial association, the Community Health Services (Saskatchewan) Association, was formed in July of 1962, organizing and assisting in the establishment of associations in small towns and cities across the province. As in the Sault Ste. Marie case, the American influence must be noted. Speakers were sent from the Group Health Association of America (GHAA) to discuss American experience in prepaid group practice with

interested associations in Saskatchewan (Gruending, 1974: 9). As Gruending documents, at the peak of organization, the

...provincial association represented 25 associations which had succeeded in establishing facilities. The provincial office was staffed by two field workers. But, with the end of the strike, both the association and individual clinics experienced hard times.... The provincial office had to close in 1966 (Gruending, 1974: 10).

In all, only about twelve of the associations managed to attract doctors (Crichton, 1978: 6), and of these only eight or nine managed to survive over the next few years (Badgley, 1967: 103) (9).

The Saskatoon Agreement reached between the doctors and the government left control in the hands of the medical profession. CHCs could only rent facilities to physicians; the physicians were paid on a fee-for-service basis, and those maintaining a desire to work in a community health centre could redistribute their income, at considerable personal sacrifice, in order to fund the other programs of the CHC.

In spite of these difficulties, three of the CHCs - in Regina, Saskatoon, and Prince Albert - developed into relatively large and complex organizations, employing many professionals and offering diverse and multi-speciality services on an holistic model (Gruending, 1974; Rands and Crossman, 1972). The remainder of the clinics were small, many were located in rural areas, and were able to offer only a limited number of services of a more conventional type.

2.3-----Countervailing Forces Limiting Early CHC Development

The foregoing historical description of early CHC development begs a number of questions. In light of the theoretical considerations presented in the first chapter, how can this development, and the roles played by the interested parties, be understood? What factors were important in influencing the evolution and growth of the CHC concept?

The early community health centres in Canada faced a number of obstacles which were to seriously inhibit their expansion. A look at the historical accounts available on the CHCs in both Sault Ste. Marie and Saskatchewan would seem to point to three factors which seriously impeded their growth and development. These were, first, the rather fierce opposition from the medical profession, second, the lack of commitment and interest in the CHC alternative by both federal and provincial levels of government, and third, the diminishing level of interest and optimism of those involved in supporting the alternative. These will now be looked at in turn.

As we shall see, the medical societies and associations in both provinces, and in Canada more generally, were opposed to alternative forms of primary health care delivery, especially to those controlled by the consumer. Because this form of primary health care involved doctors becoming salaried employees of a community board, this precedent, if more widespread, could

forecast loss of autonomy and control over the definition of illness and the health care process. Obviously, the same concerns held true for physicians in Saskatchewan, who were being dealt a double blow by having the government so intimately involved in the sacred doctor-patient relationship through medicare.

Saskatchewan's experiences have been well-documented, where the organized medical contingent in the province did its best to discourage doctors from joining staff at CHCs, to the point where most of the clinics had to close because they could not attract physicians to staff them (10). Because the CHC physicians had taken sides with the NDP government in the medicare crisis and had not respected the strike of the physicians, their status as adversaries was long maintained in the province.

In Sault Ste. Marie, the medical society went as far as to place a warning in the December 1963 edition of the *Canadian Medical Association Journal*:

The Sault Ste. Marie Medical Society has established an information service to advise doctors contemplating practice in the area on matters of local importance. The establishment of a consumer-sponsored clinic in the Soo has given rise to certain misunderstandings within the profession, and newcomers in their own interest should investigate the situation before making commitments.

In both provinces the tactic of refusing or delaying hospital privileges to qualified doctors was used (Gruending, 1974: 8; Badgley and Wolfe, 1967: 104; Lomas, 1985: 74), and referrals were not made to, or received from, health centre doctors

(Badgley and Wolfe, 1967: 103; Lomas, 1985: 73). In Saskatchewan a government inquiry was launched to investigate complaints by health centre doctors, who had great difficulty in obtaining staff privileges in local hospitals (11). Lawsuits were filed or threatened in both provinces by health centre doctors, when they were refused local hospital privileges and their patients were denied referred services. In Sault Ste. Marie charges of professional misconduct were actually laid by the Ontario College of Physicians and Surgeons after strong complaints against a number of doctors and anaesthetists who refused services to health centre patients and doctors. In addition, tactics of ignoring or snubbing health centre doctors, and refusing entrance into local medical societies, were commonly applied. These tactics led to high turnover rates of health centre doctors, who could not handle the intense alienation from the medical community (Lomas, 1985: 23; Griffith, 1974: 5).

It was not simply the local medical societies which expressed distaste for the CHC concept; indeed, both the provincial associations and the Canadian Medical Association were vocal in their disapproval of community groups organizing and ultimately directing medical care. A brief statement by the Special Committee on Group Practice of the Canadian Medical Association, for instance, illustrates this disdain:

It is the overall impression of the Special Committee on Group Practice, however, that everything else being equal, there appears to be no advantage to the public or the profession in outside sponsorship of groups. The profession, by accepting positions in such groups, are tending to put their destinies into the

hands of others - while it would be undoubtedly in their greatest interest to establish their own group practices where at all possible. In conclusion, therefore, the committee would most strongly recommend against this type of arrangement (1967: 34).

Further, the medical profession, as a self-regulating profession, has used its powers to hamper CHC development through its own legislation on advertising. In the Saskatchewan case, the College of Physicians and Surgeons attempted to prevent CHCs from making their services known by ruling that any form of advertising of services was unethical (Rands and Crossman, 1972: 7). As will be seen later in the case of Ontario, this factor had somewhat serious ramifications to the growth of the CHC.

Thus, in a very direct manner, the organized medical societies in both provinces, and in Canada more generally, attempted to discourage CHC growth. To a large extent their attempts were quite successful. The inability of CHC associations in Saskatchewan to attract doctors must to some extent be traced to the intense pressure exerted on medical colleagues to conform to the position of the Saskatchewan Medical Association. And, if one is to accept Lomas's interpretation of the high turnover rate of medical personnel in Sault Ste. Marie, the direct pressure placed on CHCs by the organized medical society there cannot be ignored.

Second, although the notion of a comprehensive and integrated health care system had been around for a while, i.e., from the reports of Heagerty and Sigerist, for example, neither the

federal nor provincial governments appeared to be very interested in or committed to this alternative, at least not at that point in time. The accounts of CHC development in both Ontario and Saskatchewan would seem to point to two possible reasons for this lack of interest.

The first, and most obvious was the momentum behind the completion of an insurance based system - to be achieved by complementing the already established hospital insurance program with insurance for medical care. The interest in health insurance was very great in the 1960's. The federal government was signalling its intent, and had already appointed a Royal Commission which strongly recommended the extension of insurance to cover all medically required services (Royal Commission on Health Services, 1964). A shift in midstream to a completely different organization of health care, emphasizing prevention and integration, was not an option that was being considered. As Torrance (1981: 19) suggests, "Health insurance ... is essentially a reformist rather than revolutionary notion, involving changes in the way people pay for health services, rather than reorganization of the way services are provided."

Most provincial governments also showed no real interest in establishing anything other than medical care insurance. Some provinces, of which Ontario is a prime example, were not particularly keen even towards universal medical care insurance, preferring instead to implement a means-tested supplemental insurance scheme, and to leave the medical sector alone.

However, the Ontario government did appoint in 1963 the Ontario Medical Services Insurance Inquiry. Although no time frame was indicated, the government introduced Bill 163, "An Act Respecting Medical Service Insurance". This bill did not include provisions for alternative organization of health services, but simply for an alternative way of paying physicians. In addition, the bill specified that everyone should be free to receive care wherever, and from whomever, they chose. Thus, defined rosters of patients or prepaid group settings would not be desirable (Lomas, 1985: 58). Although Bill 163 was delayed and eventually dismissed, it became ominously clear that medicare, to the government of Ontario, meant that it would simply pay for services and leave intact the conventional, physician-dominated and curative model of medical care.

The two provinces that stand out as the clearest exceptions to this were Saskatchewan, as was discussed earlier, and Quebec (see Chapter III). In Saskatchewan, the earlier interest in comprehensive and integrated care was no longer an important part of the government's plan by the time it was set to implement medicare. There were reasons for this lack of interest, however. To see lack of interest as a cause of the problems of CHCs is to overlook the dynamics bringing about the situation.

For this reason, a second possibility must be considered for the governments' largely inhibiting policies towards CHCs: the pressures exerted on governments themselves were responsible for

the lack of interest in CHCs. This explanation would seem to be very plausible for the case of Saskatchewan, where the state found itself embroiled in a bitter dispute with the medical profession over medicare. The pressure exerted by the medical profession to undermine the CHC alternative must not be underestimated. The populace of the province developed a serious rift during the strike, between, on the one hand, the bulk of the medical profession and its supporting Keep Our Doctors (KOD) committees, and on the other, the community health centres and others who supported the government and what it was trying to achieve. The polarization over the strike had been preceded by very direct involvement by the medical profession in the electoral battle of 1959. It tried unsuccessfully to check the CCF's plans to implement medicare upon re-election (Badgley and Wolfe, 1967: 30; Tollefson, 1963: 54).

In light of the polarization of the population, it is probable that the political implications of nourishing the growth of CHCs, which were themselves a by-product of the conflict, were simply too grave. Although CHCs could continue to exist, it would seem that the CCF government, for reasons of political expediency, felt compelled to give in to the medical profession on the issue of community control. The CHC alternative would be permitted to exist only within the parameters of a fee-for-service, curatively-based, and physician-dominated system. The Saskatoon Agreement specified that the relationship between the consumer organizations and the physicians would be

one of landlord-tenant. The consumer groups could lease facilities to physicians, but payment on a strictly fee-for-service basis would go only to the physicians. According to the Saskatoon Agreement, "...the interests of such enrolled doctors must be safeguarded from improper citizen pressure" (Tollefson, 1963: Appendix F, emphasis mine). Thus:

The main source of clinic income was earned by the doctors under the Saskatchewan Medical Care Insurance Commission (SMCIC) fee-for-service schedule. At considerable financial sacrifice, doctors used a part of their income to establish and administer the co-operative and to help the provincial community clinic movement.... The Saskatoon Agreement was not conducive to delivery of health care by a co-operative of physicians and consumers (Gruending, 1974: 15).

With medicare's arrival in Ontario in 1969, the CHC in Sault Ste. Marie and the newly-opened CHC in St. Catharines were allowed to continue operations as community-sponsored alternatives. Lomas provides evidence of persistent lobbying of the state by health centre representatives (1985: 80). In addition, several briefs were presented to various committees and commissions of inquiry in an attempt to ensure legal status for health centres that had enrolled clientele (12). Whereas the CHC's could have been forced into a landlord-tenant type relationship with their doctors, providing facilities for a simple fee-for-service practice, the door was left open for funding through a per capita payment system.

In Ontario, where CHCs were not yet widespread enough to make an impact, it is not yet possible to demonstrate this same kind of direct pressure on the government to limit CHC

development and what it stood for. One can only guess that the government would have known the position of the profession, and, given the fact that medicare itself was being instituted despite the wishes of the profession, one would not really expect any government to unnecessarily antagonize the profession. Hence, it is not surprising that medicare legislation reflected the conventional and accepted medical model. In Ontario, this had a number of repercussions for the CHCs. First, it meant that doctors in health centres would no longer be salaried employees of the health centre; instead, they were to be independent partners on the board. Given the lack of commitment of some of the physicians to comprehensive community health, the threat of the physicians altering the status quo of the health centre became very real. The legislation "had confirmed the view that doctors, not consumers, were the primary decision-makers in health care and thus helped legitimize doctors' demands for more control" (Lomas, 1985: 88). Second, it reflected the insistence upon fee-for-service as the only mode of remuneration. Hence, the CHC's funding would be based solely on a figure derived from average fee-for-service costs. This meant that the additional services of the CHC were not recognized or funded. And third, the legislation reflected the medical profession's distaste for enrolled populations. It emphasized that the patient would have "free-choice" of physicians, from outside the centre if he or she so chose. The difficulties arose in that costs for use of services outside the CHC, by patients of that organization, would

be charged back to the CHC and subtracted from its capitation payment. Given the lack of incentive for outside physicians to contain costs, the implications of this charge-back scheme were seen in the decreasing number of capitation patients and in the transfer of many patients to a fee-for-service status, the latter of which is against the general philosophy of the CHC movement. The number of fee-for-service patients rose from eighteen per cent in 1969 to forty per cent at the Sault Ste. Marie centre in 1972 (Lomas, 1985: 89). In the newly established St. Catherine's centre, where all of the physicians were new to the community and had no previous ties with the seven thousand original subscribers, almost forty per cent of all services for which the centre was responsible were "out of plan" services (Vayda, 1977: 386).

Finally, it is important to note that these constraints erected by governments and the existing medical establishments were not without their toll on the social movement supporting CHCs. First, after the initial organizational work was completed, the role of the community in these early CHCs became unclear. Government refusal to fund medical care on bases other than fee-for-service meant that in Saskatchewan, both under the NDP and under the Liberals that succeeded it, the economic power lay in the hands of the physicians. As Gruending (1974: 21) documents:

The circumstances imposed by the Saskatoon agreement made it difficult for the board to accept that it had a really important role to play. One of the lay pioneers says, "It was a job to foist enough non-medical

responsibility onto the board so they felt they had some sort of responsibility".

In addition, the pressures exerted by the medical establishment on the CHCs had the effect of gradually neutralizing the impact of what the social movement was trying to achieve. A community association in a very small community in Saskatchewan, for instance, was unable to find a physician for four years, and had to pay taxes on the empty building it had constructed and equipped. Even when it did find a physician, the community's only input could be as landlord (13). Although this small association has managed to survive despite the heavy odds against it, many others did not, as evidenced by the dozen or so associations that disappeared. Gruending sums up these pressures on the movement in the following quote:

Resumption of medical care in late July 1962 led to a waning popular interest in consumer facilities. The restrictive terms of the Saskatoon Agreement ending the strike, opposition of the medical profession, and marginal support from the government all crippled the movement (1974: 10).

In Ontario, it was the impending nature of government medical insurance, as well as opposition from the medical establishment, that would seem to have dampened the enthusiasm of the social movement. As Lomas documents, the originators and organizers of the Sault Ste. Marie health centre felt very keenly the negative effects of the impending medicare legislation:

...the imminent arrival of medicare discouraged enrolling at the health centre. Premier Robarts announced in 1965 that medicare would be a centennial project starting in July 1967. Griffeth [the centre's administrator] commented, 'we would go to a union and say, "This is the story, this is what we are trying to do". The answer would be "The government is taking

everything over; this union, this local, has always been for national health insurance - medicare - and all of our problems are going to be solved then." ...People don't differentiate payment of service from delivery of service'. Medicare did not, in fact, start until October 1969, but its ever-present possibility permeated the 1960's, inhibiting the health centre's expansion and exploration of other areas (1985: 70).

In addition, within the existing CHCs themselves, the ambiguity of the consumer role, as the medical profession took over the day-to-day affairs of the centre, exacerbated the problems. The role and the importance of the community itself became less clear as both the government and the medical profession became more important in the running of this primary health care organization (Griffith, 1974; Lomas, 1985). More will be said about this problem in the following chapters.

2.4-----Summary

In summary, the legal, financial, and, for lack of a better word, motivational constraints imposed on the CHC movement in the wake of medicare's arrival would seem, at first glance, to have been sufficient to inhibit seriously the further development of this alternative. Indeed, the power of the centres to make their own decisions and financial arrangements had shifted to the state and to the medical establishment. The opportunity to define health and illness and to organize health care based on that definition was seriously curtailed with the coming of universal medical insurance.

The advent of medicare had three serious repercussions for

community health centre development. First, it drastically changed the "rules of the game": community groups initiating new health centres would have to deal with very different circumstances, both bureaucratic and financial. Second, the national program helped to solidify the existing status quo in the health sector. It reinforced and formalized the dominance of both the medical profession and the medical model. Finally, the universal nature of coverage under medicare diminished popular involvement in organizing care on the community's behalf. Economic incentives for individuals and communities to take provision of health care into their own hands disappeared with the advent of medicare, as the state made care accessible to most of the population.

The question that remains is why the state intervened as it did? The theoretical paradigms presented in Chapter I offer somewhat different insights into this question.

The most immediately obvious argument would be that it was the medical profession's position of strength - its ability to persuade (or bully) the state into maintaining the physician-dominated health care system - that really determined what kind of a state-supported health care system would be adopted in Canada. In Alford's terminology, the dominant structural interests, with physicians strategically placed in the elected government and in the bureaucracy, and with well-organized lobby groups making their wishes known, have been

able to maintain their position of dominance. From this viewpoint, medicare has reflected the preferences of this dominant structural interest, at the expense of the repressed structural interests (in this case, the community health centre movement).

The fact that the wishes of the medical profession were clearly reflected in government policy on CHCs does not by necessity mean, however, that it was the interest group itself that brought about these policies. To accept such a view would be to ignore the larger fact that the acceptance of medicare itself was very much against the wishes of the organized profession in the first place. It may simply be that the interests of the medical profession and those of the state were not that far apart at the time. This leads us to consider the insights the marxist paradigm can provide to the question of the state's intervention.

First, although economic and ideological pressures dictated that the state intervene to fund social programs such as health care, further intervention to actually organize health care would be seen as far too collectivist or socialist a move for the state to adopt. In this sense, it would not only be the medical profession that would oppose the changes sought by the health centre movement. The maintenance of a free market setting is of utmost importance to the capitalist state, for it to some degree insures the state of general support by the capitalist class.

Second, the ~~ad hoc~~ path of development of the health sector, chosen in earlier decades by the Canadian state, imposed historical constraints on what the state could consider in the 1960s. The existing system was a disjointed one, developed in response to various pressures for both accumulation and legitimization spending. With medicare's implementation, it was obvious that the state was concerned with the effects of ill health on the economic health of the nation. And, at the time, there were no real reasons to expect that the accepted curative model, wherein commensurate improvements in health are achieved with spending on curative care, would not prove to be reasonable. With no prior experience in the medical insurance field, and with as yet very limited interest in reorganization of the health sector, one could conclude that the state's choice of health insurance simply reflected its belief that making insurance available to all would confront the economic repercussions of an unhealthy population. As we shall see in the following chapters, the state was very quickly to change its tune.

ENDNOTES

(1) See Swenger (1972), Badgley (1972), Roemer (1971) for descriptions of international health centre development in Britain, USSR, Europe, and the U.S.

(2) See, for instance, the arguments of Simeon, 1972; Smiley, 1963; Stevenson, 1982; Kudrle and Marmor, 1981.

(3) For instance, Stevenson (1982: 134) documents that Ontario, B.C., and Alberta were against the Rowell-Sirois recommendations for provincial redistribution following the second World War. Armstrong (1981: 212) cites a clear example of such a case. Ontario's interests were clearly outlined by Premier Hepburn in his address to the Rowell-Sirois Commission when he

...rejected the arguments of the poorer provinces that the provision of a uniform standard of social services for Canadians required federal programs: "It may be in a country with Canada's economic diversities 'federal codes' are impractical." The cost of social programs ought to be charged against the incomes arising in each area; for "Equity between the provinces is impossible. Prince Edward Island can never be like Manitoba; Ontario may not have the coal and petroleum with which Alberta is so richly endowed; and yet, somehow we must get along together."

(4) According to Granatstein, "...in July 1944... 55 per cent of a national sample expected prosperity to follow the war, and a month later 53 per cent of young Canadians questioned thought opportunities would be better after the war.... Much of it sprang from the government's preparations for peace. The family allowance scheme, the unemployment insurance benefits, the huge sums allocated to housing, development, and job creating reconstruction policies, however conservative their intent, changed the way Canadians perceived their world" (1975: 421-422).

(5) Swartz (1977: 337) footnotes this point with evidence from Ontario. "According to a confidential report from the insurance companies to the federal government, in 1953 only 46 % of Canadians had any hospital insurance. This insurance in turn covered at best 35 % of hospital costs. Consequently, by 1955 Group A hospitals in Ontario reported operating deficits of \$13 million (Willard to Martin, Feb. 1955, Martin Papers, v.28)."

(6) The descriptions of Sault Ste. Marie and Saskatchewan come from a number of data sources. For Sault Ste. Marie, I am relying heavily on the work of Lomas (1985), and also on Vayda (1977), documents from the Community Health Centre Project ("Hastings Report"), and other accounts of the centre. For Saskatchewan, the data sources are not as limited; many accounts of the physicians strike, also provide descriptions of CHC

development (Badgley and Wolfe, 1967; Tollefson, 1963), and other accounts of CHC development are also available (Gruending, 1974; Rands and Crossman, 1972).

(7) It was not the first CHC to open; as we shall see, the Saskatchewan CHCs were actually implemented in 1962, whereas the Sault Ste. Marie clinic didn't open its doors until early 1963. However, organizational activity began in Sault Ste. Marie in late 1959.

(8) As Lomas documents, the steelworkers union was far from satisfied with medical care in the city. Geographical isolation contributed to a very serious shortage of physicians and specialists in the city. The fact that most of the city's doctors ignored the need for group practice and instead continued to practice on a solo basis meant that access to health care was very limited. Care was limited to a nine to five, five day a week basis, and even during these hours waiting rooms were usually jammed. To exacerbate the situation, the costs of services, both primary and secondary, were relatively high. As of 1961, for instance, an office visit in the city cost \$4.80, compared to costs in Toronto of \$3.75. Most insurance plans would only reimburse \$2.00 for an office visit. These excessive rates held in the provision of hospital services as well (Dominion Bureau of Statistics, Comparison of Retail Prices, Nov, 1961. Cited in Lomas, 1985: 7-10). This was not a result of excessively stingy insurance plans - instead the doctors in Sault Ste. Marie simply charged considerably more for their services and had opted out of Physicians Services Incorporated, the provincial physician-sponsored plan, in order to obtain these high fees (Lomas, 1985: 7-10).

(9) There seems to be a discrepancy among a number of authors as to how many associations were able to survive. While Crichton (1978) states that of 12 original associations, there were 8 or 9 that were successful, Badgley (1979) puts the number at 40 original associations, of which 3 or 4 survived. Gruending (1975) further complicates the issue by stating there were 25 associations formed, of which 10 were able to survive.

(10) See Badgley and Wolfe, 1967.

(11) See Saskatchewan, Report of the Honourable Mr. Justice Marcyn Woods on Hospital Staff Appointments. Regina, 1963.

(12) Briefs were submitted to the Hagey Committee, "Ontario Medical Services Insurance Inquiry", in early 1964, and to the Committee on the Healing Arts in 1967.

(13) Submission by the Wynward Community Health Association to Health Services Review '79, Public Archives of Canada, RG 29, Acc. 84-85/099, Box #6.

CHAPTER III

A GROWING INTEREST IN THE CHC: 1968-1973

3.1-----Introduction

Whereas the climate may have seemed very bleak for the pioneers of the CHC movement at the end of the 1960s, there was in fact a rejuvenation of hope as the decade came to a close. The coming of medicare did not forecast the end of the community health centre's existence, nor did it preclude the development of new alternative forms of health care. In fact, a more widespread interest was developing in alternative health care, an interest that came from two directions. On the one hand, a broader social movement was taking shape, one which called for more than the simple reforms of medicare. On the other hand, both the federal and provincial governments began looking more closely at reorganization of the health care system.

In review, the advent of universal health insurance in Canada could have signalled the end of alternative health care organizations. It was no longer possible or legal for interested groups to set up alternative financial arrangements for primary care without special status from the provincial governments, regardless of the level of interest and the number of persons or groups involved. An interested body could no longer simply collect premiums and hire physicians. All new alternatives were in theory required to function within the parameters of the government insurance scheme, which, as discussed earlier,

operated from a curative, fee-for-service schedule. However, this did not stop the social movement and its attempts to bring about change; nor did it preclude government involvement with funding exploratory alternatives, albeit on a very ad hoc basis.

This chapter will present the history of the community health centre under the present medicare system. It will cover the period of 1968-1973, when the impetus for CHC development was perhaps the strongest. The chapter will be organized into two sections, the first a discussion of the social movement struggling to organize community-based health organizations, and the second an outline of government interest during this period.

As mentioned earlier, special attention will be paid to the province of Ontario, both in this chapter and in the next. The reason for this emphasis is, as we shall see, that Ontario's situation was one of a very strong and persistent social movement. This is not to suggest that other provinces were not experiencing the social movement as well; it is more the case that in other provinces much of the impetus for CHC development came from governments interested in reform.

3.2-----The Social Movement

A grassroots social movement calling for the provision of community-based health and social services was developing in the 1960s and early 1970s in Canada. A climate of political and social activism was prevalent, one which emanated from a number of directions: from trade unions, from students, from numerous citizen's groups, and from a growing body of reform-minded young professionals and advocates of change. This movement was by no means limited to the area of health - indeed, social services, education, housing, day care, and the like were assailed by demands for change and demands for the right of citizens' groups to control, or have a significant voice in, the way services were distributed and administered (1).

Perhaps as a sign of the relative prosperity of the period, or perhaps as an indication of the desire to defuse the political climate, governments on the federal, provincial, and municipal levels supported, or actually encouraged, this social movement. Funds were channelled to groups wanting to set up alternative forms of health care and social service delivery, through federal programs such as Opportunities for Youth (OFY), Local Initiatives Program (LIP), and the Company of Young Canadians (CYC), and through provincial and municipal programs too numerous to mention. Private institutions and organizations also helped to fund community-sponsored health and social service programs, aimed at special populations and problems. Health care was one

area which experienced this kind of development, and across the country many new health centres were established.

Unfortunately, the area of consumer involvement (or community participation) in health is one which does not seem to have attracted much academic interest in Canada. The more general topic of urban redevelopment has generated a greater degree of interest, especially in the U.S., yet the specific nature of community participation in health has been for the most part very hastily brushed over. Because of this fact, it has been very difficult to get a fix on the "who" and "why" of consumer participation. Impressions, as opposed to more substantive evidence, have been offered by many of those involved in community health centre development. Furthermore, the only existing comprehensive data bases on CHCs - those inventories compiled by the Community Health Branch of Health and Welfare Canada in 1974 and 1984 - are consistently vague with respect to the nature of the initiating bodies (2). To know that "concerned citizens" or "local health societies" were instrumental in initiating a community health centre does not shed much light on, for instance, the class or ethnic origins of the social movement.

It does seem clear, however, that the social movement involved in the early 1970s was a diverse one. Although aimed for the most part at setting up alternative health care for underdeveloped areas or special populations, those involved were from many different backgrounds. Stinson's (1975) description of

the broader social movement for urban redevelopment identifies several major forces supporting or working for the social movement. In addition to the indigenous citizen organizations themselves, he includes community development workers and professional "advocates" working on behalf of communities as important catalysts of community development. Governments too, as they have invited community groups to participate in bringing about social change, have been important in the development of community-based organizations. This outline would seem to be very pertinent in the discussion of community health centres. The CHCs that emerged in the early years of the decade, though community-based in outcome, were very often started as a direct result of stimulus of the community by "outside", non-community forces.

Thus, the social movement, though to a large degree located in lower class areas, was not simply a class-based phenomenon. It was much more broadly-based in its initiation. In Ontario, as in other parts of the country, several major forces helped stimulate CHC development. For instance, numerous university medical schools supported the CHC concept as a way to meet the special needs of certain populations. In conjunction with community groups, these CHCs were set up in Ontario - the St. George's Health Centre and the Flemington Health Centre in Toronto, and the Charlton Family Centre in Hamilton - and in other provinces - for instance, the R.E.A.C.H. Centre in Vancouver, and a small CHC set up by Memorial University's

Faculty of Medicine in St. John's, Newfoundland. Medical students also provided an impetus for CHC development. At its 1969 convention, the Canadian Association of Medical Students supported community health centres that would provide integrated health and social services (Tsalikis, 1982a: 149). Working with community groups, these reform-minded young professionals helped to establish Klinik Inc. in Winnipeg, Clinique Communautaire de Pointe Ste. Charles in Montreal, and the Northend Community Clinic in Halifax.

The union movement also continued its important role in Ontario. As mentioned in the previous chapter, the UAW in St. Catharines joined ranks with the pioneering centre in Sault Ste. Marie, and opened the St. Catharines and District Community Group Health Foundation in July of 1969, just a few months prior to the commencement of medicare in Ontario. Its organization had been going on for a number of years despite government intentions to implement medical care insurance. With the onset of the provincial plan, it, along with the centre at Sault Ste. Marie, was put on capitation funding under a special branch of the Ministry of Health. In addition, organizational work had been going on in the late 1960s and early 1970s in Ottawa in an attempt to establish a union health centre there. An association had been formed to organize a health centre on behalf of the Canadian Union of Public Employees, the Public Service Alliance of Canada, and other area unions. Named the Ottawa and District Community Health Centre Foundation, this group lobbied the

Ontario government for permission to set up a third union centre. Full time staff was hired, and over \$100,000 was spent, but the government of Ontario finally refused the Ottawa request (3).

Associations and individuals working within the community as "community development" agents were also important. Unfortunately, it is difficult to ascertain the extent to which outside community development workers were involved, as the descriptions and profiles of CHCs developed at that time are not always clear as to the nature of the "community" groups initiating CHCs. However, accounts of this period demonstrate the widespread nature of the community development phenomenon. As we shall see in the case of Quebec, the government actually provided paid "animateurs sociaux" to help build community associations in that province.

Several accounts of CHC development have concluded that real community involvement has been characteristic of a handful of "middle class" reformers that have only half-hearted support by the "community" itself. Hepworth (1976), for instance, had this to say about local community health and social service centres:

The initiative for the creation of such centres has come almost exclusively from governments, professional people, and social agencies, not from local community residents.

The extent to which professional people may themselves be local residents will obviously vary, but more of the professionals involved appear to express their concerns by helping poor people help themselves, activating local residents to say what they want and in fact asking them to dictate to both professionals and governments what should happen and what should be provided at the local or community level (1976: 88-89).

Hastings (1978), in a retrospective look at CHC development, echoed this impression. He suggests that it was most often middle class reformers that prompted CHC development, with a much lower level of initial interest on the part of the indigenous members of the communities for which CHCs were set up.

Whatever the case, community health centres often developed out of a community movement that had first been active around other issues such as housing, tenants rights, provision of playgrounds, and education. In Ottawa, Toronto, Hamilton, and several smaller towns and cities across the country community centres were organized to provide health care, preventive services, and health education to specific populations. They received a mix of funding from various branches of the ministries of health and social services, and from private foundations and associations. The St. Anne's Clinic in Ottawa, Regent Park Community Health Centre, York Community Services, and Springhurst Community Health Centre in Toronto began to provide for the needs of low income, working class areas (4).

For the most part, the evidence suggests that this social movement advocating community centres was initially an urban phenomenon. Mark McGuire, the executive director of the Association of Ontario Health Centres, points out three reasons for this urban bias of community health centres (5). First was the relative absence of political and social ferment in rural areas, in the late 60's and early 70's. In urban areas, the

grassroots political movement of urban redevelopment, begun in response to broader issues of basic neighborhood rights, gained momentum and expanded its focus to include more specific issues such as health care. For example, members of the Alexandra Park Community Centre in Toronto, a community association formed for the betterment of a low income housing project, expanded its focus to provide, in the summer of 1972, a dental clinic for its inhabitants (Globe and Mail, July 6, 1972). It was in milieux such as this that the urban movement was built.

Second, the fact that rural populations are to some extent the "captive audiences" of their health professionals has made it very dangerous for these populations to demand change. More specifically, the preference of physicians to practice in urban areas makes it difficult for rural areas to obtain physicians services in the first place. To jeopardize accessibility to basic health care by challenging the status quo has thus not been a desirable move. In contrast, in larger centres where doctors are more plentiful, the same pressures to maintain the status quo are not in place.

Third, McGuire does not attribute the same political acumen to rural populations, in the sense that sources of alternative funding and promising points to lobby are not as well known in rural areas. Although it is not possible to subject this reasoning to rigorous testing in this thesis, the point must at least be kept in mind. Whatever the case, it would be safe to

say that almost all of the community-based health centres developed during this period were located in larger population centers.

The above discussion has attempted to address the question of who has been involved in the social movement for community-based health care. Warner's article has attempted to address the question of why those involved were motivated to struggle for such changes in the health care field. Although lacking somewhat in substantive backing, his article helps to shed some light on the consumer involvement phenomenon.

Warner concludes that there are a number of possible reasons for consumer involvement: the quest for power by individuals or groups, the philosophical belief in participation as the basis of a democratic society, the desire to counter the increasing professionalization and bureaucratization taking place in the medical sector, and the desire to address perceived deficiencies in the quality of health care and its delivery. It is on the two latter points that Warner places the most emphasis. The issue of basic accessibility having been for the most part addressed by medicare, the focus has shifted, according to Warner, from quantity to quality. An increasingly vocal grassroots movement was now challenging the nature of health care and the way in which it is delivered.

The two latter reasons are inextricably linked, for the desire to reverse the trend toward technocratic and dehumanized

medicine is also the desire to address the deficiencies of the predominant medical model. Warner sees the desire on the part of consumers to re-humanize medicine, to focus on the whole individual, as an attempt to bring health care back to the hands of the individual. In other words, it is an attempt to allow the individual, or the community, whose health is at issue to decide its own priorities and make known its perceived needs. It is to Tonnies that Warner turns in his summary of the consumer participation movement in health:

Tonnies (1955), while talking of the inevitability of social change along a *gemeinschaft-gesellschaft* continuum, also envisaged the possibility of *gemeinschaft*-like (community-like) incursions into an otherwise *gesellschaft*-like (association-like) society, if "real" causes exist. *Gemeinschaft*-like community forces may, in the health field, attempt to reverse the increasing professionalization and bureaucratization of medicine and health service. There is considerable data to suggest that communities, both at the local level and through their governments, are demanding that institutional behaviour be more personal, more controllable, and more accountable (Warner, 1981: 367).

Unfortunately, information on the social movement behind CHC development is quite limited. It is clear, however, that though the movement was widespread, it was of an unorganized nature in most provinces. In Ontario, for instance, CHCs and the groups sponsoring them were for the most part unaware of other similar alternative organizations. During this period there was no real communication network linking the experiences and information of those involved (6). Given the diversity of sponsorship and funding, and the geographic distances separating most organizations, it is not surprising that CHCs operated from very

different premises and offered a wide array of services.

The common foundation underlying these alternatives, however, was their desire to have community influence over health care. In Godbout's words, the community health centre became "...the only place, in those impressive professional and bureaucratic edifices known in Western countries as health care systems, where users have a formal right to influence the nature of services offered ..." (Godbout, 1981: 153, emphasis mine). However, this formal right has been somewhat less easy to maintain in practice. More will be said about what has happened to the social movement in Chapter IV.

The CHC movement could not have survived for very long under the medicare system had it not been for a growing state interest in alternative health care arrangements. Certain provinces embarked upon programs of either experimental or more long range CHC development. In the process, these governments built on to a social movement that already existed, and encouraged citizen participation as an important component of the social redevelopment process.

An important distinction is being made here, between two different scenarios of CHC development - on the one hand that which originates as a social movement, the aims of which were eventually addressed by government, and on the other hand that which occurs as a result of government legislation and invitation to participate. The former phenomenon could be labelled a

"bottom - up" process, while the latter is more of a "top - down" phenomenon. Several authors have made reference to this distinction (Renaud, 1981; Tsalikis, 1982a; Hepworth, 1976). Hepworth distinguishes between the "organic model" and the "legislated design" (1976: 85-90).

Although to some extent this distinction is being maintained here, it is important to exercise caution in the application of this typology. As we shall see in the following pages, CHC development in Ontario is generally assumed to be of the former type, as it was very much a grassroots phenomenon. However, these alternatives would not have been able to exist had the government of the province not been informally interested in the alternative. Likewise, in other provinces such as Quebec, Manitoba, and British Columbia, where government policy was adopted to develop the CHC concept, the cornerstone of community participation that was essential to that policy could not have existed if not for interest and activity on the part of the community.

With this in mind, the following section will discuss government interest in the community health centre. As we shall see, the early 1970s and their impending economic crises had much to do with the expansion of interest in the CHC concept.

3.3-----Government Interest in Community Health Centres

Chapter II demonstrated the apparent bias towards the medical profession's dominance of the health sector in provincial medicare legislation. Now, just a few short years later, many provincial governments were effecting what seemed to be a rather dramatic reversal. During the late 1960s and early 1970s numerous government-sponsored reports on the health care system criticized the status quo. Provincial governments had begun to fund and, in some cases, actually encourage community-sponsored health alternatives.

There are a number of possible reasons for this sudden government interest. First, this was the period of Canada's "war on poverty", during which there were a variety of efforts to redress the inequalities of Canadian capitalism through urban social development. The encouragement of community participation was seen as one way to improve social conditions. Crichton emphasizes this reason in the third volume of the "Hastings Report" on community health centres when she speaks of the need for community development, or "animation sociale", as "part of the therapy for sick (deprived) communities" (1972: 2-15). Related to this, it is also quite probable that this support came as an attempt to address the radicalism of the era - an attempt at legitimizing the system by meeting demands for change, and in the process co-opting those demanding the change. However, the single most important factor influencing a rising interest in and

support for CHCs as the 1960s came to a close was undoubtedly the preoccupation with rising health expenditures on the part of both the federal and provincial governments. Although this concern was not something entirely new (it had been expressed since the Heagerty report in 1943), it took the passage of the Medical Care Act (1966) and the ensuing projections for health care costs to spur earnest attention to the issue.

With the implementation of universal medicare, government expenditures on health began to increase very drastically. Table 3.1 shows consolidated government spending on health, for all levels of government.

TABLE 3.1
CONSOLIDATED GOVERNMENT EXPENDITURE ON HEALTH 1965-1979
ALL LEVELS OF GOVERNMENT

Year	000's of Dollars	Annual % Change
1965	1,589,900	----
1966	1,924,600	21.0
1967	2,298,000	19.4
1968	2,615,300	13.8
1969	3,386,100	29.5
1970	4,106,731	21.3
1971	4,842,708	17.9
1972	5,477,993	13.1
1973	6,069,434	10.8
1974	7,357,494	21.2
1975	8,961,018	21.8
1976	10,140,499	13.2
1977	10,994,908	7.9
1978	12,039,173	9.5
1979	13,442,224	11.6

(SOURCE: From Statistics Canada, Consolidated Government
Finance, 68-202)

2

OF/DE

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MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

In light of the annual increases during the late 1960s and early 1970s, it is understandable that living up to the commitment to provide insurance for primary medical care was cause for much consternation for the federal and provincial governments. Economists were projecting skyrocketing health care costs in the coming decades. The Economic Council of Canada, for example, predicted in a 1969 report that spending in health and education, if continued at the rate at which it was then increasing, would take up all of Canada's Gross National Product by the end of the century (Economic Council of Canada, 1969). It is not surprising, then, that as early as 1968, three or four years prior to the final adoption of the medicare program by all provinces of Canada, a special federal-provincial task force - the Task Force on the Costs of Health Services - had been set up to study the expected fiscal problem, and to suggest reorganization measures to make it more cost effective. As Tsalikis (1982a: 138) notes, the irony of this situation was that the system's "...reorganization began before the process of organization was complete."

The Task Force's report presented "findings" that would be repeated many times over the next few years. It singled out, among other things, the lack of co-ordination and integration of the health system, the outrageous costs being generated by inefficiency in and overuse of hospitals, and the exclusion of alternative and less costly forms of primary health care delivery to that of costly fee-for-service practice.

Though the report made 348 recommendations, it pointed out that four themes stood out:

- 1) that increased productivity was essential given the labour-intensive nature of the health industry;
- 2) that economies were absolutely essential given the "remorseless" escalation of costs;
- 3) that regional organization was essential given the need for cost efficiency;
- 4) that public participation was essential given the scope of reform required. (from Vol. I, 6-8, cited in Alcorn, 1981: 252).

In light of these four themes, one of the recommendations of the Task Force was that "...first priority be given to establishing community health centres containing a full range of preventive, diagnostic, and curative services (Vol. 1, 67-69). It also recommended numerous other changes, including an emphasis on alternative and cheaper primary health care providers (for instance, nurse practitioners which would receive the training to assume the simple but time-consuming tasks of the general practitioner), alternative means of payment (specifically capitation and salary), and the need to reorganize and rationalize the entire health care system to make it more cost efficient.

The encouragement of alternative forms of health care as a way of controlling health care costs had some well-studied precedents in North America. In the U.S. the prepaid health plans of organizations such as Kaiser Permanente and H.I.P. were demonstrating lower cost and hospitalization rates. Although these plans were not government-financed, they employed many of the same principles as the CHC concept envisaged under government

sponsorship in Canada. These Health Maintenance Organizations (HMOs) had become popular in the U.S. beginning in the early 1970s, after the Nixon administration, alarmed at rising health expenditures in that country, passed legislation encouraging their development as a more cost-efficient method of health care delivery. HMOs have four characteristics:

1) Each has a defined (enrolled) population for whom it provides a wide range of health services, including hospital and physician services.

2) Each provides physician services by using either an organized group practice which is an integral part of the HMO, or individual physicians in private practice who agree to provide services for it. The physicians may or may not be reimbursed on a fee-for-service basis. All HMOs do not own the hospitals they use.

3) Each is financed by its members' capitation payments ... not by fees charged for each service provided. Thus, an HMO's revenue depends on the number of members (enrollees) that it has, not on the number and mix of services it provides. Its costs, however, do depend on the number and type of services it renders.

4) Each has explicit internal mechanisms to monitor the quality of care provided members and to control costs (Soderstrom, 1978: 60).

Numerous studies were carried out on the HMOs in the early 1970s (see Donabedian, 1969; Roemer, 1973) and the literature seemed to support the claims of the HMOs that they indeed had lower hospitalization rates, and could thus offer lower enrollment rates to their members. Thus, primary health care organizations employing capitation as the means of funding were of interest to governments desiring to lower health care costs.

The Canadian CHCs in Saskatchewan and Ontario had also been

studied in the 1960s and 1970s. Health centres had been compiling statistics on their own, and these pointed to an overall decrease in hospitalization rates and thus in costs per patient for the CHC (7). On the basis of these preliminary statistics, several evaluations were undertaken. The World Health Organization, with the support of the Ontario government, began a four year study of the Sault Ste. Marie centre in 1966 (Hastings et. al., 1973). In Saskatchewan, a government-sponsored study was set up by the Liberal government in 1969 (Anderson and Crichton, 1973). A third study was carried out after the NDP's re-election in Saskatchewan in 1971 (McPhee, 1973).

These studies came to somewhat similar conclusions. All agreed that health centre populations showed lower hospitalization rates than did the general population, or comparable patient populations from fee-for-service practices. And although they differed somewhat on their perception of the actual cost savings from these lower hospitalization rates, they agreed that their findings were positive enough to recommend further development of CHCs as cost containment devices.

Following the recommendations of the Task Force Reports, and the positive information on costs from evaluations that had already been carried out, the federal and provincial health ministers set up a more intensive look at the CHC concept. This special project, the Community Health Centre Project, reflected the growing belief by many health professionals and

administrators that ~~the~~ CHC was an organizational form which could provide an increased quality of health care and level of health in a more efficient manner. In short, it seemed to be a form of organization that could address the four themes emphasized in the Task Force Reports.

The "Hastings Report" stressed the need to make fundamental changes in the focus of primary health care - to encourage the development of health promotion and prevention through the proliferation of community health centres. As in the ~~Task Force Reports~~, the Hastings Report acknowledged the international evidence on community-based health organizations. It outlined a number of benefits which might be achieved through an emphasis on CHCs in the rest of the country.

The report envisaged primary health care which was administered by a multi-disciplinary team of health workers, including physicians, social workers, nutritionists, nurse practitioners and other health professionals. The health centre was to be controlled by the community, which was seen to be more sensitive to its own needs. Community boards were expected to offer health care that would be much more adaptable to the needs and resources of the community. Health promotion programs and integrated health and social services would emphasize care of the whole individual, and remuneration through capitation rather than fee-for-service would ensure this approach by the medical team. In summary, the Hastings Report offered a much wiser and more

comprehensive use of health resources.

It is obvious in the report that its recommendations did not emanate from purely economic concerns - the importance to the individual and the community is clearly conveyed in the report. However, the economic import is undeniable; by de-emphasizing costly medical intervention on the secondary level, by stressing less expensive primary health care, including the use of non-physician personnel such as nurse-practitioners, and by promoting changes in individual behaviour through the preventive approach of the CHC, economic benefits could be expected. Furthermore, a switch away from fee-for-service primary care and its open-ended nature would be a bonus to the restraint of health care costs.

Based on these expectations of the CHC concept, Hastings suggested the development of a sufficient number of CHCs that evaluations could be achieved on their effectiveness. He urged the federal government to provide a "thrust fund" to the provinces in order that an experimental program could be set up.

However, a secondary theme in the Report forewarned of a new emphasis on individual assumption of responsibility for illness and health, an emphasis that would be developed and more clearly stated in Lalonde's "White Paper" (see Chapter IV) in 1974. The report voiced the realization that expensive medical technology was not necessarily the panacea it had been seen to be in the 1950's and 1960s, and that attention needed to be paid to the

social and economic factors causally related to ill health. The importance of holistic health care, instead of medical intervention to cure illness, was clearly stressed.

Community health centres can and should provide a setting for formal and informal education necessary to change attitudes. The public should understand that modern scientific medicine is limited in what it can accomplish - many ills cannot be remedied. Individuals must take real responsibility for personal and family health (diet, smoking) (Hastings, 1972: 19, emphasis mine).

This emphasis in itself is not, of course, a negative thing. Indeed, the health centre movement had been stressing lifestyle change for many years. What it did foreshadow was an overemphasis on individual causes of illness, to the almost virtual exclusion of addressing or even acknowledging the factors beyond the individual's control that have been responsible for illness. This factor will be discussed in much more detail in the following chapter. Suffice it to say that it was in the Hastings Report, a report that was so frequently and hopefully referred to by the proponents of the CHC, that this theme first appeared.

Several provincial governments began to study and experiment with the CHC alternative in the early 1970s. These provinces included Quebec, Manitoba, Saskatchewan, British Columbia, and Ontario (8). It would be simplistic to summarize this provincial interest as coming solely as a result of concern with costs, however important a motivating factor this was. For all but Ontario, this interest also had much to do with alternative

political philosophies. The Quebec example is perhaps the most notable here. The changes of "The Quiet Revolution" in that province brought forth a new focus on the social aspects of medicine and health, a focus which resulted in the development of a significant number of Centres Locales des Services Communitaires (CLSC), the Quebec version of the CHC.

In the 1960s and 1970s a very important social movement in Quebec propelled that province into the forefront in the area of community health. Under the growing pressure of the new middle class technocrats, the old system of church domination of the health care system was being challenged and overcome (Lesemann, 1984; Renaud, 1981). In the medical field, a new generation of family practitioners was calling for a radical reorganization of the system; a reorganization that would see doctors become more socially and holistically oriented, and that would see "... the end to the reign of practitioners and guilds over the medical world" (quoted in Lesemann, 1984: 57). The newly established University of Sherbrooke included a teaching hospital where this new programme of social medicine was being taught. Furthermore, a group of radical social workers in Quebec emerged in the mid-1960s as self-defined "animateurs sociaux", working to organize social action committees in low income areas, in order to fight poverty and to help identify and address the community's needs. A number of early community health centres were established in the mid to late 1960s as a result of these initiatives. One notable example, the Clinique Communautaire de

Pointe St-Charles in Montreal, was established in 1968.

On the government's part, a comprehensive study of the health and social services was commissioned by the Union Nationale government of Daniel Johnson in 1968. The Report of the Commission of Inquiry on Health and Social Welfare (the "Castonguay-Nepveu Report") was published in 1970. In it, the commissioners recommended drastic, sweeping changes to the health and social services of the province.

Lee (1979: 5) outlines a number of reasons for Quebec's interest in implementing these sweeping changes. Poor distribution of services in many areas of the province, the lack of any kind of an organized system or network between different components of the health "system" - a remnant of the predominance of church-sponsored and private hospitals - and overall, the rising costs of health care in the modernizing province all pointed to the need for some kind of rationalization of the system. In addition, the duplication of services resulting from the development of separate systems for the French and English was problematic, as was the lack of any regional planning bodies to look out for and plan for the health care needs of a rural population.

Several accounts of the Quebec phenomenon have suggested that the government's interest also had much to do with Quebec's desire to develop a different social fabric from that emerging in the rest of the country under the proposals for the "medicare"

program (Renaud, 1976; Tsalikis, 1982a). Whatever the reasons for their singularly comprehensive approach, the Commission's reports outlined a completely reorganized and rationalized health care system, stressing decentralization of power, a holistic approach involving teamwork of health professionals, and a breakdown of the province into health regions, the object of which was to consolidate and rationalize resources and needs. These health regions would consist of three operational levels. The Local Health Centre was to be the first level of entry to the new health care system. It was to be in effect a CHC, and would provide health and social services to the surrounding local community. The second level was named the Community Health Centre, and was actually the general hospital, while the third level was the University Health Centre, another name for specialized hospitals linked with medical schools. Each three-tiered region would be responsible to the government's combined health and social service ministry.

Claude Castonguay was invited to join the Quebec Liberal party in 1970, and was elected with the Liberal government that year. He was appointed Minister of Social Affairs (upon merging of the Ministries of Health and of Family and Social Welfare). Upon assuming this portfolio, Castonguay was free to implement his reorganization scheme of the Quebec health care system. What followed was Bill 65, passed in 1971.

The new health care system was thus implemented "from above",

in the sense that the reforms of the Commission's report became official policy. The proposed Local Health Centres were to be the first level of contact in the three-tiered system. Named Centre Local des Services Communautaires or CLSC, these health care organizations were to embrace many of the same criteria of the CHC described later in Hastings' report. According to Castonguay (1971: 193-197):

... the Quebec government intends to set up an integrated network of health and social services whose specific characteristic will be to ensure at a local level a multivalent and multidisciplinary approach, keeping more specialized services and equipment for subregional or regional levels.... in order to reach the objective of improving the state of health and social living conditions of individuals, families, and the collectivity itself, we are promoting integration of services within local community service centres where a global approach to problems will be made possible, the knowledge of the environment more adequate, and the participation of the people more productive.

In fact, the Quebec governments, both Liberal, and later Parti Quebecois, continued the development of the CLSC throughout the 1970s and 1980s. However, as will be discussed later, this development has not been without its difficulties and setbacks, and the original enthusiasm for community participation and decentralization of decision-making has not necessarily been maintained.

The other provinces that expressed sufficient interest to actually see through to an official policy on CHC development were solely on the left of the political spectrum. In Manitoba and in B.C. the election of N.D.P. governments brought with them novel approaches to health and social services. In Manitoba, in

1972, the White Paper on Health Policy was released. In it, a program of CHC development was suggested, providing a way to "restore unity of health care, providing within a single framework the services and professionals to assist people over a broad range of health and social problems" (Manitoba, 1972: 39). Six health and social service centres were funded, mostly aimed at serving "problem" populations such as the elderly, native Indians, and rural and northern areas. Reforms allowing such development were informal and administrative in nature until 1975, when legislation was passed to unify health and social services, thus providing a legal basis for the provision of comprehensive care (see Ryant, 1977; Hepworth, 1977). According to Swenger (1972: 13):

... traditional practices have tended to divide societies' problems - we must direct our efforts to the total person or family within the total environment. What is envisaged is the "Single Unit Delivery System". It is in the Regional Office that we will deliver programs of personal services, income security, ecological and environmental services. An advisory council has been proposed by users and providers

In British Columbia, it was the "Foulkes Report" (Health Security for British Columbians) in 1973 that first recommended the CHC as an "ideal mechanism for entrance into the health care system at the community level" (Smart and Stotsky, 1981: 33; see also Clague et al., 1984). It too offered the same critique of the conventional health care system. The newly elected N.D.P. government was interested in the CHC concept and set up its own CHC development group. The government funded five CHCs as pilot projects, and provided health and social service

personnel, "as well as programs to fit the needs of various communities (Smart and Stotsky, 1981: 33). It also paid salaries to board members who were responsible for the administrative duties of the centre, for hiring of staff, and for general decision-making.

Finally, 1971 marked the re-election of the N.D.P. in Saskatchewan. The community movement, which had become somewhat dormant under the restrictive terms of the Saskatoon Agreement, experienced a resurgence of activity. Numerous groups, including people from universities, unions, women's groups, the NDP, and nurses associations were active in lobbying the government for an emphasis on preventive health and integrated services (Globe and Mail, July 5, 1972). The health ministry under the NDP was making some rather promising noises, and it soon introduced a funding scheme wherein CHCs would be paid global budgets. Community boards would now have control over the funding and the operation of their centres. As Young (1981) documents, community members fought to regain control, the result of which, in the Saskatoon case, was a fierce battle fought between the community board and the physicians, and a migration of many physicians and patients from the CHC in that city.

What of the medical profession? How was it responding to this suddenly increased interest by the state? As could be expected, the medical profession was hostile to these innovations. Initially, both the Canadian Medical Association

and the Canadian Hospital Association were receptive to the recommendations of Hastings' report. However, they changed their minds within days and a renunciation of support was issued by the President of the Canadian Medical Association (Crichton 1978: 8). As Hastings (1978) commented, "(t)he reaction began to occur as the Report was really read and the commitment to change expected was appreciated". Hospital Associations argued that, if a "need" existed, the hospitals should fill it (Smart and Stotsky, 1981: 34).

For the medical profession, the issue seemed to be fourfold. First, the relationship between CHC development and economic savings was thought to be a spurious one. Alternatives would not reduce costs; their services would be add-on in nature and would increase demand and thus costs. Second, any savings that might possibly occur would come only as a result of loss of physician autonomy - of "...administrative control over medical personnel to decide on which type of health facility the patient requires" (Ontario Medical Review, 1972: 667). Third, the emphasis of many CHCs on the teamwork approach of health and social service professionals by nature went against the grain of the training and experience of most medical professionals. The physician as the only decision-maker and as the senior and highest paid member of the medical staff was necessarily threatened by the equalizing approach of the Hastings Report. And fourth, the CHC could become a controlling tool in the hands of the government:

Whereas the medical profession cannot be overly critical of the concept of community health centres as

a means of health care delivery, it should be very clear that in the context that the concept is presented the health centre might become but an administrative device to ensure absolute control of the pattern of medical practice (Ontario Medical Review, 1972: 668).

Numerous tactics to directly thwart CHC development have been utilized by the medical profession. As discussed earlier, the refusal to grant hospital privileges to health centre doctors has been used in both Saskatchewan and in Ontario. In Quebec, a strategy borrowed from American doctors has been particularly successful in undermining the CLSC. Based on the belief that whatever the government can do the private sector can do better, Quebec doctors were advised that "Instead of bleating about the government development of Community Health Centres ... why not set some up ourselves" (Wallace, 1972). Tsalikis (1982a: 151) documents that, as a CLSC went into the planning stage, a private polyclinic was set up in the same neighborhood to compete directly. Well over 400 of these have been set up (compared to the 150 or so CLSC), and they have encouraged a second class image for the CLSC. Several less direct tactics have also been used. Crichton (1978) argues that medical journals have been hesitant to review positive studies on these alternatives. And, as argued by an involved member of the Sault Ste. Marie centre, the medical profession, while condemning alternatives, has not taken it upon themselves to actually visit or find out what goes on in health centres (Ontario Medical Review, 1973: 12).

3.4-----Summary

The period of 1968 to 1973 was marked by a growing state interest in alternatives such as health centres. This state interest coincided with a period of strong popular support for community participation and, more specifically, for community-run health organizations. Furthermore, left-of-centre political parties in the western provinces had embraced the aims of community control and of holistic approaches to health and social services. Development and expansion of CHCs in British Columbia, Manitoba, and Saskatchewan coincided with the election of N.D.P. governments in these provinces. Although economic considerations were reflected in government documents from these provinces, the "reform" of primary health care was to a great degree ideologically inspired.

Undoubtedly the most important reason for the growth of CHCs during this period was the state's interest in rationalizing the health care system. Although the demands of the social movement were important, the evidence that exists on the social movement suggests a relatively weak and very disorganized phenomenon - certainly not strong enough to coerce the state into action on its behalf. The question that remains is what was behind the state's interest in rationalization? The theoretical approaches presented in Chapter I offer somewhat different explanations for this interest. On one hand, Alford's analysis would lead us to believe that the interest originated in challenging structural

interests - in the bureaucratic rationalizers and middle class technocrats that seek control over health resources by writing "crisis" reports. This argument would seem most applicable to the case of Quebec (see Renaud, 1981). The expanding new middle class of technocrats like Castonguay, according to this approach, were trying to wrest power and control of the health sector from the professional monopolists. On the other hand, the marxist perspective would explain the state's sudden interest in health centres and other innovations as a reaction to the economic crisis in the health sector. In this sense, the state was now more willing to actively intervene in the health sector - to actually involve itself in activities other than simple funding. The critical factor in the state's intervention in the free market of health was the economic imperative - the need to gain control over spiralling costs and to maintain the "health" of the capitalist economy.

It is difficult to make any conclusions about this flurry of interest without first determining what happened to the community health centre in the following years. Chapter IV will explore subsequent CHC development, from 1974 to the present. It will also take a more intensive look at the province of Ontario and the process of CHC development in that province.

ENDNOTES

(1) Information on the social movement comes from a number of sources. See Carota, 1970; Stinson, 1975; Draper, 1971 for a general discussion of consumer participation. More specific information on CHCs was gathered from newspaper accounts, the Health and Welfare Inventories (see following endnote), and numerous articles and mimeographed documents on CHCs. Unfortunately, much of the data is quite limited, providing very general descriptions of the social movement.

(2) The federal health bureaucracy has twice compiled inventories of the CHCs that exist across the country, Community Health Centres in Canada, Directorate of Community Health, 1975, and Community Health Centres of Canada: Inventory, Community Health Services Division, Department of National Health and Welfare, March 1984 (draft). These inventories, while very helpful to this thesis, have several inherent difficulties which make them somewhat problematic. First, they are not complete. The way in which data were collected meant that an undetermined number of centres did not respond. Second, the questions used to glean information on aspects such as sponsorship and initiation were very open to interpretation, and the answers received gave very vague descriptions of the histories of the centres.

(3) Interview with Dr. Ralph Sutherland, Sept. 9/85. Also see Globe and Mail, Oct. 12, 1972.

(4) Not mentioned in the above discussion of community based clinics, but equally important in the further development of alternatives in Ontario, was the emergence of physician sponsored variants of health centres. In 1971 health ministry made arrangements with a group of physicians at St. Marys Medical Clinic in St. Marys, to provide capitation funding for primary health services. In 1973, arrangements were reached with other physicians in Hamilton and Burlington to provide salary plus overhead for a nurse practitioner and for family physicians. These alternatives were similar to CHCs in that they attempted to provide alternative forms of care, often stressing prevention, but different in that community sponsorship or even participation were not present. As will be seen in the following chapter, this form of physician sponsored primary care would gain an important position in the later half of the decade.

(5) Interview with Mark McGuire, Sept. 19/85.

(6) Interview with Mark McGuire, Sept. 19/85.

(7) As Lomas reports, in Ontario, administrators at the Sault Ste. Marie clinic had been watching their cost statistics from very early on. Using data from the Ontario government's Hospital Services Commission, the centre was able to show that its mode of

practice was having a positive effect on hospitalization rates. Indeed, as reported to the Ontario legislature by Donald C. MacDonald, the leader of the NDP in 1966, an annual hospitalization rate of 680 per 1000 population for the Sault Ste. Marie centre compared very favourably with a rate of 1400 per 1000 for the general population in that city, and also very well to a rate of 1850 per 1000 for the general population of Ontario (Legislature of Ontario, Debates, 3 May 1966: 3025). The CHCs in Saskatchewan, and particularly in Saskatoon, "...had been monitoring their practice over the years, creating a body of social science around their delivery of medical care." In 1968, the Saskatoon Community Health Foundation "...was created to research the cost and delivery of health care. The foundation sponsored a major health conference in Saskatoon during 1969, where statistics were presented indicating that the clinic was providing savings through fewer hospital admissions". (Gruending, 1974: 40).

(8) This chapter will concentrate on the first three provinces only. The following chapter will look at Ontario, as it represents a somewhat different phenomenon.

CHAPTER IV

THE COMMUNITY HEALTH CENTRE: 1974 - 1986

4.1-----Introduction

The case of Ontario presents a definitive contrast to the provinces discussed in Chapter III. The governments of the western provinces and Quebec proved willing to intervene in the health sector in order to actually attempt reorganization of their systems. For the western provinces this intervention was somewhat tentative and exploratory, whereas for Quebec a radical reorganization of the health care system had been undertaken. This willingness to intervene, obviously against the wishes of established medical interests, was precipitated by political ideologies, as well as by economic considerations.

Ontario did not experience a similar commitment to reorganization of the health sector along the lines of community health centres (1). With no recent history of radical or alternative politics, there have been no launchings of experimental projects based on ideological beliefs such as co-operatism or populism. In fact, what has characterized the province has been its refusal to get involved in anything other than the funding of the health care system, despite the existence of a rather strong alternative health movement, and increasing health expenditures in the early 1970s.

The provincial government in Ontario has shown some interest

in arrangements similar to the community health centre. Several advisory bodies and task forces on health had, indeed, studied the health care system in the province and had recommended a de-emphasis on the curative approach and the development of less costly approaches to ambulatory and home care (2). The government had extended funding through various appendages of the health bureaucracy to diverse health organizations sponsored by numerous associations and institutions. Yet a sustained state interest in or commitment to community-sponsored associations has eluded the social movement.

This chapter will concentrate on CHCs during the period of 1974 to the present. The primary focus will be on what was happening in Ontario at that time (3), although we will also return briefly to the other provinces discussed in Chapter III. Finally, this chapter is not intended to come to conclusions on the how's and why's of health policy that may be somehow applied to the rest of Canada. This description of the Ontario phenomenon is provided with the aim of taking a more intensive look at some of the forces and factors that should be taken into consideration by students of health policy in other areas of Canada.

4.2.-----The State and CHCs in Ontario

Despite the rather intense level of interest being generated in other provinces and by the federal/provincial Community Health Centre Project, and despite the high level of community interest

in the province, the usual bureaucratic and governmental documents extolling the virtues of community participation in health have been conspicuously absent in Ontario. The belief or statement that the community itself was best suited to determine its own priorities in health does not appear as a common (or even minor) theme in the reports produced for or by the Ontario Ministry of Health in the early 1970s (4).

As we shall see, Ontario's initial interest in the CHC, and in other alternatives, hinged only on the ability of these alternatives to cut health care costs. As discussed in the previous chapter, much evidence was accumulating from both Canada and the U.S. that they did indeed present the possibility for reductions in health care dollars spent on both primary and secondary care. Even then, however, the Ontario government was slow to show interest. It was not until late in the fall of 1973 that any formal arrangements to develop or evaluate health care alternatives came into being. Health Minister R.T. Potter, "...anxious to find a way to respond to pressures for the development of community health centres in the province ..." created within the ministry the Project Development and Implementation Group (PDIG) to explore the feasibility of their implementation (Program Development Branch, 1981: 5).

The PDIG, which began operation in the spring of 1974, seemed interested in supporting the initiative of numerous types of alternatives. By doing so, it would be possible to comparatively

evaluate the different kinds of alternatives, and take these evaluations into account in the government's formulation of health policy. The guidelines set out by the PDIG suggested a political environment conducive to CHC development. They specified that health centres could be sponsored by any group, individual, or organization as long as the health care they provided coincided with the following goals:

- (1) Continuity of care would be emphasized rather than high volumes of episodic care;
- (2) Care would have a basic health rather than a disease orientation;
- (3) Economy and effectiveness would be achieved by use of the services of other health care professionals such as nurse practitioners and community workers in place of physician services where appropriate;
- (4) The resources of the public health system, already publicly financed, would be utilized; and
- (5) The resources of the social services system would be utilized by establishing co-operative management (Program Development Branch, 1981: 6-7).

However, in addition to these goals, several guidelines imposed by the government indicated that it was not really interested in actively encouraging community-sponsored health organizations. No capital operating funds or start-up money would be made available to groups sponsoring CHCs. Nor would any initiative be made by the health ministry to develop CHCs, even in underdeveloped areas. There would be no publicization of available funding. The development of CHCs would be entirely an evolutionary process. Physician-sponsored health clinics could more easily be set up under these rules, for they came already equipped with somewhat stable and well-developed clienteles and often with pre-existing physical resources. As we shall see, physician-sponsored health centres (later called Health Service

Organizations, or HSOs) did become somewhat more successful alternatives in Ontario. Community health centres, which would have to attract clientele and staff, and set up the physical plant themselves with no financial help, were not as easily developed. Furthermore, the guidelines also specified that alternative health care arrangements would be supported only as long as they took no more out of the economic pot than conventional fee-for-service medicine, regardless of the type or number of services they provided.

The PDIG was made responsible for the very diverse range of "Community Health Service Organizations" previously funded through a number of public and private sources(5). Excluded, however, were the union-sponsored health centres in Sault Ste. Marie and St. Catharines. And, though it could not actively encourage health centre development, in its brief existence this group was responsible for making funding arrangements with some twenty-six new and previously existing health organizations (6). However, in April, 1975, before the PDIG's funding arrangements were even finalized, a freeze was placed on any further developments. Although the interim per capita funding arrangements would be continued for the existing centres, the development of any new alternative organizations was effectively halted. The PDIG's approach of establishing a diverse range of alternatives, from which the most promising models could be studied, was very shortlived. The health minister indicated that a new approach would be undertaken: a methodology for evaluating

the existing centres would be developed.

It is obvious that this move by the ministry was designed to halt any further development of the CHC. To call for evaluation at such an early stage of the game and with such a small and heterogeneous collection of alternative health organizations signals a stalling technique; a desire to "study" the situation instead of doing anything concrete. The question that must be addressed here is what brought about this rather abrupt termination of the PDIG's mandate in 1975? The reason for termination given by the ministry was that evidence on the effectiveness of alternatives was lacking, as was any method of evaluating these alternatives. As discussed in Chapter III, however, a number of studies had already been carried out on CHCs in Saskatchewan and Sault Ste. Marie, and these indicated that cost savings could be expected from CHCs.

A terse statement found in the Program Development Branch's history of the HSO program points out a different, and more political reason for the freeze:

As the number of projects increased, so did criticism and opposition from proponents of the traditional health care system. Within the ministry itself there was not full agreement on the project and opposition from internal and external sources seriously impeded the developmental task (Program Development Branch, 1981: 10).

What were these internal and external sources? The document quoted above goes no further in its discussion. To find out what these sources of opposition were, one must look to specific areas

within Ontario society itself, and to the more general political atmosphere in Canada and in other Western societies.

First, it is quite obvious that the medical profession, as noted previously, was not happy about alternative arrangements such as CHCs. In the aftermath of the Hastings Report, the Ontario Medical Association was no more enthusiastic than its counterparts in the rest of the country. Editorials in the *Ontario Medical Review* were tactfully condemnatory.

In response to the growth of alternatives that had already taken place, the medical profession had attempted to directly limit their success. A tactic used earlier against CHCs in Saskatchewan was emulated: the Ontario College of Physicians and Surgeons published in 1973 a warning notice aimed at CHCs and other alternatives. It described "Offences which may result in erasure or suspension":

...any form of advertising, canvassing or promotion by, or on behalf of a medical insurance or prepaid medical plan that recognizes for payment only the medical services provided to the subscribers performed by the members of a limited or restricted group of physicians is, in effect, a form of indirectly advertising or promoting the services of the group, and it is considered unethical for a member of the College to be a member of such a group. ("Warning Notice and Special Notices", 1973. College of Physicians and Surgeons of Ontario, p.3).

This warning notice by the self-regulating medical profession has had the effect of seriously limiting the spread of information about CHCs. The warning has made it difficult for CHCs to make their services known to the community, and it has continued to

play this role to the present.

And what of direct influence by the medical profession on the state? A review of numerous accounts dealing with CHC development finds clear agreement on the fact that the profession was instrumental in swaying the government's decision against further development (7). According to Dr. Michael Rachlis, of the Medical Reform Group of Ontario, "...there is no doubt the medical profession openly campaigned against health service organizations" (Smart and Stotsky, 1981: 34). Through public statements disputing the Hastings recommendations, and through individual protestations and OMA lobbying, the successfulness and strength of the medical lobby was one major factor in influencing the decision to halt development.

As for the internal forces inhibiting the PDIG's approach, it is important to note that the health bureaucracy itself was not in agreement on its desirability. There were several bureaucratic organizations within the ministry which were responsible for different aspects of health reform. These groups had very different ideas as to how to go about implementing this reform. According to one member of the former PDIG,

There was a lot of internal resistance to the whole notion of community centres.... There was a general belief that fees-for-service was what we understood, what we paid for, and that some of this other stuff was really for the birds. (Greer, cited in Lomas, 1985: 110).

It was the Special Projects Branch, which had been given

responsibility over the two union sponsored health centres, that was in the forefront of opposition to the exploratory approach of the PBIG (8). They were calling for a more rigorous, evaluative approach, an approach which would match existing alternatives to conventional practice units for comparative evaluation. As we shall see, this was the approach that won out in the end.

It is also necessary to take a brief look at the more global external forces that may very well have been shaping Ontario's approach at this point in time. More specifically, what kinds of national or global political-economic pressures had bearing on the health sector? In answering this question, it is first important to note that health care costs were levelling off in Canada, as compared to dramatic increases with the onset of medicare a few years earlier (see TABLE 3.1). There was no longer the same economic incentive, so important in the late 1960s and early 1970s, to get health care costs in particular under control through radical reorganizations of the health sector. At the same time, however, the Western world was beginning to hear much about the need for general restraint in the mid 1970s. Inflation and unemployment were on the rise in Canada. The federal government was expressing a desire to limit its transfer payments to the provinces in the areas of health, education, and welfare. It had already promised that it would not coerce the provinces into any further expensive cost-shared programs like medicare. In short, the optimism and expansion of the welfare state during the post-war period, with its emphasis

on universal and comprehensive government provision of services, was being replaced by a new ideology of restraint and a shift away from collectivism to individualism.

In the health sector it was Marc Lalonde's White Paper, *A New Perspective on the Health of Canadians* (1974), which most clearly articulated this new approach. Although this document itself has nothing specific to do with the Ontario case, its "new perspective" had much to say about the new ideology of individualism being pushed by the federal state, and subsequently, by the provinces.

The publication of the White Paper received attention both at home and abroad as an outstanding example of the new "holistic" approach to health and illness (9). Although at first glance this White Paper would seem to be encouraging the development of alternative and holistic health care, a closer look shows it to be a clear example of the federal government's waning support of change in the health sector.

The analysis and critique of Canada's health care system presented in Lalonde's report was very straightforward and even radical, as far as government documents are concerned. Instead of concentrating solely on the biological causes of illness, this document identified four major components of health care and illness:

1. Human biology (the basic biological and organic makeup of the individual),
2. Environment (factors external to the human body over which the individual has little or no control),

3. Lifestyle (those factors of illness and health over which the individual does have control), and

4. Health care organization (the existing system of health care in the country).

The report emphasized the lack of prevention and health promotion in Canada, stressing that 94.9 per cent of health care expenditures in 1973-74 went to basically therapeutic and curative care. Furthermore, the observations of the Hastings Report concerning the social and economic factors involved in health and illness were further developed. Lalonde's paper referred to the health care system as a mere "catching net" for the many victims of the health risks emanating from the "ominous forces" inhibiting social progress in Western societies.

Although the focus of Lalonde's analysis would seem to have heralded a forthcoming battle with these ominous forces, his proposals for action reflect the growing lack of interest in refocussing and reorganizing the health care system. They also reflect a continuing refusal to address the economic, social, and environmental causes of illness. Undue emphasis was placed on individual prevention, through lifestyle modification programs such as "Participation" and nutritional awareness programs. The "ominous forces" he emphasized were limited to lifestyle related ones; heart disease, car accidents and cancer predominated. The environmental factors over which the individual has little or no control were virtually ignored, as was any emphasis on the effects of stress, occupational illnesses, and the like.

Lalonde concluded his report on a pessimistic note: due to

the magnitude of expenditures on the present health care system, the prospects for change and for new government policies that would address these ominous forces were very dismal. Although the report did deal with the desirability of expansion of community-based health care organization, no federal funds for research or development would be forthcoming.

The import of this often-quoted document is clear. Its rhetorical value lay in its success at shifting responsibility for health promotion and prevention to the individual, despite the admission of extra-individual forces responsible for much illness. The federal government, through this report, was signalling its lack of commitment to anything but the status quo: a health system dealing only with symptoms, and addressing symptoms only with curative care and individual prevention. This new perspective would become the preferential policy of the federal government. It provided a popular and non-challenging alternative to change, which, for the most part, has maintained the status quo in the health care sector.

It was in this atmosphere, one of shifting responsibility away from the state and onto the individual, that many provincial governments were attempting to address the issue of health sector reform. The pressure to refrain from adding any additional services in this political and economic climate, no matter if they could possibly prove in the long run to reduce costs, must not be underestimated. This was especially so at the time since

federal-provincial cost sharing arrangements allowed no flexibility for provinces to experiment with alternatives. Until 1977, when block funding arrangements were finalized, experimental programs such as CHC development were not covered under cost sharing arrangements (10).

Following the Ontario government's freeze on CHC development, the Ontario Council of Health, the senior advisory body to the health ministry, appointed Dr. W.O. Spitzer of McMaster University Medical Centre to develop a methodology for evaluation. The rationale behind evaluation was that alternative organizations could be meaningfully compared to "Normative Practice Units", and that these comparisons could be used to formulate policy directing the development of future health care arrangements.

A number of studies had already been done in Ontario, and these studies had come to contradictory conclusions. The World Health Organization's study of the Sault Ste. Marie health centre (Hastings et. al, 1973) found hospital utilization by health centre patients to be lower than those of a matched population under conventional care by about one quarter. A 1974 evaluation on the quality of health care received under per capita funding arrangements in the St. Mary's Medical Clinic found that there was only a minor improvement in quality of care rendered (Sibley, 1974). Two 1975 studies of nurse-practitioner use in health centres found improvements in cost and efficiency associated with their use. Both found that much physician time taken for mundane

tasks could be freed up, and subsequently practice could be expanded (Ontario Council of Health, 1975; G.M. Batchelor et al, 1975). A study updating Hasting and Mott's World Health Organization analysis of the Sault Ste. Marie Group Health Centre was funded under contract by the Ontario Ministry of Health in 1975 (see Badgley, 1979). This study was a comparison of Ontario's two union-sponsored clinics with six unnamed fee-for-service group practices in both northern and southern Ontario. Though noting fewer hospital admissions for the union-sponsored centres, the clinics were found to be "somewhat disappointing.... The government would be justified in terminating its capitation contracts with the clinics..." as they had not achieved "...the utilization patterns which their founders had anticipated " (quoted in Badgley, 1979: 365-370). Almost simultaneously, the Special Projects Branch, responsible for Sault Ste. Marie and Ste. Catharines, was carrying on its own evaluation studies (11). These evaluations matched the union health centres with similar fee-for-service group practices in Oshawa and Brantford respectively. The results of these studies, published in 1976, compared the volume, quality and costs of care for the two practice types, and found that the Sault clinic saved about twenty per cent in the utilization of hospital days and costs, while the St. Catharines clinic, which was still new and struggling, was not financially viable.

The ambiguity of these findings is not surprising when one considers that these studies lacked a frame of reference or a set

of evaluative tools that could be agreed upon by all those involved. These studies were primarily interested in costs. Even then, costs were often considered only along a very short term, narrow range of criteria. Numerous other factors were usually not even taken into account in determining the impact of alternatives. These included the quality and appropriateness of care, the accessibility of that care to the community, the benefits accrued from extra-medical services and activities, and the long term benefits to health that could only be measured over time (12).

In fairness to Spitzer's evaluation methodology, and to the goals of the Ontario government, an attempt was made to address some of these issues. The report contained a number of indices that would theoretically allow evaluation of such things as utilization of health services and financial performance (U-F Index), accessibility (A Index), and quality of care (Q Index). Although fine in theory, however, the construction of these indices was extraordinarily biased against alternative health facilities (13). The government received many complaints from community groups and health professionals over the extent to which the framework, if used, would discriminate against alternatives. By attempting to reduce "health" to a question of costs, that could somehow be compared to simple fee-for-service costs, evaluations would be overlooking many of the less obvious benefits of alternative health arrangements. These benefits would include the non-medical services provided (i.e.,

nutritional counselling, health promotion programs), the benefits to the individual and the workforce of having "one-stop" diagnostic and treatment facilities, the absence of extra-billing charges and other fees charged many patients in fee-for-service care, and, in general, the benefits to the health of the individual and the community through the holistic and preventive approach to health practiced in many alternative health organizations. A good example of the latter point can be seen in the case of the South Riverdale Community Health Centre, located in urban Toronto. Doctors in this CHC were able to recognize a problem with lead poisoning of children. The subsequent political actions of its members and staff were sufficient to force more stringent anti-pollution constraints on a local metal factory in 1974. It has continued to fight against lead pollution even to the present, urging a ban on leaded gas in a 1985 submission to a commission on the environment (The Citizen, July 26, 1985).

Spitzer's report did receive applause from the alternative health movement for its recommendation that at least fifty alternatives needed to be developed for evaluation purposes. And although a "Primary Care Unit" was subsequently set up in the ministry to develop something more useable out of Spitzer's indices and evaluation scheme, nothing concrete has yet come out of it. It would seem that the Ministry of Health recognized the difficulties it would face in implementing Spitzer's methodology. However, a decision still had to be made about what to do with

these alternative health organizations. In June of 1976, the problem was passed on to the newly formed Program Development Branch. Alternative health organizations would wait another three years before a concrete policy was determined.

Between 1976 and 1979 the Program Development Branch was developing a system whereby eligible alternatives would be paid a per capita rate equivalent to fee-for-service monthly patient rates, for all enrolled patients whose health insurance premiums were paid up. After protestations by alternative health organizations, the ministry conceded that the capitation rate would be age and sex specific. In other words, payments would be based on the age and sex profile of the patient population. This was important in that many health centres had patient populations that included a disproportionately large number of elderly, which are heavy users of health services. However, the capitation rate was still not to be adjusted in recognition of the levels of illness in the population being served. This has remained a funding problem to the present, as health centres serving the poor do not get an adjustment for the greater health costs incurred by a large proportion of less healthy patients (Association of Ontario Health Centres, 1985: 8).

It was not until the spring of 1979 that the Program Development Branch's funding scheme was approved by the Ontario government. It provided for capitation funding, as described above. It also included a funding device to encourage

alternatives to be responsible for all primary care to enrolled members. This was called capitation-negation, and under this scheme the ministry would deduct from an HSO's monthly payment the individual capitation rate for any patient who, in that month, used the services of duplicate practitioners outside the organization. Although this was punitive enough to health centres, it was definitely an improvement over the system of charging back the full costs of services rendered outside the organization (14). The funding arrangements also offered an incentive for decreased hospital use, called the Ambulatory Care Incentive Payment (ACIP). This program would pay to qualifying organizations a percentage of their hospital savings over the year. This has proved successful for healthier patient populations, but obviously, when the population is elderly, for instance, it is much more difficult to keep patients out of hospital, and thus it is much more difficult to qualify for the ACIP benefits.

This program was definitely an exciting improvement. However, there was a catch. According to the ministry's calculations, only thirteen of the twenty-six alternatives that existed in Ontario would be viable under such a system (Program Development Branch, 1981: 24). These were officially called Health Service Organizations (HSOs). Only two of these, including Sault Ste. Marie, were community run alternatives. The rest were physician or hospital owned and operated. For these lucky thirteen, they were now assured a stable, committed funding

base. For the other category, into which most CHCs fell, the assurance of future support looked grim. If they could build sufficient rosters of patients - sufficient in size and stability & they would be admitted into the program. These were officially labelled Community Health Centres.

The community-based health organizations would wait until 1982 for any official word from the health ministry that they were to survive. In the meantime, they continued on unstable and usually insufficient interim global funding. It was in the fall of 1982 that the health minister, Larry Grossman, made a long awaited statement about the future of the CHC alternative. "Ontario Health Centres" were, he said, "...an idea whose time had come". No longer would they be considered experimental. Based on the recommendations of the soon to be released Task Force to Review Primary Health Care (1982), the minister seemed to be finally committing his bureaucracy to a program of CHC development which would assure "stable and ongoing funding in the same manner as the other established elements within the system" (Speech by Larry Grossman, Oct. 28, 1982).

However, as always, there was a catch. CHCs were envisioned as the perfect plug for a very specific gap. They would become service centres for the needy - for the underdeveloped rural and urban areas. Any group desiring funding under the new CHC program would have to demonstrate conclusively that a need existed; a need that was not being filled by conventional

practice.

Existing CHCs were thus guaranteed funding under the Ontario government's Community Health Centre Program, the final guidelines for which were completed in 1985. However, it would seem that the requirements for the development of any new CHCs have been made so difficult and inaccessible to community groups as to effectively preclude their being established. As predicted by community groups in submissions to the ministry, it remains next to impossible for a community group without extensive know-how and experience to surpass all the administrative hurdles necessary to establish a new CHC. Many have been trying for a number of years (15). Carrying out an acceptable needs survey without funds to hire a professional, and competing with the many other demands for very limited funding being submitted to the regional health councils has precluded much in the way of further development (16).

The Ontario state has shown no real desire to develop community-sponsored alternative health organizations. Although the PDIG was initiated as a response to the social and economic pressures of the early 1970s, support for its exploratory mandate was very shortlived. Since 1975, the Ontario state has waffled, trying to decide what to do with the twenty or so health organizations it had become responsible for during its ill-fated PDIG experiment.

In contrast to the other provinces discussed in Chapter III,

the position of the Ontario state has been that it will not intervene in the organization of health services. The free market setting must be maintained, and to that end a very supplemental role has been found for the CHCs that were first encouraged under the PDIG. Any new CHCs will serve areas in which the current system is not interested: rural isolated communities and underserved urban populations. Only when a proposed organization fits into this non-challenging role will the state consider its utility. As Lomas (1985: 180) argues, it is now who the CHC serves that is important, and not how they provide services.

This non-interventionist attitude is amplified in Ontario's policy of not encouraging the development of CHCs, even as a second class supplements to conventional primary care. Under both the Conservative and present Liberal governments, the Community Health Programs Branch, responsible for alternative health organizations, may respond to but not initiate interest in CHCs in underserved areas. According to one member of the Branch, "...it is up to community groups to find us" (17). An interested group must find out on its own what bureaucratic channels it must navigate. In cities where other CHCs already exist, this process may be facilitated through communication between alternative health organizations. In rural areas, this expectation is very unrealistic. The Community Health Programs Branch is not permitted to make known the funding and resources it has available.

Physician-sponsored HSOs are much less problematic as challenges to the status quo in the health sector. They can be set up with much less government involvement and cost, involving only negotiations with the ministry of health over capitation payments, and the notification of patients concerning the change of funding. In fact, there are now twenty-four HSOs in Ontario. The organized medical profession in Ontario no longer views the HSOs and the existing CHC policy as quite the threat to the status quo that it once did. A special body has been set up within the Ontario Medical Association to look out for physicians employed in alternatives to fee-for-service care.

In summary, then, Ontario's approach to reform in the health sector has never emphasized the role of community participation. Nor has it advocated state intervention to organize health care, but for a very brief 'exploratory foray' in 1974. Although the Ontario state made several reforms to the health sector comparable to those of other provinces, such as the regionalization of the province under District Health Councils, there was no real interest in the community health centre as a means to alter mainstream health care.

Has the outcome of CHC development in Ontario differed significantly from that in the provinces discussed in Chapter III? We will conclude this chapter with a brief summary of the outcome of community health centre development in the rest of the country.

4.3-----The Success of the CHC in Canada

Across Canada, community health centres found themselves in very similar positions as the 1970s came to a close. Provincial governments quickly lost interest in the reforms they had so enthusiastically embraced during the early years of the decade. The spiralling health care costs and the immediate economic crisis faced during that period of time were no longer quite so compelling. Furthermore, the federal government was no longer taking a leadership role in the health sector. It was, in fact, relinquishing its role as the setter of standards for health care by pulling out of shared-cost funding arrangements, and by shifting responsibility for health to the provinces and to the individual. Finally, the radicalism of the early 1970s and the existence of left-of-centre provincial governments were no longer providing an ideological impetus for CHC development.

In the western provinces, CHCs are no longer paid any attention by governments, as the New Democrats in those provinces were replaced by conservative governments. In British Columbia, a change back to the Social Credit government in 1975 could have brought the termination of the program, as the Socreds had soundly criticized the program while the N.D.P. was in power. Political pressure exerted on the new government to maintain the program, however, prompted the B.C. government to set up an evaluation team to study its economic viability. This team, made up of representatives of the B.C. Medical Association, various

government representatives from the health and human resources ministries, and a University of British Columbia Commerce professor surprisingly made a favourable judgement on the CHCs, noting decreases of 20 to 25 per cent in hospital utilization for areas containing CHCs. Lower costs per capita of provincial spending were also noted, prompting a recommendation that the program be expanded in B.C. However, CHCs have not been expanded; four continue to exist as established, but aberrant, components of the conventional health care system.

Much the same scenario was repeated in Saskatchewan and Manitoba. In both provinces the established CHCs have been permitted to survive, and have continued to receive funding from provincial ministries of health. According to an administrator in a Manitoba centre, "[t]he present Conservative government has adopted a very benign attitude toward us... They neither attack, nor do they visibly support, as long as we don't become too political" (Smart and Stotsky, 1981: 33).

In the case of Quebec, the reality of reform has not matched up to the rather grandiose plans for complete reorganization of the health sector (Lesemann, 1984; Renaud, 1981). Although changes have been brought about in other aspects of Quebec's health care system, the CLSC, envisioned as the vehicle that would transform primary care and become the basis of a new primary care system, has been relegated to a very secondary role. CLSCs have become primary care centres for the poor and for rural

areas unserved by the mainstream health care system. Community participation, seen initially as the cornerstone of effective reform, has been abandoned in practice, in favour of government control and centralization of decision-making power. The state quickly learned that community control of health centres meant diversification, as community groups focussed on very different aspects of health care organization and delivery. Furthermore, community control often meant vocal left-wing radicalism - an embarrassing position for the state to be in, considering it was financially responsible for these health organizations. The Quebec government moved to take control of the CLSCs in 1974 and 1975, drastically reducing the role of the community, standardizing programs, and deciding priorities for further development.

The second class image of CLSCs was exacerbated as physicians in Quebec mounted a very successful attack on their development, countering planned CLSCs with physician-sponsored polyclinics that were set up and operational within a fraction of the time. As Lesemann (1984: 249) documents, the medical profession's campaign for private clinics was backed financially by "...major Canadian banks, which, in collaboration with drug companies in the United States and Ontario, declared themselves ready to encourage the development of private medical facilities". Polyclinics have quickly outnumbered the CLSCs, totalling about 450 in 1980 to the CLSCs' 100 or so (Rheault, 1980).

In Chapter I, we briefly outlined a number of factors that would indicate how successful the CHC alternative had been in Canada. These success indicators fell into two categories: quantitative and qualitative. The immediately obvious factor to be considered is that of quantity. On that measure, one would have to conclude that CHCs have not been very successful. Quebec is the only province to boast more than a handful of alternatives, yet even then, when compared to the initial plans for reform and the conviction and purpose with which reform was begun, the plan to complete the entire network of CLSCs with a total of only 160 is not all that impressive (Kagis, 1984). Furthermore, the prognosis for further development is not very promising - in the western provinces expansion of CHCs is not being considered, and in Ontario the rules and regulations have precluded much in the way of further development. Although new CHCs may, in theory, receive government funding in Ontario, in practice only the most committed and determined of community groups would survive the process involved. In Quebec, CLSC expansion has basically become a question of bureaucratic preference, not of community initiation. An underserved area is diagnosed as being in need of health services, and a new CLSC is prescribed by the ministry (see Lesemann, 1984).

Many factors inherent in the nature of the health care system, and in the actual practice of community participation, have limited the ability of CHCs to match up to the ideals embraced at the outset of development. This leads us to the

question of qualitative success. The available information on CHCs in Canada suggests mixed conclusions on qualitative success. The parameters of the fee-for-service, curative health care system continue to define CHCs and the way they must operate. Although budget negotiations are complex, and the methods of setting budgets differ between provinces, the insistence that costs somehow parallel fee-for-service averages has been a problem for many CHCs from the beginning. The difficulties involved in determining budgets for organizations stressing health promotion programs, preventive services, and non-medical services, from a position of comparing these costs to fee-for-service care, has made things very difficult for CHCs in some provinces. Furthermore, there have been no real attempts to integrate curative care, health promotion services, and social services in most provincial bureaucracies. From an administrative aspect, this means that very often a number of detailed budget statements must be prepared for the different agencies within the responsible bureaucracies. Funding for other programs may come from private agencies (for instance, the Centretown Community Resource Centre's grant for a "Lifestyles" program from the Kellogg Foundation), further complicating the funding process and exacerbating the disjointed nature of the health care "system" in which these more integrated and holistic alternatives are attempting to operate.

The qualitative success of CHCs has also been further hampered by the constraints imposed by the established medical

profession. Although it is no longer overtly hostile, the medical profession's restrictions on advertising remain. Furthermore, the medical education system remains oriented towards the curative medical model. The more holistic model emphasized by alternative health organizations remains at odds with the present training received by most health care professionals. As a result, physicians, have been reluctant to work in CHCs. There are high turnover rates, as recent graduates from medical schools gain experience in CHCs and then move on to private practice. The teamwork approach has proved difficult, and attempts to equalize wages and status of health team members have proved unrealistic within the parameters of the present health care system.

What of the central tenet of the CHC movement, that of community participation? As discussed in previous chapters, the difficulties faced by the community boards and associations once CHCs became established have made the ideal difficult to attain. Because the real enthusiasm was often found in middle class reformers, with only marginal support by the community at large, the "community participation" often became more symbolic than real. This is not to say, however, that true examples of dynamic community participation do not exist. It is more the case that, once established, there was no longer the same tangible goal to rally behind, and the community health centre became simply the place to go for health care.

The above summary of the success of the CHC alternative might lead one to conclude that the CHC concept is not a workable one - that it has no deserved place in the health sector in Canada. Indeed, CHCs have been given a very secondary role in the health care system, assigned only the responsibility for taking care of those the conventional system does not want to serve. Yet it is clear that CHCs have, and continue to, provide valuable and necessary functions. In the studies that have been done on cost effectiveness, they have shown lower hospitalization rates for their patients, although it is difficult to assess whether this is a result of the care given in CHCs or the type of self-selecting populations they may serve (18). They are in the forefront of health promotion, offering many programs stressing lifestyle changes, nutrition, and the like, very much in line with the "new perspective" on individual responsibility for health. And finally, to a lesser degree, they have been active in pointing out the economic, social, and environmental causes of illness, stressing occupational health, pollution concerns, and housing issues.

Community health centres have had an impact, however limited, on the organization of primary health care. In Saskatchewan in the 1930s, in Sault Ste. Marie in the 1960s, and in Quebec in the 1970s, the threat of consumer organizations has prompted change in the medical profession. The conventional primary care system has been forced to respond to the new approaches of the alternative health organizations. It has done so in two ways,

one, by bullying, threatening, and legislating against the emerging movement, and two, by directly competing with it and offering more accessible and responsive care in the medical marketplace. In this sense, although CHCs have not been quantitatively successful, they have to a small degree influenced the quality and accessibility of the conventional medical system.

ENDNOTES

(1) Information on the Ontario phenomenon was collected in a number of ways. Government and archival documents dealing both with the health care system in general and the CHC in particular were useful. The accounts of Lomas (1985), Kelman (1978), and others also supplied important facts. Interviews were conducted with persons involved in the CHC movement and in government (see Appendix A). Finally, numerous documents from CHCs in Ontario, and from the Association of Ontario Health Centres, were used.

(2) See Report of the Committee on the Healing Arts (1970), Report of the Health Planning Task Force (1974), the Report of the Ontario Council of Health on the Health Care Delivery Systems: Community Health Care (1970), A Review of the Report of the Committee on the Community Health Centre Project (1973).

(3) The primary rationale behind the focus on Ontario is, as mentioned earlier, that it provides a contrast to the other provinces in the way CHC development took place. Two other reasons prompted the choice of Ontario for a more intensive look at CHCs, and these were much more reasons of convenience. Although Quebec offers a very fertile field of study, the author would have to rely on a very limited body of information written in English. Finally, the information required to study other provinces is not readily available. In depth data collection from other provinces is a task beyond the scope of the present project.

(4) Although it could be argued here that this very low level of government interest in alternative forms of health care delivery is not particularly unique, given the similar absences in so many other provinces with no history of interest, it must be kept in mind that, contrary to these other provinces, such as the four Atlantic provinces, and Alberta, there was a very considerable demand for such services in Ontario.

(5) It included physician sponsored and run solo practices and group practices under capitation, health practices using nurse practitioners, hospital and university sponsored clinics, both with and without community involvement. It also included community sponsored centres offering only conventional primary care, community centres offering multispecialty services and preventive programs, and other alternatives.

(6) The Metro Toronto Health Service Organization Working Group reports another eight or so with letters of intent and sixty more preparing or submitting briefs to the ministry.

(7) This direct link has been argued by many, including Lomas (1985), Metro Toronto Health Service Organization Working Group (1978), Smart and Stotsky, (1981), and also Mark McGuire (interview, 1985). Unfortunately, this is hard to verify, as

these accounts are very short on specifics.

(8) Evidence for this comes from Lomas' (1985) interview with Bessie Weatherhead of the PDIG, and Kelman's, (1978) interview with Ray Berry, head of the Special Projects Branch.

(9) Illich (1975) makes mention of the Lalonde Report in the introduction to Medical Nemesis. Navarro (1976) and Ham (1982) also discuss its implications.

(10) See Brown (1980) for a discussion of EPF and federal/provincial cost sharing arrangements.

(11) See Ontario Ministry of Health Data Development and Evaluation Branch, 1976a and 1976b.

(12) For a more detailed discussion of evaluation see Badgley (1979), Medical Reform Group (1980), Lomas (1985), Program Development Branch (1981).

(13) The construction of these indices used very arbitrary values assigned to different types of care. The provision of a service under conventional care was automatically given a higher value than that given in alternative arrangements. The result was an evaluation scheme very biased against alternatives. For more detail, see Bernstein (1979).

(14) The capitation-negation arrangement was necessary to avoid the ministry paying twice for a patient's care.

(15) Interviews with Mark McGuire, Dr. Ralph Sutherland, and Maija Kagis.

(16) There have been two new Community Health Centres since 1982, one in Merrickville, and one in Toronto.

(17) Interview with David Brindle of Community Health Programs Branch, Ontario Ministry of Health, May 27/86.

(18) Because provincial governments do not keep useable statistics on health at the individual level, it is difficult to determine to what extent these lower hospitalization rates may be a result of the care given in the CHC, and to what extent they may reflect a self-selected clientele of individuals inherently more interested in personal health promotion.

CONCLUSION

Although medical technology and the content of curative health care have experienced overwhelmingly rapid evolution over the past few decades, the organization of primary health care in Canada has remained relatively unchanged. Small changes have occurred; group practice arrangements among physicians have become much more popular, for example, and of course medicare has changed the method of payment for primary care. Yet, primary medical care remains dominated by the curative model of health, with most care being dispensed according to an understanding of health that stresses intervention in illness by specially trained administrators of curative practices.

In this thesis, we have taken an exploratory look into one form of primary health care that has challenged the conventional medical system. We have looked at the community health centre concept, the social movement behind it, and its existence within the health care system in Canada. The challenges it has faced in dealing with the established medical sector and the state have been examined, in an attempt to determine how successful this alternative has been.

We have concluded that, as far as numbers are concerned, the community health centre alternative has not been very successful. While the existing CHCs, established under the exploratory programs of a number of provinces in the early seventies, have

been able to hold their ground, there are no present indications of state interest in expanding the alternative. CHCs have been able to account for only a very miniscule amount of the primary health care delivered in Canada. As an alternative, they have been relegated to a very supplemental role. Several more qualitative successes were noted, however, specifically the CHC's farsighted approach to health promotion and preventive medicine, and its competitive impact on conventional medical practice.

In the thesis we have attempted to address the reasons for the CHC's lack of success, and to that end we initially proposed that three "actors" - the social movement, the medical profession, and the state - must be closely examined. Throughout the study we have sought to determine the relationship between these three actors and the CHC's success.

The historical approach undertaken in Chapters I and II led us to the state as the central actor in determining the community health centre's existence. The state has become increasingly involved in the health care sector, beginning with simple grants for hospital construction, continuing to state insurance for hospital care, and on to the provision of a more comprehensive insurance package that includes primary health care. Although the state does not exercise its control over the day to day functioning of the health sector, it is the state that now has the ultimate say over funding decisions and other matters concerning the organization of health care delivery. For this

reason, understanding the present status of the CHC alternative necessarily involves the development of a theory of the state and the health sector. Two theoretical paradigms were presented as conceptual tools to aid in developing an understanding of the state's role. These theories - the elitist approach of Robert Alford and the marxist approach of Vicente Navarro - have pointed us in two rather different directions in seeking an understanding of the state's role.

Alford's approach leads us to view the interest in alternative health organizations as a product of the growth of a challenging "structural interest group", a technocratic elite, that attempts to gain control over the medical sector. It does so by convincing the government that a state of crisis exists in the health sector that must be addressed through radical reorganization, which really means the transfer of power from the medical elite to the technocratic elite. Health alternatives such as the community health centre are part of the proposed reorganization package, although the challenging interests have no real commitment to increased community control, but only see it as a means to attract diffuse support for their goals.

The failure of alternative approaches to health results from the unequal positions of power of the structural interests. Challenging and repressed structural interests are at a disadvantage, in light of the history of professional strength and autonomy of the dominant medical profession. The pervasive

infiltration of dominant structural interests in the administrative apparatuses of the health sector, and their close links with government maintain their understanding or model of health care and illness as an "official" understanding. This is in spite of the cries of "crisis" from challenging interests and the protestations from repressed interests, in this case, the community health centre movement.

This approach would seem to provide a good description of kinds of changes taking place in the health sector in the early 1970s, and especially in Quebec, where the technocratic elite was able to gain an electoral mandate and thus implement its reforms as official government policy. However, in this study we have seen that the state had genuine reason to fear an economic crisis in the health sector. State interest in alternative forms of primary care, and radical reforms of the entire health sector, coincide with periods of rapidly increasing health costs. For this reason, we must turn to our second theoretical paradigm.

The neo-marxist approach leads us to a much different analysis of the lack of success of challenging alternatives in the health sector. According to this approach, medical care is dominated by a certain understanding of health and illness, an understanding that is rooted first and foremost in the class basis of the capitalist mode of production. The nature of the state in capitalist society is one that is protective of the long-term interests of capital. The present health system

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conceals the true causes of illness and lays blame on the individual by stressing a very biologically-oriented understanding of illness. To embrace an alternative conceptual understanding of health and illness would be to undermine the dominant position of capitalism and the capitalist state. To stress the importance of social and economic causal factors of illness (as opposed to individual and organic ones) would be to expose the state to a crisis, for the prognoses and prescriptions for health would have to involve the addressing of these social, economic, and environmental issues.

Both of the approaches outlined above offer important insights into the study at hand. However, the difficulties one faces in reconciling the two bodies of theory are somewhat problematic, for the elitist/marxist debate is one which is not being carried out on common ground. The variants of elitist theory are very much micro-level analyses - they look for the most part at individual and group level actions and decisions. The marxist approach to health is very much a macro-level analysis. The roles of individuals and interest groups are not as important as class issues and the overall nature of the capitalist state.

This author feels that the study of the health sector in Canada, and the attempt to explain the relative failure of challenging alternatives, must by necessity involve both macro and micro-level analyses. Both are important in explaining the

phenomenon. Neither approach is alone sufficient in addressing a very complex problem. An understanding of the state's role must be broad enough to take into account the economic reasons underlying it, as well as the ideological and the political reasons. Unfortunately, there does not seem to be much evidence of theories that attempt to bridge the chasm between the macro-level and micro-level approaches. In this sense, it is important to echo Ham's (1982) emphasis of the need to develop a "mediating framework" between the approaches.

This study has provided an exploratory look at one specific alternative to the conventional health care model. The insights it has provided open avenues of further research into the factors influencing the state's decision to support or not to support certain reforms in the health sector. Comparative studies between the state's approach to health sector reform in Canada and in other countries could lead to a further understanding of what factors are important in prompting more sustained state support for alternatives that challenge the accepted medical model.

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APPENDIX A
Persons Interviewed

Maija Kagiš, Sandy Hill Health Centre, Ottawa.	Jan. 31, 1985
Wayne Edgar, Centretown Community Resource Centre	Sept. 6, 1985
Dr. Ralph Sutherland, University of Ottawa	Sept. 9, 1985
Mark McGuire, Association of Ontario Health Centres, Toronto	Sept. 19, 1985
David Brindle, Community Health Programs Branch, Ontario Ministry of Health, Toronto	May 27, 1985

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