

A Big Job, Getting Bigger

In our ever-growing health care agenda, the community is one actor that just won't go away

BY DON MCNAIR

In matters of health care, “community control” concerns the degree to which residents of a town or neighbourhood who have no medical training determine which services are available there to get people well or keep them well, how those services are delivered, and how effective they are.

Community control didn't use to be an issue in Canada. Before 1850, communities controlled the health care experienced by most of the peoples in what was then British North America. By and large, what a person's family, friends, neighbours – and their ancestors – knew, believed, and did about health defined the care he or she received, for good or for ill.

About 20 events and decisions (summarized here) have reshaped that primacy, often to erode it. Epidemic has been the most frequent driver of change. The presence or fear of widespread, deadly disease has spurred dissatisfaction with current services and elevated new champions of health care: charitable organizations, the medical profession, government, and private business. Each has offered something that others did not provide, or did not provide well, whether in terms of diagnosis, enforcement, finance, research, or the range of health care itself.

In the last two or three generations this multiplicity of rivals has reduced towns and neighbourhoods to a very small role indeed in their health care. That is new. But that too cannot last. It just isn't healthy.

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Successive outbreaks of smallpox, dysentery, and diphtheria in the 1630s halve the population of the Wendat (Huron) north of the St. Lawrence River. When ritual, holy objects, and sweat baths fail to cure the diseases, panic and despair set in – and suspicion of the French newcomers. The French, in turn, believe their Aboriginal allies abandon sick family members out of hard-heartedness. To minister to the sick, Ursuline Nuns open the Hôtel-Dieu, Canada's first hospital, in a warehouse near Québec in 1639.

For the next 200 years charitable organizations will follow this example, establishing and managing hospitals on the basis of private and public bequests. The hospitals' primary function is to offer refuge to the incurable or to the indigent. Atypically, one of the most prominent nursing orders, the Grey Nuns (Sisters of Charity), will draw most of its revenue for many years from a brewery and cartage business.¹



Grey Nuns at the Roman Catholic Mission and Hospital in Igluligaarjuk, Nunavut, 1935. Credit: D.L. McKeand. Collection of Library and Archives Canada, Access Number 1974-366 NPC.

The Hôpital général de Montréal “was soon filled to capacity, sheltering the elderly, orphans, prostitutes, the mentally ill, physically handicapped, chronically ill & abandoned infants.”²

¹ Historic Trauma and Aboriginal Healing (The Aboriginal Healing Foundation Research Series; Ottawa: Aboriginal Healing Foundation, 2004), pp. 30-32. Jean-Claude Martin, “Hospital,” *Canadian Encyclopedia*, Ed. James H. Marsh, Vol. 2 (Edmonton: Hurtig, 1985), pp. 833-34. Phyllis Marie Jensen, “Nursing,” *Canadian Encyclopedia*, *op. cit.*, p. 1303.

² Soeurs Grises de Montréal, “Bref historique Marguerite d’Youville, fondatrice.” June 25, 2007 <<http://www.sgm.qc.ca/sgm/francais/frameset.htm>>.

“Under the supervision of the six medical practitioners comprising the Board of Health ... together with a committee of Health Wardens consisting of the stipendiary magistrates & local merchants, new drains were made, old drains were cleaned, & scavengers were hired to collect the night-soil from homes, residents being forbidden to throw any garbage into the streets.”

Public health measures to counter cholera in St. John's, Newfoundland, 1854³

During epidemics of cholera and typhus in the mid-1800s, Toronto, St. John's, Montréal, and other towns appoint boards of local citizens to enforce quarantine and sanitation regulations. While the boards, like the regulations, are emergency measures, there is a growing awareness of how waste disposal, water quality, nutrition, and living conditions affect the health of whole communities, and are therefore issues of public health. Ontario's Public Health Act (1884) is the first in Canada to oblige municipalities to elect health boards and appoint medical staff to control virulent disease and enforce minimum standards of sanitation. By the turn of the century, there are 800 boards in the province. Their range of activities extends to immunization, pasteurization, the control of venereal diseases, maternal and child health, and occupational hazards. Some general practitioners protest that family practice is suffering on account of salaried public health physicians and nurses.

In 1916, Saskatchewan permits rural municipalities to band together as Union Hospital Districts with the power to levy taxes for purposes of building and operating hospitals. In the same year municipal councils are empowered to contract for local medical (i.e., doctor) services in return for a salary or fee-for-service. Provincial medical societies are prepared to tolerate the latter Municipal Doctor System in areas where private practice is “no longer viable.” In fact, some doctors are ready to work under layperson management in exchange for the security of income. Within 20 years, the Municipal Doctor System has extended to a range of preventive and curative services as well as specialties, and finds adherents across the Prairies.⁵

“... a few words of advice to those persons who are led, by economical considerations, to attempt the cure of slight ... illnesses, without the attendance of a qualified medical man. If you think the case does not require such attendance, do nothing at all ... then, if the patient becomes worse & you send for a surgeon, you have at least the satisfaction of knowing that the disease has not been increased by rash or improper physicking.” Dr. Robert Hall Bakewell, 1857⁷

In 1918-19, soldiers returning from Europe introduce Spanish Influenza to Canada, killing 50,000 – nearly as many Canadians as died in action. The crush of patients wholly overtakes private and charitable medical and hospital services. Volunteers organize infirmaries (and orphanages) in schools, hotels, and university residences. Under the terms of Confederation in 1867, health services are a provincial responsibility. Spurred by the public health crisis, the federal government now draws together powers from, among others, the ministries of Agriculture, Immigration, Trade, and the Fisheries to create a national Department of Health. It is a minor portfolio concerned with food and drug standards, marine hospitals, statistics, and child care instruction, as well as infectious disease control. Like doctors and hospitals, most of its records are written or typed papers, stored where the data was first collected, or transmitted by post. This will apply throughout Canada's health sector into the next century.⁶

³ Melvin Baker, “Disease and Public Health Measures in St. John's, Newfoundland, 1832-1855,” *Newfoundland Quarterly*, 78,4 (Spring 1983): 28.

⁴ David Naylor et al., *Learning from SARS: Renewal of Public Health in Canada* (Ottawa: Health Canada, 2003), p. 44-45. Janice Dickin McGinnis, “Public Health,” *Canadian Encyclopedia*, op. cit., Vol 3, pp. 1507-08. Anne Crichton et al, *Health Care: A Community Concern? Developments in the Organization of Canadian Health Services* (Calgary: University of Calgary Press, 1997), p. 118.

⁵ Aleck Ostry, “The Roots of North America's First Comprehensive Public Health Insurance System,” *Hygiea Internationalis*, 2,1 (2002):26-31. Gordon S. Lawson, “Municipal Doctor System,” *The Encyclopedia of Saskatchewan*, 25 June 2007 <http://esask.uregina.ca/entry/municipal_doctor_system.html>.

⁶ McGinnis, *ibid*.

⁷ Dr. Robert Hall Bakewell, *Practical Hints on the Management of the Sick-Room* (1857), pp. 6-7.



In a working class neighbourhood of Québec City during World War II Dr. Jacques Tremblay develops a concept of co-operative medicine: a practice based on teams of specialists, preventive care, periodic payment, and member control of management. This is the basis of the *Coopérative de santé de Québec* (1944) whose members' annual fee of \$5 and monthly dues of \$3 cover consultation costs only. Enlarged within two years to become the *Services de santé du Québec* the co-op can offer group insurance coverage of surgical and hospital expenses across Québec.¹⁰

(left) The final stages of penicillin processing prior shipment from the Connaught Laboratory, Toronto, 1944. Credit: Harry Rowed, National Film Board. Collection of Library and Archives Canada, Access Number 1971-271 NPC.

In the 1920s and 1930s the discovery of diphtheria and tetanus toxoids and a tuberculosis vaccine, and their subsequent mass-manufacture, advance medical laboratories and the pharmaceutical industry to the forefront of preventive medicine. By 1950, the diminishing threat of infectious disease will also permit medical ingenuity to focus instead on surgical and medical technology and on the solution to chronic, non-communicable diseases. Over the years 1920-60, life expectancy of Canadian women climbs from 61 to 74, of men from 59 to 68. In the public imagination most of the credit for this achievement goes to the health care provided to individuals by medical professionals in a clinic or hospital, not to better standards in working conditions, in public hygiene, or in nutrition.⁸

The star of professional medicine may be rising, but citizens' ability to pay for it falls off dramatically in the years 1929-39. The Great Depression leaves physicians, municipalities, religious orders, and charitable organizations hard pressed to care for the impoverished. Medical bills are often paid in kind or not at all. In 1938, Saskatchewan permits 10 or more people to form nonprofit "benefit associations" that can use membership fees to pay for the services of doctors working under contract. The province's physicians resist these consumer-sponsored plans; the public, too, is far more supportive of medical insurance that doctors or medical societies initiate and control.⁹

(below) One of the oldest approaches to local health insurance was the "Check-Off System." It reduced the pay packet of an employee or member to create pools of funds for a variety of purposes, including health. According to this receipt, deductions of 40 cents and 30 cents from the weekly pay of a Dominion Coal Company miner in Sydney, Nova Scotia were to cover possible doctor and hospital expenses.¹¹

DOMINION COAL CO., LTD.	
DOMINION NO. 10 COLLIERY FORM NO. 17	
NO. 782	PAY ENDING 1936
NAME	
DAYS	
TONS	
TONS	
YARDS	
TIMBER & CONSIDERATION	
LESS HELP	
TOTAL EARNINGS	
SUPPLIES	
RENT	
COAL	
TRUCKAGE	
WATER	
SANITATION	
POLL TAX	
CHECKWEIGHMAN	
DOCTOR	2.00
UNION DUES	
RELIEF ASSOCIATION	40
CHURCH	30
HOSPITAL	30
CASH ADVANCED	
BALANCE PAYABLE	20.15

⁸ Naylor, *ibid.* McGinnis, *ibid.* Statistics Canada, "Life expectancy at birth, by sex, by province," 25 June 2007 <<http://www40.statcan.ca/101/cst01/health26.htm>>.

⁹ Gordon S. Lawson, "Consumer and Doctor-Sponsored Medical Care Associations," *Encyclopedia of Saskatchewan*. 25 June 2007 <http://esask.uregina.ca/entry/consumer_and_doctor-sponsored_medical_care_associations.html>.

¹⁰ Jean-Pierre Girard, *Notre système de santé, autrement : L'engagement citoyen par les coopératives* (Montréal: Éditions BLG, 2006), pp. 42-45.

¹¹ "The Check-Off: A precursor of medicare in Canada?" — Reprinted from CMAJ 06-Dec-05; 173(12), Page(s) 1504-1506 by permission of the publisher © 2005 Canadian Medical Association.

9 In 1946, Saskatchewan's Swift Current Health Region launches a publicly-funded hospital and medical care program that integrates doctor services, hospitalization, children's dental care, and a public health service at an annual cost under \$20 per person. (An earlier experiment in universal health care insurance in the same area, the "Matt Anderson Plan," had faltered because of its inclusion of prescription drugs and its confinement to the municipal level.) Originally, the provincial government had intended Swift Current as a modest demonstration of publicly-funded preventive medicine. It "got away on them" due to determined local champions and public enthusiasm. A polio epidemic may well have bankrupted the region, nevertheless, were it not for the rapid and efficient introduction of province-wide insurance of in-patient hospital expenses in 1947. In order to ensure public "buy-in" to this Hospital Services Plan, only 40% of its costs come out of general revenues; the rest is covered by a \$5 per person premium, collected on commission by municipalities. The Health Region's doctors will soon discover that a rising demand for their services may not boost their income, however. If higher taxes are impolitic (due to a bad harvest, for example), the health budget remains frozen.¹²



Doctors and their supporters protest Saskatchewan's implementation of Medicare, July 11, 1962. Saskatchewan Archives Board R-A12109-4.

9 British Columbia and other provinces begin to follow Saskatchewan's example of hospital insurance, but public pressure for a national plan is growing. With the signing of the Hospital Insurance and Diagnostic Services Act (1957), the federal government offers to cover 55% of the costs of provincial hospital insurance plans that cover 99% of the population for standard ward care. By 1961, all provinces have conforming hospital insurance plans. (In a major move towards secularization, Québec's *Loi des hôpitaux* replaces religious orders with independent corporations to administer hospitals.) This action, on top of the National Health Grant Program (1948), which made millions of dollars available to the provinces for hospital construction, announces the federal government's determination to play a pivotal role in national health care delivery, and to focus on hospital care and diagnostic services – the most expensive health care services.¹³

10 While supportive of publicly-funded hospital insurance, an increasing number of Saskatchewan's doctors oppose a "single-payer" system of universal medical and hospital care, in which government is the sole billing party and sets the fee and service schedule. Most withdraw all but emergency medical services in July 1962 in protest over the draft legislation for such a system, "Medicare." The public outcry is immense. Many citizens form "Keep Our Doctors" committees to back the strike; many others dust off their right to form benefit associations ("community health associations"), hire doctors, and organize their own health services. After three weeks, the doctors and the government settle. Physicians accept a plan that enshrines private practice by permitting them to bill patients directly, and at rates higher than what the province will cover. Community health associations are confined to acting as landlords for medical practice. An association in Regina is one of the few to press on, committed to the concept of "community clinics" that integrate a variety of medical practices with one another, with social services, and with guidance from local residents.¹⁴

¹² Maureen Mathews, "Swift Current Health Region," *The Encyclopedia of Saskatchewan*. 25 June 2007 <http://esask.uregina.ca/entry/swift_current_health_region.html>.

C. Stuart Houston, "Hospital Services Plan," *ibid.* 25 June 2007 <http://esask.uregina.ca/entry/hospital_services_plan.html>.

G. Gordon Ferguson, "Medical Economics: The Swift Current Health Region," *Canadian Medical Association Journal*, vol. 62 (February 1950), 195-96.

¹³ Marilyn Dunlop, "Health Policy," *The Canadian Encyclopedia*, *op. cit.*, Vol. 2, p. 801.

¹⁴ Gregory P. Marchildon, "Doctors' Strike," *The Encyclopedia of Saskatchewan*. 25 June 2007 <http://esask.uregina.ca/entry/doctors_strike.html>.

Robert S. Reid, *More Than Medicare* (Regina: Community Health Services Association, 1988), pp. 3-24.

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The report of the Royal Commission on Health Services by Justice Emmett Hall (1964) recommends that Ottawa follow Saskatchewan's lead, and create a national insurance plan that covers the costs of medical services as well as hospital care, but also prescription drugs and some services provided in the home. The federal government is willing to go part way. Under the terms of the Medical Care Act (1966) it offers to share half the costs of provincial medical and hospital insurance plans that are 1) accessible, 2) universal, 3) portable, 4) comprehensive (of a specified range of medically-necessary services), and 5) publicly administered on a nonprofit basis. By 1971, all provinces have completed plans that comply with the terms of this national Medicare program. The differences in detail are great, but in their similarities these provincial plans create the sense of a national health system. Practically all expenditures for physicians and for hospital care are paid by government, financed through compulsory premiums or general revenues. Private means figure much higher in the payment of dental, chronic care, and pharmaceutical costs. All provinces rely almost exclusively on the nonprofit or private sectors – hospital corporations and physicians working in solo practice – to provide services.¹⁵

(photo) Originally established in 1926 to provide health care to Jewish immigrants in Winnipeg's North End, Mount Carmel Clinic evolved into the first community health clinic in Canada in response to the changing demographics of the community. Anne Ross (seated centre) intuitively understood in the 1950's that the health of an individual went beyond physical health. The Clinic played an advocacy role and provided such services as counselling and child care. Photo courtesy of Dee Dee Rizzo.

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In the late 1960s, a spirit of social revolution finds expression in the establishment of community clinics in working class districts of Montréal. The Saint-Henri Health Co-operative, for one, is co-owned and -managed by consumers and producers (i.e., medical professionals). Its revenue comes from monthly member fees, billings to the provincial health insurance plan, charitable grants, and government-funded employment programs run by the co-op.

Inspired by these examples, the Report of the Castonguay-Nepveu Commission (1970) recommends a network of publicly-owned health centres to serve as Quebec's system of primary health care. Unlike the doctors and hospitals, these *Centres locaux de services communautaires* (CLSCs) will emphasize preventive and multidisciplinary medical practice, the living conditions that favour good health, and building the capacity of local citizens and professionals to design and manage the system.

Over the next 20 years, the CLSC network will absorb the community clinics, but its growth will be dogged by the demands of the democratic model and insufficient government funding. Private practice is far more attractive to doctors than salaried, government positions. CLSC numbers peak at 166, well short of the projected 210. They are on the periphery of a system of primary health care for which private clinics form the mainstay.¹⁶



¹⁵ Marilyn Dunlop, *ibid.* Raisa Deber, "Health Care Reform: Lessons from Canada," *American Journal of Public Health*, 93,1 (January 2003): 20-24. In 2001, about 70% of Canadian health expenditures were met by public funds, making it one of the least publicly financed national health systems among industrialized countries. ¹⁶ Girard, *op. cit.*, pp. 28, 55, 59.

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In 1971, alarmed by the rising costs of Medicare, Ottawa commissions the Community Health Centre Project under Dr. John Hastings. His report the following year calls for the provinces to develop a “significant number of community health centres ... as non-profit corporate bodies in a fully-integrated health services system.” A smaller, cheaper, more convenient alternative to hospitals for out-patients, the centres, unlike private clinics, will offer multidisciplinary care. Close to the “real world,” the centres will also be better places than hospitals to train general practitioners. One prominent example of this model is REACH clinic, in Vancouver’s East End, an area heavily populated by immigrants from Italy and China. Launched by Dr. Roger Tonkin in 1969 in response to a request from the neighbourhood, REACH is a nonprofit association run by a board of doctors and residents. Provincial insurance billings cover the salaries of four doctors, a registered nurse, and a nutritionist; a Local Initiatives Program grant pays for a free preventive dental service, nurse practitioners, and a community project co-ordinator. Like Québec, Ontario will make great efforts to develop this model of primary health care over the coming generation. Its preventive approach is found to lower hospital use and drug expenses. Its tendency to act as a public advocate can make it a political nuisance, however. Doctors also oppose salaried employment and the replacement of their services with those of nurses and other, less costly practitioners.¹⁷

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The Medicare funding formula is revised in 1977. By matching a federal dollar for every dollar spent provincially on many doctor and hospital costs, the original arrangement is found to give the provinces a lot of control over the national health budget, but little room to explore health care beyond Medicare’s “service floor.” To correct this, the Established Programs Financing Act transfers some taxation authority from Ottawa to the provinces and introduces a block grant for “extended health services.”

This arrangement gives the provinces more power over how they spend money, in health care and in other matters. It also enables Ottawa to adjust the transfer of tax dollars to suit other agendas – like fighting a growing national deficit. In response to changes to the transfer formula in 1982, 1986, 1989, and 1991 – and to serve their own interests in lower taxes – provinces will make drastic cuts to hospital and public health budgets. They will also use regional health authorities to eliminate redundant, under-used services, or other apparent inefficiencies in health care delivery.

If and how Medicare is to be made affordable will remain a point of fierce public debate for a generation and the basis for numerous national and provincial reports, including two Royal Commissions. The one point on which all agree is that Canada’s health care providers must strive to fulfill specific, measurable objectives and standards and become accountable for the actual results of care. However short of money the system is, it desperately lacks clarity in its many purposes and evidence of their achievement.¹⁸

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*The Regina Health Services Association sought to establish “a group practice clinic in which the membership could work together with doctors to provide a comprehensive range of social, medical & welfare services. While the doctors would retain autonomy in the clinic on medical matters, the membership could provide invaluable assistance in the social & welfare fields.”*²⁰

In the 1970s, the (uninsured) administrative costs of medical practice go up, while the fee schedule for insured services does not. Many medical professionals start to use extra-billing and user fees, or “balance billing,” to make up the difference. Parliament passes the Canada Health Act in 1984 to reaffirm the five principles of Medicare and to stipulate that balance billing runs counter to the principle of accessibility. The federal government will reduce cash transfers to provinces that permit these practices, dollar for dollar. This legislation both enshrines and entrenches the schedule of insured medical and hospital services; creativity in health care delivery will have to take place elsewhere.¹⁹

¹⁷ Peter Thompson, “Hospitals Without Walls,” *UBC Reports*, 19,7 (March 29, 1973): 4, 9-11.

Sari Tudiver, Ph.D and Madelyn Hall, “Women and Health Care Delivery In Canada,” Canada-U.S.A. Women’s Health Forum: Commissioned Papers (Ottawa: Health Canada, July 1996), pp. 20-21.

¹⁸ Michael Rachlis, *Prescription for Excellence: How Innovation is Saving Canada’s Health Care System* (Toronto: HarperCollins, 2004), p. 34-35.

Deber, “Health Care Reform,” *op. cit.*, 4-5. Jean-Louis Denis et al, “Templates and Pilots in the Framing of Public Sector Reform,” Working Paper presented at EGOS 2003, Copenhagen, p. 10.

¹⁹ Patricia M. Baranek, Raisa B. Deber, A. Paul Williams, *Almost Home: Reforming Home and Community Care in Ontario* (University of Toronto Press, 2004), p. 7.

²⁰ Robert S. Reid, *op. cit.*, p.15.

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At a conference entitled “Beyond Health Care” held in Toronto in 1984 Drs. Trevor Hancock and Leonard Duhal argue that health is less about medical care than about a person’s access to food, shelter, transportation, clean air and water, education, physical safety, and good jobs. These “social determinants of health” are what define the Healthy City or Healthy Community. This is the basis for a World Health Organization movement by that name that within 20 years will include hundreds of cities and towns across Canada. In places like Parksville, B.C. Healthy Communities means a city-wide process to define common values to guide local planning. Elsewhere, Healthy Communities is limited to the promotion of wise decisions about diet, exercise, and other aspects of personal lifestyle.²¹

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In the 1980s, a seismic shift commences in the health sector. First, hospital and medical care for the elderly comes to be understood as a major factor in rising health care costs, one certain to carry still more weight as Canada’s population ages. Second, there is a growing conviction that a range of health and support services, provided long-term to seniors right in their homes or in home-like settings, improves their quality of life and postpones institutional care. Finally, new computer and telecommunications technology make it possible to decentralize quality care.

As a result, while closing hospitals and nursing homes in the 1980s and 1990s, provinces introduce a battery of publicly-funded programs to encourage nonprofit and for-profit contractors to

offer housing, supervision, transportation, home-making, and companionship to seniors and the infirm closer to home. As extended health services, this home care is subject to provincial means and politics, not to Medicare.

The sector balloons. By 2001, it commands \$3.5 billion in annual expenditures (77% of that public spending), over ten times the 1981 figure. The growth is greatest in Québec after 1996, when the government promotes an array of small-scale economic initiatives as part of an anti-poverty strategy. In 2002-03, 103 home care enterprises (42 of them co-ops) do \$91.7 million in business and employ 6,000 Québécois, half of them full time.²²

Women’s health clinics and collectives blossomed across Canada in the 1970s and 80s. They challenged the authority of medical professionals in women’s lives and the exclusion of political, social, and environmental factors from issues of personal health. (Photo) Members of the Women Healthsharing Collective, Toronto, 1982. Photo courtesy of Anne Rochon Ford.



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In 1992, the physician in the village of St-Étienne-des-Grès, QC, retires. Neither a public nor private clinic will take his place, so three years later 1,000 residents finally establish a consumer co-op to supply their health services. They buy shares at \$50-\$250. With that capital, a generous mortgage from the credit union, and a municipal tax holiday on some land, the co-op builds a 10,000 sq. ft. office and attracts a variety of medical professionals as tenants. It branches out to hire a physiotherapist and manage a long-term residential care facility. Originally a consumer co-op, the *Coopérative des services de santé Les Grès* will later change its status to that of a “solidarity co-operative,” recognized by Québec in 1997 as a way for consumers, producers, and other stakeholders to share ownership and direction. By 2001, over 60 health care co-ops will be operating in Québec.²³

²¹ Trevor Hancock, “Healthy Cities and Communities: Past, Present, and Future.” 25 June 2007 < <http://www.scahec.net/courses/PH%20Modules/Mod4Hancock.pdf>>.

²² Baranek et al, *op. cit.*, pp. 3-11, 15, 300-305. Roy Romanow, *Building on Values: The Future of Health Care in Canada* (Ottawa, 2002), pp. 174-75. Girard, *op. cit.*, pp. 66-68.

²³ Girard, *op. cit.*, pp. 62-63, 85-95.



To combat an alarming incidence of infectious disease, family violence, and drug abuse in the province's Aboriginal population, Ontario establishes Aboriginal Health Access Centres (AHACs) in 1997. Like community health centres, AHACs are nonprofits that provide publicly-insured health services. Unlike them, AHACs supplement clinical care, health promotion, and disease prevention with care from traditional healers and elders. (photo left) As a provider of HIV/AIDS-related services in Ottawa, the Wabano Centre for Aboriginal Health is a major supporter of the annual AIDS Walk for Life. Credit: Wabano Centre.

In June 2000, the absence of government oversight in the testing of Walkerton, Ontario's water supply is partly responsible for a bacterial infection that leaves 2300 residents sick and seven dead. Two years later, an outbreak of the SARS virus in Toronto is fatal to 44 of hundreds of victims. These tragedies, plus the transmission of West Nile virus and BSE and the sustained threat from HIV, reveal the dangers of public health systems that do not communicate across jurisdictions, and that have been short-changed in favour of personal health services. The stage is set for renewed federal investment in the health systems of the provinces and territories, and the country as a whole.

A national public health agency is established in 2004. Additional funds are also allocated to Canada Health Infoway, a nonprofit corporation created in 2000 to coax from the health sector innovations in the keeping of electronic health records (EHR). The aim is to guide the growth of a seamless network for nation-wide transmission of health records for use in labs, clinics, hospitals, and on the phone. Unfortunately, physicians are unlikely to switch to this new system if the fee schedule does not cover its cost.²⁴

²⁴ Naylor, *op. cit.* pp. 211-212. Canada Health Infoway, "EHR 2015: Advancing Canada's Next Generation of Health Care," p. 2-6. 25 June 2007 <http://www.infoway-inforoute.ca/en/pdf/Vision_2015_Advancing_Canadas_next_generation_of_healthcare.pdf>.

²⁵ B.C. Ministry of Health, "Tripartite First Nations Health Plan," 25 June 2007 <http://www.healthservices.gov.bc.ca/cpa/mediasite/pdf/tripartite_plan.pdf>.

In Vancouver, June 2007, leaders of First Nations and both provincial and federal health ministers sign a 10-year agreement to bridge the gulf between the health of Aboriginal people and other British Columbians: seven years less life expectancy, 40% higher incidence of diabetes, and four times the need for dental day surgery, for example. Dozens of clinics and centres are already active in Aboriginal communities, and funded through a complex mixture of federal and provincial programs. The Tripartite First Nations Health Plan (Canada's first) will co-ordinate these programs, bring greater Aboriginal authority to the planning, delivery, and monitoring of health services, and make them more accountable for results. Health Canada, for its part, "... will continue to evolve its role from that of a designer and deliverer ... to that of funder and governance partner ..." of health services designed and delivered primarily by First Nations and their health organizations.²⁵

Over the past 350 years, communities, then charities, the medical profession, government at all levels, and business – each in its own way has claimed for itself some special authority in the health of Canadians. What had been good enough health and health care at one time and place were no longer. A new "actor" had to step forward to set things right.

Yet our understanding of health and ill-health, our expectations for quality of life, and our ability to counteract disease and injury have continued to spiral upward – overwhelming the capacity of each new claimant to deliver. The time appears ripe for the claimants to recognize that they each (or even two or three of them) are incapable of keeping Canadians healthy. The health system of the future will rest on a division of responsibilities between all of them, but with a substantial portion assigned to the people who actually want and need the care, in the places where they live.



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