

Week 2 Sept 21: The Canadian Health Care System II (ch. 11)

LECTURE

? Video Notes:

- Poverty = poor health / rich = better health
- The more money the healthier
- Forces that influence health
 - housing
 - family
 - education
 - job
 - social networks
- The choices we make influence the choices we have
- Affordable housing, diversity, early childhood development -> invest to create better health.
- Clean safe affordable housing, job security
- improve community health to create better health.

Lecture Notes

From week one slide:

- Food labels are small - main reason is because of the french translations
 - Causes hard to read warnings which increases risks of illnesses
- Will be good if NDP focused on pharmaceuticals
- 4% increase in food banks
 - Research - ppl who use food banks are stressed out with the amount of forms etc.
 - This is an incredible health issue
 - This is not seen as a health issue for some reason
 - (The article in week 1 slide)
- Poverty is a bigger factor to poor health than smoking.

From week 2 slides (00:20:00)

- Health care system came about - one things that displays healthcare, childcare, tuition, public transportation is the liberalism vs socialism. 22:44
- **Liberalism:** Free market to society. "From the political science literature a belief in certain aspects that associated with english governments (UK, Canada, US)
 - and it's a political philosophy that the way it plays out is with the emphasis on:
Box 11.1 "
 - *Personal freedom:* Absence of coercion; individuals can pursue their own interests.



- Social Democratic = planned economy / Liberal = Market economy
- **Box 11.4** - The government needs to step in and manage the pharmaceutical privatization. This will avoid over pricing when a company has THE only pill to stop one from dying per se.

Video Lecture notes:

- The Co-operative Commonwealth Federation (CCF) was forerunner of NDP (created in 1962) and was the first socialist government elected in North America (1944).
- Tommy Douglas - a Baptist Minister - was premier during this time period & NDP
- Tommy Douglas gave up being a Baptist Minister to go into politics because he couldn't do both - in Saskatchewan
- Previously he was a CCF member of Parliament in Ottawa
- Later went on to be first leader of the federal NDP
- 1975 he was member of parliament
- 1959 - Tommy Douglas took medicare national
- 1962 = doctor's strike
- 1984 = Health Act passed

Lecture resume:

- 2 Specific provisions of the health act: User Charges & Extra-billing
- 2 Conditions: (1) Provincial government required to provide annual estimates and statements on extra billing and user charges, and, (2) provide voluntary and annual statement describing the operation of their plans.
- Anything that takes place in a hospital is covered (ex. surgical dental work), but once outside of the hospital settings, it is not covered (ex. Fillings for a tooth).

--REFER TO THE LAST SLIDE FOR A SET OF QUESTION--

Week 3 Sept 28: Different Approaches to Health (ch. 1)
(started with last week's slides)

- Health has different definitions. WHO "state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."
- 4 broad concepts of health that lead to different definitions of problems, different strategies, different target groups and different people responsible for the activities of promoting health:
 - Medical approach (Traditional) - Biomedical
 - Behavioural (Lifestyle)
 - Socio-Environment (Societal)
 - Political Economy (structural-Critical)

Medical Approach

- **Health concept** is biomedical, absence of disease and or disability.
- **Leading Health problems:** defined in terms of disease categories and physiological risk factors such as physiological deviation from the norm: CVD, AIDS, Diabetes, obesity, arthritis, mental disease, hypertension, etc.
- **Principal Strategies:** Surgical interventions, drug and other therapies, health care medically managed health behaviour change (diet, exercise, patient education, patient compliance), screening for physiological and genetic risk factors.
- **Target:** Focus on people in high risk (babies, old people, ppl in bad neighbourhood)
- **General Approach:** Individualized
- **Actors** (people who are in charge): Physicians, nurses, allied health workers.
- This is where most money goes

Behaviour Approach (lifestyle)

- Assumption that ppl made their state of health choice
- **Health concept:** is individualized, health as energy, functional ability, disease-preventing lifestyles
- **Leading Health problems:** defined in terms of behavioural risk factors: smoking, poor eating habits, lack of fitness, drug abuse, alcohol abuse, poor stress coping, lack of life-skills, etc.
- **Principal Strategies:** health education, social marketing, advocacy for public policies supporting lifestyle choices (e.g. smoking bans, low fat meat production, bicycle paths, ad bans)
- **Target:** high risk groups, children and youth
- **General Approach:** individualized, elements of societal focus as related to public policy
- **Actors:** public health workers, illness-related advocacy groups (e.g., Cancer Society), governments

Socio-Environment (Societal)

- Not your fault/body - it's the environment.
- **Health concept:** is a positive state defined in connectedness to one's family/ friends/ community, being in control, ability to do things that are important or have meaning, community and societal structures supporting human development
- **Leading Health problems:** defined in terms of psychosocial risk factors and socio-environmental risk conditions: poverty, income gap, isolation, powerlessness, pollution, stressful environments, hazardous living and working conditions, etc.
- **Principal Strategies:** small group development, community development (when community can get together to improve health), coalition building (groups that is more

poor = immigrants, aboriginals, refugees - everyone that “isn’t white middle class males” .), political action and advocacy, societal change

- **Target:** high risk societal conditions
- **General Approach:** societal, focussed on organization of communities and society, development of just political/economic policies
- **Actors:** citizens, social development and welfare organizations, political movements and parties

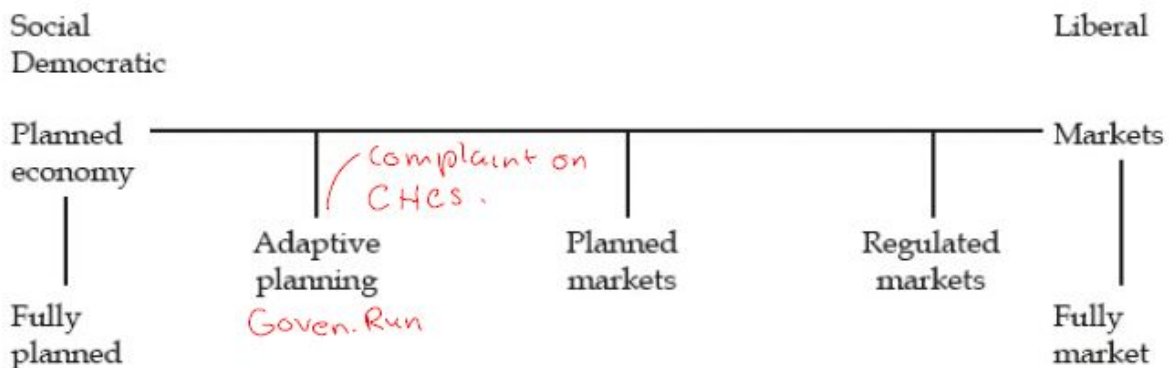
Political Economy (structural-Critical)

- **Health concept:** is related to equitable distribution of resources within a society and the organization and exercise of political and economic power by various institutions and class groupings
- **Leading Health problems:** defined in terms of inequity in the distribution and control of economic and social power. Of particular interest is dominance by the wealthy and the influence of multinational corporations over the economic and social life of a society at the expense of the health of the population.
- **Principal Strategies:** political action by organized labour and social democratic political parties, regulating business and promoting influence by labour and the general population, establishing health supporting public policies associated with the welfare state
- **Target:** influence of the wealthy and powerful
- **General Approach:** structural, focussed on the political and economic organization of society and political institutions
- **Actors:** Political movements and parties
- The essential beliefs of Positivism are:
 - Belief in an external world that exists independent of human interpretation
 - Belief that objective knowledge about the world can be acquired through direct sense experience.
 - Phenomena that cannot be observed either directly through experience or observation are excluded from what is considered by positivists to be credible knowledge.
 - “Value-free” investigation of scientific and social phenomena.
- It’s not just behaviour, it’s not just medicine, what’s the best predictor of whether you live or die? - it’s income and inequality.
- The poorer the city is, the higher the death rate

Boxes Mentioned in Lecture

Box 11.3: Planned Market Initiatives

Planned market initiatives reflect a set of conscious choices about how to introduce market-style incentives into existing allocation-based management structures. In other words, to promote efficiency, the government intercedes in a publicly insured health care system by introducing market-based tools to maximize social welfare. An example of the planned market approach is in the reforms adopted by Britain, shown below.



Planned markets: Intermediate position between command-and-control planning systems and pure market systems.

Regulated markets: State power limits certain socially disruptive behaviours that occurred previously.

Planned market: State uses select market instruments to achieve government policy objectives.

Adaptive planning: Management decentralized to regional planning bodies to enhance responsiveness to local needs. (Saltman and von Otter 1992: 16)

~~Exam~~

Box 11.4: Market Failure and Pharmaceutical Price Regulation

One reason pharmaceutical prices are regulated in Canada is due to their price inelasticity. Price inelasticity refers to the concept that the demand for them is inelastic: if the price of these products rises sharply, most people would simply pay the extra cost because they require the product for health reasons. In time of need, the decision to purchase a medicine is insensitive to the cost of the product, even when a consumer pays directly. Since price competition for patented products does not exist, which normally decreases prices to competitive levels, profit-maximizing firms will charge prices that are too high and produce output levels that are too low from the allocational point of view (Brander 1992). Since increasing the price of pharmaceuticals has little effect on their demand, consumers and the public bear the consequences of high prices (Wiktorowicz 1995). In Canada, the Patented Medicines Prices Review Board (PMPRB) regulates the prices of pharmaceuticals to ensure their accessibility to the population and to public drug benefit plans. In contrast, medicines whose patents have expired are subject to competition from generic product manufacturers, which drives down their prices. For this reason, Canada does not regulate the prices of generic products.

Tables Mentioned in Lecture

Table 11.1: International Health Care Systems: Comparing Financing and Delivery

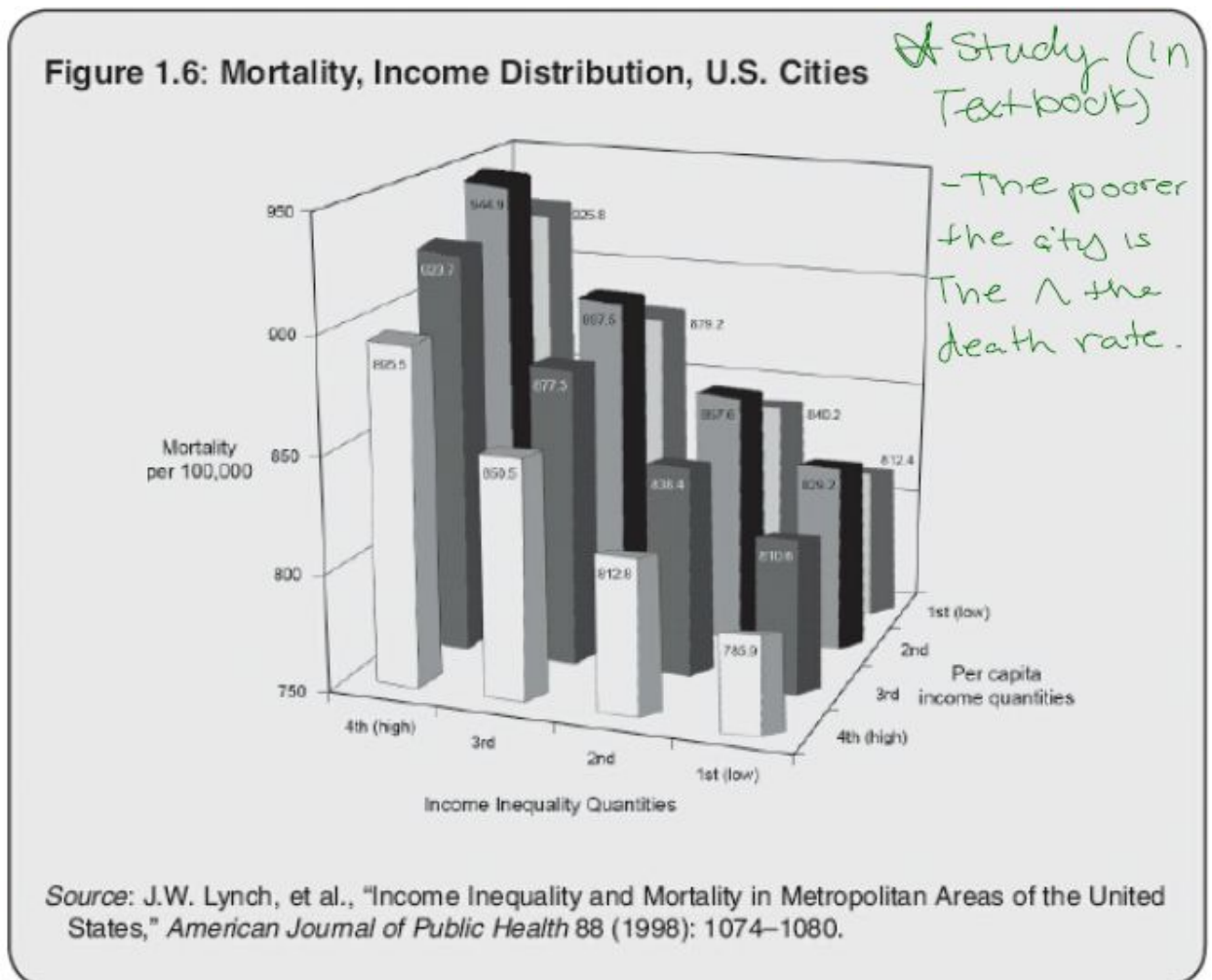
Delivery	Financing	
	Public	Private
Public	Britain, Sweden: National Health Service	—
Private	Canada, France: Public insurance system	Germany,* Netherlands, Switzerland,* U.S.: Private insurance

* Mixture of private insurance and government subsidy: government regulates and subsidizes private mutual aid societies.

Week 4 Oct 5: Sociological Perspectives (ch. 2)

starts @ last week's slide 36 - figure 1.2

- US life expectancy in 2002 was 77 age while sweden was 80 years - what about these countries → has to do with income and inequality.
- One reason why a country/jurisdiction has a big gap between the rich and poor is because of the taxes on the wealthy are lower. They also spend less on services for the ppl - The poor ppl do not have access to the services and thus morbidity rises.
- The jurisdictions in US that have the desperately poor ppl will need to spend money on law enforcement as the desperately poor get into drugs/robbery. (Slide 37 of week 2).
- Canada has a big gap between the rich and poor, sweden doesn't have much (they have childcare, dental care, pharmacare).



EXAM

- The higher up you are, the more people that die.
- From front to back - wealthiest cities to poorest cities.
- The poorer the city is, the higher the death rate.

- As you go from right to left, the inequality increases.
- At each level of income (high, low, middle), the more inequality increases, the higher the death rate.
- Thus the stronger factor is that the more inequality a jurisdiction has, the higher the death rate - rather than the income contributing to mortality.

Resume regular slides

- Epidemiologist usually do not have a theory as to why somethings causes death. More along the lines of smoking, stress.
- 9. Institutional contradiction = When companies pay minimum wage. Ex. Walmart, tim horton - when they make more money but pay employers less.

Video note: Charles Wright Mills documentary (duration 5:32)

- Charles wright mills was born on August 28 1916 in Texas.
- Went to the university of Texas for philosophy, sociology, cultural anthropology, social psychology, and economics. Then received PhD at university of wisconsin.
- 1945 @ columbia University he did a job as a research associate. Then became a professor after a year. + made books such as the sociological perspectives, white collar.
- Mills believed that America:
 - was separated in three different classes; and the upper class was in control. The other classes were made to think that their opinion were unimportant.
 - Ran on corporations & led by the white collar workers.
- The theory of power: Upper class was lead by military, political and economic leaders that provide the means to produce wealth. They recognize themselves to be separate and powerful.
- The sociological imagination: focus on comparison on social issues and personal issues.
- Died 1962 - 45 years old.
- ppl are not being provided with the tools needed to do work.

Video notes: Social Theories Overview: (Duration 4:09) + lecture notes

- **Functionalism (STABILITY)**
 - Looks at how the society can exist and survive over time
 - States that society always tries to come to an equilibrium - trying to stabilize.
 - Structures that make up the society like Institution (structures that full fills the need of society) remain constant and will only change if absolutely necessary when the society loses stability.
 - ex. Business institution that had to adapt to online shopping. Amazon taken customers thus stores had to find ways to attract the customers back.
 - Minor changes an institution makes to balance in society - only change to be constant.

- **Conflict theory (CHANGES)**
 - How society change and adapt over time through conflict.
 - Polarization occurs between disagreements and thus agreements need to be made.
 - EX. the class struggle. The workers wanted change while factory workers were fine. The solution : Workers had more power than before while the factory owners had less.
 - Therefore 2 opposing sides that result in a new society. - Conflict creating a new society.

- **Social constructionism (THINGS ARE GIVEN VALUE)**
 - Looks at what society is rather than how it exist/changes.
 - Everything is created from the minds of the society. There is an agreement that something has meaning and value.
 - Ex. Money.
 - Therefore, everything only has value because we agree it has value.

- **Symbolic Interactionism (LEARNING HOW INDIVIDUALS ACT)**
 - Focuses on the individual and how they behave
 - Based in ideas on how we give meaning to things.
 - ex. A tree can be used for shade while to another it can be used for home for spiders.
 - Not everyone has the same meanings.
 - Therefore symbolic interactionism says that we interact with the world to give it meaning.

Lecture continue...

- Canada's health care system is best explained by the **conflict theory**. There was a group of people (Tommy Douglas) that disagreed with what our society didn't go well with.
- America's civilized movement was based on **conflict theory**.
- If you are a **Functionalist** you do not see conflict.
- ex of functionalist theory: Work at a CHC from 9-5 but clients cannot make it at those times thus the CHC uses more hours. No one fights/argues
- **Conflict theory** best describes big changes. - involves movement that for example blocks traffic on road to get point across.
- **Symbolic Interactionism Symbolic Interactionism** ex. Whether sheiks will be able to join RCMP because of their turban.
- **Symbolic Interactionism** = You put meaning into certain things.
- **Functionalism** Is more conservative.

VIDEO: Functionalism (duration 5:40)

- A system of thinking based on Emile Durkheim.
- Looks @ society from a large scale perspective.
- Made up of a bunch of connected structures to help equalize society.
 - Institutions - Structures that meet the needs of society. ex. education systems, financial institutions, business, marriage, laws, mass media, medicine, religion, police forces.
 - Social Facts - Ways of thinking and acting formed by the society that existed before any individual and will continue to exist after any individual is dead. They are unique objects that cannot be influenced by an individual. They have an effect over the individual that only noticed when we go against them. EX. Law, religious faith, suicide.
- Wha hold society together? how can it be stable? - Durkheim thought that small society was held together by similarities and the individual was self sufficient, but this only works for small societies and societal change and grow large.
- in functionalism, a change to either production, distribution, or coordination would force the others in the large population to adapt in order to maintain a stable state society. Social change upsets equilibrium thus it only changes just enough to find the stability again.
- functionalism focuses completely on the institution with little regard to the individual.

Lecture continue...

- functionalism is a way of understanding how you keep going.
- 17. (box 2.1) If you get sick we can get exempted from the normal social role but in reality this does not happen.

Box 2.1: The Sick Role

- *if u get sick you...*
The exemption from normal social role responsibilities
- The exemption from responsibility for his or her illness
- The state of being ill is itself undesirable and the person has the obligation to want to "get well" and return to a normal social role
- The sick person also has the obligation to seek technically competent help and comply with treatment regimens

Source: Adapted from Talcott Parsons, *The Social System* (New York: The Free Press, 1951).

- Symbolic interaction suggest we should look at culture, history and interact with them to find out why stuff are important.

Video notes: Symbolic Interaction (duration 3:33)

- Focuses on the small skills perspective of the interactions between the individuals. ex. when hanging out with friends,
- by looking at the small skills, symbolic interaction explains the individual in the society and their interactions with others. Through that it can explain social order and change.
- Theory by George Herbert Mead in the early 20th century.
 - Believed that the development of the individual was a social process.
 - ppl change with the interaction with objects, ppl, ideas and they assign meaning to things in order to decide on how to act.
- Herbert blumer explained 3 tenants to explain symbolic interaction:
 - 1. Act based on meaning we give something.
 - 2. Give meaning to things based on social interactions
 - 3. The meaning we give something is not permanent - it can change due to everyday life ex. experience.

Lecture continue...

- symbolic interaction is similar to social constructionism in the sense of seeing the world.

Video: Social Constructionism (Duration 2:44)

- Things in society only exist because we give them meaning through social agreement. ex. Nations, books, money, identity.
- 2 threads to SC.
 - 1. Weak
 - Dependent on brute facts.
 - Institutional facts
 - 2. Strong
 - Language and social habits.
 - No brute facts
 - Thoughts on human, not facts.

Video: Conflict theory (duration 4:36)

- Focus on studying society by the inequality of different groups.
- Karl Marx
 - Believed that society evolved through several stages.
 - Feudalism -> capitalism -> socialism
- In the capitalist society, the upper class called Bourgeoisie while lower class called proletariat.
- The upper class had power, the lower class had no opinion.

Week 5 Oct 19: Political Economy Perspective (ch. 3)

Starts with last week slides (29):

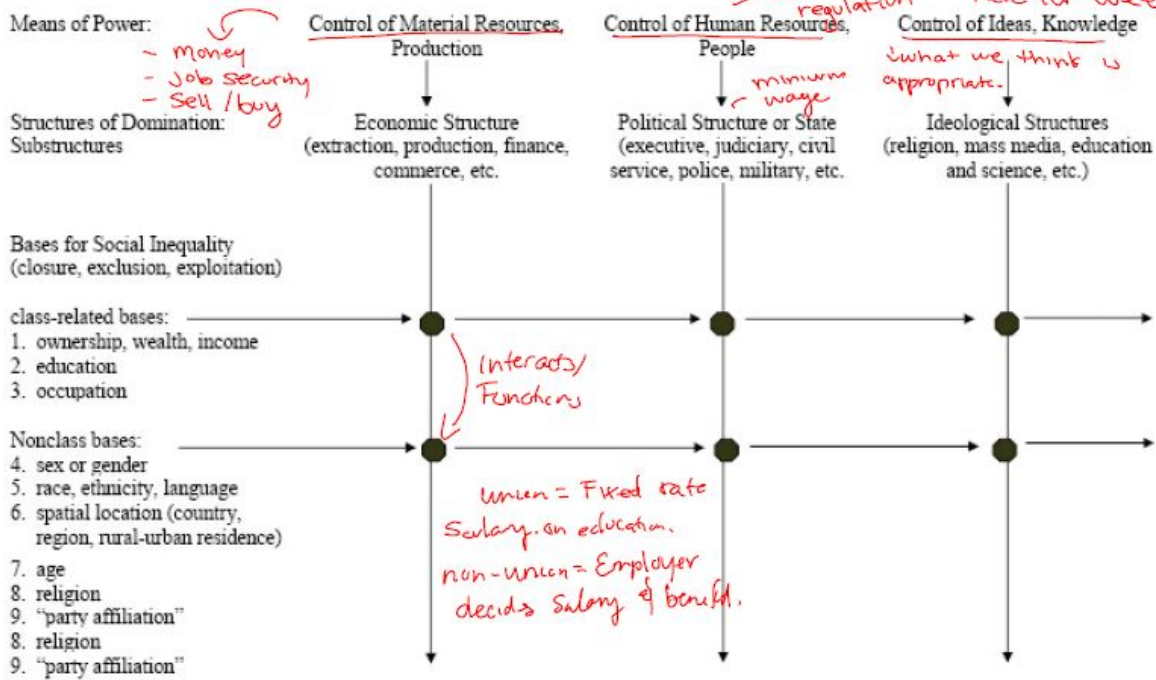
- 31 - 8:00

Lecture continue...25:50

- There are 2 kinds of political economy approaches. One is like the functionalist approach
- 8. Materialist approach is similar to conflict theory.

3 main institutions that shape our life.

Figure 4.2: The Major Means of Power, Structures of Domination, and Bases for Social Inequality.



Source: Grabb, E. (2002). *Theories of Social Inequality*. Toronto: Harcourt Canada, p. 224.

How we organize & run society (from 3 things @ top) to determine SDI.

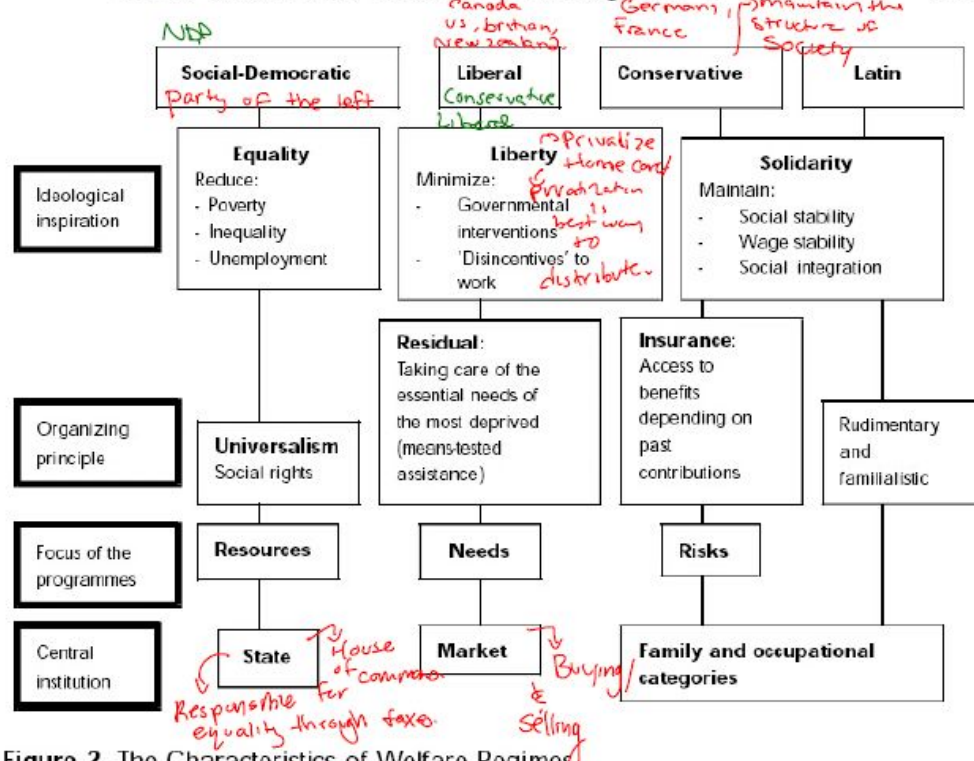


Figure 2 The Characteristics of Welfare Regimes

Source: Saint-Arnaud, S., & Bernard, P. (2003). Convergence or resilience? A hierarchial cluster analysis of the welfare regimes in advanced countries. *Current Sociology*, 51(5), 18 499-527.

Week 7 Nov 2: Research Methods and social determinants of Health (ch. 5 & 6)

- **Box 5.1: Knowledge Paradigms in Health Studies** “Ways of thinking on how we find stuff out”
- **Key Questions:**
 - *Ontological:* What is the nature of the knowable? Or what is the nature of reality? what is it that we are trying to find out. For some ppl it’s numbers/data, for others it’s lived experience.
 - *Epistemological:* What is the nature of the relationship between the knower (the inquirer) and the known (or knowledge)? What is the relationship between me and you (the person trying to find data on).
 - *Methodological:* How should the inquirer go about finding out this knowledge? Which method to go about.
- All the methods above combined is the best way to experiment.
- But if you would chose one it would be #2 as it is the position with the community. “being in their shoes”, hanging out with them.

- 4. Scientific approach (the first approach).
- 5. 1980s started cutting welfare benefits, minimum wage fell behind, poor ppl become poorer - more likely to become homeless.
- mid 1990s mortality began to get worse.
- The best way to find out what is going on is to go out and interview them
- 7. **Positivism** - Scientific stuff. Philosophy of science.
 - No difference between natural and social sciences inquiries.
 - Purpose of inquiry is to develop general principles and laws and identify cause and effect relationships in the world.
 - Knowledge is advanced through observation of the observable and measurable
 - There is a distinction between facts and values; inquiry is value free.
 - The tendency is to view phenomena at the individual level.
 - The emphasis is on experimental methods, surveys and observations within a quantitative methodology.
 - The focus is upon individual characteristics and how these interact with environmental events to create health and illness.
 - It's objective, it's scientific
 - Cause and effect
 - Science is objective
 - plays in health care by ppl looking at the characteristics of individuals are looked upon (ie. smoking)
- 8. Sampling theory - A randomly selected participants that represents the whole population.
- 11. Longitudinal Study - follow ppl over time.
-
- **Idealism**
- Related to sociological approach
- If you believe something, that is real knowledge, even if it's not true. Doesn't matter if it's accurate.
 - Social reality is understood through the meanings that individuals place on events.
 - The purpose of identity existing multiple realities.
 - The individual is the active creator of the world.
 - Reality results from the interactions of individuals with societal structures.
 - If events are perceived as real, they are real in their consequences.
 - The emphasis is on ethnographic method whereby individuals' understandings or the world are made explicit.
 - The focus is on the lived experienced of ppl and how these shape individuals' experience of health and illness.

- **Realism**
 - Reality exists independently of individuals' constructions
 - Interpretations that individuals have of events are shaped by societal structures.
 - Individuals are active creators of the world
 - The quest is for identifying societal structures that influence events
 - A concern with meanings and how they are shaped by societal structures is manifested in the idea of "false consciousness" by which Individuals misunderstand their world.
 - The emphasis is on a variety of methods to identify the social structures that shape social phenomena and Individuals' understandings of these phenomena.
 - The focus is on identifying the social structure that create health and illness and Individuals' understandings of their incidence, and identifying means of promoting social change.
 - Do more critical analysis
- 25. In summary, Traditional approach (what are the assumptions), Motion of ideas, the big picture - the story behind the story.
- Which approach is good @ looking to make means of analysing inequality? Dennis likes the third approach because it look at the big picture

Random notes:

Neglected disease: a global disease that does not cause death.

Easy Way to Memorize the Welfare states:

SD:SNFD

L:UUCA

C:GIFP

Capitalist:Japan, Great Britain, Switzerland, Taiwan, Germany.

Biomedical Approach: medical diagnosis,

Functional Approach: like the biomedical approach, this views disability as an individual condition or pathology. Treated with services.

Environmental approach: personal ability and limitations as resulting from an individual's characteristics interacting with the environment. - barrier free designs to buildings, transportation close by and affordable.

Rights outcome approach: look at picture.

Table 14.1

	Individual Pathology		Social Pathology	
	Biomedical Approach	Functional Approach	Environmental Approach	Rights-Outcome Approach
Source of disability	Disability is due to an individual's abnormality and the extent of his or her functional limitations.	Disability is a pathology that is best treated with services that enable the individual to become as socially functional as possible.	Disability arises from the failure of ordinary environments to accommodate people's differences.	Disability has social causes resulting from the way in which individuals relate to how society is organized.
Primary mode of action	Diagnosis and treatment	Service provision (e.g., rehabilitation)	Policy change (e.g., to building codes)	Human rights principles and legal challenges

o that of all other workers, the equivalent of almost 5,500 more would be at work full-time each year (Canadian Institute for Health Information 2001). Gender is a critical component in understanding the increases and thus in addressing these outcomes. Indeed, gender is critical to understanding health care, reforms, and consequences (Box 13.2).

Box 13.2: Medication and Women

“Women respond to certain drugs differently from men, use more medications than men, and are more likely to experience adverse drug reactions.”

This underscores the need for targeted studies to understand these gender differences and identify ways to improve the safety of medication use in women, as described in the January/February 2005 Special Issue of the *Journal of Women's Health* 14(1), a peer-reviewed journal published by Mary Ann Liebert, Inc. (www.liebertpub.com). The entire issue is available free online at www.liebertonline.com/toc/jwh/14/1;jsessionid=jBJw7TQTGmDe.

Box13.1= the Romanow recognizes gender as a determinat of health.

privatization is particularly problematic because women are increasingly involved in paid employment, hence are not readily available to care for sick relatives. If they do take on care, both their paid work and their unpaid caring work are compromised. This can in turn result in greater stress and negative health consequences for the provider, and often also greater risks for those being cared for who may not be receiving the most appropriate care. There is also the added burden of greater financial costs for the entire household.

Box 12.6: The Case against Privatization

Armstrong et al. (1999) highlight that there are at least three major differences between health care delivery and goods production, differences that raise significant questions about how appropriate market-based techniques are for the provision of health care.

First, care providers assume and demand autonomy in making decisions based on their assessments of complex individual needs. This is particularly the case with doctors, who determine many of the health care expenditures. In contrast, *strategies in the for-profit sector assume and demand managerial control over processes and decision making.*

A second major difference between the two sectors relates to sales. *In the for-profit sector, selling more is critical to maintaining profit growth.* Customers are encouraged to spend and use more. In health care reform, however, the stated purpose is to spend and use less. Utilization reviews are intended to reduce the number of procedures and processes to lower costs and improve care.

This is related to a third major difference between health care delivery and for-profit production. *Customer choice is defined as a primary basis for competition in the market,* but many patients lack the knowledge, the capacity, or the time to decide among alternatives. In other words, many are not in a position to exercise the choice that is seen as a fundamental basis for efficiency in for-profit settings. This unpredictability makes care delivery less amenable than goods production to managerial planning and costing based on assumptions about regularity and uniformity among products.

Although some argue that the only conceivable solution to rising costs in health care and other public services is thought to be further market penetration and the adoption of more for-profit practices, Armstrong et al. (2003) argue that mixing public and private, for-profit partnerships squeezes out public values and practices. What are left are corporate, for-profit values and methods combined with limited choice. In its worst form, it substitutes profit maximization for essential care, it can limit access to critically needed services, it can deliver substandard services to consumers, and/or sets inadequate standards.

of such professions as nurse-midwives and nurse practitioners. Note that these recommendations were made in a context of a perceived physician shortage. Although nurse practitioners experienced a short-lived surge of interest between the early 1970s to early 1980s (Angus and Bourgeault 1988–1989), nurse-midwifery failed to capture enough political support at that time to become more fully integrated into the publicly funded health care system (Bourgeault 2005b).

Box 12.2: Health Human Resource Issues

Health human resources addresses three basic problems:

- *Problems with supply:* The numbers of health care professionals providing services to a population
- *Problems with mix:* The relative numbers of health care professionals providing various types of specialty services
- *Problems with distribution:* The location or deployment of health care professionals across geographic areas

Some 10 years later, the Ontario government appointed a Health Professional Legislation Review (HPLR) in 1982 to respond to various pressures for change in the way health professions were regulated. The mandate of the HPLR was to make

... powerful professions dominated by men (see Box 12.1). Thus, while women make up the bulk of health care providers, their employment is not evenly distributed.

Box 12.1: Types of Health Care Providers

Wardwell (1981) and Willis (1989) both define the three different kinds of professions in terms of their relationship to the dominant medical profession:

- *ancillary or subordinate professions* that are different as ... *under the direct control of supervision by medicine*
- *limited professions* that are defined as ... *practicing independently of medicine but with a limited scope of practice (in terms of patient or treatment modality)*
- *marginal or excluded professions* which are defined as ... *practicing outside of the mainstream medical system and denied official legitimacy*

Some female professions, such as midwifery, were excluded altogether from many segments of the Canadian health care division of labour. Indeed, another consequence of medicine's quest for dominance has been the exclusion of health care provider groups altogether. In addition to midwifery, many provider groups that were excluded from the health care system — such as naturopaths — were also excluded from the health care system.

3. Prohibited senior NHS doctors from private appointment
4. Increased role for nurses
5. Contracts with private acute and long-term care facilities for National Health Service patient beds

1. monopsony (single-payer) control over providers gives superior cost control
2. public financing avoids "cherry picking," where private insurers profit by refusing high-risk individuals

For *delivery* of medically required services, the best approach is private non-profit as:

1. public delivery often means less responsiveness to clients, and mixed incentives for cost-efficiency and quality
2. for-profit delivery is acceptable only when outcome standards can be clearly specified and monitored, which is difficult to develop for health care as it is a complex service

The lesson for Canada from this international comparison is that the public system should be well funded to maintain confidence.

...ining health care insurance has been...
 ...ble to afford it, leaving them without insurance.

Table 11.1: International Health Care Systems: Comparing Financing and Delivery

Delivery	Financing	
	Public	Private
Public	Britain, Sweden: National Health Service	—
Private	Canada, France: Public insurance system	Germany,* Netherlands, Switzerland,* U.S.: Private insurance

...ixture of private insurance and government subsidy: government regulates and subsidizes
 ...ate mutual aid societies.

...e reforms...