

Foundations of Health Studies (HH HLST 1010 3.0) Exam Review

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Year Taken: Fall Term (2019 – 2020)

Week 2

History

- pre-WWII: private delivery and private payment
- Movement towards the establishment of a national healthcare system in Canada emerged after WWII
- Stalled by federal-provincial bickering over jurisdiction and responsibility
- 1957: Federal, Hospital and Diagnostic Services Act: 60% of pop'n covered; disparities between provinces and gaps in services

Tommy Douglas

- First elected as a CCF MP
- In 1947, Douglas introduced the Saskatchewan Hospital Insurance Plan
- 1961: Saskatchewan Medical Insurance Act
- July 1, 1962: The SMIA came into effect, covering all doctor's services
- July 1-July 23, 1962: Saskatchewan Doctors strike
- The Saskatchewan Act became the inspiration and model for the federal system we have today

History

- Development since 1966
- Canada Health Act (1984): put a cap on how much doctors could charge the government for their services
- Canada's healthcare system has periodic revisions (i.e. what is covered; who is eligible, etc.)

Note:

- The Canada Health Act and the Medical Care Act are not the same thing!

Features of Canadian Healthcare System

1. Canada's healthcare system is publicly funded and privately delivered
 - a. True
2. Canada's health care system is privately funded and publicly delivered
3. UK's health care is publicly funded and publicly delivered

Organization

- How many healthcare systems does Canada have?
- 14
- 1 Federal System (Health Canada) + 10 provincial + 3 territorial systems = 14

- Federal government provides fiscal (\$) transfers to provinces/territories (Canada Health Transfers) for the administration of their healthcare systems
- Each province/territory has authority over the funding and administration of healthcare services within its boundaries
- But, the federal government has standards of conformity that the provinces must abide by if they are to receive federal funding
- Each province must also conform to the 5 principles of Medicare in order to receive federal support

Organization

- In addition, the federal government pays for:
 - First nations peoples on reserve
 - Metis peoples
 - Serving members of the Canadian Armed Forces
 - Eligible veterans
 - People in federal prisons
 - Some refugee claimants

5 principles of the CDN Healthcare System:

1. Public administration

- a. Health insurance plans “must be administered and operated on a non-profit basis by a public authority” (Section 8, Canada Health Act)
- b. Patients should not have to pay out of pocket for ‘medically necessary services’
- c. Dr Brian Day:
 - i. Argues private services should be available for those who can pay to reduce wait times
 - ii. April 2018: doctors who charge patients for private services pay fines
 - iii. (contravenes CHA) Nov 2018: BC Supreme Court: doctors will not pay fines while case is in court

2. Comprehensiveness

- a. Health care insurance plans must cover “all insured services provided by hospitals, medical practitioners, or dentists” (Section 9, Canada Health Act)
- b. Note: The dental services must be surgical dental procedures, performed in a hospital

3. Universality

- a. Everyone covered under the insurance plan is “provided for on uniform terms and conditions” (Section 10, CHA)
- b. Refugees and immigrants are subject to a waiting period, as are returning Canadians;
- c. Indigenous people and members of the Armed Forces are sometimes covered under different (federal) insurance plans

4. Portability

- a. People who move from one province to another are ‘covered’ by their ‘home’ province for up to three months; after that, they receive coverage in their new province

5. Accessibility
 - a. The insurance plan must provide “reasonable access” to insured services

Tensions in the CDN healthcare system

1. Federal-provincial tensions
2. Egalitarian ends (publicly funded, universal, accessible services) in tension with market-based means (delivered by doctors in private practice)
3. Determining ‘medically necessary services’
4. Historical tensions between government and doctors regarding payment/salaries

Tensions

1. Federal-provincial tensions
 - a. Determining amount of Federal Health Transfers
 - b. Determining criteria for consequences for provinces if they do not abide by Canada Health Act (e.g. allowing more private services)
2. Egalitarian ends (publicly funded, universal, accessible services) in tension with market-based means (delivered by doctors in private practice)
 - a. Philosophical tension ---resolvable?
 - b. Originates in original agreement b/w government and doctors of Medical Care Act: compromise, allow doctors to practice privately

Week 3: Epidemiology

Perspectives on health

- For the next 4 weeks, we will study different ‘lenses’ or ways to analyse health/ healthcare system

Epidemiology definitions

- Area of medicine concerned with causes, distribution, and control of disease in specific populations
- Root: “epidemic”: outbreak of disease that affects many people at the same time
- Epidemiology identifies causal effects of variables on health outcomes through data collection and analysis

Epidemiology: Example -

From text:

- John Snow noted cholera deaths in particular neighbourhoods: asked people source of water; determined water was contaminated; removed pump handles - (Did not know that bacteria in the water was cause)

Current example

- Epidemiologists have documented a connection between high levels of pollution and cancer rates
- I.e. how does one variable (pollution) cause an effect in another (cancer rates)? Epidemiologists collect data and analyse

Epidemiology: Features

- Epidemiology considered a positivist science
- I.e. objective knowledge about the world can be gained through measurement and observation; scientists separate from phenomenon being studies

Epidemiology: Primary concerns

- Primary concerns:
- Determine factors that produce disease in organs (i.e. associations of cells) p.16
- Study incidence and prevalence of diseases and identify factors leading to them
- Make population aware of how population-level factors affect their health (eg. noise, pollution)
- Identify risk factors

Epidemiology: What are risk factors?

- Risk factor: a behaviour or other life circumstance that increases one's chances of being negatively affected by causes of disease or poor health

Goal

- Behavioural interventions (eg. move away from the polluted place in which you live)

Epidemiology: Bezruchka's critique

- Traditionally, epidemiologists have focused on identifying risk factors and causes of disease; not focused on changing or removing risk factors at the population level
- Traditionally, epidemiologists do not identify how behavioural changes can come about, or the obstacles that prevent them
- Critical epidemiologists: Suggest policy changes that facilitate individual decisions (i.e. fewer highways; don't build near highways etc)

Epidemiology: Key terms

- **Incidence:** number of new cases of an illness in a population over a specific period of time
- Example: there were 10 new cases of chickenpox in the TDSB between sept and dec, 2018
- **Prevalence:** proportion of individuals in a population with a disease at a point in time (found by taking the number of individuals with the condition divided by the total population; expressed as a percentage or proportion); existing cases
- Example: right now, 1% of the population is living with heart disease
- **Morbidity:** level of wellness/illness; the rate of disease in a population in a specified community or area over a specific period of time; higher morbidity = shorter lifespan
- Example: increased air pollution in downtown Toronto causes an increase in morbidity from respiratory disease
- **Mortality:** risk of death; rates of death from a specific condition in a specified community or area over a specific period of time
- Example: postoperative mortality rate of high-risk brain surgery was 50% - Control (in a epidemiological study):
- Controlling one variable in a study, thus eliminating its effect; allows results to be generalized
- Example: control for age in a study examining rates of fitness

Co-founders in a study:

Variables beyond the ones being studied

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- Example: measuring health in an aging population; a co-founder could be location of home

'Shoe leather epidemiology'

- Going door to door; going to the population to gather as much data as possible

Self-assessed health:

- An individual's self-assessment of their own state of wellness; is an effective and accurate indicator of wellness

Methods in epidemiological research

1. Ecological studies

- Observational studies carried out at a population level rather than individual level. Differences in outcomes between populations, or over time, are attributed to risk factors in a population

2. Cross-sectional studies

- Individuals with a defined disease, risk factor, or other condition of interest are identified and studies at a particular point in time (also called 'prevalence studies')
- Do not study variables over time

3. Case control

- The experimental (or studied) group consists of individuals with a disease or particular outcome of interest. Individuals without the disease are selected for the control group or comparison group

4. Cohort or Longitudinal studies

- Individuals are followed through time to monitor the natural history of a disease, to observe prognosis in relation to treatment, or to investigate etiology
- Example: In the early days of the AIDS epidemic, cohort studies provided information about the course of HIV infection

5. Random Control Trial (RCT):

- Similar to a controlled laboratory experiment. Intervention given to 'experimental' group; differences between experimental and control participants are measured
- Example: drug trials

6. Multi-level modelling

- Study takes into account individual, neighbourhood, and national characteristics; require computer programming

Critiques of epidemiology

- Must be careful with interpretation
- Correlation does not equal to causality

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Bezruchka, S (2010). Epidemiological Approaches To Population Health Key

points:

- Social inequality is 'bad' for our health
- Investment in healthcare system may be less important than addressing social inequality
- Levels of 'caring and sharing' determines health
- 'Caring and sharing': level of government investment in population influences health outcomes

Lecture #4 September 30th, 2019

Sociology: "the study of the development, organization, functioning, and the classification of human societies"

Sociology

- 'Micro' - i.e. studying human agency and interactions
- 'Macro' - i.e. studying society wide organizations and systems
- Can consist of empirical research and critical analysis
- Critical analysis of, and development of theory about society; can be applied to social policy
- Interdisciplinary

History

- Can trace origins of the study of society back to recorded 'Western' thought -- i.e. BCE
- Formalizing sociology as a discipline began in the middle of the 1700s (18th century)
- August Comte (1789-1857) often referred to as the 'father of sociology' - first modern philosopher to formalize the study of society
- Comte advocated positivism, or the study of phenomena based on empirical evidence

Sociology: Key figures

- Karl Max, Emile Durkheim, Max Weber considered key 'architects' of modern social science
- Marx: Critique of society based on conflict theory; conflict between the owners of production and labourers
- Durkheim: formally established sociology as an academic discipline; structural functionalism
- Weber: connected economics + sociology; 'Protestant work ethic'; bureaucracy

Humanist sociology

- Connect the social, personal, and historical dimensions of our lives

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- Human issues must be understood within their broader social context

The Sociological Imagination (book)

“People do not usually define the troubles they endure in terms of historical change and institutional contradiction... intimate connection between the patterns of our own

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lives and the course of world history” (C. Wright Mills, The Sociological Imagination, 1959)

- We can understand our personal troubles by understanding the structural formations behind them

Sociological perspectives and healthcare

Sociological analyses are necessary because they shed light on

- The organization of society and how it affects the organization of health care and health care institutions, the concept of health, the provision of health care, and the impact on health outcomes

Sociology in medicine

- Application of sociological theory or concepts within the field of medicine to explain health-related issues, inform public health policy
- Sociology in: medically-oriented
- Example: understand the social conditions that lead people to engage in addictive behaviour
- Use of sociological analyses + critique (Weber, marx, feminism, anti-racism, postmodern) to understand medical organizations, institutions and practices
- Example: what role does the medical profession play in healthcare costs in Canada?

Structural Functionalism

- Informed by Durkheimian (1858-1917) tradition which emphasizes social systems and maintaining social order
- Highlights social relations between individuals and groups in society and how it is structured to maintain social order
- Emphasis on interdependency between individuals and on society for survival
- Example: Talcott Parsons, The Social System (1951)
- In health or medicine, Parsons stressed the function of modern medical practice in society, and complementary roles of physicians and patient, usually referred to as the ‘Sick Role’

The sick role

- 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

Limitations of Parsons’s ‘Sick Role’

- Most appropriate for acute conditions, rather than chronic conditions and disabilities - Limited application

- Emphasizes the dominance of physician, submissiveness of patient to medical intervention

Critiques of Structural Functionalism

- “Assumptions of consensus-based society made up of interconnected roles... society is not necessarily consensus-based and ... The wielding of power is not always functional but is associated with several negative consequences” (Bourgeault, 2010, p. 43)
- Critiques of Structural Functionalism also emerge in symbolic interactionism and materialist/conflict theory

Symbolic Interactionism

- Emerged from Weberian critical theory tradition in which the focus is “not on social institutions, but on interacting individuals and the meanings they create” (Bourgeault, p. 44) Principles:
- Individuals respond towards things on basis of meanings they attach to them
- Meanings arise from “social interaction”
- Social action grows out of “fitting together of individual lines of action” (Jary & Jary 1991:509, as cited in Bourgeault, p. 44)
- Symbolic interactionists focus less on large, macro systems in society, and more on micro, subjective aspects of social life
- Examples:
- Goffman (1961, 1963): individuals develop identity based on how others view them; stigma; labelling theory.
- Hughes (1971): “illness career”.
- Charmaz (1987): “reconstitution of the self” after illness

Social Constructionism

- We construct our realities (‘facts’) through social interaction
- “Everyday knowledge is creatively produced by individuals” (Berger and Luckmann, cited in Bourgeault, p. 45)
- Issues traditionally considered self-evident are interpreted as problematic and socially constructed
- Examples
- Illnesses and diagnoses are socially constructed
- What was 20 years ago considered an ‘active’ child could now be given a distinct diagnosis
- “Disease entities do not exist in any objective sense, but are political accomplishments... disease categories reinforce existing social structures” (p. 45)
- Explains the medicalization of daily life through
- Conceptual level (medical language)
- Institutional level (medical personnel supervise and act as gatekeepers);
- Interactional level (physicians treat difficulties as medical problems) - Explains how bodily concerns are constructed as ‘problems’

The Process of Medicalization of Deviance

1. Behaviour is first defined as deviant before the emergence of a medical definition
2. Prospecting, the “discovery” of a medical conception of the disease/deviant behaviour is first announced in a medical journal
3. Claims-making. Both medical and non-medical interests engage in “claims-making” activities to promote the new medical designation
4. Legitimacy. Securing medical turf, which usually involves some type of appeal to the state for recognition of the medical designation
5. Institutionalization of medical designation in an official medical and or legal classification system and in the establishment of treatment organizations

Social Constructionism

- Neighbour: think of another example of a diagnosis that has ‘come into being’ in the past 20 years
- Consider why you think that has happened - Who does this diagnosis most affect?

Critiques of Symbolic Interactionism & Social Constructionism

- Subjective, micro-level analyses - do not necessarily help us understand the broader societal context
- Social constructionism does not always address the ‘real’, lived experiences of people, particularly around the body and our immediate surroundings. Eg: social model of disability
- Descriptive rather than explanatory in orientation

Materialism/ Conflict theory

- Macro- or structural level of analysis
- Society is based on conflict
- Based on work and theories of Karl Max (Marxist theory)
- Karl Marx (1818-1883)
- Communist Manifesto 1848
- Das Kapital (post-death) - Critiques:
- The use of people’s labour to produce a profit
- The exploitation of people, through their labour, to produce a profit for the people who own the ‘means of production’ Key terms:
- Concerned with material conditions of life
- The material world and our actions in it shape ideas more than ideas shape the world
- Marxism / Materialism critiques capitalist modes of production
- Class conflict
- Society is in a constant state of class conflict
- I.e. Proletariat vs Bourgeoisie
- Proletariat: the workers
- Bourgeoisie: the owners
- Revolution
- Eventually, the proletariat will rise up against the bourgeoisie

Materialism / Marxism

- Marx critiqued the emergent capitalist system

- Despite his predictions of revolution, capitalism has been remarkably resilient. Why?
- 'Successful': dominates world markets, trade; world poverty & violence decreasing
- Is successful in that it thrives on inequality, oppression due to unequal work conditions

Materialism / Conflict theory: Implications for health

- Contradiction between pursuit of profit and workers' safety
- Short-term, precarious work = intensification & fragmentation of work, and alienation from the work process - increased stress, decreased value & contribution in society
- Driving down of wages and economic inequality results in uneven distribution of resources and access to healthcare
- Impact on healthcare systems: controlling costs and intensification of work
- Traditional bio-medicine (individual pathology as opposed to social or environmental causes) is congruent with principles of capitalism
- Corporatization of healthcare facilities

Critiques of Materialism

- Class analysis criticized as overly-simplistic depiction of society; true revolution is difficult to achieve
- Capitalism resilient due to lure of profit + power

Sociological approaches: Summary

- Structural functionalism
- Conflict theory
- Social constructionism
- Symbolic interactionism

Postmodernism

- Sometimes referred to post-structuralism
- Key thinkers: Derrida, Baudrillard, Foucault
- Micro-sociology: based on personal subjectivities
- Advocated plurality of standpoints or perspectives and cultural relativism
- No objective truth or objectivity, only different knowledges

Postmodernism: Connections to healthcare

- Patient narratives and their context are relevant
- Foucault's theory of the governance of the body and the knowledge / power of the medical profession helps us to understand physicians' power to define health and illness
- Also explains emergence of diagnoses
- Foucault coined the phrase the 'clinical gaze' which denotes the shift in medicine from patients' descriptions of their afflictions to clinical observations and decisionmaking by doctors

How do sociological theories inform our understanding of the healthcare system?

- Helps us understand the difference between the social production of illness and the social construction of illness - Social production:

- Related to the system of production and distribution of resources in a society
- Unequal distribution leads to different levels of wellness in a society and differential access to health care
- Helps us understand how power and knowledge in society determine how healthcare is organized and delivered
- Helps us understand how economic divisions in society (and the politics that keep those divisions in place) make it difficult to introduce changes to the system
- Helps us understand the meanings that society attaches to definitions of 'health', 'wellness', care, as well as the roles that support those definitions
- How disease is defined by various groups, power to define disease within a society
- Example: Doctors define mental illness and women's health conditions in ways that diminish the status, position, and perceived reliability of these two groups

Lecture #5 October 7, 2019

Political economy: definitions

- Political economy "focuses on the links between health and the economic, political, and social life of people in different groups, classes. Regions, or societies" (Coburn, 2010, p. 65)
- Asks: "Why do some people, groups, nations, or groups of nations have better health than others?... Why is there inequality in health and access to healthcare?" (p. 65)
- Understands politics and economics as related
- States, markets, ideas, discourses and civil society are interrelated - For our purposes: these influence health

Political economy: Examples in Canadian history

- Harold Innis (1894-1952) analyzed how staples such as fish and fur shaped Canadian social, political, and economic life

Current example

- GM pulling its production out of Oshawa: What are the economic, political, and social implications?
- What are the health implications?

Political Economy & Ideology

- The political economy perspective states that political ideology (predominant system of ideas or beliefs) drives political and economic order
- The type of society of which we are a part shapes. Enables, and constrains everything within it -- i.e. what is considered important, what we 'want'

- Example: a socialist society emphasizes a shared economy, equity, and government responsibility
- These features inform their policies and decisions
- Whereas a capitalist society emphasizes the free market, competition, and profit

Defining Ideologies: Socialism

- Assets are owned by the community; benefits distributed to all
- Higher degree of government intervention (eg. taxes, fund healthcare; government funding of public education)
- “Aspires to a higher degree of ‘equality of result” - Socialism based on theories of materialism - Review: What is **materialism**?
- Concerned with material aspects of people’s lives; more concerned with the way people live rather than ideas; world shapes ideas more than ideas shape the world
- Materialism is concerned with how goods and services are produced and people’s relationship to that production (i.e. owner? Worker? Bourgeoisie? proletariat?)
- NOTE: Coburn (this week’s reading) uses a critical materialist approach
- Uses a materialist perspective to analyse the relationship between political economy and people’s health

Defining Ideologies: Liberalism

- Liberalism stems from word ‘libre’ = freedom - Features:
- Personal freedom: Absence of coercion; individuals pursue own interests
- Limited government intervention in society
- Equality of rights
- Everyone abides by the same rules
- Traditionally, liberal thinking emphasized equality of opportunity
- Recently, political economists have emphasized the need for equality of outcome

Defining Ideologies: Neoliberalism

- Neoliberalism: system of financial governance that emerged in late 1970s, early 1980s (Regan, Thatcher)
- Reaction to increased social security post WWII
- Embraced by UK, US, Canada, Australia
- Also embraced by IMF and World Bank through Structural Adjustment Programs
- Espouses free market economy, competition
- Minimal government intervention, lower taxes, fewer social supports - Relies on capitalist financial systems (i.e. profit-orientated) - Neoliberal policies tend to:
- Align with greater inequality and “less social cohesion” (Coburn, p. 70)
- “May lead to more unequal health outcomes between socioeconomic groups within countries” (Tayler et al, 2009)

Defining Ideologies: Capitalism

- Capitalism: world’s predominant system of financial governance including Canada
- The goal of capitalist systems is profit and the exploitation of labour to make a profit

Defining Ideologies

- What do political ideologies have to do with health and healthcare?
- Ideologies direct government policies and decision-making

Typologies of Welfare States

- "Welfare states can be classified according to their emphasis on capitalist development versus provision of social entitlements to their citizens" (Jongbloed, p. 204)
- I.e. spectrum of level of support from government distributed to its citizens

Esping-Anderson's 3 states:

- A political theory based on a political economy perspective
- Focuses on the economic impact of particular ideologies on wealth distribution and poverty levels
- Examines political / social impact of ideologies of individualism vs solidarity in society
- Describes the extent to which a government financially supports its citizens

Esping-Anderson identified 3 main welfare state typologies

1. Social democratic welfare states
 2. Liberal welfare states
 3. Conservative (corporate) welfare states
- Note: Esping-Anderson's uses of the terms 'liberal' and 'conservative' differ from those in the Canadian political system
 - Liberal: free-market system
 - Conservative: family, traditional system

1. Social democratic welfare states

- High government intervention welfare systems
- Goal: to reduce unemployment, poverty, and inequality
- Social assistance not as limited by means testing or 'gatekeeping' mechanisms
- High unionization, worker involvement in decision-making
- 'Generous' benefits
- High levels of female employment
- Lower levels of income inequality and poverty
- Highest % of income derived from wages; lowest % of income from capital investments
- Examples: Scandinavian countries: Sweden, Norway, Denmark

2. Liberal Welfare States

- "Residual" welfare system --i.e. Government steps in when other sources of support break down and individuals are unable to secure their own means of survival
- Support is 'means-tested'; 'proof'; geared towards low-income groups
- Financial supports and transfers are moderate
- Social assistance is limited by traditional work-ethic attitudes that stigmatize the needy and attribute failure to individual rather than societal failures

- Liberal nations limit welfare benefits since it is believed generous benefits lead to a preference for welfare dependency rather than gainful employment
- Greater incidence of low wage earnings, higher income inequalities, and the highest poverty rates
- These economies derive the greatest proportion of income from capital investment rather than wages

3. Conservative, Corporatist welfare states

- Fall midway in their provisions
- Class and status-based insurance schemes; access to provisions dependent on past contributions
- Reliance on family and social networks
- Examples: France, Germany, Italy, Portugal

4. 'Latin' Welfare Typology

- Bamba (2007) revises and adds to Esping-Anderson's work
- Also reliance on the family & voluntary sector
- Fragmented welfare provision & health coverage
- Work insurance schemes
- Prevalent in Latin, Central & South American countries; Bamba includes Italy, Portugal in this typology

Decommodification

- **Commodification** means the production of goods or services for sale in the marketplace
- **Decommodification** refers to the degree to which goods and services are available without the need for individual wealth; degree to which individuals can live a reasonable life without relying on market wages
- Examples of items that are commodified/decommodified to varying degrees:
- Water; transit; recreation (eg. pools); day care; health care
- Rates of commodification / decommodification vary according to welfare typologies:
- In Social Democratic Welfare states, fewer goods & services are commodified; more decommodified
- In Liberal Welfare states, more goods are commodified (i.e. avail on market); fewer decommodified
- Example:
- Sweden: daycare is universal, mostly publicly funded, affordable
- Canada: daycare remains market-based; 'you get what you pay for'
- Measures of decommodification and gini coefficient values vary depending on a country's welfare typology
- FINAL NOTE: Scholars have critiqued Esping-Anderson's work on a number of fronts
- Gender-neutral
- Limited range of countries (18) and regimes; possibilities for other regimes (eg. latin, Asian)
- Focuses on financial transfers; ignores actual delivery

Connections to healthcare

- Liberal political economies have the lowest health care expenditures and the lowest coverage by public medical care
- Social Democratic economies have more public health care expenditures and more extensive health care coverage

Increases in

- Support for social democratic parties
- Proportion of people voting
- Public health care spending
- Proportion of people employed
- Female labour force participation
- Income equality
- National wealth

Leads to

- Decline in infant mortality
- Increase in life expectancy in OECD countries

- Greater social inequality = more vulnerable groups in society
- Groups with less social & economic advantage suffer more with respect to the SDOH
 - Precarious employment; poor housing can't afford non-covered services (eg. ambulance)
- In a free market economy, "the wants of the wealthy trump the needs of the poor" (Coburn, p. 73)
- "Everyone for themselves", said the elephant dancing among the chickens" (Charles Read, as cited by T. Douglas in Coburn, p. 73)
- Greater social equity = equitable health
- Greater social equity = less expensive healthcare

Week 6 October 21, 2019

The principles of human rights

1. Universality
 - a. All people are entitled to human rights; “all people are born free and equal in dignity and rights.”
 - i. Universal Declaration of Human Rights, 1948
2. Inalienability
 - a. Rights cannot be taken away from people nor transferred to another
 - b. Example: right to vote; rights of woman are not ‘given’ to a man once married.
3. Indivisibility
 - a. All human rights have equal status; rights cannot be compromised at the expense of other rights
 - b. Example: right to shelter should not prevent access to education
4. Interdependence and interrelatedness
 - a. Each one contributes to the realization of a person’s human dignity; the fulfilment of one right often depends on the fulfilment of others
5. Equality and non-discrimination
 - a. All individuals are equal as human beings; cannot suffer discrimination based on race, colour, ethnicity, gender, age, ability, sexual orientation etc.
6. Participation and inclusion
 - a. All people have the right to participate in decision making that affects their lives and well-being
7. Accountability and the rule of law
 - a. States and duty-bearers are answerable for the observance of human rights

United nations declaration of human rights

- 10 December 1948
- “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world...”

Distinction between declaration & conventions

- **Declaration:** indicates countries’ intention to uphold the precepts of the agreement; NOT legally binding
- Example: United Nations Declaration of Human Rights - Not legally binding:
- Instrument does not have force of law
- Lays out agreed-upon principles & objectives
- Holds moral weight
- Also called Customary International Law, or ‘soft law’

- **Convention:** signatory countries agree to the principles of the agreement in laws; is legally binding
- Example: United Nations Convention on the rights of Persons with Disabilities - Two steps:

1. Signing

- a. Signature expresses willingness of the state to continue with the treaty-making process
- b. Qualifies state to ratify
- c. Obligation to refrain from acts that defeat the purpose of the treaty: examine internal laws that may impede
- d. Not (yet) legally bound by terms

2. Ratifying

- a. State confirms its consent to be legally bound by the terms of an instrument
- b. Will be monitored internationally
- c. Internal laws must adhere to the convention's agreements

How do agreements protect human rights?

- Articulates the full scope of rights to which all persons are entitled; people should not have to claim the rights that are inherently theirs
- Allows the UN oversight over signatory nations
- Hold signatory nations accountable to the international community
- Give people tools and mechanisms through which they can make claims against governments for human rights abuses

Question

- Are conventions implemented in every country that ratifies them, due to their 'legally binding' nature?
- If not, why not?

Where does Canada stand? -- Example

- 'UN official sparks debate over Canadian food security'
- By Laura Payton, CBC News Posted: May 16, 2012 10:30AM
- "UN special rapporteur for food Olivier De Schutter said he was in Canada to launch a conversation over a national food strategy... 'We have a large number of Canadians who were unacceptably too poor to feed themselves decently'".
- Government (2012) response:
- "Immigration Minister Jason Kenney suggested De Schutter is wasting his organization's money by visiting a developed country....
- "It would be our hope that the contributions we make to the United Nations are used to help starving people in developing countries, not to give lectures to wealthy and developed countries like Canada.'".

Conventions that intersect with health

- International Covenant on Social, Political, & Economic Rights (1966)
- Convention of the Elimination of Discrimination against Women (1979)
- Convention of the Rights of the Child (1989)
- Convention of the Protection of the Rights of Migrant Workers and Members of their Families (1990)
- Convention of the Rights of Persons with Disabilities (2006)

How can a human rights approach ensure people's health & wellbeing?

1. Health is intersectional

- a. A human rights approach acknowledges all facets of a person's life
- b. Social determinants of health
- c. Health more than absence of disease
2. "A human rights framework forces governments to address health disparities and holds government accountable for the societal barriers to good health" (Rioux, 2010, p.112)
3. A human rights approach to health moves from the individual to the social (p. 112)
4. The emphasis on equal outcome encourages more aggressive strategies for people who are marginalized or considered vulnerable
5. Allows for nuanced intervention in an increasingly diverse society (p. 95)
6. Allows us to address the inequities in the way that healthcare "is made available to people" (p. 95)
7. Provides a framework for intervention as healthcare becomes increasingly technologized (i.e. everyone should have access to the same technology).
8. Allows for intervention of laws and justice systems
9. Strengthens role of public health in fostering conditions needed for health, and understanding links between poverty and health

What are the implications of a human rights framework for health?

1. Implications: Access to healthcare
 - a. Understands health as something to which everyone is entitled, not something that is earned
 - b. Example: OHIP access for refugees / newcomers
 - c. People are not covered for 1st three months unless they receive IFHP or are a Convention refugee (i.e. sponsored)
2. Implications: Marginalized groups
 - a. Human rights approach advocated equal outcomes, which implies increased support & strategies
 - b. Example: people with disabilities may require increased interventions for same outcome
 - c. HR framework challenged traditional medical model of disability and focused on disability as contingent on social forces, barriers, and understandings (p. 107)
 - d. Medical interventions sometimes "differentially applied" (p. 104)
 - e. Scarcity framework and triaging of resources can result in the "non-selective treatment of people with disabilities" (p. 104) or chronic conditions
 - f. Nico Montoya considered "inadmissible to Canada because of the potential burden the child would place on the healthcare system".
 - g. "Inadmissibility of one of a family's members applies to everyone on the application."
3. Implications: Global economy
 - a. Human rights can hold governments and corporations accountable to ensure safe working conditions, fair wages, the right to unionize, health benefits, parental leaves, etc.
4. Implications: Health research
 - a. Ensures participants have given free and informed consent
 - b. Ensures participants are not coerced into participation

- c. Ensures research is proposed and scrutinized in the public arena; this, harmful research and medical practices are less likely

Critiques of a human rights approach to health

1. Rights a normative western concept
 - a. Local cultures and traditions challenge the universal application of human rights
2. Needs and concerns pitted against each other
 - a. Mrs. E. vs Eve (1985)
 - b. Mother of a woman with an intellectual disability wanted to have her daughter sterilized with court consent (not daughter's)
 - c. Permission was denied by the Supreme Court of Canada
3. Equality vs Equity; Universal VS Targeted
 - a. By working towards 'equal outcomes', do we emphasize and perpetuate divisions in society?
4. Human rights instruments weak: not enforceable by law
5. Often, states or institutions mandated to accommodate "to the point of undue hardship"; = subjective
 - a. Eg: schools not admitting students with disabilities
6. People must 'claim' through legal channels; claims considered illegitimate
 - a. I.e. in some UN conventions, people must make claims in the country of their citizenship

Week 7 October 28, 2019

Basic concepts

- “Society is inherently gendered such that men and women have fundamentally different experiences and access to power, and these differences are not natural but are socially constructed” (Bourgeault, 2010, oo. 50-51)
- Language used to describe different groups of people
- Political motivations
- Historical practices
- ... all have had more influence on how we understand different groups of people than physiological markers Reminder: Lecture #4
- Social constructionism: we construct our realities (‘facts’) through social interaction
- Issues traditionally considered self-evident are interpreted as problematic and socially constructed Social constructionism:
- For example: men understood as stronger, more capable, better leaders, etc
- Certain races of people smarter than others
- Disabled people less capable
- Socially-produced categories allow society to classify and categorize people in response to misunderstanding, ignorance and fear
- To oppress and control people considered ‘different’
- Embedded in Euro, Caucasian, and male-centric assumption of intelligence and authority
- People with disabilities have a higher unemployment rate than non-disabled people, and are more likely to be employed in precarious work (Wilton, 2006)

Counter-narratives

- Movements that deconstruct these assumptions; they are rooted in feminist, antiracism, and anti-ableist work

Feminism

- “A doctrine or movement that advocated equal rights for women” (Oxford Canadian Dictionary, 2004)
- “Uncovering the roots of women’s oppression and the political strategies” that will assist in women’s liberation. (Federici, 2014, p. 7)
- “Concerned with gender inequalities as a result of systems of patriarchy” (Bourgeault, 2010, pp.50-51)
- ‘Patriarchy’ refers to systems of male dominance within past and present societies and the implications of that dominance in the lives of all people in society
- Resisting all “existing structures of domination and oppression.” (Magnet et al., 2014, 1)
- Goal: Feminism works to deconstruct patriarchy, not only through a re-configuration of the relations between men and women, but in the structure of society itself

History: Wave Metaphor

- 1st wave: 1890s to 1920s
- Characterized by: Suffragettes; voting rights; recognized as persons
- 2nd wave: 1960s-1980s
- Characterized by: Equal rights and opportunities
- 3rd wave: mid 1990s to present

- Characterized by: intersectionality; breaking down societal barriers; illuminating 'those who don't count'

1st wave

- Canadian cohort:
- The Famous Five asked The Supreme Court of Canada, 1927:
- "Does the word 'person' in section 24 of the British North America Act, 1867, include female persons?"
- Emily Murphy, Nellie McClung, Henrietta Edwards, Louise McKinney, Irene Parlby

2nd wave: Equal Rights & Opportunities -

Demands for:

- Equal pay for equal work
- Reproductive rights
- Equal opportunity
- Safety, shelters, attention to oppression & sexual violence

3rd wave

- Mid 1990s onward:
- Women critical of Feminism's lack of intersectionality
- Judith Butler: gender performativity
- Bell hooks: "Ain't I a woman"
- Saras Ahmed: politics of affect; postcolonialism
- Rosi Braidotti: 'posthuman'; constructed, flexible identities

Feminist analyses of health and healthcare

- Feminism draws attention to the medicalization of daily life - For example:
- Childbirth, menopause as medical 'problems' that require hospitalization, medication, etc
- Feminism draws attention to the impact of gendered roles on health and well-being
- Women as carers, home-makers
- Women perceived as 'natural' for certain jobs, professions
- Feminism brings attention to specific healthcare needs of women, the need for gender-specific research etc.
- There are some situations that require 'gendered' attention - For example:
- Reproductive health
- Cancers specific to women
- Women and men experience cardiac arrests differently, etc.
- Historically, research done on men

Principles of critical race theory

1. Racism is endemic and 'normalized'
 - a. "Social order is maintained and perpetuated by racial subordination" (Bell, p. 907)
 - b. "White preference for black mediocrity" (p. 897)
2. 'Material determinism'
 - a. Racialized hierarchies serve material and psychological purposes

3. Race is socially constructed
 - a. 'Race' (as we know it) is based on faulty classifications and interpretations
4. Differential racialization
 - a. Different groups are racialized differently, depending on historical moment and economic needs
5. Anti-essentialism and Intersectionality key
 - a. "Black and brown bodies were viewed as less developed than white bodies, more 'primitive'... even sub-species of humans.... This was used to justify slavery, segregation, unequal treatment, harassment, violence, and even murder: (Annamma et al., 2)
6. Unique voice
 - a. "The narrative voice, the teller, is important to critical race theory in a way not understandable by those whose voices are tacitly deemed legitimate and authoritarian" (Bell, 907)

Critical Race Theory

- "Social structures, ideology, and our everyday experiences are fundamentally... racialized" (Bourgeault, 2010, p. 53)
- "Racialized is used to signal that race is a historically and socially constructed category of differentiation and not in any way a 'natural' one" (Nestel, 1997, p. 316, cited in Bourgeault, p. 53)
- "Although we commonly consider racism to be an expression of individual prejudice, it is also structured into a very nature of our society" (Bourgeault, p. 53)

Racialization and health

- Race structures opportunities for access to health care:
- Where are hospitals located? Drop-in clinics?
- Race structures for health and well-being:
- How are social determinants of health racialized?
- I.e. neighbourhood planning; housing; density; food 'deserts', recreation, income, etc.
- How is the provision of care racialized?
- Racial representations in medical professions - Professional perceptions of pain, etc.

Colonization and health

- Specifically examines how colonization has affected the economies and health systems of colonized nations
- Most are developing nations, or are 'nations within nations' upon which European styles of governance, economics, and health care have been imposed
- Introduction of Western disease
- Example in Canada: Indigenous people, which experience shorter life expectancy, higher infant mortality, etc
- "Systemic and structured racism is the ultimate cause of these social and economic circumstances" (Bourgeault, p. 54)

Racialization & Health

- Discrimination re: social determinants of health
- Discrimination re: access
- Discrimination re: perceived need for care

Critical Dis / Ability Analysis -

Disability as constructed:

- People with disabilities are not disabled as much by their impairments, as they are by the physical and attitudinal barriers imposed on them by society

Disability and wellbeing

- People with disabilities confront issues of access on a daily basis
- Access issues are systemic
- As our population ages, more and more people will require accommodations to require access
- In Canada, people with disabilities are much more likely to live in poverty than the rest of the population
- In Canada, people with disabilities are also more likely to be unemployed

Disability, social support, and Canada's 'residual' system

- In Ontario, people with disabilities must 'prove', through gatekeepers that they are 'disabled enough' to receive social supports

McColl et al (2008): 4 barriers in accessing HC system:

1. Physical barriers
2. Attitudinal barriers
3. Lack of expertise and knowledge about disability
4. Systemic factors that block access or equity

2. Attitudinal barriers

- Lowered expectations; less 'worthy'
- Assumption that impairment defines person
- Assumption that dis in body, not in environment
- No awareness that dis a part of life, not acute - Paradox:
- Doctors do not give enough attention to disability, and simultaneously blame all issues on disability

3. Lack of expertise

- Medical schools do not adequately prepare family doctors
- Working in a sustained way with people with disabilities counters traditional biomedicine's emphasis on curing and healing

4. Systemic Barriers

- Barriers throughout the system that prevent people with disabilities from gaining access

- Example: Doctors who work in a Fee-for-Service environment feel pressure when people with disabilities require more time; i.e. Salaried doctors have the “economic luxury” of allotting more time (McColl et al., p. e140)
- Example: Doctors are “gatekeepers” for access to services for people with disabilities

Conclusion

- Systemic discrimination in the healthcare system results in differential access, treatment, and representation of marginalized groups

Guest lecture Nov 4, 2019

Social Class and Health Inequalities

Social class

- “Social structures persistently organize and pattern life in a particular society, and social class is one of these structures”
- “Recognizes that individuals are not disadvantaged because they are lazy, stupid, or lacking in ambition”
- Organizes people in terms of relative disadvantage; is a means through which pattern and privilege are rewarded
- Corresponds roughly to the work that an individual does/occupation that they hold

High SES

- Describes differences in health related to social and economic circumstances
- Does not attribute moral or justice-based value to these differences

Health inequities

- Unfair and avoidable differences in health related to social and economic disadvantage

Causal factors in illness and death

Social causation model

- Social class, SES -----> Health Status

Social selection model

- Social class, SES ←----- Health Status

What shapes people’s health?

- 50% social and economic circumstances
- 25% health care
- 15% biology and genetics

- 10% built and natural environment

Based on Toronto

“The Unequal City”

- When compared with highest income group:
- Low income men are 50% more likely to die before age 75
- Low income women are 85% more likely to have diabetes
- Low income women 15-24 are twice as likely to report chlamydia infection - If all income groups had the same health status as the highest income group:
- 932 fewer premature deaths per year
- 62,111 fewer people living with diabetes

Contributing factors

- Ontario Works recipients report having less than \$1/day to spend on food

Infant mortality in Nunavut

- Leading causes of death are SUDI/SIDS, infection

Week 9: November 11, 2019 lecture notes

Defining social determinants of health

- “It is one of the greatest of contemporary social injustices that people who live in the most disadvantaged circumstances have more illnesses, more disability and shorter lives than those who are more affluent.”

What are the social determinants of health?

- Social determinants of health are the economic and social conditions that influence the health of individuals, communities, and jurisdictions
- “While healthy eating and physical activity were traditionally considered individual lifestyle choices, public health has shifted its perspectives in the past several

decades to encompass the broader context in which these choices are made... daily living, working conditions, and structural determinants” (Gore & Kothari, 2012, para 2)

- I.e. telling people to eat more vegetables is not helpful if you live in a ‘food desert’
- Social determinants of health include the quantity and quality of the resources that a society makes available to its members
- “... concerned with the organization and distribution of economic and social resources among the population” (Raphael, 2010, p. 146)

SDOH have a history

- Rudolph Virchow (1821-1902)
- Drew links between social conditions and health
- “Medicine is a social science and politics is nothing but medicine on a large scale... If medicine is to fulfil her great task, then she must enter the social and political life” (p. 148)

How do social determinants shape health?

- Social determinants provide the prerequisites for health, such as shelter, food, warmth, and the ability to participate in society
- Poor social conditions cause stress and anxiety, leading to poor health
- Poor social conditions can limit people’s choices and work against desirable changes in behaviour

Political economy perspective of the SDOH Two

fundamental questions:

1. How do differences in distribution come about?
 - a. For example, how is it that housing differences exist on such a wide range in Toronto, and how did they come to be?
 2. What can be done about differences in distribution?
 - a. How can we ensure that everyone has an affordable, reasonable place to live
- A political economy perspective is concerned with “systematic underinvestment” across a wide range of human, physical, health, and social infrastructure” (Raphael, 2010)

Early life

- Adequate income either inside or outside of the working force
- Universal, quality childcare and early education
- Support services for parents and children (eg. postnatal care, drop-ins, food workshops)

Education

- Support for literacy programmes
- Government investment in education (lower tuition & fees, etc.)
- Universal access & educational support
- Admissions & language assistance

Employment and working conditions

- Training and retraining programmes

-
- Unionization and support for collective bargaining
Increasing worker input into workplaces
- Workplace regulations (eg. minimum wage; caps on hours worked; sufficient staff, etc.)

Food security

- Adequate income and poverty-reduction policies
- Government support of 'access to food' projects
- Government support of farmers, food co-ops, smaller businesses
- Providing affordable housing (i.e. less spent on rent)
- Urban planning to create neighbourhood hubs, including grocery stores

Health services

- Broaden medicare to include SDOH & social factors
- Increase 70/30 public / private ratio
- Ensure healthcare is available (i.e. is there a health centre or offices in each neighbourhood?)
- Ensure care is accessible (i.e. physical access, interpreters, culturally-sensitive care, etc.)

Housing

- Adequate income and affordable housing
- Reasonable rent controls and housing supplements
- Social housing for those in need
- Emphasis on homes, not shelters; 'Housing first'

Income and income distribution

- Fair taxation policy (wealthy pay more)
- Guaranteed basic income, adequate minimum wages
- Social assistance levels that support health
- Revise 'residual' systems that provide inadequate support

Social exclusion

- Developing and enforcing anti-discrimination laws
- Providing ESL and job training
- Approval programs for foreign credentials
- Supporting other health determinants (eg. recreation, social connection)

Social safety net

- Providing adequate financial supports, i.e. employment insurance, maternity benefits, medication assistance, pensions, etc.
- Revise residual systems and criteria

Research provides evidence of the link between social determinants & health

- Why do some nations (provinces, municipalities) “take up this information and apply it in the formulation of public policy while others do not?... why is there a gap between knowledge and action on the SDOH in Canada?” (Raphael, 2010, p. 160)

Links between public policy and the SDOH

- “Differences in public policy (reflect) differing commitments to citizen support informed by the political ideologies of governing parties within each nation”
- Traditionally, where do Canada’s three major political parties stand with regard to commitment to addressing the SDOH?

Ten traditional tips for better health

1. Don’t smoke. If you can, stop. If you can’t, cut down
2. Follow a balanced diet with plenty of fruit and vegetables
3. Keep physically active
4. Manage stress by, for example, talking things through and making time to relax
5. If you drink alcohol, do so in moderation
6. Cover up in the sun, and protect children from sunburn
7. Practice safer sex
8. Take up cancer screening opportunities
9. Be safe on the roads: follow the highway code
10. Learn the first aid ABC: airways, breathing, circulation

Ten social determinants tips for better health

1. Don’t be poor. If you can, stop. If you can’t, try not to be poor for long
2. Don’t have poor parents
3. Own a car
4. Don’t work in a stressful, low paid manual job
5. Don’t live in damp, low quality housing
6. Be able to afford to go on a foreign holiday and sunbathe
7. Practice not losing your job and don’t become unemployed
8. Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled
9. Don’t live next to a busy major road or near a polluting factory
10. Learn how to fill in the complex housing benefit / asylum application forms before you become homeless and destitute

Video: Unnatural Causes notes

- Lack of healthcare is not the cause of disease and illness - Death:
- At what age? At what degree of suffering? With what degree of preventable treatment?
- The wealth of the top 1% in America is greater than the bottom 90% combined
- Life expectancy is nearly 80 years, which is 2 more years than the national average
- Over 70% of affluent Americans report very good to excellent health

- In the middle levels, good health decreases significantly
- America is classless and therefore, thought that they would not experience social gradients in health, like Britain did
- But there were social gradients everywhere within it
- Research shows college graduates live 2 ½ years longer than highschool graduates

In the last 20 years, tuition has increased by about 30%

- For most Americans, home ownership is a way to build financial security
- Half of all American households live at or below \$48,000/year - district 21 - District 5
- A third of the residences here have never received a HS diploma
- Life expectancy is 9 years less than district 16
- 30% live below the poverty line
- Life expectancy should not be depended on the essential resources available to you
- Social class is the largest SDOH
- Control of destiny
- Ability to manipulate the pressures that affect one's life
- Stress is affected due to a person being threatened, raises blood pressure, alerts the body
- Cortisol is released among other hormones
- Stress is good, but what happens when it stays for a long period of time
- Cortisol can impair immune function, reduce memory, cause brain areas to shrink at high amounts
- Stress is everywhere
- Chronic stress is not equally distributed along a hierarchy
- Researchers compared stress levels to social status
- More income = less cortisol release
- More education = less cortisol release
- Experiment exposed healthy people to a virus
- Those with less chronic stress acquired less colds
- 1 in 5 men work in a high demand, low control jobs (like cory in district 21)
- More likely to experience high pressure, and less likely to have it lowered even as they sleep
- 21% of American population lives in poverty
- Not knowing if you will be able to provide food on the table, etc. creates unending stress
- Release of these hormones has a direct impact on health, as previous stated
- The more years a child's parents own their home, the less likely they are to acquire colds as adults
- African Americans die earlier across the social gradient
- Not be of "bad genetics"
- The burden of being constantly "on-guard" is linked to biological affects that change one's vulnerability to disease
- A century ago, the average American lived about 48 years
- 1950s

- Income inequality was decreasing
- Medical advancements increased health
- 1960s
- Civil-rights laws, medicare and medicaid
- Prosperity
- 1970s
- Economic policy is health policy
- 1976: wealth inequality reached an all time low
- The poor are getting poorer, and the middle class is getting squeezed
- If we provide access to all, we still have a hierarchy but we reduce disparities - goal - Moved in the opposite direction
- Wealth = health
- Strongest relationship in America
- Wealth - health gradient is not as prominent in other industrialized nations
- Ireland - free college education
- Reducing child poverty to a mere 4.2% (didn't catch who does this, my bad)
- Countries where wealth is more equitably distributed are more healthy
- Power is a public health issue

Week 10 lecture notes November 18, 2019

What is a political system?

- A coordinated set of principles, laws, ideas, and procedures relating to a particular form of government
- In Canada, political systems + healthcare systems are closely related
- Canadian healthcare system is publicly-funded
- Tax dollars --- fed & prov governments --- health funding & decisions

Canada is a Federal State. This means:

- It is a confederation of one central or common government and several separate 'provincial' governments

-
- It defines how the central and provincial governments work together
- Desire to preserve the distinct identity of each province, yet felt it necessary to form a federation for “protection against the threat of American invasion or economic strangulation” (Forsey, p. 8)

In terms of governance, one major difference between Canada and the United States is that:

- a. Canada is a republic and the US is a constitutional monarchy
- b. Canada is a constitutional monarchy and the US is a republic
- c. Canada is an absolute monarchy and the US is a republic

In Canada, health care and education are primarily delivered:

- a. Provincially
- b. Federally
- c. health : federal; education; provincial

In Canada, which populations receive their health care federally?

- a. People in the military
- b. Aboriginal Canadians
- c. People in federal penitentiaries
- d. All of the above
- e. None of the above

The Canadian Charter of Rights and Freedoms

- a. Came into existence with the Constitution Act in 1982
- b. Protects the democratic, fundamental freedoms, mobility, legal, equality, official language rights of all Canadians
- c. Means that now federal and provincial laws can be challenged and thrown out of the courts
- d. None of the above
- e. All of the above

- Currently, Canada's electoral system is a 'first-past-the-post system'
- Some groups are calling for electoral reform, to introduce proportional representation (Bryant, 2010, p. 252)

What is proportional representation?

- An electoral system in which parties gain seats in proportion to the number of votes cast for them
- "Minority government situations have been associated with progressive public policy in Canada" (p. 253). Why?

What are 'Transfers'?

- Government distribution of fiscal resources that are generated by the economy to the population as services, supports, welfare payments, pensions, health, family supports, etc. (Bryant, 2010, p. 241)
- High transfers result in higher health outcomes; i.e. decrease in infant mortality & increase in life span (Bryant, 2010)
- Decline in infant mortality and increase in life expectancy also connected to:
- Support for social democratic parties; increased voting; increase in public health care; increase in union membership; increase in women working; increase in income equality; increase in national wealth

What are Canada health transfers?

- The money that the federal government transfers to provincial / territorial governments for the administration of provincial / territorial healthcare systems **What is policy?**
- Tools that are meant to build a more just society
- Policy: anagram
- “A plan of action adopted or pursued by an individual, government, party, business, etc.” (Collins Cnd English Dictionary & Thesaurus, 2004)
- “Actions (and inactions) of the state addressed to governance, regulation, and organization for the public good” (Bickenback, 2012, pp.2-3)

Definitions (Continued)

- **Law:** established standards and procedures that are meant to implement justice in society; general agreement that if they are broken, there is recourse
- **Policy:** a plan of action adopted or pursued by an individual, government, party, business; rules within an organization
- **Ethics:** framework for decision-making

- Ideally, policy should be tools that are used to implement change for the social good
- Laws does not necessarily provide the tools; ethics are used to inform law & policy

Analytical tools

1. Ideology of government in power
 2. History
 3. Economics: national and international economic conditions (for example, recession, depression, trade, oil prices, etc.)
 4. Current trends / social movements: events in society, population and demographic changes, etc.
 5. Pressure from individuals and interest groups
 6. Significant events (often tragic)
-
1. Ideology
 - a. When a government’s central ideology is concerned with ensuring equity amongst all its peoples, then its policies will reflect that desire
 - b. When a government’s central ideology is to allow markets, trade, and profit to dominate decision-making, then its policies will reflect its desire for noninvolvement
 2. History
 - a. Government decisions are informed by what came before
 - b. Example: Canada Health Act (1984), informed by weakness and limitations of original Medical Care Act (1966)
 3. Economics
 - a. Example:
 - b. Financial recession 2008

- c. Canadian and American governments bailed out several banks and large corporations (eg. CIBC, BMO, Scotiabank, GM)
- 4. Current Trends / Social movements
 - a. Example:
 - i. #MeToo movement has influenced development of sexual harassment policy
- 5.** Key figures / Pressure from individuals and interest groups
 - a. Example:
 - i. Mothers against drunk driving (MADD)

Establishment of Medicare

Founding of medicare

1. Ideology of government in power:
 - a. Saskatchewan, 1961: CCF: Socialist party with left-leaning tendencies (1961)
 - b. Determined to establish a stronger welfare state and ensure equity
 - c. Federally, 1966: newly-elected Liberal government
2. History
 - a. History of inequitable access to health care, based on income
 - b. Douglas witnessed Winnipeg General Strike
 - c. Federal government saw that Sask system was working
 - d. Feds wanted to follow increased public support for Medicare
3. Economic situation
 - a. Saskatchewan: government had planned fiscally (car insurance)
 - b. Determination to develop post-war welfare states
 - c. Covered only hospitals and doctors' services
4. Current trends / social movements
 - a. International trend to increase strength of social welfare state in post-war nations
 - b. Beginnings of civil rights movement
5. Pressure from individuals and interest groups
 - a. Key figure: Tommy Douglas
 - b. Baptist minister, believed in a radical, socialized version of religion
 - c. Believed in the possibility of a utopian society; did not believe people should 'qualify' for social assistance, etc.
 - d. Charismatic, leader, good orator, well-liked, etc.
- 6.** Significant events
 - a. General social movement towards development of welfare state post WWII
 - b. Hall (assigned by Diefenbaker) report in 1964-65 recommended that medicare become national

Medical Assistance in dying (Maid), or Bill C-14

1. Ideology of Government in power
 - a. Liberal government
 - b. Did not appeal the Supreme Court of Canada ruling (2015) that stated that lack of access to medical assistance in dying was unconstitutional
2. History

- a. Sue Rodriguez (1993); Charter Challenge that illegality of assisted suicide violated section 7 of Charter (life, liberty, security of person). This challenge was not upheld
 - b. Ruling overturned in 2015 with Carter vs. Canada: denying assisted dying in some cases violated Sec 7
 - c. “Only patients suffering from incurable illness whose natural death is ‘reasonably foreseeable’ are eligible for a medically assisted death.”
3. Economics
 - a. Proponents argue this is a human rights issue, less about economics
 - b. Critics fear that ruling raises possibility of ‘valuing’ people’s lives in context of ‘economic burden’
 4. Current events / social movements
 - a. Liberal society; autonomy of individual paramount
 - b. Control of death as well as life
 5. Pressure from individuals / interest groups
 - a. Dying with dignity Canada
 6. Significant events
 - a. Increasing publicity of individual cases

Operationalizing law into policy

- Each province now creates its own policies within its own healthcare system to uphold C-14
- There are provisions for doctors who do not wish to perform medically-assisted death

Lecture notes November 25, 2019

Several definitions for healthcare workers

- Ancillary (or subordinate) professions
- Limited professions
- Marginal professions
- ‘Allied’ health professionals
- ‘Para’ health professionals
- ‘Auxiliary’ health professions

Definitions of ‘professionalism’

- ‘Professional’: Traditional bio-medicine
- Doctors
- Nurse
- Physios - Radiologists - Etc.
- ‘Auxiliary’ or alterative:
- Homeopathy
- Naturopathy
- Acupuncture

- Etc
- May desire recognition & status of other group, without 'biomed' focus

Struggle for power and recognition raises questions:

-
- From whose perspective are these designations made?
- Who decides which profession belongs in which category? (i.e. professional, recognized, legitimate)
- How do professions gain recognized, legal status?

Healthcare regulation: history:

- Up until mid-1800s
- Few trained physicians; some offices in urban centres
- Local (Indigenous) and Euro-centric practices
- Little to no regulation
- Hospitals were 'almshouses': people went to die; mostly run by religious orders
- Key scientific discoveries (eg. TB bacterium)
- Increased use of scientific method
- Establishment & standardization of medical school programs
- First licensing acts, first medical journals biomedicine became 'dominant form of healing' (Gilmour et al., 2002, p. 150)
- By turn of 20th century
- Medicine had established itself as the leading health profession (Coburn et al., 1983)
- Managed to "carve a unique place for itself at the top of the healing hierarchy" (Gilmour et al., 2002, p. 150)
- By the end of WWI, medicine more or less "had a monopoly over the provision of care" (Coburn, 1989, p. 97)

Has medical dominance declined?

- Medicare, 1966: increased government oversight and regulation -- decreased doctors' power?
- Many doctors were opposed to Medicare because it posed a threat to their "economic and clinical autonomy" (Bearwood, 1999, p. 317)
- Even with this shift, most scholars agree that medicine continues to "occupy the preeminent positions among the health care professionals in Western society" (Gilmour et al., 2002, p. 151)
- What other reasons for the surge in auxiliary health professionals throughout 20th century?
- Modernization of medical care, increasingly specific diagnostics and treatments, advanced technology
- Increased specialization + professions

Example

- X-ray in 1920s --- College of Radiology, 1935
- Lab technicians - Prenatal testing
- Cancer screening
- Gradual increase in professionalization expansion of health professions, regulations, and accreditation throughout the 20th century

Healthcare regulation: rationalization, reforms

- The increase in lower-paid professionals allows government to pay less for 'same services'
- This is justified via the notion that these roles are 'less skilled'
- However, auxiliary health professionals have historically been women; gendered aspect to this division

What is the 'Rationalization' of healthcare?

- 'Rationaliation' refers to government efforts to save money - This is done in a number of ways:
- Using less expensive workers
- Creating reforms within the system
- 'Managing' healthcare through reduction in inappropriate use of services; emphasis on preventative and primary care, etc. (Bourgeault, p. 318)

What are examples of healthcare reform?

- Reforms concern improvement in health outcomes and cutting costs
- Examples
- Shorter hospital stays
- More outpatient services and day surgeries
- Cutting beds and staff
- Contracting out
- Deinstitutionalization (p. 316)

- Rationalization and reforms are also made possible through divisions of labour, which are regulated via Regulatory Colleges

What are professional colleges?

- Regulatory bodies that regulate professional practices in order to serve and protect the public
- Example: college of physicians and surgeons of Ontario
- Different from professional associations, which are professional administrative bodies for ongoing education, decision-making and the establishment of political positions - Example: Canadian Medical Association

What do professional colleges do?

- Oversee the practice of professional
- Protect the public interest
- Set standards for practice
- Have evaluation procedures in place to ensure workers are practicing safely, effectively, ethically
- Self-regulating: determine the rules that govern their profession (Adapted from COTO, CPTO)

- Receive complaints from the public about the practice of its members

- Councils within each College: members of the profession as well as people from the general public. Councils conduct the hearings of complaints which have been lodged against a member of the College
- Legally, in recognized professions, practitioners must belong to a College in order to practice in Canada
- Colleges 'discipline' a member if the member has shown a "deliberate disregard for patient welfare, engaged in reprehensible behaviour, or demonstrated extreme substandard care" (College of Physicians and Surgeons of Ontario)
- Bestow recognition, status and power to different professions within the healthcare system (Coburn 1993)
- For example, through 20th century, professions 'added' to list:
- Ontario College of Midwives; 1993
- College of Occupational Therapists of Ontario: Association began 1920s; gained College 1994
- Recognition as a 'College' increases public trust

From government's perspectives:

- Enhances public protection through standardization
- Can reduce costs by allowing less expensive practitioners to provide a range of services (Glimour et al., 2002)
- Can make healthcare more efficient: "rationalize"

Professional Colleges, Development

- Through the 20th century
- Medicine tended to "exclude, limit or subordinate competitor occupations such as chiropractic, midwifery, dentistry and pharmacy, and nursing" (Coburn, 1993, p. 131)
- Doctors also held administrative positions (eg. CEOs, Ministry of Health, etc.)

Developments

- Increasing professions: lack of clarity — who does what?
- Para-health professionals seeking to "escape medical domination" (Coburn, 1993, p. 133).
- Increasing pressure to respond to social movements (for example, the women's movement in the 1960s and 70s—most paraprofessions were dominated by women).
- 1991: Passage of the Regulated health Professions Act (RHPA) in Ontario
- 74 professions applied; 24 approved
- More have been added since

Examples of regulated professions

- Audiology & speech language pathology
- Chiropody
- Chiropractic
- Dentistry

- Homeopathy
- Kinesiology

- Medicine
- Midwifery
- Naturopathy
- Optometry
- Psychotherapy
- Traditional Chinese Medicine

Are regulatory colleges a trade-off?

On the one hand

- 'Credibility' and status -- recognition of professionalism and increased demand for services
- Increased opportunity for services to be paid for by the government
- "Provides protection for the public from unqualified, incompetent, or unscrupulous practitioners" (Gilmour, 2002, p. 150)
- Which profession have most to gain from College status?

On the other hand

- Increased state control with regard to funding & organization
- Less autonomy and control within the profession; more bureaucracy, less professional practice
- Pressure to constrain costs
- Smaller professions may have difficulty defending their ability to provide certain 'licensed acts'

Licensed Acts

- "Health professionals do not have a monopoly over whole areas of endeavour... but instead have the authority to perform specific 'licensed acts'" (Coburn, 1993, p. 135)
- 'Scope of practice': indicates what a profession can / cannot do
- •Ontario: 14 licensed acts (for example: diagnosis; performing a procedure below the dermis; managing labour).
- •Medicine: can perform 13 of 14 (has a wide scope practice).
- •Nurses: can perform 4.
- •Physiotherapists: none, but may receive permission to perform certain 'acts' if they are put on a roster.
- •Occupational therapists, speech-language therapists, and dieticians: none.
- Professions can ask government to amend their list of 'licensed acts'
- -Specialized 'acts' will limit unregulated practitioners and will protect the public (Gilmour et al., 2002).
- - Also limits smaller professions from practicing (eg. Homeopathy).
- However, broadening lists of 'licensed acts' also means the government can allow low-cost professions to provide services ('rationalization').
- For example, having PSWs perform nursing duties—saves government \$\$\$.

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- College status authorizes that some, or all, of the profession's services will be covered under Medicare (in Ontario, OHIP).
- Medicare only assumes coverage for "medically necessary services", i.e. services provided by hospitals and physicians
- Provincial governments decide what services will be covered:
- These vary from province to province.
These fluctuate within provinces.
- "Effective November 1, 2004, routine eye exam services provided by both optometrists and physicians for patients age 20 to 64 years are no longer insured" (MofHLTC, Bulletin # 8089).
- Smaller alternative professions (eg. homeopathy, naturopathy, traditional Chinese medicine) face more difficulty defending financial coverage of their services than traditional, biomedical practices, or those that perform one of the designated 'licensed acts'.
- Payment of services for treatment outside of traditional biomedicine is dependent on individual insurance plans with employers.

Midwifery

- Despite history, was strongly opposed by the powerful medical establishment by the beginning of the 20th century.
- - Bourgeault (2010) suggests that this is an example of gender-based discrimination in professional practice.
- - Control of birthing by doctors meant less competition and more control over family care.
- - By the 1950s in Ontario, midwifery had almost disappeared from healthcare practice.
- Medicare (1966): midwifery services were not included.
- Women who chose to have a midwife had to pay for their services and had to acknowledge that midwives' care was not regulated through a College.

Social movement:

- Increasing public pressure, fuelled in part by the feminist movement and greater demand by women for female-centric care led to a re-emergence of midwifery as a recognized profession.
- Midwifery became a recognized and regulated profession in Ontario with the passage of the RHPA in 1991.

Conclusion

- Traditional biomedicine has historically dominated the Canadian healthcare system
- Other professions, especially those considered complementary or alternative, have had to work their way towards recognized status through pressure on the government and acknowledgement by social movements.
- A total of 24 health professions achieved regulated status via the RHPA in 1991; the number is now 26.

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- Licensed Acts can both secure and limit the practice and power of various health professions.
- Financial coverage of services is assisted but not guaranteed by inclusion in the RHPA; coverage fluctuates and varies from province to province.
- Increasing de-listing of services suggests an increase in the privatization of health care.
- Complementary and Alternative practices must work harder to ensure recognition and status within the healthcare system.

Exam study tips:

Study the slides

- Be prepared to integrate material from more than one lecture
- Be familiar with the readings i.e. know the principal author's name, and the main point of the article -- what was the author trying to say?

Example

Author	Name of article & publication	Main point(s)	Course connections
Evans, R.	Canada , <i>J of health policy & law</i>	Summary of Cnd health care system and how it works (++)	Explains foundation of HC system (++)

Sample exam question:

Choose the most correct statement:

A)Health profession regulation in Ontario was legislated soon after WWI

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- B) The original health professions regulation in Ontario included 75 professions.
- C) Medicine (i.e. Doctors) are not included in Ontario's health professions regulation legislation.
- D) The Regulated Health Professions Act was passed in 1991.

Lecture notes December 2, 2019

Informatics: The study of information

The study of how health data, information and knowledge are collected, stored, retrieved, processed, used and communicated

- For communication, problem-solving and decision-making with the goal of improving health care

Informatics: Features and definitions

- **Digitalization:**
- Digitized record-keeping and information sharing emerged in the late 20th century
- Move from paper-based to electronic record-keeping and information -
- **Connectivity:**
- Between patients and doctors
- Between doctors and doctors, & all health providers
- Moving technology into the general populations
- International connectivity: to seek information and to reach remote and underserved areas
- **Increased information**
- Wwww has moved information and technology solely from providers to patients to general population
- Healthcare professionals must be prepared to face more 'informed' patients / consumers
- Many governments are now invested implementing EHRs, with the intention of "streamlining care, reducing mistakes, and cutting costs" (Garrety et al., 2014, p.70)

Ehealth: the digitalization of the information used within the healthcare system, particularly in regard to patient records and care

EHRs: Electronic Health Record: electronic version of individuals's health files; goal is to include information from all sources

EMRs: Electronic Medical Record software: refers to the software system that physicians use to collect, manage, and store EHRs

PHRs: Personal Health Record: the records that patients access and maintain

EHRs: Implication

- Allows for sharing & retrieval of patient information

-
- Allows for insertion of non-subjective mechanisms -i.e. Patient alerts, decisionmaking, clinical guidelines
- Changes how patient care is conducted and how workplaces function (centralized data entry sites)
- Allows for integration with other networks or information technologies (i.e. web, clinical information systems)

Benefits

1. Better access to healthcare services by the public
 - a. More coordinated appointment scheduling between professional offices (primary care professionals, specialists, labs, etc)
 - b. Reduced test / lab duplication
 - c. Potentially less wait time for treatment
 - d. Consumer empowered wellness programs for higher awareness and self health management

2. Better delivery of healthcare by professionals
 - a. Immediate access to critical information
 - b. Legibility (access)
 - c. Coordinated service delivery & follow up; access & retrieval of information across institutions; simultaneous access at multiple locations
 - d. Standardized, searchable medical terms
 - e. Faster turnaround on results
 - f. Improved intra- and inter- professional communications
 - g. Improved coordination of service scheduling
 - h. Decision support
 - i. Access to online professional development
3. Health organizations provide more effective & efficient management of healthcare services
 - a. Reduced duplication of services
 - b. Improved health safety
 - c. Reduced liability and improved fiscal accountability through greater predictability of health care expenditures
 - d. Allows pt records to be automatically linked to other systems
 - e. Trend analysis
 - f. Alerts **Issues**

- Difficult to introduce & implement into hospitals and offices; complex 'organisms' with established infrastructure
- Expensive maintenance & support
- Resources & training are costly and time-consuming
- Technology must 'catch up' to measure efficiency, safety & impact on decisionmaking & patient care
- Lack of standard re: language and use
- Lack of usability
- Time-consuming to complete

Professional resistance to change:

- Changes to workflow
- Professional reluctance to give up control of being primary source of information for patient care
- Inertia; lack of energy / desire to implement change and invest in time needed Fear:
- 'Cookbook' medicine: standardized language means EHRs can become "ordering devices, describe specific casual relationships, and consequently privilege one language system over equally plausible others" (Bar-Lev, 2015, p. 405)
- doctors / nurses must 'choose' from list of terminology, diagnoses, etc. -- little room for discretion, description
- Unable to give a "fair representation" of what they are clinically encountering
- May satisfy administrations (i.e. #'s of diagnoses seen), but does not leave room for description, nuance, problem-exploration
- Hence, limits the 'art' of medicine to objective data & measurement

Political: particular language systems are 'privileged'

- Their influence on the way in which “medical interventions are recorded, interpreted, and administered” (p. 404)... means that EMRs are “inherently political” (p. 405)

Privacy, confidentiality and security:

- Records access and security, confidentiality, ownership
- Increase in numbers of people who have access to patient information and have the skills to access patient records **Privacy:**
- It is not possible to achieve both perfect confidentiality and perfect access
- Needs-to-know assessment: for healthcare professionals; for parents (or parents for their children)
- How much information should be sent from one provider to another?
- How much information should be available to patients? To the governments?

Security:

- **Data security:** protection of data from accidental or intentional disclosure to or alteration by unauthorized persons
- Protection of data in non-secure spaces -- i.e. non-protected networks, over the internet
- Protection of software, hardware, connectivity
- authentication , access control, encrypted information, staying technologically current (i.e. smart cards, etc.) **System security**
- Measures to keep system safe from unauthorized access, physical harm, damage
- Administrative procedures
- Disaster recovery

Privacy & confidentiality laws Federal

legislation:

- **Privacy Act (1985):** protects the privacy of individuals with respect to personal information about themselves held by a government institution and that provide individuals with a right of access to that information”
- **Statistics Act (1985):** “the authority to” collect, compile, analyze, abstract, and publish information on the economic, social and general conditions of the country and its citizens” Balanced by the “legal requirement for the agency to protect the confidentiality of respondents to Statistics Canada”
- **Personal Information Protection and Electronic Documents Act (2000):** to establish... rules to govern the collection, use and disclosure of personal information in a manner that recognizes the right of privacy of individuals with respect to their personal information and the need of organizations to collect, use or disclose personal information for purposes that a reasonable person would consider appropriate in the circumstances **Provincial legislation:**
- **PHIPA: Personal Health Information Protection Act, Ontario (2004):** established rules for the collection, use and disclosure of personal health information that protect the confidentiality of that information and the privacy of the individuals; provides individuals with the right to access that information **Individual institutions & their administration:**
- Each hospital / healthcare centre has its own policies & procedures - Do these laws ensure a secure system? Why or why not?

Canada Health Infoway

- An independent, non-profit, government-funded organization (est 2001), that works with provinces and territories to establish digital health projects in Canada

Ontario: Current situation

- 2/3 Ontarians currently covered by EMR software
- 8/10 physicians using EMR software in their practice
- Doctors can receive hospital reports into their EMR software within 30 minutes (as opposed to several days by mail or fax)
- 325,000 'vulnerable' clients are served through EMR software at CHCs
- Medication history of all Ontario seniors is accessible to healthcare providers in all Ontario hospitals and ERs
- 100% of hospitals can share e-reports and diagnostic images with hospitals in their region

Ongoing concerns in Canadian Healthcare 'Privatization

creep'

- Increased health services paid 'out of pocket'
- Ration of public / private at risk of decreasing

Decreased funding from federal and provincial governments

- Decreased Federal transfers
- Decreased compliance from provinces = decreased transfers
- Provincial governments' decision to cut healthcare funding

Reduced spending on public health

- Funds directed toward curative, not preventative medicine
- Decreased funding to low-cost, community-based healthcare (eg. breakfast clubs; public education; immunization clinics, etc.) **Ongoing lack of Pharmacare & drug regulation**

- Federal government spends a lot of health budget on drugs - Drug reform needed: federal regulation; single-buyer system, etc.

The 7 themes of HLST 1010

1. Defining the field of health studies

- a. Health studies moves beyond traditional epidemiological and diagnostic / treatment approaches
- b. Health studies must now consider health, illness, and health care using political economy, sociological, and human rights approaches
- c. Is also about human capacity to "realize aspirations and access opportunities for human fulfilment" (p. 436)

2. Conflict vs consensus models (p. 437 of the text)

- a. Consensus models (eg. structural functionalism) are “driven by an assumption of consensus among different groups in society... Stability and minimal conflict is assumed”
- b. “Conflict model focus on tension in society and the role played by power - such as the balance between the market and publicly controlled structures - and how these shape the experience of health and health care”
- c. “Political and economic forces are key contributors to these tensions

3. Prevention vs Care (p. 438)

- a. Conflict between prevention (i.e. SDOH, health public policy, societal organization, etc) and traditional biomedical care (diagnosis & treatment)
- b. Operating & research funds allocated overwhelmingly towards care, not prevention. Illness is more concrete observable, and treatable
- c. “Policy-makers, reinforced by the medical profession, the media, and public understandings of health, direct their attention to lifestyle approaches and narrow healthcare issues”

4. The Public vs Private debate

- a. Concerned with ownership and control of public resources and the healthcare system
- b. The privatization of public resources such as housing, income, healthcare, and education has implication for the social determinants of health and the public’s well-being
- c. Decommodification (i.e. not having to pay for benefits & services) of resources results in stronger public sectors and better health outcomes
- d. Healthcare system under constant pressure to increase privatization, rationalized as a way to cut costs

5. Constructing illness and disability (p. 440)

- a. - When disability & illness are viewed primarily in terms of disease and divergence from the ‘norm’, then disability & illness remain individual problems, power remains with the medical profession, and little is done to alter oppressive structures & barriers in society (physical, political, economic, attitudinal).
- b. - Measuring health only by morbidity and mortality rather than “by the conditions that affect them” means that “money and policy decisions go towards investment in medical care”, not towards changing social structures or addressing human rights issues

6. The role of public policy (p. 441)

- a. - public policy refers to “decisions made by governments and other large organizations [i.e. hospitals] on how to address identified problems”
- b. - public policy shapes the “quality of the social determinants of health and the organization and delivery of healthcare services”.
- c. - government and public ideology drives policy.
- d. - health professionals receive little “training in public policy analysis”

7. The future of the welfare states

- a. - social democratic welfare regimes create conditions necessary for health (equitable distribution of wealth; progressive tax policies; support to children, families, & women; economies that support full employment).
- b. -liberal welfare states have modest universal transfers and modest social insurance plans.
- c. - states governed by a neoliberal ideology have the least generous social welfare policies
- d. -ideologies are “malleable and social policies can be changed” (p. 442).
- e. - economic globalization, in which markets determine political, social, & economic activity, poses a risk to health.

What have we learned?

- Social, political and economic conditions, particularly those which reflect inequity in the population, all influence population health and health outcomes. Health goes beyond healthy living habits
- There are three principal social welfare state typologies: Social Democratic, Liberal, and Conservative / Familial. Each typology reflects a specific ideology; each ideology in turn influences policies and decision-making, including those involving health.
- - SDOH are important indicators of health; investment in the SDOH would decrease social inequality and improve population health.
- - There are different frameworks which can be used to analyse health and the healthcare system. These include epidemiological, sociological, political economy, human rights approaches; critical race, gender, and disability lenses.
- There are population groups existing in Canadian society who experience marginalization in all systems, including health.
- - Government policy needs to be directed towards correcting social and economic inequality in order to achieve better health for all Canadians.