CONTROL OF THE CANADIAN HEALTH CARE SYSTEM: MEDICAL POWER VERSUS STATE REGULATION

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Declaration

I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any university. To the best of my knowledge and belief, it does not contain any material previously published or written by another person except where reference is made in the text.

Laura Brewer
Preface

My interest in this area was sparked by the 1980’s doctor’s strike in Ontario. After several conversations with young doctors about the impetus for the doctors’ actions and their arrogance regarding the public’s ability to understand the issues under dispute intrigued me greatly. Yet every one of those doctors expressed a different view of the Ontario government’s position on health care, particularly with regard to delivery of health services. Underlying the different accounts shared was the belief that the state was no longer “holding up its side of the bargain”. The more I asked about what bargain had been struck, who had negotiated it and how it was being challenged, the fewer answers these doctors had. It struck me what blind faith physicians had in their “leaders”, as they saw reflected in the opinions of the Ontario Medical Association (OMA).

If the result of this doctors strike was any indication, the doctors had completely misjudged the government’s influence and public scrutiny of the issues. This lead me to analyse the relationship that had developed between the state, the medical profession and the public. The disputes reflected in the doctors’ strike indicated the difficulty these three parties have in determining the nature and conditions of the health care delivery system. It became clear that the medical profession had dominated the relationship with the state with the public showing little interest. When this changed the nature of the relationship between the interested parties became strained. My interests lay in the terms and conditions under which the public, the state and the profession negotiate health care delivery issues.
Acknowledgments

A project of this magnitude cannot be completed without the encouragement and assistance of others. Associate Professor Adam Jamrozik, Professor F.L. Jones and Professor Bruce McFarlane contributed their academic expertise without restricting my own insights; for this I am grateful.

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My greatest thanks goes to Bijit Bora who never lost the enthusiasm or belief in my ability, even when my own temporarily dwindled. He typed drafts, gave helpful suggestions on statistical presentation and contributed in ways that are difficult to express. Kendall, Katie and Zac never really understood what “mom” was doing but they allowed me the time and space I needed to complete this undertaking; I dedicate this thesis to them.
Abstract

The debates over the status of professionalism which include arguments from deprofessionalisation, proletarianisation, corporatisation, rationalisation and bureaucratisation theorists often go untested empirically. Upon examination of the application of the theories to the medical profession, this becomes even clearer. The evidence cited about the medical profession in Canada, although varying from study to study, emphasises the circumstances surround the implementation of Medicare alone.

This thesis demonstrates the difficulties with this focus, suggesting that the empirical evidence does not support the proletarianisation of the medical profession in Canada arguments. Statistics from the Canadian Medical Association’s censuses of Canadian physicians as well as interviews with doctors in non-conventional practice settings indicate that doctors employed in bureaucratic organisations continue to enjoy autonomy and decision-making power in these organisations. Examining the struggles between the state and the medical profession since the state’s implementation of Medicare suggest that the new strategies adopted by the physicians may protect them from any further erosion of their powerful position in the health care arena.
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CHAPTER 1

INTRODUCTION

Since the 1970s there has been a debate over the status of professionalism; a debate that grew out of the many threats, challenges and questioning of the dominance of professions in society, particularly western developed societies. Arguably the most studied of these professions, medicine, has been the focus of interest within this debate. Two recent publications, *The Milbank Quarterly* (1988) and Hafferty and McKinlay (1993), were dedicated, entirely, to cross-cultural comparative analyses of the medical profession.

Within this debate Eliot Freidson is the principal spokesperson for the medical dominance position. He continually reasserts his claims that, despite the many challenges mounted against the medical profession in the United States, the profession continues to dominate the practice and organisation of medicine because of the protection and patronage of the state (1994, 33). McKinlay and Arches (1985) challenge this assertion, arguing that physicians, like all occupations, have been forced into proletarian functions due to the bureaucratisation inherent in capitalist expansion. Marie Haug (1973, 1988) sees the medical profession losing its monopoly over knowledge and public acceptance of its authority, leading, ultimately, to the deprofessionalisation of medicine.

This debate is explored in this thesis in order to achieve two central aims. Firstly, this thesis seeks to highlight some of the problems in the level of theorising in many of the arguments over the status of professionalism. Secondly, it attempts to determine which of the processes under debate is more significant in determining the status of the medical profession in Canada. Coburn (1993, 102) argues that Canadian medicine had gained control of the context of practice, hospitals and other health occupations by the end of the first World War. But since that time, there has been an erosion of the profession’s
monopoly, particularly over the context of care, suggesting the gradual proletarianisation of medicine.

Wahn (1987, 438) claims that Canadian physicians’ work is being continually rationalised to the extent that many are experiencing economic and organisational alienation. On the other hand, Swartz (1977, 327) argues that the medical profession in Canada maintains control of the health care system, particularly in the hospitals. This position is gained, he argues, by the profession’s ability to acquire control over the definition of disease, as well as how, when and where to treat it.

There has been little empirical evidence offered in support of the claims made about the medical profession in Canada. And too often assertions are made based on arguments about the medical profession in other countries, particularly the United States or the United Kingdom. The history of the medical profession in Canada has been different from that in other countries and this must be taken into account when theorising about the status of medicine in Canada.

In order to understand the position of the medical profession in Canada it is important to explore the sociological debates surrounding the status of professionalism generally. Chapter 2 presents an overview of this literature, outlining the proletarianisation, deprofessionalisation and professionalisation theses. Each of the three processes is discussed and measurable indicators are suggested. Theorists within one camp are measuring the process in very different ways from theorists in another camp (in many cases individuals within the same camp are using different measures), so it is important to look to the indicators.

Many of the arguments about the status of professionalism revolve, in part, around the definitional difficulties surrounding the notion of professions. There has been a preoccupation amongst students of the professions (particularly in North America) with defining what constitutes a profession, highlighting distinctive characteristics (Goode, 1957; Greenwood, 1957, for example) or the steps or stages an occupational group
must achieve in the professionalisation process (Wilensky, 1964, Caplow, 1964, Pavalko, 1971, Etzioni, 1969, for example). Other theorists focus on the political process or the power an occupation needs to overcome competition and establish itself as the only group that can perform the duties it seeks to monopolise (Ritzer, 1977; Johnson, 1972, for example). The selective emphasis in definition that individual theorists attach to a profession often dictate the predictions one makes. According to Hall's (1983) damning review of the sociology of the professions, the debates of the mid-1970s, and the inherent definitional problems, put an end to the study of professions. What Hall failed to recognise is that these debates led students of occupations and professions to abandon the definitional focus of the previous fifty years and to concentrate, once again, on the societal features which have changed the nature of the labour force and therefore, the dynamics of professionalism. As society develops and the nature of work changes, study of the professions continues to be both interesting, useful and important.

The proletarianisation argument flows from many theories of "the new middle class", focusing on the economic component of labour which suggests a "series of degradations of work, career prospects, autonomy and salary differentials," are bound up with the progressive removal of the function of capital from many professional groups (Roslender, 1981). Proletarianisation, used in this sense, means we can speak of the proletarianisation of the professional if the professional is experiencing or has experienced a loss or decline in the decision-making power over capital or labour.

Proletarianisation of professionals has been broadly defined as the process of becoming a dependent salaried employee, implying subordination based on the appropriation of power over the process by a non-professional management. Derber (1983) argues that proletarianisation theorists have failed to properly conceptualise the meaning of dependent professional employment. He explains proletarianisation analyses rest on a structural definition of two distinct types of proletarianisation: technical, which refers to the loss of control over the process of work ("the means") through management; and
ideological, which refers to the loss of control over the product ("the ends"), leading to managerial control over the goals and social purposes of one's work.

The classic deprofessionalisation position was advanced by Marie Haug who argues that "ideological challenges to professional status suggest a deprofessionalised future" (1975, 197). Professional, according to Haug, is a status term; deprofessionalisation is a status-equalising process directly assaulting the status position of occupational incumbents (pp. 198-199).

Larson, accepting the deprofessionalisation position, argues that professionals are losing the capacity to maintain control over the division of labour as a whole, including the allocation of tasks and the exercise of authority over others. Professionals are simply performing one or few tasks within the division of labour under the direction of managers (1979).

The professionalised position is presented by post-industrialists who claim that theoretical knowledge is the central source of power in post-industrial society, which is characterised by the expansion of the service economy and, therefore, domination of the professional and technical class. The growth of the professional-technical class, with its control over scientific and theoretical knowledge, means that property and political position fade as the bases of power, being replaced by knowledge (Kleinberg, 1973,45). Bell, Freidson and other post-industrialists point out that the authority of professionals as "technical experts" has expanded during the period of transformation of professionals from free practitioners to employees, while the move to bureaucratic organisation provides a stable institutional base for the continuation of professional authority and control.

We can see that these arguments were originally presented as a view of the future status of professionalism and since that time the predictions have been tested with evidence accumulated since the debate began. A number of studies of the medical profession, for example, have put to the test the predictions of the 1970s. Freidson (1994) claims that
the medical profession in the United States continues to maintain its powerful position, achieved by way of its "corporate authority". Starr (1982), again looking at organised medicine in the U.S., argues the profession is becoming "socially transformed". Others emphasise the gradual proletarianisation of physicians demonstrated through such things as state patronage, increasing bureaucratisation and loss of control over the means and/or ends of their labour (Lowellsmith, 1994; Derber, 1982; McKinlay and Arches, 1985, for example). However, many of the cases presented have not been empirically tested and remain unconvincing.

To address this deficiency, the theoretical perspectives presented in Chapter 2 had to be operationalised in order to gain some understanding of their significance for the Canadian health care scene. Chapter 3, which lays out the methodological approach used in this study, led to one form of operationalisation. A number of contemporary and historical data sources were employed to help assess the position of the Canadian medical profession in this debate. In order to grasp the complexities of the position of the profession a number primary sources, such as federal health acts, provincial government proposals, position papers of the Canadian Medical Association (CMA) and provincial medical bodies were used. Commentaries on the history of medicine in Canada were considered in order to gain a greater understanding of the relationship between the state and the medical profession.

Contemporary sources such as the CMA's Physician Manpower Surveys, York University Survey of Physicians in Canada were used to help empirically assess the current position of the profession. Recent policy papers were reviewed to gain insight into the official position of the key players. Commentaries on health care developments were engaged in to establish the state of the relationship between the key players in the health care system, particularly the medical profession, the state and the public. Interviews with physicians in various work settings were conducted in order to provide a fuller context for the physician questionnaires as well as obtain a feel for the views of
those physicians who were not practising in the traditional settings versus those that were.

The numerous sources surveyed helped take the theoretical arguments out of the abstract and into the reality of the work practices of Canadian doctors. This thesis begins with an analysis of the theoretical perspectives presented in Chapter 2 with reference to the status of professionalism in bureaucratic settings, generally. Chapter 4 clarifies the debate by locating professions and individual professionals in their employing organisations. We recall the arguments put forward by the proletarianisation and deprofessionalisation theorists that professionalism is compromised by employment in bureaucratic settings. We also note that Freidson (1994, 40-42), representing the professionalisation position, argues that professionalism is not compromised by institutional employment. His view will be assessed through an examination of the literature on "professional organisations".

Although there is an abundance of human organisation literature on professionals in bureaucracies, it mainly concentrates on the problematic integration of salaried professionals into structured organisations. Since this bureaucratic-professional conflict dominates much of the literature, there has been limited study of "professional bureaucracies" and the topic of salaried professionalism is left virtually unexplored. To address this weakness, Chapter 4 discusses both the human organisation and the sociological literature on professionals in organisations.

The interest of Chapter 4 lies with the traditionally "free" professionals (doctors and lawyers, for example) permanent move to employee status. It questions the "professional-bureaucratic conflict" through close examination of the structural features of professional bureaucracies. The various types of organisations which employ professionals are analysed highlighting the common features. It is argued that organisations staffed by professionals characteristically involve decentralised decision-making and management through consultation with staff rather than arbitrary unilateral
decision-making. It requires management's faith in individual employees' ability to make decisions in the best interest of the client/product and the organisation. Organisational needs are blended with staff preferences and employees are given as much latitude as possible (Guy, 1985).

Developments in organisational theory suggest that institutions which hire professionals function effectively because they operate as 'loosely coupled systems' (Weick as cited by Freidson, 1984:13). We examine such institutions to determine the "degree of bureaucracy" in professional practice settings. The management structure of professional bureaucracies suggest a "flattening of the organisational hierarchy or decentralisation by spinning off divisions which are then allowed to function autonomously" (Raelin, 1986a, 24). Strategies are designed and implemented by organisations to accommodate professional interests while facilitating organisational task accomplishment. These strategies range from professional career ladders to "transition to management" programs as well as professional socialisation into corporate culture (Raelin, 1986a and 1986b; Reed, 1992; Whalley, 1986).

Professionals occupy positions which involve decision-making; so they command importance in the employing organisation and exercise control over their own work (Barret, 1970; Waters, 1989). "New class" theories, which explore the power relations in professional organisations, argue that professionals control the bureaucracies where they are employed (Kristol, 1978, 27). According to Spangler (1986, 186), this argument is valid only if professional employees interests do not become self-centred, otherwise employers can develop strategies to bring individuals under control. Professionals must focus on the goals of the profession rather than those of the individual in order to maintain their autonomy.

Professionals employees are different from other employees because they maintain power and autonomy in the workplace and their work is evaluated along a system of collegial freedom rather than hierarchical administration. The indeterminacy of professional
knowledge helps protect employees from evaluation by superiors. It also protects autonomy by preventing technical means of standardisation and routinisation (Derber et al., 1990; Gouldner, 1979; Waters, 1989).

Freidson examined the issue of whether employment status affects a professional’s autonomy and/or economic rewards. He concludes that when one "examines the conditions surrounding self-employment in actual historical circumstances, it is impossible to argue that the self-employed enjoy greater economic security, higher economic rewards and more autonomy at work than the employed" (1984:9). Others argue that for the professional, bureaucracy creates conditions with fixed rules and jurisdictions created by others in a hierarchical command system (Oppenheimer, 1973 for example).

The ultimate question of whether bureaucratisation reduces professional autonomy and control is addressed in Chapter 4 while the dynamics of the employment settings of Canada’s doctors is dealt with in Chapter 5. Although there have been a number of arguments advanced on the status of Canadian medicine, they have not been convincingly argued because they have lacked an understanding of what, precisely, doctors are doing in the workplace. Chapter 5 attempts to overcome this by applying the arguments presented by the proletarianisation of medicine theorists (Chapter 2) and the bureaucratic organisation of professional labour literature (Chapter 4) to the work settings of Canadian physicians.

An examination of the structural features of a range of physician practice settings is conducted to determine the degree of bureaucracy, the management structures, and the level of autonomy, authority and control physicians have in their workplaces. The activities of self-employed doctors in solo practice are compared with physicians in group practices, hospitals, clinics, government and companies, where remuneration is either fee-for-service or salaried. Each of these settings entails different remuneration schemes, management practices, kinds of tasks and the ways these tasks are allocated,
which allows us to draw conclusions about not only the diversity of practice arrangements, but the dynamics. We can understand, more completely, the proletarianisation of medicine arguments and their relevance. As is explained in Chapter 3, the data used to analyse the work settings of doctors in Canada is, predominantly, the Canadian Medical Association’s Physician Resource Data Bank. This gives us statistical information of the activities of physicians across the country for the periods 1982, 1986 and 1990. This evidence, combined with interviews with physicians across settings, allowed us insights into the complexities of the employment settings, suggesting that medical practitioners have not compromised their professionalism, nor lost power as a result of becoming salaried employees.

Upon completion of the analysis of the relevance of the proletarianisation of the professions argument with regard to Canadian physicians, we are able to move on to the ways in which the profession, as a whole, has been able to face its challenges from the many interest groups which have mounted threats against its powerful position in the Canadian health care field. The deprofessionalisation arguments allow us to explore the ways in which a profession’s power can be undermined.

Terence Johnson (1972) emphasises that the power and authority of professionals sets them apart from other occupations. The professions exercise a monopoly over their expertise including the power to exclude competing occupations and the power to control their own profession (recruitment, legislation, licensure and so on). But professional autonomy and authority are dependent on state-granted power and internal organisation, which become extremely important considering the possibilities for internal disruption through state interest in the professions.

The question of professional monopolisation has always been a major concern of competing occupations, but questions are now being raised by the public and the state. The public is questioning whether the authority granted to the professions and the privileges entailed provide significant benefits to the consumer. The state, on the other
hand, is more concerned with the effects of reduced competition, innovation and change and the increasing cost of professional services. A number of studies are questioning the supposed benefits of professional licensure (Ostry, 1984, for example).

Chapter 6 presents a brief account of the professionalisation of medicine in Canada, highlighting the position of the state as well as medical representatives in the development of the profession, thus, providing keys to understanding its present and future position in society. This Chapter has been divided into three periods of significance in the development of the profession: Organisation, Establishment and Negotiation.

The organisation period covers the early struggles of practitioners in establishing status over other health providers and non-orthodox medical people by convincing the state and the public of their “expert” status. The idea that scientific knowledge served as the basis of medical practice, was the key aspect in convincing the state and the public, thus elevating the orthodox medical community into a powerful profession. It allowed this elite community to establish legislation that would prevent homeopaths, naturopaths, midwives and others from providing legitimate health care. It also served to unite conventional medical practitioners while excluding others, an important strategy in the professionalisation process. The unity of conventional practitioners manifested itself in elite medical societies, with exclusive membership, leading eventually to the establishment of the Canadian Medical Association (CMA).

The establishment era saw the licensing and registration of medical practitioners dominate the agenda of the elite medical societies. Establishing medical training on a university basis served to assure the public and the state that the scientific and esoteric knowledge base would lead to improved standards of care. But it also served as a further exclusionary measure on the part of the elite practitioner groups; non-orthodox practitioners would have to adopt the orthodox ideology gained through university training. The relationship between the state and the profession became clear; the
profession had developed its authority over medical practice, other health occupations and the public and the state sanctioned this position, remaining uninterested in health matters except under extreme circumstances. This situation was about to change when the state moved to express greater interest by way of seeking to establish a health insurance scheme (Medicare) for Canadians -the negotiation stage.

The negotiation period is characterised by complicated discussions, official and unofficial, amongst the medical profession, the state and other interest groups. Analysis of these discussions and their outcomes allows us to pursue the deprofessionalisation of medicine arguments presented in Chapter 2. This is accomplished through an examination of the legislative developments (federal and provincial) surrounding the introduction of Medicare and the experimentation with alternative medical service delivery models, particularly Community Health Centres (CHCs). The negotiations and outcomes of these two movements are compared, giving us important insight into the strategies of the key players. Although there is a focus on the official legislation, the views of many interested parties were included. These were gained through social accounts of the events, newspapers and physician opinion surveys conducted in 1982 and 1993 as well as through physician interviews.

Taylor (1978, 379) argues that the events leading up to the introduction of the Canadian government's national health insurance program was plagued with serious and difficult political decisions, complex administrative structures and complicated funding arrangements. It was put in place in every province despite the rejection of the medical profession. Chapter 6 highlights the important aspects of the negotiations, emphasising the role of the profession in the process.

As medicine had its dominant position in health care firmly embedded in the system, challenges from the state were met with the same strategies that gained the profession the status it attained. These strategies included convincing arguments about the value of its scientific basis which served to guarantee its knowledge monopoly, developing a
homogeneous practitioner community, accomplished through unity and exclusionary measures, solidified through universal education, and infiltration of the state apparatuses concerned with health matters. Chapter 6 seeks to determine why these strategies worked to gain the medical profession the status it did, yet, failed to thwart the federal government’s Medicare movement.

Although the issue of a national health insurance scheme had been raised by the federal government as early as 1919, it took fifty years to become a reality. It perhaps signalled the first time the state and the medical profession had to enter serious negotiations since the early 1900s when orthodox medicine fought to establish professional status. The medical profession did not support the government’s scheme and many have argued that the government’s implementation of Medicare, despite medicine’s opposition, places the government in control of medical services (MacDermot, 1967, 93 for example). Coburn (1988) argues the implementation of the health insurance scheme led to a decrease in the power of the Canadian medical profession. But as a result of the implementation of Medicare, physicians benefited financially as they became part of a system that assured they were paid for all their services (Barer and Evans, 1986). So, in effect, the practitioners gained economic power, complicating the analysis of the effects of the Medicare movement on the profession of medicine. This thesis suggests it was premature to draw conclusions on how the events surrounding Medicare have affected medical dominance. Granted the profession, having lost this battle, suffered a blow to its powerful position. But was its power irrevocably reduced? The profession certainly had to re-evaluate its strategies to protect itself from further threats to its position in the health care system. If we look further at negotiations between these two powerful groups we can see that these strategies were put in place during the period of negotiation over alternative health delivery systems, an encounter equally significant in determining the fate of the profession. So, before we can draw conclusions on whether or not we are witnessing the deprofessionalisation of Canadian medicine we need to look beyond the issue of Medicare. Chapter 7 takes up this task through a careful look
at the twenty years of CHC experimentation, comparing the circumstances, strategies and outcomes with those of Medicare movement.

As is demonstrated in Chapter 6, the basic pattern of medical control over health and health care had been established in Canada by the early 1900s. After that time an enormous growth in that power developed. The medical profession had become the major force in shaping health care. A solo-fee-for-service system emerged, with physicians in charge, controlling their own interests and priorities. By the end of World War II medicine had its interests embedded in the system and had the overwhelming support of the public. But the health care industry became more complicated. The days of the general practitioner were taken over by specialists and the solo practice had to develop to accommodate hospital based technology. Medicine could no longer be viewed as small business. While organised medicine had established its control over the content of care, competing occupations and the public, it was being challenged on its insistence that only the medical profession could and should determine the conditions under which health services could be delivered. With the costs of services increasing rapidly and steadily, the state and the public began to question this insistence. Having conquered the affordability aspect of health services with the establishment of Medicare, a number of groups in society began to focus on accessibility of services.

Following the Hall Commission (which endorsed the national health insurance scheme) there were a number of provincial inquiries into the health needs of Canadians. Research into health care delivery recognised the growing costs and sought alternatives to address this. This led to several recommendations for the establishment of health centres as an alternative delivery system. The same groups who initially campaigned for a health insurance program that all Canadians could afford, labour and western agrarian groups began to demand health care in remote and medically under-serviced urban areas. Health care occupational groups, which were competing for health care privileges, and middle class social activists began to lobby the medical profession and the state on behalf of the underprivileged. The federal government reports and many provincial health
ministries supported the idea of Community Health Centres (CHCs) as a means of accommodating these demands as well as cutting health care costs. The medical profession responded as it always had: it would not support state intervention into health care. We will see that the profession strategically couched its objections at a number of levels which, ultimately, lead to the failure of the movement.

There are important differences between the two movements under study here. The Medicare campaign was more political in nature, initiated from below and adopted by the federal government and, eventually, the provincial governments which all stood to gain enormous political support by implementing a health insurance scheme for Canadians from all class backgrounds. The CHC movement was aimed at the clinical/technical aspect of medical services and medical ideology, aspects which are highly protected by the profession, making them difficult to access and assess. Medicine’s success in thwarting CHC development demonstrates the continued power and strength of the profession despite the setbacks which resulted from the Medicare movement.

Chapters 7 and 8 detail the position of the interested parties in these movements - the strategies developed and the prospects for each in future negotiation over health care. Some theories of the state are offered in Chapter 8 to aid in our understanding of the nature of the health care system - how it operates, where the power lies and how decisions are made. Pluralist and elitist theories direct us to the key players in the health care arena while neo-marxist arguments take us beyond a micro focus and see the nature of capitalism, itself, as the key to understanding the health care system.

Elitist theories recognise that certain groups in society exercise more power than others in influencing the state, often to the extent of dominating particular economic sectors. There is a constant battle in the health care system between the dominant and emergent interest groups. Repressed interest groups, according to Alford (1975), typically have little influence due to a lack of resources and power. Therefore, dominant groups, in
this case the profession of medicine, have been successful in holding the balance of power. But the move by professions into bureaucratic structures may serve to increase the power and position of challengers. Ivan Illich (1975; 1976) argues that the technocratic elite in the health care arena has the skill and knowledge necessary both to operate and to control medical bureaucracies. Creation of bureaucratic health settings favours bureaucrats who can readily take charge of the more centralised technology, which, according to Illich, means taking charge of the whole health care sector.

The issue of how and why health care policy is made is addressed by neo-marxist theories of the state and health. Neo-marxists argue that the most prominent force in determining the nature of medicine has been the capitalist system and the capitalist class. Medical professionals are simply the administrators, not the creators, of medical dependency. The state represents the interests of capitalism and the influential members of the state in the health care system are capitalists (Navarro, 1976b, 440). The state intervenes in order to stimulate and strengthen the economy or, according to neo­marxist theory, to facilitate accumulation in the hands of the capitalist class. In the area of health services, the government can accomplish this goal by shifting the delivery of health care to the private sector where, it is claimed, health care can be delivered more efficiently. Payment of services then becomes public but profit accumulation becomes private. In other words, the state foots the bill for the profit of capital (Navarro, 1976b, 450).

Rising health care costs (or any fiscal crisis) dictate that cutbacks must be made, prompting the state to look at more efficient health care delivery. At the same time, the medical sector of the capitalist state exerts pressures for the maintenance of the status quo, preserving capital accumulation in the medical sector. The fact that key physicians were part of the medical sector of the Canadian state during the early development of medicine in Canada is important to our understanding of the theoretical arguments presented by the "Elitist" and "Neo-Marxist" theories of the state and health care.
This study is important as it demonstrates the changing nature of professionalism as society becomes more and more complex. It gives us an understanding of how policy decisions are made and the dynamics of the process. It helps us understand the nature of the state and how it responds to public pressure and the influence of other groups with invested interests. It makes us aware of the key players in the professionalism process and it allows us to explore and question the future of professionalism.
CHAPTER 2

THE STATUS OF PROFESSIONALISM

Numerous studies have documented the powerful position of the medical profession in different societies. The sociology of occupations and professions literature from the 1920s to the 1970s has focused on historical processes that have allowed certain occupational groups, such as medicine, to establish a maintain professional status. More recently the literature has focussed on the many ways in which medicine's powerful position has come into question: for example, the effect of litigation (Wolinsky, 1993; Dingwall 1994), competing occupations (Willis, 1989; Witz, 1994; Saks, 1994), managerialism (Hunter, 1994; Germov, 1995), gender and the politics of health care (Dayal, 1994), the increasing availability of medical knowledge to lay persons (Haug, 1988; Williams and Popay, 1994), self help groups (Kelleher, 1994), and the media (Bury and Gabe, 1994). The Milbank Quarterly dedicated an entire publication to a cross cultural comparison of the changing nature of the profession (Milbank Quarterly, 1988, Vol 66, Supp 2). Again much of the focus of these studies were challenges to medicine's dominance of the health care system.

These, and many other studies, are exploring the prevailing view of medical dominance, giving us a better understanding of the theoretical arguments prevalent in the sociology of the professions: professional dominance, deprofessionalisation and proletarianisation (corporatisation, nationalisation, bureaucratisation) theses. The debates over the future of professionalism originated in the 1970s and continue to date. In the early days of the debate the dominant trend in the literature suggested a continuation of professional

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1 See Carr-Saunders and Wlson, 1933; Elliott, P. 1972; Hughes, E. 1958; Jackson, J.A. 1970, for examples.

2 Hafferty and McKinlay (1993) edited a collection of some of the same works in an expanded form, as well as a number of others, entitled The Changing Medical Profession: An International Perspective.
control as "knowledge becomes a more important commodity" (Klegon 1978, 277). There are a number of variations on this argument. It is claimed that the shift from mechanised to automated production processes brings about major changes in the class, status and power structures in society, with an increased prevalence of professional expertise as the basis of a higher position (Faunce and Clelland, 1967). Another variation of the professionalised future position suggests that the reorganisation of production, including greater control, discipline and division of labour, will require experts in complex equipment and specialised knowledge. This trend will lead to a new role for the professional, maintaining the claim to expert knowledge and delegation of more routinised work to others. So professionals become diagnosticians and consultants, reassigning what Hughes (1963) calls the "dirty work" to semi-professionals and technicians (Engel & Hall, 1973).

In the mid 1970s, Eliot Freidson\(^3\) argued that there will be a shift away from managerial authority towards an emphasis on the authority of expertise (professionals). Professions, according to Freidson, are resistant to rationalisation by the very nature of their skills and expertise and by the way they organise themselves into stable occupations (1973).

The many variations on the professionalisation theme differ in regard to the extent of the increased significance of the professions, but agree there is an intensification of the role of the expert. There are challenges to this stand from a number of different camps. Haug (1975, 1988), for example, argues that an erosion of the knowledge monopoly of professionals due to increasing levels of public schooling, the changes in accessibility of knowledge through computerisation and new divisions of labour, which disseminate practice skills and information more widely, result in a decline of trust in professional decision-making and a reduction in professional power and authority over clients.

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\(^{3}\) Eliot Freidson has been the leading authority on the professional and medical dominance theses and, therefore will be referred to continually throughout this study.
"Ideological challenges to professional status accompany these developments, which converge to suggest a deprofessionalised future" (Haug, 1975, 199).

Oppenheimer (1973, 233) claims "there are strong indications that the income position, employment picture and job conditions of the increasingly bureaucratically-located professional are helping to create proletarian conditions". These conditions lead to defensive reactions (trade unionism, for example) which can be considered the beginning of a working class consciousness.

The arguments have changed over time as different issues have come to bear on the debate. The important thing is that the debate continues and many of the arguments have gone untested. These were predictions about the future of professionalism that began in the 1970s. We have accumulated a lot of evidence since the 1970s that needs to be explored in order to shed more light on this issue. It is important to understand the complexities of the arguments and how they have developed. This chapter presents the literature on the status of professionalism, concentrating on the three key arguments — professional dominance, proletarianisation, deprofessionalisation. How these arguments have been applied to the medical profession will be examined, focussing on numerous dimensions. It is interesting to note the shift in literary concentration from the professional dominance position in the 1970s to the proletarianised/deprofessionalised position in the 1990s. Therefore this chapter is structured to accommodate this: the professional dominance stance is presented followed by the challenges from the proletarianisation and deprofessionalisation theorists. The professional dominance position will be revisited to allow us to grasp the response of those who continue to argue the dominant position in light of the critiques put forward. It is important to

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4 It is important to note that many theorists use the terms deprofessionalisation and proletarianisation synonymously. But these two concepts have different meanings as will be apparent; they are conceived of separately in this analysis. Corporatisation, bureaucratisation and rationalisation are terms used to describe a particular aspect of deprofessionalisation and/or proletarianisation and, therefore, they have been incorporated onto the discussion under these more general headings.
understand that this debate not only reflects different interpretations of events, but also reveals difficulties that surround the definitional emphasis that theorists adopt in their research. This is explored in the following section.

**Roots of the Debate**

The debate over the position of the professions in modern society, in part, reflects the selective emphasis in definition individual theorists attach to 'professions'. This is compounded by the lack of definition in many theoretical arguments and one is left uncertain about which occupational groups are under discussion. There are, of course, good reasons for this to arise; there has been a great deal of research dedicated to defining the professions. We will now consider that literature. It is impossible to cover the extensive body of sociological literature but the important arguments are captured, beginning with the early theories of the 1950s, working through to the more recent definitional literature from the sociology of the professions.

The trait or attribute theories of the 1950s and 1960s dominated the sociological literature on the professions. Using this method of analysis, scholars examined several elite occupations and noted certain characteristics that distinguished these occupations from others. Such attributes or traits were deemed to be those which define these occupations as professions. The underlying assumption is that these characteristics are necessary and sufficient for an occupation to be considered a profession.

One of the classic illustrations of the trait approach was demonstrated by Ernest Greenwood, who listed what he considered the essential characteristics of an "ideal" profession:

1. A base of systematic theory;
2. Authority recognised by the clientele of the professional group;
(3) Broad community sanction and approval of this authority;
(4) A code of ethics;
(5) A professional culture sustained by professional associations.

(Greenwood, 1957, 47)

Greenwood defines a systematic body of theory as "a system of abstract propositions that describe in general terms the classes of phenomena comprising the profession's focus of interest" (p. 51). This body of theory serves as a base from which professionals rationalise what they do; it is, therefore, necessary before a professional can apply the skills.

The fact that professionals base their practice on abstract knowledge is the foundation of their professional authority which entails two distinct features. The nature of professional knowledge dictates that professionals have clients rather than customers: a customer knows what s/he wants and shops around until s/he finds it. In contrast, a professional tells a client what s/he needs and the client surrenders to the professional's authority. The underlying assumption is that the client is unable to assess the situation due to its specialised knowledge base. Secondly, for clients' protection, a professional's authority is deemed to be confined solely to those areas in which the professional has been trained.

The community recognises a profession by granting it a monopoly. An occupation striving for professional recognition seeks to acquire this monopoly by demonstrating that the performance of their occupational skill requires specialised education. Those who possess this education are deemed to deliver a superior service, while the human need being served is of sufficient social purpose to warrant the skill and education and monopoly powers (Greenwood, 1957).

Through the frequent interaction of members, a professional culture develops outlining the values, norms and symbols of the profession. A common culture is also
demonstrated by a code of ethics, compelling ethical behaviour on the part of its members. This code is characterised by emotional neutrality toward clients and the provision of service to whomever requests it, regardless of age, sex or religion. Collegial relations are egalitarian; professional colleagues must support one another; and there can be no competition for clients. If competition amongst professionals was not discouraged, the client would become a customer, that is, someone who could "pick and choose" by evaluating the various physician's capacities (Greenwood, 1957, 45-55).

While Greenwood considered all five traits to be essential to a profession, William Goode identified two necessary characteristics: a body of abstract knowledge and the ideal of service. This body of knowledge must be "difficult in that the ordinary man (sic) sees a mystery about it". The service ideal dictates that the solutions a professional finds should be based on client needs and are not necessarily in the best interest of the profession itself. The profession thereby demands real sacrifice from practitioners. Goode later revised his theory to emphasise that public support and trust was the only necessary professional characteristic from which all others were generated (Goode, 1957, 194-200).

The trait approach generated two branches: stage models or the process approach (Wilensky, 1964; Caplow, 1964) and continuum models (Pavalko, 1971; Etzioni, 1969). Wilensky and Caplow incorporated the stage model into their studies of the professions, stating that occupations go through stages or steps of development before an occupation can become a professional. Wilensky lists these stages as:

1. The creation of a full-time occupation;
2. The establishment of university training;
3. The formation of a professional association;
(4) The redefining of the core tasks so as to assign the "dirty work" to subordinates;

(5) Political agitation directed towards the protection of the association by law;

(6) The adoption of a formal code of ethics.

(Wilensky, 1964, 140)

Wilensky then categorises an occupation in accordance with the stage it has reached. Those which have reached the final stage have developed the traits necessary for classification as a profession. He found a good deal of support for his argument by examining the history of eighteen occupations which displayed varying degrees of professionalism. This led him to the following occupational categories:

(1) Established professions (eg. law, medicine, clergy);

(2) Professions-in-process (eg. nursing, pharmacy, school teaching);

(3) New professions (eg. hospital administration);

(4) Doubtful professions (eg. advertising).

(Wilensky, 1964, 144)

Caplow, using a similar historical approach to studying professions, reached a different classification:

(1) Established professions: practice based on theoretical knowledge;

(2) New professions: based on their own fundamental studies (eg. engineering);

(3) Semi-professions: no theoretical study but technical skill (eg. nursing);

(4) Would-be professions: require neither theoretical knowledge nor technical skills but a familiarity with modern practices (eg. business administration).

(Caplow, 1964)

The process approach directs us to the historical developments of occupations but there are problems with this level of theorising. According to Ritzer, the process approach
"tends to become rather routine". For an occupation to professionalise it simply must pass through all the "stages". This approach generalises from the past to the present to the future when it is clear that different historical time frames suggest different criteria for professionalisation. But the most severe criticism of this approach is the "underestimation of the significance of the political process" (1977, 47). Parsons noted that professions are characterised by creativity, risk-taking and exercise of refined judgement (1951, 470-471), characteristics ignored under these approaches.

The notion of categorising professions led to the continuum model of studying occupations. This allows one to place an occupation on a continuum that ranges from ordinary work at one extreme to professional activities at the opposite extreme. Etzioni used this model to highlight the quantitative differences between semi-professions and professions. According to Etzioni semi-professions have a shorter training period, their status is less legitimised, their right to privileged communication is less established, they have a less specialised body of knowledge, and they have less autonomy from supervision or societal control than the professions (Etzioni, 1969, 231-232). The continuum model allows one to look at occupations that may have some professional characteristics but not others, or possess all characteristics in varying degrees.

The traditional theoretical approaches to studying the professions which were popular from the 1950s to the late 1960s came under severe criticism in the early 1970s, giving rise to new theoretical developments. Many sociologists studying occupations and the professions began to question the merit of trait theories. One criticism was directed at the inconsistency of numerous lists of traits put forth in defining professions. Perhaps, the most fundamental inadequacy of the trait approach lay in the fact that it failed to understand professions "in terms of their power relations in society - their source of power and authority and the way in which they use them" (Johnson, 1972, 39).

Klegon suggests that, even if there were basic traits of professions, we need to "explore the process which allowed certain occupational groups to take on those traits" (1978,
He emphasises the importance of looking at professions in relation to other occupational groups and social institutions. The implications of an occupation gaining professional status and the consequences of this status, that is, the conditions under which an occupational group may acquire the 'power' to professionalise, are important considerations (Klegon, 1978, 267-268).

Terence Johnson emphasises the need to focus on the practitioner-client relationship and changes in the distribution of power in society as major factors transforming the nature of the clientele and, therefore, the institutions of control (1972, 38). In this context power is 'the ability of an occupation (in its associational form) to obtain and retain a set of rights, privileges and obligations from societal groups that otherwise might not grant them' (Ritzer, 1986, 79). This definition implies the potential for resistance from various groups such as the public, the state or competing occupations; resistance that must be overcome by the occupation seeking professional status.

The power approach operates from the premise that there are no intrinsic qualitative differences between occupations except that some, especially the professions, possess greater power. It could also be argued that the characteristics of professions listed by trait theorists stem from the power they possess. Power allows a profession to create these traits or "convince significant others that they possess them when they really do not" (Ritzer, 1977, 57). In addition, different professions have been able to convince society that these traits are important.

The important aspect of understanding professionalism, according to Johnson, is establishing the source of power. He argues the power stems from structures of uncertainty and how they are addressed. Johnson works from the premise that:

In all differentiated societies, the emergence of specialised occupational skills, whether productive of goods or services, creates relationships of social and economic dependence and, paradoxically, relationships of social distance.

(Johnson, 1972, 41)
This relationship is evident in the practitioner-client (producer-consumer) relationship. Social distance creates uncertainty in the relationship, resulting in tension. To resolve the inherent tension, the relationship must either be dissolved or controlled. Depending on the degree of uncertainty, various institutions arise to reduce it. Professionalism (i.e. occupational control) is one:

**Professionalism, then, becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of particular occupations. A profession is not then, an occupation, but a means of controlling an occupation.**

(Johnson, 1972, 45)

Johnson outlines three broad possibilities for reducing the tension in the producer-consumer relationship. One of these applies to the discussion at hand, where the producer defines the needs of the consumer and the manner in which these needs are to be met. Professionalism only occurs where certain conditions are present. A dependent clientele is necessary for the institution of professionalism to emerge fully, and the consumer group should be large and relatively heterogeneous in nature.

Professionalism involves a one-to-one relationship initiated by the client and terminated by the professional. Consumer choice, a major element in consumer control, is weakened because the consumer group is heterogeneous. Withholding the fee becomes an important mechanism of control, as it is the only real recourse available to a client. The professional association, made up of practitioners themselves, is also concerned with protecting the consumer group, but its main objective is the protection of the profession.

Professionalism is also associated with a "homogeneous occupational community" (i.e. relatively homogeneous in regard to outlook and interest). A homogeneous practitioner group, according to Johnson, is characterised by a relatively "low degree of specialisation within the occupation and by recruitment from similar social backgrounds" (1972, 53).
As already noted, much debate has stemmed from a lack of consensus about what constitutes a profession or the professionalisation process. This has lead many theorists to abandon a definitional aspect completely and, as Freidson aptly notes:

In order to think clearly and systematically about anything, one must delimit the subject matter to be addressed by empirical and intellectual analysis. We cannot develop theory if we are not certain what we are talking about.

(1994, 14)

We will see that the theorists presented here differ in regard to the aspect of professionalism they deem as central. Oppenheimer, for example, identifies the key to professional status as residing in the ability to maintain autonomy and control over one's own work. Loss of autonomy, through subjection to a hierarchical authority system, leads to proletarian work conditions and the inherent development of a working class consciousness. Freidson focuses on the theoretical knowledge base as central to professional dominance. Knowledge based occupations are "naturally resistant to the rationalising, routinising effects of bureaucratic authority in the very nature of the skill and knowledge possessed by such occupations" (1977, 27). Haug (1988) highlights the authority and power that professionals have over their clients; a decline in this power typifies the deprofessionalisation process. The decline in power over clients results from a loss of control over the knowledge monopoly as the public become more aware and knowledgeable, thereby questioning professional authority.

It would appear that the debate over the status of professionalism lies, in part, in the selective emphasis in definition theorists use to explore the professions. This does not necessarily mean that individuals have not conceived of a grander definition but focus on one aspect in theorising about the status of professionalism. Willis, for example, uses a more encompassing measure of threats to medical dominance, as we will see. He argues that in order to claim that deprofessionalisation is occurring, or has occurred, we need to examine challenges to professional autonomy, authority and sovereignty (1988, 171; 1993, 107).
It is important to keep these aspects of the debate in mind when considering the interpretations and predictions the different theorists propose. Each of the trends in professionalism will be considered in this chapter, recognising the difficulties that arise from definitional bias.

Professional Dominance

Bell argued that post-industrial society, characterised by the expansion of the service economy (emphasising trade, health, finance, education and government), is a society in which the professional and technical class is pre-eminent, with theoretical knowledge as the central source of power (1968, 152). The growth of the professional technical class, with its control of scientific and theoretical information, means that property and political position will fade as the basis of power, replaced by knowledge (Kleinberg, 1973, 45).

Freidson (1994, 62; 1973) defines professionalisation as a shift in the form of occupational authority characterised by control, coordination and creation of labour determined by persons who actually perform productive labour. Bell, Freidson and other post-industrialists note that the authority of professionals as 'technical experts' has expanded during the period of transformation of professionals from free practitioners to employees; the move to bureaucratic organisations provides a stable institutional base for the exercise of professional authority.

Engel and Hall suggest that the bureaucratic setting is ideal for allowing increased opportunity for self-less professional service. The nature of service becomes modified, according to Engel and Hall. Traditional service, provided by an individual practitioner, with knowledge obtained from a single discipline, in a fee-for-service relationship with individual clients is adapted to 'team service', groups educated in diverse fields and
remunerated through salaries. In effect, professionals maintain their claim to expert knowledge, delegating more routinised labour to others (1973, 75-88).5

**The Process**

Faunce and Clelland argue that the shift from mechanised to automated production processes and the continuing bureaucratisation of organisations will bring about an increased prevalence of professionals and the increasing acknowledgment of professional expertise as the basis of a "high position in the class, status and power structures of society" (1967, 341-352). Engel & Hall (1973) argue that several societal changes lead to the intensification of the role of the professional: the vast knowledge explosion, advances in technology and greater demand for more and newer products and services.

Freidson argues the cost of the comparatively long period of training given professionals has become too great to allow them to supply all services the public is demanding. Sooner or later, many of the routinised skills will be transferred from the hands of the professionals into the hands of less expensively trained workers (1977, 29). In other words, Freidson is also predicting a trend toward a redefinition of both the function and jurisdiction of professionals.

Freidson suggests that knowledge-based work is, but its very nature, not amenable to mechanisation and rationalisation (1993). This level of theorising is neither adequate nor clear. When a profession attains a particular level of organisation, it can create effective obstacles to the encroachment of the rationalisation process of management.

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5 There appear to be two separate trends being discussed. One is the predicted increase in the proportion of professional workers, the other is an increased number of professions; occupations which gain the organised power to control the terms, conditions and content of their work. This thesis is concerned with the power of already established professions, particularly medicine, and the subsequent challenges to that established position. The main proponent of the continued dominance of the professions is E. Freidson who has held this position for over twenty years. He focuses his arguments around the medical profession in the United States, and much of the critique of this position is directed at Freidson's claims.
Freidson argues that the source of professional dominance is acquired through its relationship with the state and the public. A profession's control over work is seen as political; the state aids in the establishment and maintenance of the profession's pre-eminence. Professional autonomy is "therefore carved to its relationship to the sovereign state from which it is not ultimately autonomous" (1994, 40). The public must be convinced of the value of professional work in order for a profession to secure and maintain its dominant position. A profession like medicine must "make itself attractive to the general public" in order to "win a secure status" (1970b, 188).

Freidson's position remains unaltered, confirming his stance on professional dominance despite the many and varied changes taking place in the professions. He continues to argue:

...that the simple fact of employment of professionals such as physicians and lawyers by large scale public and private organisations does not, in and of itself, threaten the spirit and ethos of professionalism.

(1994; 200)6

The arguments presented by Willis (1988, 1989, 1993) with regard to the medical profession in Australia support the notion of professional dominance. Unlike Freidson, Willis focuses his theoretical understanding of dominance on three levels: autonomy over professional's own work; the profession's authority over related occupations; and sovereignty over the profession's area of expertise in the wider society (1988, 171).

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Willis argues that in order for professional dominance to come under threat it must come at each of these levels.

**Indicators**

In a professionalised society professional services will no longer be provided on an individual, client-to-practitioner level but develop into group practice as well as practice within bureaucratic settings, according to Engel & Hall (1973). They predicted that professional practice would no longer be based on one body of theoretical knowledge, but would expand to numerous fields as teams of professionals take on a client. They also suggest that team practice allows professionals greater opportunity to provide more and better service to clients.

Raelin (1984) suggests that the creation of the role of professional administration has alleviated any potential conflict between the need for integration by management and the need for autonomy by the professional. The professional will perform both managerial duties and supply professional services: the new role for the professional.

Freidson stresses that the expansion of knowledge has generated pressure towards internal specialisation. It has been increasingly difficult for the generalist to assimilate and keep abreast of the developments in all areas of a professional field, so specialties have begun to emerge on a large scale (1977, 27). This is seen as an important indicator of the new role of professionals in their maintenance of dominance. Others argue that the trend toward specialisation contributes to deprofessionalisation in that increasingly narrow professionals can be expected to be doing the same work, over and over again, without knowledge or control of the whole productive process (Haug, 1975). \(^7\)

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Freidson points out that this is true, as far as it goes, but such reasoning is based on confusing different processes: developing specialisation and organising specialisation.

Developing specialisation has been common in the history of the professions, where the professionals themselves specialise and negotiate with fellow workers for an area of expertise within the occupation's division of labour. They do not, thereby, lose organised control over their work. Organising specialisation, on the other hand, a 'superior authority' breaks a task down into its simplest units, requiring the least possible skill to perform, and then hires, trains and supervises workers to perform them in the division of labour created. In both cases, specialisation does indeed occur, but in the case of developing specialisation, it is the worker who invents, chooses and controls the tasks, trains for it in depth and pursues its complexity on the basis of increasingly esoteric skill. In the case of organising specialisation, it is management that creates a task which has been broken down into specialised activities requiring little training or skill (Braverman, 1974: 85-121). Both are indeed specialisation, but an increase in the development aspect within the professions cannot be said to be analogous to a rise in the organisational aspect (Freidson, 1977, 27; 1994, 118-119). Evidence of managerial creation and control of work within the professions would have to be demonstrated before claims of proletarianisation/deprofessionalisation could be supported. If specialisation is organised by professionals in managerial roles, this would also shed a different light on the effects of specialisation on the professions.

We now move from a general discussion of professional dominance to how the arguments have been applied to the medical profession in modern western societies. Again, this helps paint a clearer picture of the range of arguments as well as how they can be applied to a particular occupational group.
Medical Dominance

According to Freidson (1970, 1985, 1994), medicine in the United States maintains a dominant position in practice and in organisation. The medical profession is able to maintain this position through the protection and patronage of the state convinced of the value of medicine’s work (1970b, 272-273; 1994, 33).

Willis (1988, 171) agrees with this assertion although he argues that it is void of an analysis of the nature of the relationship between the interested parties. He examines the medical profession in Australia, concluding that, on the whole, the dominant position is being maintained, "though its form and mode of operation is changing" (1988, 174). He argues that there have been but token challenges to medicine's autonomy from consumer movements, but, overall, the threats to the authority of the profession have been overstated; "at the level of the state, medical sovereignty largely continues" (p.178).

Illich (1976) and Arney (1982) viewed the case of physicians in the U.S. and support a medical dominance position. Illich argues that the medical profession creates a need for its services to such an extent that people come to think of all of their problems as medical, thereby increasing the need for medical professionals and the power of the medical profession. Arney (1982) looks at the very powerful position of obstetricians in the United States and how they have come to control pregnancy and childbirth through medicalisation of these conditions.

The Proletarianisation Thesis

Although there have been numerous examinations of the proletarianisation of the professions, many of the studies fail to define this term. This section helps us to grasp this concept to see how it can be applied to the medical profession. Many theories of the new middle class deal with the notion of economic proletarianisation which involves "a series of degradation of work, career prospects, autonomy and salary differentials" bound up with the "progressive removal of the function of capital" from many
professional groups (Roslender, 1981). Used in this sense, we can talk about proletarianisation if the professional has experienced a loss of or decline in the decision making power over capital or labour.

Proletarianisation has been broadly defined as dependent salaried employment, implying subordination based on the appropriation of power over the labour process by a non-professional management (See Oppenheimer et al, 1982, for example). Post-industrialists, such as Freidson, clearly reject the applicability of this broad conception to professional employment. Freidson states that the trend away from self-employment toward employment in organisations is much too "mechanical ... to have analytical value in and of itself" (1977, 25). Self-employment is too crude a measure of a professional's control over his/her labour (1994, 41). He reminds us that some established professionals such as ministers and professors have almost never experienced self-employment; they have been organised in churches and universities. The issue is not salaried employment or self-employment as such, but the content, terms and conditions of a professional's work:

If workers have a monopoly in the labour market, and the power to control their own work, they can dictate the content, terms and conditions of their employment as well as their self-employment. Without monopoly and dominance, their position when self-employed is hardly less desperate when employed ...

(Freidson, 1977, 25)

Derber et al (1990, 136) and Derber (1983) argue that both professionalisation and "orthodox" proletarianisation theorists have failed to properly conceptualise the meaning of dependent professional employment. He explains that respective analyses rest on a structural definition of two distinct types of proletarianisation - ideological and technical. Technical proletarianisation refers to the loss of control over the process of work, or what Derber terms "the means", and occurs when and if management subjects workers to a technical plan of production and or rhythm or pace of work over which the worker has no input. Ideological proletarianisation refers to the loss of control over the product - "the ends"; the managerial appropriation of control over the goals and social
purposes of one's work. Ideological proletarianisation is characterised by powerlessness to choose or define:

1. the final product of one's labour;
2. the product's disposition in the market;
3. the product's uses in the larger society;
4. the values or social policy of the organisation which purchases one's labour.

(Derber, 1983)

There are degrees of ideological proletarianisation based on the extent to which the worker has the capacity to shape or control broad organisational policy and the specific goals and purposes of one's own work. According to Derber, ideological and technical proletarianisation can go hand in hand but most studies focus on the technical aspect only, assuming that the workers have already lost their rights in deciding the disposition and uses of the product of their labour, if they ever had any.

Finally, Derber argues that professionals have not been subjected to the intense job rationalisation indicative of technical proletarianisation but ideological proletarianisation is being experienced, undermining the profession's power and capacity to affect their position. Salaried professionals, according to Derber, market their services to two basic types of employers - profit (or surplus) institutions and non-profit organisations. Both of these include a system of control over the professionals employed, ensuring that the goals and uses of their labour primarily serve institutional interests (1983, 309-341).

Derber et al's 1990 book seeks to test the arguments put forward in his previous writings as well as the arguments of other proletarianisation theorists. This leads them to refute the proletarianisation of professions arguments. The problem is that most proletarianisation theorists fail to examine the organisations employing professionals to determine the structures of "control" operating. This leads to scepticism in accepting the arguments. We need to understand the dynamics of professional employment settings, measuring the degree of control, level of autonomy, hierarchical structure of
professional labour. This will be undertaken in the following chapter when we examine
the bureaucratic organisation of these institutions.

The Process

The proletarianisation of the professional is seen by Oppenheimer to result from the
growth of bureaucratic organisation structures. Bureaucracy creates, for the individual,
factory-like conditions, with fixed rules and jurisdictions created by others in a
hierarchical command system (Oppenheimer, 1973, 214). Oppenheimer neglects to
consider where professionals are located in the hierarchy of authority, if indeed
professional bureaucracies operate this way. If, for example, they are the management,
the argument is weakened, as these are not considered proletarianised occupational
positions. A professional who moves from a fee-for-service private practice to a
position of authority in an extensive division of labour does not signify a change in class
location. The roles of professionals are changing but this does not necessarily imply a
change in class location.

Oppenheimer revised his stance in 1982, stating that the professions are undergoing a
process of deprofessionalisation, where professionalism is being eroded, rather than the
more extreme proletarianisation process (Oppenheimer, O'Donnell & Johnson, 1982,
250-51). Yet the indicators of this process remain unchanged. The process develops
out of the need for the state to rationalise and decrease costs; asserting managerial
control over all forms of labour, even professional labour. This process forces
professional employees to resort to collective action to protect their position. A strata
of professionals, now seen as administrators, hold positions where they are controlling,
supervising and coordinating a greater strata of professional employees (Oppenheimer et
al, 1982, 251): a greater division of labour within individual professions. Again,
Oppenheimer has not examined the structures of those organisations employing
professionals. Perhaps there is an "elite" group from one profession organising the
labour of other members of the profession employed within the same organisation. But
how is this elite group organising professional labour? This is an important question in light of the evidence which suggests that more and more professionals are 'seeking' salaried employment.

McKinlay and Arches (1985, 161) argue that loss of control over one's work because of managerial authority and bureaucratic restraints is part of the proletarianisation process. The broad definition of proletarianisation used focuses on location, content and essentiality of professional tasks which results from bureaucratisation.

According to Larson, there are three important dimensions of the deprofessionalised conditions. The first is at an economic level, where professional work is conditioned by a quantitative element of skill, speed or time pressure. Secondly, at the organisational level professional skills and qualifications are de-individualised through the organisation of the work setting. And finally, at a technical level, the execution of a professional's work is taken out of their control (1980, 139; 1979).

Indicators

McKinlay and Stoeckle (1988) put forward seven aspects of professionalism which are compromised or lost in the proletarianisation process, stating that at least one of these must be involved:

(1) criteria for entrance (the credentialing system and membership requirements)

(2) content of training (scope and content of curriculum)

(3) autonomy over terms and conditions of work (ways the outcomes are accomplished)

(4) objects of labour (the ends: product & clients)
tools of labour
means of labour (buildings, harbours, land)
the amount and rate of remuneration (wage/salary levels, fee schedules)

The indicators put forward by Oppenheimer differ from those laid out by McKinlay and Stoeckle but we can see some overlap:

1. the professional performs only one task in an extensive division of labour
2. the pace of work; the characteristics of the workplace; the nature of the product; the uses to which it is put are determined by higher authorities not by the professional
3. primary source of professional income is a wage.
4. the professional moves toward collective bargaining to defend his/her position from deteriorating living and/or working standards.

Oppenheimer's arguments focus on the autonomy aspect of individual bureaucratically-employed professionals. He implies that moving from self-employment to employment within bureaucratic organisations is sufficient to render one proletarianised. Yet professions have never been defined by their direct source of income. McKinlay and Stoeckle, on the other hand, focus on the level of the profession as affected by the proletarianisation process, not individual professionals. The criteria laid out suggest that increasing bureaucratic employment of professionals compromises the professionalism of the occupation itself.

Proletarianisation of Medicine

McKinlay and Arches are the most comprehensive proponents of the proletarianisation of the medical profession position. They argue that "as a result of bureaucratisation being forced on medical practice as a consequence of the logic of capitalist expansion,
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physicians are being reduced to a proletarian function" (1985, 161). This position is developed further by McKinlay and Stoeckle (1988), listing numerous criteria indicative of the proletarianisation of the medical profession in U.S.: entrance criteria, medical curriculum, autonomy over work, the ends, the tools and means of labour, and remuneration amount and scheme.

Navarro (1988, 72-73) argues that the use of the term proletarianisation is misleading and does not actually define nor explain what is happening in medicine. He argues that the commodification and corporatisation of medicine is what threatens the position of physicians and these cannot be conceptualised with the proletarianisation process.

We could argue that Derber’s (1983) notion of ideological proletarianisation could be better understood as deprofessionalisation as it can be applied only within the realm of professionalism. We are left, perhaps, with more questions about the value of using the measures of proletarianisation to explain what is happening to the medical profession, particularly in Canada. We will see in Chapters 4 and 5 the problems and weaknesses of the proletarianisation of medicine arguments, generally, and, particularly, in the realm of Canadian medicine.

The Deprofessionalisation Thesis

The classic deprofessionalisation position was advanced by Haug in 1975 who argued that "ideological challenges to professional status suggest a deprofessionalised future". Professional, according to Haug, is a status term; deprofessionalisation is a status equalising process; directly attacking the status position of occupational incumbents. Haug's view is based on three features: an erosion of the knowledge monopoly resulting from rising levels of public education, computerisation which increases the accessibility of knowledge, and the new divisions of labour which disseminate practice skills and information more widely. These threats to exclusive professional information control formulate the basis of the deprofessionalisation process (Haug, 197-199).
The Process

Traditionally, the role of the higher education system was to protect and perpetuate the knowledge monopoly by controlling access to elite training through numerous intellectual, social and financial hurdles. But the general educational level of the public has increased considerably in more recent history, rendering it more difficult for professions to insulate themselves from the "rising tide of general education and expanded public sophistication" (Haug, 1988, 50).

Experiential professional knowledge and academic training in domains of professional expertise are now more widely disseminated through books, magazines, TV, and so on. Computer storage and retrieval of academic knowledge means that knowledge need no longer be "packed into the professional's head" or in a specialised library where it is relatively inaccessible. It is now available not only to those who know, but also to those who know how to get it (Haug, 1975, 200; 1988, 51).

The new divisions of labour which are emerging in professional domains also threaten professional exclusive information control. By sharing previously "professional" responsibilities with non-professionals, the profession "opens the door to rivalry with other occupational groups", which can carve an area of expertise out of the profession's former domain (Haug, 1975, 202).

Haug's 1988 paper takes the deprofessionalisation argument further by continuing to look at threats to the knowledge monopoly but extends into other aspects of professionalism: authority over patients and autonomy. She demonstrates the increased patient questioning of physicians and demands to be included in the diagnostic and treatment decision making processes (1988, 52-53). This erosion in the trust in physician opinion is due to increased awareness and knowledge (p.51). Accompanying the decline in professional power over clients, Haug argues, is a reduction in their autonomy due to organisational constraints or peer control (1988; 54-55). Haug does not take a hard stand on her predictions of the 1970s and the evidence with the medical
profession since. She argues that more time is necessary before we can reach firm conclusions; others have taken a more definitive stand.

Rothman supports Haug's view, emphasising the changing client population and consumerism as important contributors to the decline in professional dominance. Clients are challenging the authority of professionals as they become increasingly knowledgeable. He cites the growing number of do-it-yourself manuals on the market, which range from legal issues to medical, as evidence that professions are suffering from routinisation and standardisation so that what once required expert knowledge and professional judgement has been reduced to simple procedure, available to consumers (Rothman, 1984, 191).

Navarro's critique of the proletarianisation of medicine view leads him to take a stance within the deprofessionalisation camp (although he does not explicitly state this). He acknowledges the decline in power of the medical profession, but argues that it cannot "be equalled with the proletarianisation of the medical profession" (1988, 69). He is particularly critical of MacKinlay and Arches' (1985) measures of proletarianisation as not going far enough, emphasising the need to include "the transformation of an intellectual activity into a manual one", something he claims is missing from the proletarianisation of medicine arguments (Navarro, 1988, 70). Navarro does conclude that professionals are losing autonomy (p.72) but neglects to demonstrate this phenomenon or indeed what he means by it.

Stoeckle (1988) argues that rapid corporatisation of medical practice, increased use of medical technology, and the use of information technology in clinical decision-making suggest physicians are losing much of the autonomy that had once been characteristic of their profession. The reduction in autonomy is consistent with less power in the control of their medical practices, reduction in pay, and reduced control or management of one's individual practice (1988, 84). The institutional, inter-professional and interpersonal
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rewards no longer accompany medical practice as it comes under bureaucratic and institutional control (pp. 85-87).

Williams and Popay (1994) share similar views to Haug (1973, 1975, 1988), arguing there have been challenges mounted against the trust in professional authority and knowledge from the lay community. They see this as a "political challenge to the status of scientific knowledge and the power of those whom we are encouraged to trust with such knowledge" (p.135).

Indicators

The many theories of deprofessionalisation bring to light a number of indicators of the process that challenges professional dominance. Haug emphasises that the process is characterised by a decline in trust in professional decision making and, thereby, a reduction in professional power and authority over clients (1975; 1988). The trust and humanitarian public image of professionals has been eroded in this age of consumerism and 'client revolt'. This has lead to a rise in the public demand for professional accountability for actions, not just justification to peers (Haug and Sussman, 1969). The public is questioning professional ethical standards and service ideal, argues Haug, citing as evidence the rise in number of malpractice suits and second opinions sought by clients. Haug abandons this as a measure of deprofessionalisation because "identifying departures from the formal ideal applies to individual practitioners who have fallen from grace, while the ethical code of the profession as a whole can remain intact" (1988, 49).

The logical consequence of the weakening of the knowledge monopoly and the decline in public trust in professional service ethic is that professional autonomy is undermined. Therefore, professionals no longer have the freedom, they once had, to exercise power over their clients (Haug, 1975; 1988). Haug also notes that further threats to professional autonomy come about through the establishment of group practices where professionals are "theoretically subject to bureaucratic restraints" (1988, 54).
evidence she notes this process revealed in a book titled *Managing Doctors*, a clear cut statement of intent to contain autonomy (Haug, 1988, 55). It is worth noting that Haug has not examined the management structures of employee professionals.

Derber (1983) cites the decline or loss of professionals' power over the goals and social purposes of their products as an index of deprofessionalisation; when the product's (service's) disposition in the market is determined and controlled by management. This implies that professionals also lose control over the selection and allocation of tasks as well as control over subordinates, as management controls the entire process.

Rothman indicates that deprofessionalisation is characterised by a decline in autonomy over one's work and a decline in monopolistic privileges as clients challenge professional authority (1984, 189-192). He supports Haug's suggestion that, as clients become more aware of both their rights and their needs, they are more likely to seek to be involved in the decision making that was traditionally seen as the sole domain of the professional, leading to a decline in professional autonomy.

It has been argued that the trend toward specialisation contributes to the deprofessionalisation process in that increasingly narrow specialists can be expected to do repetitive tasks, without knowledge or control over the whole production process (Haug, 1975). It appears that Haug has abandoned this as a measure of deprofessionalisation as it goes unmentioned in her later work. Perhaps it runs contrary to her arguments about the erosion of professional knowledge monopoly. It could be argued that specialised knowledge is less accessible to the lay person striving to gain general medical knowledge.

It is important to consider the notion of professional specialisation in light of the earlier arguments about management control over professional labour. We need to consider who is organising the specialisation process - the profession itself or outside managers. As Freidson (1977, 27) noted, if it is the professional who "invents, chooses and
controls his[sic] task, trains for it in depth and pursues its minutes and complexity on the basis of increasingly esoteric skill ...", we cannot label this deprofessionalisation.

**Deprofessionalisation of Medicine**

Marie Haug (1975, 1988), reacting to the popular view of professional dominance, advanced the argument that the medical profession, in the U.S., was losing its monopoly over knowledge, public acceptance of the service ethic and authority over clients. Increasing rates of education and the emphasis on health promotion have given the lay person a greater awareness and knowledge of health care issues. The media has actively documented cases of medical negligence, again contributing to a decline in the status of the medical profession. Light and Levine (1988) agree that the deprofessionalisation of medicine has resulted from consumer revolt. Termov (1995, 56) argues that the recognition of health rights and independent complaint mechanisms represent examples of the deprofessionalisation of the Australian medical profession.

Stoeckle (1988, 84) suggests that the rapid corporatisation of medical practice in the U.S. means physicians are losing autonomy: less control over medical practice, reduction in pay and reduced management over their individual practices. Hunter, examining the health policy agenda and resource allocation in Britain, concludes that policy decisions result from struggles between doctors and managers with management dominating. Yet Hunter points out that:

> All the indications are that the involvement of doctors in management will continue to grow in keeping with the mounting pressures on governments to contain costs, to hold doctors more accountable for what they do, to investigate the causes of clinical valuation and to propose solutions to them ... and to give closer attention to the whole issue of health outcomes and the impact of health care and medicine on these.

(1994, 15).
Despite these claims, Hunter concludes that the managerial challenge to medicine can be deflected, leaving the medical profession intact or even strengthened (p.15). In other words, medical dominance may only be temporarily challenged; not irrevocably eroded.

**Professional Dominance Revisited: Freidson's Response to his Critics**

As Freidson remains the primary defender of the professional dominance position, and many of the arguments that fall under the deprofessionalisation and proletarianisation camps are responses to Freidson's arguments, it seems appropriate to allow Freidson the final word. Freidson (1994) addressed the critiques of his position in a book entitled *Professionalism Reborn*. He acknowledges that the position of professionals and the nature of their practice are changing but argues that the essential elements of professionalism are simply taking on a new form:

> Professionalism is being reborn in a hierarchical form in which everyday practitioners become subject to the control of professional elites who continue to exercise the considerable technical, administrative and cultural authority that professions have had in the past.

(1994, 9)

Freidson (1994, 31-32) notes that, in many ways, it is impossible to come to some conclusion about whether the professions remain powerful or if there is a decline in this power through deprofessionalisation, proletarianisation, rationalisation, bureaucratisation or corporatisation because the arguments are posed using non-comparable language. Looking at one nation's historic experience defeats the purpose because it renders their professional analysis non-comparable. He argues that professional power "lies in the control of work by professional workers themselves", not outsiders.

Addressing the particular arguments put forward by proletarianisation (corporatisation, bureaucratisation) theorists Freidson points out that "proletarianisation or literal deskilling of professionals, has not been documented (1994, 42). Self-employment,
alone, is a poor measure of whether professionals control their own work (p. 41). It is important to understand the relationship between the state and the profession to understand the significant role the profession plays in policy decisions (1994, 40). The deprofessionalisation arguments have not sufficiently considered this relationship and the effect it has on professional power.

Finally, Freidson identifies the evidence he considers necessary to support his professional dominance position. Because professional autonomy is legally granted, and as long as it is not taken away, professional autonomy continues (Wolinsky, 1993, 19). How the autonomy is granted and maintained is important to understanding the dominant position of the profession of medicine. Therefore, Chapters 6 and 7 of this thesis explore the relationship between the Canadian state and the medical professional to grasp the complexity of the status of professionalism debates.

**Medicine in Canada**

Coburn (1983, 1988, 1993) documents the position of medicine in Canada arguing that by the end of World War I the profession controlled the context of medical practice, means of health production in the hospital and other health occupations and clients (1988, 97). Coburn notes that since that period there have been threats to medical dominance over clients, other occupations and most notably the context of care (1993, 102).

Coburn acknowledges the difficulties conceptualising the proletarianisation process as it implies movement from one class to another. In order to grasp this movement we need to understand the "class structure/class relationships/class struggles"; yet few writers have addressed these issues. We are, therefore, left with the view that proletarianisation is simply losing status and power (1988, 93-94). We are again reminded of the lack of conceptual clarity around the notions of professionalisation, proletarianisation and deprofessionalisation.
Wahn (1987) comes to very similar conclusions about the Canadian medical profession as Larson (1980) does about the American situation. He argues that physicians' work is being rationalised to such an extent that many are "experiencing forms of economic and organisational alienation very similar to those experienced by the skilled craftsmen of the Industrial Revolution" (p.438): economic, organisational and technical alienation. Wahn's position is drawn from the idea that salaried employment leads to alienation. He cites examples of attempts at organisational control in hospital and the subsequent threats to medicine's power. Wahn's conclusions have included much anecdotal evidence and calls for a more empirical analysis of what physicians are doing in the organisations where they are employed.

Johnson (1972) argues that a move away from self-employment to salaried employment leads to the erosion of the privileged positions of the professions, resulting in a loss of autonomy. He cites figures for a number of professions in Canada demonstrating a general move away from self employment but "doctors and surgeons, the highest paid profession, have stood against this tendency, increasing their proportion of self-employment" (p.168). The comparative figures used are from 1951 to 1961 and we will determine whether this trend has continued. But, more importantly, we will see (Chapter Four) that collecting a salary is not a good measure, in and of itself, of proletarianisation or deprofessionalisation.

Swartz (1977) criticises Johnson's (1972) indicators of proletarianisation of professions – the percentage of an occupation paid on a salary basis and income gains. Yet he agrees with Johnson's overall position regarding physicians in Canada: "in gaining its monopoly the medical profession acquired full control over the definition of disease, as well as how, when and where to treat it. In short they were given de facto control over the production process" (1977, 327). Swartz supports his arguments through examination of the hospital system in Canada, arguing that the structure of power in the hospital sees the medical profession on top. Swartz provides little evidence of this and makes broad assertions on the basis on his evidence in the hospital system.
As we can see, there have been a number of studies of the status of the medical profession in Canada, reaching varying conclusions. The problem of conceptual and definitional clarity runs throughout these studies. Little empirical evidence is offered in support of the arguments that salaried employment in bureaucratic settings compromises professionalism. What becomes clear is that the debate over the status of professionalism is operating on two distinct levels: the level of the individual practitioner and the level of the profession. The proletarianisation arguments generally focus on the former while the deprofessionalised position focuses, generally, on the latter. This thesis examines both levels of argument, particularly in regard to the medical profession in Canada. It examines the professionalisation process, determining the nature of the relationship between the state and the medical profession in Canada. It documents medicine's dominance in the health care arena as well as challenges to this dominance from the state.

A number of theorists have argued that the source of professional domination stems from the relationship between the profession, the state and the public (See Freidson, 1994; Coburn et al, 1983, for example). One way the state can challenge the autonomous position of medicine is through implementation of innovative health delivery systems. This thesis examines this through policy analysis, focusing on the major players. Bureaucratic threats to professionals' control over their own work are addressed by looking at the actual structures of professional employment settings, capturing the proletarianisation arguments. We are then left with a picture of the state of the profession's authority in Canada today. Before undertaking both these tasks it is important to clarify the data sources employed to undertake this project and how the conclusions were derived. Chapter 3 provides the methodological basis of this analysis.
CHAPTER 3

METHODOLOGY

The debates over the nature of professionalism and the status of the medical profession follow three general trends: professional dominance, deprofessionalisation and the proletarianisation of the professions. As highlighted in Chapter 2, each of these trends entails arguments which define the trend, outlining the process which leads to measurable indicators. In order to determine which of the trends is most relevant in the realm of the medical profession in Canada, the indicators of each need to be operationalised, requiring a wide range of sources.

Medical Dominance Thesis

As noted, the deprofessionalisation and proletarianisation of medicine arguments focus on challenges to the medical dominance thesis which, basically, claims that medicine maintains a dominant position in practice and organisation through the protection and patronage of the state. In order to test this theory an historical examination of the processes which lead to the professionalisation of medicine in Canada is conducted. This gives us a sense of how and why medicine was granted a privileged position in health and health care. The long history of the relationship between the state and the medical profession is divided into three periods which capture important dimensions of the relationship. The Organisational Period covers the early struggles of practitioners in gaining status over other health care providers and non-orthodox ‘medical’ providers while convincing the state of their ‘expect’ claims. The Establishment Era followed and licensing and registration of medical practitioners with a view to exclude the non-orthodox, dominated this period. Key events in the professionalisation process are highlighted rather than a detailed, in-depth historical analysis of the profession. An understanding of medicine’s dominance of health care in Canada is established in this section through an analysis of health care legislation, the writings of medical historians.
and social commentaries. This gives us the groundwork needed to move further into the discussion of the relationship between the state and the profession.

With the dominant position of medicine established we move to an analysis of the introduction of national health insurance (Medicare) by the federal and provincial governments which lead to a number of arguments that suggested this signalled a threat to medicine’s dominance over the health care field. This is an extremely controversial period - the Negotiation Period - when we see the changing roles of the key players in the health care field. Gaining understanding of this important period, which really began in 1919 and ended in the late 1960s, (but was under heavy negotiation after 1945) meant a shift away from an emphasis on historical discussion to a more in-depth look at federal legislation, provincial enactments and the profession’s (as well as other important actors’) response and input. These were gained through medical journal articles, letters from the presidents of the medical associations relayed through the Association’s Journals, official and unofficial submissions to relevant government inquiries. Letters to the editors of medical journals and newspaper accounts help add insight to both public and informal medical opinion.

Proletarianisation of Medicine Thesis

Having established medicine’s dominant position and the changing functions and role of the state over this period, this study then looks more closely at the proletarianisation of medicine thesis. Initially an understanding of the bureaucratic organisation of professional labour is gained through an examination of the human organisation literature and sociological studies of professionals in bureaucracies. It highlights some of the weaknesses in sociological analyses of challenges to professional dominance which fail to explore the structure of professional organisation in bureaucratic settings. The human organisation literature allows us to pursue this important aspect of the proletarianisation of professions thesis as it delves into the dynamics of employment settings - the inter-relationships, managerial organisation, decision-making structures,
hierarchies, career and promotion opportunities - areas often overlooked in sociological studies.

Once some understanding of the overall structure of professional organisations is gained, we examine more carefully the numerous employment settings of Canadian physicians. These range from solo fee-for-service practice to hospital or clinic salaried employment, from fee-for-service group practice of all sizes to the solo salaried company doctor. This is accomplished through an examination of the theoretical sociology literature and, more importantly, through the Canadian Medical Association’s (CMA) Physician Manpower Questionnaires.

The CMA’s physician resource data bank was developed to provide an inventory of data on Canada’s physician supply as well as to answer questions about the functions, distribution, age and gender of physicians in various medical fields. The origins of the data bank can be traced to the recommendations of the Requirements Committee on Physician Manpower submitted in 1976. The Committee’s Report suggested the establishment of a ‘national functional inventory’ of physicians, the purpose of which would be to improve the understanding of the professional activities of physicians in Canada. In December, 1976, the National Committee on Physician Manpower agreed to create a task force to study the feasibility of establishing such a databank. Although they were unsuccessful, the CMA began to develop a functional inventory in 1981. The rationale behind this was that these data would support policy making and planning as well as serve as a tool for reviewing government policy decisions and making appropriate recommendations.

An ad hoc committee, established by the CMA, outlined a research design that was subsequently approved by their board of directors. Lists of physicians with Canadian licences were obtained and in 1982 were sent to all these physicians, surveying them on location, functions, medical field, professional activities and so on. The 1982 census yielded an 88 percent response rate (Woodward & Adams, 1985). Unfortunately, for
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the purposes of this study, a section on salaried patient care was not included in the 1982 census but it did aid in determining some important changes in physician work patterns and settings over time. The CMA repeated revised versions of the questionnaire in 1986 and 1990. The 1986 manpower census of physicians in Canada was sent to 50,103 doctors (representing all physicians with Canadian licences as obtained from provincial licensing bodies and CMA provincial divisions) which entailed a 21-item self-administered questionnaire. After two follow-up mailings, by November 1987, 39,286 responses had been secured. Of the 78.4 percent who responded, 4.3 percent were undertaking post graduate training and were, therefore, excluded from the analysis. The final response rate was 78 percent.

Physicians were asked to indicate the level which best described their current professional activities - full-time, part-time, temporarily not practising, semi-retired and retired. Respondents were also asked to indicate the number of hours of week spent in patient care, research, administration, classroom instruction and other activities. Other questions were designed to capture patterns of continuing medical education, practice structure and salaried provision of patient care.

In 1990 another census of Canadian physicians was done along similar lines to the previous one. 52,422 questionnaires were mailed, of which 771 were ineligible (undertaking post-graduate training). There were 38,813 valid responses, a 74.2 percent response rate. The questionnaire was changed to some extent, reducing the range of questions in the professional activities section. The salaried physician categories were not as clear-cut as they were in the previous questionnaire meaning it was more difficult to determine those physicians who received a salary only in 1990 than it was in 1986. Although this drawback was taken into consideration, the 1990 results were used when appropriate and the 1986 data was included when the 1990 data was not applicable. Chapter 5 makes the distinctions in data availability for certain categories clear. The response rates for these censuses indicate they are reliable sources of data on doctors' work activities.
Where possible and appropriate the proletarianisation of medicine arguments were pursued along a historical dimension. For comparative data, information collected from Judek’s 1964 Royal Commission Report on Health Services (Medical Manpower in Canada) was used. Again, the purpose of Stanislaw Judek’s survey of physicians was to gain information on supply and demand of medical manpower in Canada, as well as the distribution of medical services and the utilisation of those services. Judek gathered the data from a number of sources including a 1962 survey of physicians, provincial medical boards, Royal College of Physicians and Surgeons of Canada, the CMA, the Royal College of Physicians and Surgeons and a number of medical faculties, and surveys conducted by the Department of National Health and Welfare in 1962. The first survey - Questionnaire on Medical Practice - looked at the distribution and utilisation of medical services in Canada and physicians’ attitudes to government proposals on national health insurance. The questionnaire was distributed to all physicians (21,000) and 12,000 valid responses were received (approximately 57 percent response rate).

The second survey - Questionnaire on the Economics of Medical Practice - sought out information on physician earnings, type of work, type of practice, size of community practised in, years of experience, time spent in professional work activities, operation expenses, costs of buildings and/or equipment and type of specialty (Judek, 1964, 203). This was again sent to all Canadian physicians (approx 21,000) and 7,000 valid responses were received, approximately 33 percent response rate. One has to question the validity of this component of Judek’s data considering the low response rate. But Judek argues that “all the evidence available to the Commission suggests that the group of doctors from which averages shown in this study are drawn is fairly representative of the medical profession in Canada” (Judek, 1964, 204). Despite Judek’s defense of the validity of the responses, this data was used cautiously in this study. It was deemed more relevant to compare the PMQ data using the fee-for-service solo medical practitioner, which epitomises medical practice in Canada, as the comparative base from
which to draw conclusions about other physician employment settings. This is explained further in Chapter 5.

The combination of the human organisational literature on professional employment structures and the empirical data from the sources described above served as the primary evidence for analysing and drawing conclusions about the validity of the proletarianisation of Canadian medicine arguments outlined in Chapter 2.

**Deprofessionalisation of Medicine Thesis**

The deprofessionalisation of the medical profession arguments are pursued primarily through an analysis of the legislative developments surrounding the introduction of Medicare and Community Health Centres in Canada. A comparative analysis of these two movements is deemed a valuable source for understanding the nature of the relationship between the medical profession and the state. The outcomes of the movements were different despite, what appears on the surface, similar responses (both formally and informally) from the medical profession. A closer look at the developments surrounding both crusades reveals the strategies of the key players.

Government documents such as the Hall Commission Report, Report of the Advisory Committee on Health Insurance (the Hegarty Report), the New Brunswick Health Care Delivery Report, Castonguay Commission Report, Québec's Health Insurance Commission Report, Ontario Hospital Services Commission Report, Manitoba's Willard Report, B.C. Royal Commission on State Health Insurance Report were analysed to gain an understanding of the complexities that surrounded the implementation of Medicare in Canada - the arguments that were put forward by the interested parties. The federal government, provincial governments, CMA and provincial medical societies responded in different ways and their input was often recorded in these government Reports. The unofficial views of the numerous interest groups are also important and
were accessed through social accounts of the events leading up to the implementation of Medicare.

Federal health care legislation and provincial enactments were also examined for the period surrounding the CHC movement. Documents such as the Task Force on Costs of Health Services Report, the CHC Report (Hastings Report), the Federal Provincial Cost Sharing Formula (1971-1972), Ontario’s Report from the Committee on the Healing Arts, Manitoba’s White Paper on Health Policy, Quebec’s Castonguay-Nepveu Report, Nova Scotia’s Health Care in Nova Scotia: A New Direction for the Seventies were scrutinised, again, to gain some understanding of the complexities of the debates and add some insight into the deprofessionalisation of medicine in Canada arguments. This covered the formal aspects of the developments through examining the input and reactions to numerous participants involved in the legislative changes. Social accounts of the events surrounding the experimentation with CHCs was deemed valuable in order to gain insights into the views of those whose voices may not have been officially heard.

Physicians’ attitudes to both the Medicare and CHC movements were then compared and analysed. This was accomplished using the York University 1982 Survey of the Medical Profession in Canada and the CMA 1993 Physician Resource Questionnaire. The York University Survey was conducted in 1982 through the Institute for Social Research. It was a five province survey of Canadian physicians designed to collect information about physicians’ opinions on health policy issues. The survey was sent to 4,721 physicians and after two follow-ups (one by mail, one by phone), 2,087 physicians responded, a response rate of 44 percent. Following the removal of deceased, retired and out-of-country physicians, the response rate was 55 percent.

In November, 1993, the CMA Physician Resource Questionnaire (PMQ) was mailed to a sample of 8,000 physicians nationally with follow-up mailings in December, 1993 and February, 1994. Approximately 3,500 valid questionnaires were returned, a response rate of 45 percent. The results of this survey, where applicable, were compared with the
1982 York University results to allow us to explore changing physician attitudes over time. Small cell counts in the 1993 results, which will limit the validity of certain multi-variable cross-tabulations, have been eliminated in this study.

The Journal of the Canadian Medical Association was used to help understand the influences of the medical society over its members. Newspaper articles were assessed, where appropriate, to try to determine public opinion and media influence, particularly in the controversial issues surrounding the implementation of Medicare.

We saw in Chapter 2 that Haug, a leading supporter of the deprofessionalisation thesis, argues that there has been an erosion of the professional knowledge monopoly so that medicine, for example, does not have exclusive control over medical knowledge. She demonstrates the increasing education of the lay community and the increased availability (through media, computers, books and so on) of medical information. This argument was tested using the 1982, 1986 and 1990 CMA PMQ databank, to determine the importance of and participation in continuing medical education. Changes in regulations for medical registration and practice were also explored to determine the extent to which physicians updated their medical knowledge, thereby reducing the risk of public access and assessability becoming a threatening factor in the clinical aspect of medicine.

**Interviews**

Initially this project was designed to pursue a survey of Ontario physicians conducted by the researcher. It became clear from the response rates to the CMA’s surveys of physicians that CMA or the Ontario Medical Association (OMA) endorsement of my questionnaire and requests for interviews would insure a better response rate. Neither Association was prepared to support or endorse the project. In 1990, a small sample of 547 doctors was collected from the phone books of these Ontario cities - Ottawa, Kingston and Toronto. They were mailed a letter asking if they would agree to be
interviewed. After many follow-ups, eleven initially agreed. Once contact was established and the nature of the research explained several had second thoughts, leaving three secured interviews. After numerous discussions about my frustration and disappointment in my attempts to secure interviews with doctors, a new approach was suggested. So in 1994, a close relative, a physician, helped to put me in contact with a number of doctors who agreed to be interviewed on their work schedules, education, workplace and attitudes to the government interest and role in health care. Seventeen doctors initially agreed and these consisted of 4 CHC General Practitioners/Family Practitioners (2 men and 2 women), 3 GPs/FPs who predominantly worked in a hospital setting (all men) and the rest worked in private practice. They are all GPs/FPs, two worked in solo practice, the rest in groups (7 men and 3 women). It was interesting to see how responsive doctors were when they perceived the interviewer to be sympathetic to their views, a perception gained simply through a close affiliation with a physician who endorsed the project.

As explained more fully in Chapter 5, in order to reduce to complexities of this study, I looked at full-time GPs/FPs only. It was felt there that a number of difficulties would arise comparing evidence across medical specialisations and that intra-specialisation idiosyncrasies would complicate issues even further. With this in mind it was felt a more comprehensive picture could be drawn by examining GPs/FPs alone, which still captures approximately 47 percent of Canadian physicians.

It was particularly important for this study that there be sufficient representation of physicians from CHCs as this was one of the movements under examination. Attaining the views of those employed in a setting that was viewed negatively by the profession was paramount. In the end, one of the physicians changed her mind and requested the interview be cancelled. But since I had become involved with the Centre, I decided to take advantage of the situation and interview its Board of Directors. One other Board was also included so two CHCs in Ottawa (the Centretown CHC and the Sandy Hill CHC) had the opinions of their Boards included in this project. This gave me valuable
information about the operation of the centres and the role of lay representation on boards. It also helped to verify the CHC doctors’ perceptions about how the centres were controlled and their own role in this process.

In the end three more physicians declined to be interviewed citing very busy schedules as the reason. They felt they were unable to spare time from their patients for this project and they were not going to take time from their families and friends in the evenings or weekends. So thirteen GPs/FPs were interviewed: three CHC physicians (1 female), 3 male physicians employed in hospitals, and seven in private practice, (2 in solo and 5 in groups of different sizes). Two physicians were practising in Toronto, one in Kingston and the rest in Ottawa. Costs were the main reason for restricting the number of cities included. The Toronto and Kingston doctors were interviewed in Ottawa.

The interviews ranged in length from 25 minutes to 1½ hours (one physician talked and talked and talked over lunch). They were unstructured in format and opened with my brief introduction to my area of interest. Interestingly the first two interviewed declined to be taped so I took cryptic notes during the interviews which were expanded immediately afterwards. It became apparent that there was value in this interview format in that a number of the doctors actually wandered through their workplace explaining how things were set up, demonstrating their efficiency and introducing other staff. So a decision was made to conduct all interviews without tape recording. In one of the CHC physician interviews this was particularly valuable as it gave me the idea and the opportunity to interview other centre staff, especially those who were active in the board meetings. Having sat on the Board of directors of a CHC as a community representative in the early 1980s gave me some understanding and made staff more receptive to discussing the doctors’ roles in the structures and functions of the CHCs. Of course this style of interview has obvious drawbacks particularly in regard to direct quotes from interviewees. But I am confident that that the views of those interviewed were accurately captured. And where direct quotes are included in this thesis, they reflect exactly what the physician said, otherwise they have been paraphrased.
The interviews helped add substance to the empirical evidence drawn from the surveys. Incidentally they also affirmed that Daniel’s (1990) argument that physicians are socialised into negative attitudes and arrogance toward subordinates, can be extended to include their attitudes to sociologists, at least this sociologist. Questions and cues had to be carefully worded to appear naive and receptive to the physicians’ opinions. It was interesting, for example, to see how eager doctors were to claim that their view was all doctors’ view, using terms like “all doctors would agree...” or “the entire profession feels...”

It was important to include the doctors’ voices in this study as it helped verify the survey evidence, and gave insight into their opinions on state interest in health care and their views on health care in Canada generally. The physicians were frank and shared their views more readily than I had anticipated. The lower response rates for the 1993 PMQ survey on physician attitudes and the 1982 York University survey made me cautious about using the results, but having interviewed those doctors, I had much more confidence in the survey results.

In summary there is a range of data sources used to operationalise the theoretical perspectives outlined in Chapter 2 so that they we can better understand the employment picture of Canadian physicians. As noted there was a limited range of sources available and attempts to gather information were often thwarted by the medical associations. The thesis, therefore, relies on a careful examination of historical evidence, secondary analysis of survey data, a systematic search of newspaper articles and medical journal publications, official government reports and unofficial views of practising physicians in a range of settings. Keeping these data sources in mind, we now turn our attention to an analysis of the proletarianisation thesis, beginning with an investigation into the dynamics of professional work settings.
CHAPTER 4

BUREAUCRATIC ORGANISATION OF PROFESSIONAL LABOUR

This chapter examines the structures of professional employment settings in order to test the assertion made in many of the proletarianisation theses that salaried employment in a bureaucratic setting renders professional employees subordinate to a non-professional management system (Derber, 1983; Oppenheimer, 1973; Oppenheimer, O'Donnell & Johnson, 1982; McKinlay and Arches, 1985, for example).

There is an abundance of human organisation literature on professionals in bureaucracies, mostly concentrating on the problematic integration of salaried professionals into structured organisations. This bureaucratic-professional tension dominates scholarly interests in this area of study, leading to a weak analysis of professional bureaucracies generally. The empirical sociological work on bureaucratised professionals focuses on the applied scientist or engineer in industrial organisations.¹ This concentration stems from the fact that engineering and applied science were the professions that first developed in bureaucratic environments. Other professions that received the main focus of sociological attention (law and medicine) have quite a different history. The "free professions", considered sociologically more interesting and important, left the area of salaried professionalism virtually unexplored.²

¹ See K. Prandy, 1965, Professional Employees: A study of Scientists and Engineers, London, Faber and Faber, for example

² I am hoping to draw conclusions about the 'free professions', generally; their employment picture in the 1990's. The analysis had to be restricted to a particular profession so has not only eliminated the traditional bureaucratic professions such as engineering and science, but has concentrated on the profession of medicine, particularly the growing and increasingly interesting group of salaried medical practitioners in Canada. (It is important to note that a number of professions "grew up" in bureaucracies. For a historical account of the development of a number of "free" and institutionalised professions comparatively, see Carr-Saunders and Wilson, 1933).
Interestingly, Max Weber dealt with the issue of professionalisation and its relationship with bureaucratisation, but did not see the two processes as contradictory but rather as complementary. Weber saw qualifications/expertise as important elements of organisations, where collegial social structures can operate (Weber, 1978, 221-222, 272). Weber argued that bureaucratisation furthers the development of the professional expert (1978, 998).

Despite Weber's view, the conflicts between bureaucracies and the professions became more and more central to the discussion of professionalism, and the literature became even more concentrated. Generally, the view is that bureaucracies are controlled from the top while professions are controlled from within. These differential modes of control provide the potential for conflict.

**Professional-Bureaucratic Conflict**

Most of the literature on salaried professionals claims that the integration of professionals into bureaucracies is problematic because professionals identify more with their profession than with the employing organisation. Professionals control their own certification and performance standards and have separate sources of legitimacy within their professions, again making the move to employee status problematic (Leitko and Szcerbacki, 1987, 52-53). Professionals, therefore, function autonomously from, and are at odds with, administrators. The assumption of conflict between professionals and their employers stems from a natural divergence of interests which emerges in popular theories of professionals in bureaucracies.

Kornhauser lists four areas of conflict between professionals and bureaucracies:

- **Goals**: commercial application of professional's skills versus the internal standards of the profession.
- **Controls**: hierarchy of the bureaucracy versus collegial control of the profession.
• Incentives: professional involvement may be limited, leading professionals into the administrative stream while jeopardising professional advancement.

• Influence: strain between the authority of the bureaucrat (based on position) and the authority of the professional (based on competence).

(Keohaurser, 1962)

Green examines Kornhauser's areas of conflict with respect to the medical profession in the hospital setting, initially highlighting important differences between medical practice in the hospital versus science in industry. First, the hospital is an autonomous professional organisation in a way that industries are not. Second, the medical profession has always been an integral part of the hospital. Science in industry is a more recent phenomenon and has not been intrinsic to the formation of the organisation. Third, doctors have been crucially involved in the determination and structure of their position in the hospital, leading to some convergence between the goals of the medical profession and those of organisation. It is the task of the administration to facilitate the work of the doctors. Finally, the client in the industrial situation is the organisation, while the client in the hospital setting is still the patient. The administration, again, facilitates the critical professional-client relationship (1975, 123).

In light of these differences, what are the chances of Kornhauser's four areas of conflict arising in a hospital setting?

• Goals: both doctors and administration are concerned with patient care but they play different roles. Each has specific goals that could lead to some conflict.

• Controls: conflict would be great if administration tried to dictate how doctors do their work. The definition of the key tasks by the two groups will largely determine the incidence of conflict over controls.
• **Incentives**: this area of conflict is unlikely to exist because the key professional posts are found within the services. Private practice is permitted and research is facilitated.

• **Influence**: problems are unlikely to occur in this area because the professional still deals directly with the client in determining how his/her competence is applied.

(Green, 1975)

Merton also emphasises the difficulties inherent in bureaucratising "intellectuals" in his consideration of the "role of the intellectual in bureaucracy". When one considers the clientele for the bureaucratic and "unattached" professional and their part in shaping the professional's role, one realises that the specificity of clients' demands shapes the latter's activities, attitudes and commitment (Merton, 1968, 269).

Merton, like Green, highlights the professional-client relationship.

The distinction is pointed up by recognising a difference in the "client" of the two kinds of "intellectuals": for the bureaucratic intellectual, it is the policy makers in the organisation for whom he is, directly or remotely, performing a staff function; for the unattached intellectual, the client is the public.

(Merton, 1968, 266)

Examining both Green's and Merton's conclusions reminds us that the ultimate conflict between professionalism and bureaucracy is seen to come between the autonomy of professionals and the control of administrators; conflict is promoted in bureaucratic organisations if administration dictates how professionals must do their work. If the goals of the organisation are not shared by professional employees then we can expect conflict to arise. Indeed much of the literature endorses this position. Green's work points to important differences between professions that grew up in organisations and those which have a history of freedom from bureaucracy. Medicine, a traditionally "free" profession, is less likely to suffer the same conflict or the same degree of conflict as other professions that develop in bureaucratic settings.
Most studies of this conflict are dated in the sense that they were undertaken at a time when salaried professional employment was not the norm for the traditional professions. Often, professionals employed in a bureaucracy used the organisation as a stepping stone to gain the finances and experience in order to set up one's own practice or buy into a partnership or associateship. Today, we are witnessing a permanent move by traditionally "free" professionals to employee status; the interest of this chapter lies in these professions.

The more recent literature suggests an opposite trend in professional/bureaucratic relationships - one that is not inherently conflictual. Guy's 1985 study of mental health care facilities reveals that professionalism and bureaucracy are not necessarily antithetical. Professionals meld their personal/professional goals with those of their employer. Spangler, looking at staff attorneys, concludes that professionals and bureaucratic styles, once thought to be antithetical, form a natural partnership (1986, 189). Professional behaviour may be shifting toward a type of group orientation in which the organisation and personal/professional loyalties tend to coincide.

What has caused this dramatic shift in professional-organisation relations? Professionals have become dependent on bureaucracies for their employment, while bureaucracies are now dependent on professionals to fulfil their organisational missions. Neither can survive without the other, so they join forces (Guy, 1985, 180). Can it be this simple? The professional seeks out an environment appropriate for practising his/her skills. When an organisation satisfies this goal, both the needs of the firm and the professional can be met and their interests no longer necessarily lead to conflict.

The dynamics of professional bureaucracies have changed as more professionals seek salaried employment. "Professional organisations" differ from other bureaucracies. They differ in structure, in organisation, in administration, and in orientation. The role of professionals within organisations has changed. Understanding these differences is
essential to understanding the nature of professionalism in the 1990s. We cannot talk about professionals today without talking about their employers.

**Structural Features of Professional Bureaucracies**

Much of the literature on the structure of professional bureaucracies stems from attempts to deal with the professional-bureaucratic conflicts discussed in the previous section. The human organisation literature comes in the form of suggestions to management on how to form compatible relationships between administrators and professional staff. When one translates the managerial jargon, important structural components unique to organisations employing a number of professionals emerge. What emerges is that professional bureaucracies differ from other bureaucracies, just as professional employees differ from other employees.

**Types of Professional Bureaucracies**

It is important to define or describe what we mean when we talk about a "professional bureaucracy". When we speak of a professional bureaucracy we may mean an organisation where the principal functions are performed by professionals. There are organisations that professionals control, rather than organisations where professionals are simply employees. Etzioni, Hall and Scott listed three types of work settings where salaried professionals may be found:

1. **Professional** organisations are those in which at least half of the employees are professionals and the goals of the organisation generally coincide with the goals of the professionals. There are two subtypes:

   - **Autonomous** professional organisations are those in which professionals control the organisation, including managerial positions. Organisational officials delegate to professional employees considerable autonomy and responsibility for the definition and implementation of goals, as well as the setting and maintenance of performance standards. Professionals determine the structure because they are the dominant source of authority (e.g. law firms);
Chapter 4

- **Heteronomous** professional organisations are those where non-professionals, or professionals oriented to the needs of the organisation rather than the profession, are in control. Professional employees are clearly subordinated to an organisational framework with rules and supervision covering many aspects of their work (e.g. social work agencies);

2. **Service** Organisations are those where professionals are provided with facilities but are neither employed by the organisation nor under its control (e.g. a doctor who uses the facilities within a hospital but is not employed by that hospital).

3. **Nonprofessional** organisations are those in which professionals are in a small, subordinate unit within the organisation (e.g. the scientist or medical practitioner employed in industry).

(Etzioni, 1969, xii-xiii; Hall, 1968, 92-104; Scott, 1965, 65-81)

Waters (1989) identifies three categories of "collegiate organisation". **Exclusively collegiate organisations** operate under internal coordination achieved by consensus on a face-to-face basis between participants and administrative tasks are carried out by professional colleagues. Internal authority over colleagues as well as external authority over clients is not mediated through a bureaucracy. **Predominantly collegiate organisations** are characterised by the centrality of the professional activity while administration is subordinated. All members participate in decision-making and all members are, thereby, subject to the decisions made (corresponds with Scott's autonomous professional organisations, described above). And **intermediate collegiate organisations** correspond with Scott's heteronomous professional organisations (again described above) where professional colleagues are incorporated into the decision-making structures (pp. 951-961).

After examining two occupations which have undergone processes of professionalisation, Fielding and Portwood present a typology of bureaucratic professions. They illustrate similarities among professions which were promoted by the state to deal with certain needs in society, which developed from the implementation of more "welfare privileges". There are a number of unique characteristics of these professions. Important to this discussion is that they can be described as "value-rational" organisations as they are committed to a service ideal and are seen as
bureaucracies of low constraint in that they operate under some form of colleague control rather than hierarchical administrative systems. This means that individual professionals have substantial control over the way they choose to handle their clients (Fielding and Portwood, 1980, 42-43).

Fielding and Portwood recognise the range of possible professional types. There are variations in the degree of dependence on the state, for example, often dependent on whether a profession developed before or after the welfare state. Their typology distinguishes between those bureaucratic professions whose credentials originate from the state or its delegated agent, and those whose credentials emanate from the professional association, leading Fielding and Portwood to conclude that "few professions have lost status, social position and autonomy by virtue of state heteronomy, and that for most professions the interdependent processes of bureaucratisation and professionalisation have been to the benefit of both themselves and the state" (Fielding and Portwood, 1980, 48).

What becomes clear from the number of professional organisational settings is that each work environment brings with it differing degrees of bureaucratic control. It is important to understand the bureaucratic structures in the various organisations.

**Degrees of Bureaucracy in Professional Practice Settings**

Scott looks at bureaucracy in the three salaried professional work settings described above [Professional organisations (autonomous and heteronomous), Service organisations and Nonprofessional organisations] along the following six dimensions:

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3 This is discussed further upon examination of the "new class" theories and power relations in professional organisations; see “Professional Power” section of this chapter. What this basically means is that there are particular "professions" which have arisen which were required by the state and were, therefore, granted their status without direct formal training by a professional body. Typically a professional training body develops afterward as well as the professional association. Examples of these bureaucratic professions are college lecturers and ophthalmic opticians (See Fielding and Portwood, 1980)
1) hierarchy of authority (pre-structured by the organisation)
2) division of labour (decided by the organisation)
3) presence of rules (degree of organisational control)
4) procedural specifications (organisationally defined)
5) impersonality (extent to which organisation members and outsiders are treated without regard to individual qualities)
6) technical competence (organisation-decided standards used to decide advancement and selection).

(Scott, 1965, 65-81)

Scott concludes that the nature of the occupational groups employed affects organisational structure. Professionals import standards into the structure to which the organisation must adjust. The manner of adjustment determines the level of bureaucracy and the overall structure of the organisation.

The work of Hall (1968) and Scott (1965) provides the base for more recent studies of professionals in organisations. Little attention has been paid to changes that developed in each setting as salaried professional employment becomes more common. There are important similarities in all of these settings (certainly amongst the professional staff) and an understanding of professional bureaucracies is within grasp. Searching out the similarities is an important task.

A 1954 study of career perspectives in a bureaucratic setting made the following observations about salaried specialists. First, specialists consider themselves to be highly influential in the job context, whether or not they are employed at the executive level. Second, they are committed to careers of skill and interested in skill gratification rather than personal benefit. Finally, place of employment is not as important as being able to use one's skills (Marvick, 1954, 99-124).

Much has changed since the 1950s, but some of Marvick's observations remain relevant today. Professionals still consider themselves to be influential within the structure and operation of their employing organisation. Place of employment remains somewhat
insignificant, while ability to use one's knowledge is extremely important. The lack of interest in personal benefit is an aspect of professionalism that truly has disappeared over time, if it ever did exist. The days of being "called" to the profession and practising one's skills without consideration of reward have passed. Recent surveys of medical doctors in Canada supports Marvick's hypotheses about the position of professionals in organisations as well as the continued importance of using one's skills and knowledge. Whether employed by the state, employed by private or public institutions, or self-employed, doctors considered their freedom to control the overall nature of their work and to influence the organisational structure as essential. Management of the organisation and day-to-day decision making were secondary (See York University, 1986 National Survey of Canadian Physicians; CMAJ, Vol 140, January 15, 1989; 1982, 1986, 1990 CMA Physician Manpower Questionnaires).

Professional influence, particularly with regard to making decisions, is an area which has received a lot of attention from Marvick's 1954 study to today. According to Guy, the stereotype of an organisation staffed by professionals is that of decentralised decision-making and the belief in the necessity of top management consulting with the middle level and line staff, rather than making arbitrary unilateral decisions. Furthermore, it implies a faith in the individual worker's ability to make decisions in the best interest of the client/product and the organisation. A professional organisation requires an effort on the part of the administration to blend the organisation's needs with staff preferences. The organisation is expected to give the staff as much latitude as possible (1985, 176-180).

Rothschild-Whitt (1979) developed an organisational continuum to encompass a number of non-conventional institutions of employment:
Rothschild-Whitt's continuum allows one to place different forms of professional organisation into a theoretical perspective. We could argue that the autonomous professional organisation resembles a collectivist democracy, whereas the heteronomous professional organisation is more typical of a horizontal bureaucracy. Professional work places tend to be considerably more horizontal than the hierarchical bureaucracy but more hierarchical than collectivist democracy (Rothschild-Whitt, 1979). Salaried physicians in Canada, for example, are employed in a variety of settings ranging from private industry to hospitals, to clinics, to government. Doctors working in private industry are more representative of Rothchild-Whitt's "complex self-managers" while those employed in hospitals or clinics reflect a "collectivist democracy". Government-employed GPs are more "bureaucratically" organised and would therefore tend to represent Rothchild-Whitt's "horizontal bureaucracy" or perhaps even the hierarchical extreme. (Chapter 5 discusses the employment settings of Canadian physicians in more detail).

She compares polar opposites of organisational structure along eight dimensions. (See Table 4.1)
### Table 4.1

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Bureaucratic Organisations</th>
<th>Collectivist-Democratic Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Authority</td>
<td>1. Authority resides in individuals by virtue of incumbency in office and/or expertise; hierarchical organisation of offices.</td>
<td>1. Authority resides in the collectivity as a whole; delegated, if at all, only temporarily and subject to recall. Compliance is to the consensus of the collective which is always fluid and open to negotiation.</td>
</tr>
<tr>
<td>2. Rules</td>
<td>2. Formalisation of fixed and universalistic rules; calculability and appeal of decision on the basis of correspondence to the formal written law.</td>
<td>2. Minimal stipulated rules; primarily ad hoc, individuated decisions; some calculability possible on the basis of knowing the substantive ethics involved in the situation.</td>
</tr>
<tr>
<td>3. Social Control</td>
<td>3. Organisational behaviour is subject to social control, primarily through direct supervision or standardised rules and sanctions, tertiary through the selection of homogeneous personnel especially at top levels.</td>
<td>3. Social controls are primarily based on personalistic or moralistic appeals and the selection of homogeneous personnel.</td>
</tr>
<tr>
<td>4. Social Relations</td>
<td>4. Ideal of impersonality. Relations are to be role-based, segmental and instrumental</td>
<td>4. Ideal of community. Relations are to be holistic, personal, of value in themselves.</td>
</tr>
<tr>
<td>5. Recruitment and Advancement</td>
<td>5a. Employment based on specialised training and formal certification. 5b. Employment constitutes a career; advancement based on seniority or achievement.</td>
<td>5a. Employment based of friends, social-political values, personality attributes, and informally assessed knowledge and skills. 5b. Concept of career advancement not meaningful; no hierarchy of positions.</td>
</tr>
<tr>
<td>6. Incentive</td>
<td>6. Remunerative incentives are primary.</td>
<td>6. Normative and solidarity incentives are primary; material incentives are secondary.</td>
</tr>
<tr>
<td>7. Social Stratification</td>
<td>7. Isomorphic distribution of prestige, privilege, and power; ie. differential rewards by office; hierarchy justifies inequality.</td>
<td>7. Egalitarian; reward differentials, if any, are strictly limited by the collectivity.</td>
</tr>
<tr>
<td>8. Differentiation</td>
<td>8a. Maximal division of labour: dichotomy between intellectual work and manual work and between administrative tasks and performance tasks. 8b. Maximal specialisation of jobs and functions; segmental roles. Technical expertise is exclusively held: ideal of the specialist expert.</td>
<td>8a. Minimal division of labour; administration is combined with performance tasks; division between intellectual and manual work is reduced. 8b. Generalisation of jobs and functions; holistic roles. Demystification of expertise: ideal of the amateur factotum.</td>
</tr>
</tbody>
</table>

(Source: Rothschild-Whitt, 1979)
A professional's role in the operation of an organisation must have more important implications for professionalism generally. How do professionals influence decision-making? Do organisations have a special obligation to their professional staff?

**Management Structure of Professional Bureaucracies**

Management in professional organisations often "flatten the organisational hierarchy or decentralise by spinning off divisions which are then allowed to function autonomously" (Raelin, 1986b, 24). The ultimate aim of these organisations is to develop and implement strategies that accommodate professional interests while sustaining organisational task accomplishment. Raelin suggested a number of strategies that have been implemented to deal with the kinds of problems that arise between professional staff and organisational administration.

Reed (1992, 94) suggests that conflicts are embedded into the very fabric of organisations. The contradictions and tensions need to be regulated by administrative and managerial techniques geared to the interests of the dominant groups - in this case the profession. Bureaucracies are structured to serve the interests of the dominant groups (1992, 101).

One contradiction that tends to develop in professional organisations concerns "overspecialisation" (organisational compartmentalisation of professionals required to perform fixed tasks apart from other professionals and managers) versus "over-professionalisation" (when professionals pay exclusive attention to their special skills and knowledge without consideration of organisational goals). Administration deals with this through the promotion of professional access to corporate culture, by expanding skill and career opportunities within the organisation and through the socialisation of staff to corporate culture (Raelin, 1986b, 175).

Professionals have to be taught about organisational life: corporate culture, internal labour market policy, organisational goals, and so on. How central the profession is to
the business of the organisation determines the opportunities for professional development and integration. According to Raelin (1986b) there are a number of factors which affect a professional's adaptation to the corporate culture. These factors operate at three different levels: individual, job and organisation.

The length of one's training, which indicates the strength of socialisation into the norms of the profession, is the individual level factor which has the greatest effect on professional integration (Raelin, 1986b). The strength of one's socialisation may also depend on the number of years a practitioner spends as a fee-for-service solo entrepreneur or group practitioner before entering a bureaucratic organisation.

Professional organisations offer professionals autonomy, challenge, variety and meaningful performance-based work, as well as work that taps creative and entrepreneurial talents and allows professionals to work without excessive supervision (Raelin, 1986b). These job level factors help smooth the move to a bureaucratic environment.

Professionals are likely to obtain an acceptable level of control over their own work in organisations where their expertise is recognised and valued, where their services are in high demand, and where administrators are aware of professional concerns (or even have professional backgrounds) (Raelin, 1986b). Such organisational factors help us understand why some professionals have not resisted bureaucratic employment, and how they have adapted to the corporate culture.

Strategies used by organisations to accommodate the autonomy versus control conflict, which has been highlighted as the ultimate conflict between professionalism and bureaucracy, range from the implementation of dual career ladders (a managerial ladder and a ladder of professional positions) to a "transition-to-management" approach. Transition-to-management was introduced as a way of giving professionals the opportunity for greater responsibility and power within the organisations. This
mechanism was initially seen as a means of giving professional employees a higher salary in lieu of an alternative career path.

The implementation of separate promotional ladders is an interesting development in professional organisations. Ritzer (1986, 215) argues that the professional career ladder, which entails a hierarchy of positions, does not carry greater professional authority. Instead it carries greater status, salary, autonomy or responsibility. Organisations recognise that, if professionals moved into and up the traditional ladder, they would move out of their area of expertise. The second ladder allows them to be rewarded and experience some mobility within their professional area. Creating a track for professionals parallel to the traditional, hierarchical track of management provides professionals with the power to allocate resources and to pursue alternative goals (Raelin 1986a). This dualism helps protect professionals from typical corporate politics and conflicts (Davidson, 1985).

The career structure within organisations gives professionals the opportunities to gain authority and status within the division of labour. According to Zussman, it is the organisational structure which allows access to the graded hierarchies associated with autonomy and power. Credentials provide employees with opportunities for certain career paths (Zussman, 1984), but credentials or "knowledge" alone do not give an individual autonomy. Management's willingness to allow professionals to carry out their work without supervision does give them autonomy (Whalley, 1986, 58-60). Access to the career structure puts professionals in the position where they can prove themselves to management or even become management.

The literature on professional careers has produced two predominant models: linear and steady-state. The linear model, restricted to study of professional employees only, states that career paths have a number of hierarchical levels to which professionals are promoted over their careers. Increased financial rewards, greater status and greater authority and/or autonomy come about with each upward move. The steady state
model, which was developed to understand the position of self-employed professionals, states that professionals enjoy greater financial rewards with increased experience and/or the establishment of a professional network, without any apparent upward mobility.4

A tournament model of career paths was proposed by Rosenbaum to allow one to examine both employee and self-employed professionals. This model combines the steady state path and linear mobility models. Movement both upward and horizontally is available to individuals within an organisation. The ladder is both external and internal to the employing organisation. A professional can advance vertically by moving within a single organisation or between organisations (Rosenbaum, 1984).5

Professional autonomy is related on two separate levels: at the individual professional level and at the level of the occupational group or profession (Engel, 1969, 12-21). Ultimately, employed professionals' concerns lay with their own autonomy. Professionals are likely to obtain an acceptable level of control over their work in organisations where their expertise is recognised and valued, their services are in high demand, and administrators are knowledgeable about professional concerns. These are the settings where professionals seek employment and where the organisation's administration seeks professional expertise. Since professional expertise and research are dependent on market strategy, the professionals' autonomy and expertise are somewhat curtailed. But the role of the professional is protected because policy-makers understand that "the vital search for knowledge depends upon the integrity of professional endeavours" (Raelin, 1986b, 2-24).


5 For bureaucratic professions the career structure generally includes the following levels: rank and file employee-supervisor-manager-executive, with various levels within each rank. The equivalent positions can be found in self-employment in partnerships, for example: rank and file employee - junior partner - senior partner.
The problem of close supervision of professional employees versus professional standards of evaluation has been examined by a number of human organisation students. They suggest that professional self-management and peer control are viable means of dealing with this contradiction. Introducing a professional administrator, as an accommodative mechanism, tends to alleviate the potential conflict between the need for control by management and the need for autonomy by professionals. Another accommodative strategy is "management by objectives". Professionals and managers work hand in hand to reach a decision about their immediate objectives, how long it will take to reach these objectives and the criteria for evaluating performance (Raelin, 1986b).

We are witnessing the development of critical professional supervisory positions in organisations. Professionals may serve as an information conduit between professional staff within one organisational department, between departments, and with the outside environment. Accommodative mechanisms, such as the creation of the role of professional-administrator, have alleviated the potential conflict between the need for control by management and the need for autonomy by the professional. Studies show that leaders want professional administrators, in the capacity of social or policy researchers, in administrative positions. Such administrators may rise above the profession in which they are immersed when making decisions (Davidson, 1985, 210-220). In other words, management and professional staff felt that professional social researchers, rather than professional scientists or professional engineers for example, would make better administrators. Davidson, in a study of professionals in organisations that they do not control, with particular emphasis on policy and procedural decision-making, concluded that administrative differences stem from differences in professional ideology: political versus professional interest in decision-making.

\textsuperscript{6} For a full discussion see Raelin (1986a and 1986b) on what he terms "gatekeeping".
When a professional takes up a salaried position within a bureaucratic organisation, a contradiction often develops between their ethical responsibility as viewed from their profession's prescriptions and corporate efficiency. Some organisations attempt to deal with this problem by formalising a code of ethics within the institution. The procedures of the organisation are modified so as to incorporate social and ethical objectives into the plans of operating management (Raelin, 1986b).

Raelin points out a number of strategies used by organisations to deal with professionals, but concludes that, ultimately, professionals manage their own work as well as that of their subordinates. Wade takes a different approach to this issue, based on professional ideology rather than structural mechanisms.

Wade developed a model of professionals in organisations which looks at the extent to which the conflicts between professionals and their employers may be resolved by means other than the conventional organisational framework. Wade's model has the following features:

1. Salaried professionals look ultimately to their training for the legitimation of their activities (no hierarchy);
2. The interactions amongst professionals and between professionals and clients are highly effective and intimate (no impersonality conflict);
3. The professional exercises autonomy within the limits of professional ethics, in selecting his (sic) goals and/or in participating with fellow professionals in forming organisational goals (no distinction between administration and policy-making).

(Wade 1967, 40-46)

The intent of the model is to provide for the maximum degree of personal freedom and professional autonomy compatible with the productivity demanded of the organisation by its clientele. Wade's model promotes a theory void of conventional bureaucratic rules, regulations and structure. Wade is perhaps too extreme in the features of his
model, but he does highlight the fact that professional bureaucracies differ from other organisations, and professional employees differ from other employees. Professional-administrative relations reflect these differences.

Guy, on the other hand, feels that professional staff are treated no different than any other staff (Guy, 1985, 14). In her study of psychiatric hospitals she makes the following observation: "managing professionals is not too different from managing non-professionals, with the exception that professionals place heavy emphasis on academic degrees and articulate their expectation to play an influential role in organisation decision making" (1985: 15). Guy's study focuses on how professional staff are treated in their employing organisations rather than how they see themselves in the workplace. She does not explore the nature of the management structures and the role of professional employees extensively enough for us to comment on the role of academic degrees and the professionals' expectation to play a role in the decision-making process. We are left wondering whether they do affect the process.

A more in-depth discussion of the management of professionals reveals yet another difference - two ideal types of salaried professionals: locals and cosmopolitans. Cosmopolitans are low on loyalty to the employing organisation, high on commitment to specialised role skills, and likely to have an outer reference group orientation. Locals, on the other hand, are high on loyalty to employing organisation, low on commitment to specialised role skills, and likely to use an inner reference group orientation (Gouldner, 1957). Professionals can be cosmopolitan or local on different personal and organisation levels and can change their orientation according to the stage of their career, organisation setting or management style. So when we are talking about managing professionals we should keep in mind this distinction. Managing locals requires different strategies from those used to manage cosmopolitans. The differences between staff professionals are as important as are the numerous features distinguishing professional employees from other staff.
Professional Employees

In 1951 C. Wright Mills suggested that the salaried position of professionals resembles that of other workers except that experts opt for status rather than class consciousness. Professionals concentrate on the way they enjoy a more privileged position than other workers and ignore their "relative powerless" position vis-a-vis employers (1951, 53-354). In 1951, this may very well have been the case. Today, salaried professionals continue to enjoy a more privileged position. If professionalism in an organisation does nothing else, it elevates one in rank. Rank accounts for the difference between professionals and non-professionals. Being tagged a professional lifts one out of the dehumanising aspects of living in a bureaucracy. What has changed since Mills' work is that professional employees are no longer powerless vis-a-vis their employers.

Professional Power

Being identified as a professional means being elevated to a position which is more likely to be involved in decisions. This inclusion into the decision-making rank implies greater importance in the organisation and greater control over one's own work site and work life (Barret, 1970). We can draw an analogy between professional organisations and private governments. Organisations, viewed as private governments, provide a number of opportunities for political action to seek greater autonomy, to dissent from organisational policies, to oppose authority, to depose existing career ladders and to transform the political structures within the organisation where one works (Perrucci et al, 1980, 149-164).

The "new class" theories explore the power relationships in professional organisations and their effects on the rest of society. The "new class" consists of scientists, lawyers, city planners, social workers, educators and so on, a great number of whom find their careers in the expanding public sector. Their interest lies in the corporate power of their class rather than financial rewards (Kristol, 1978, 14-17). Members of the "new class"
control the bureaucracies where they are employed. (Kristol, 1978, 27). Professional politics can and does do much to advance the interest of professional groups.

Gouldner argues that professionals form a new class commanding the scientific discourse on which society now depends. Professions use their specialised knowledge "to advance their own interests and power and to control their own work situation (1979, 7). Knowledge is seen as "cultural capital" and an important class resource. Martin and Szelenyi are critical of Gouldner's dependence on the notion of cultural capital and its reliance on economic rewards and suggest that theories of new class should be recast under the views of Bourdieu, who sees intellectual authority operating through words and symbols - "symbolic domination" - rather than economic power (1987, 28).

It is important for us to understand the source of professional influence or dominance in the workplace and new-class theories help us to understand the significance of professional knowledge as this source. Certainly Martin and Szelenyi recognise the differences between knowledge and capital as sources of power and acknowledge the role of culture (symbolic culture) as the power base of professionals. But as Derber et al (1990, 213) note "they fail to recognise that the secret of professional authority ... lies in the intertwining of 'symbolic' and 'practical' mastery." In other words, it is important to understand that professional power comes about through the "marriage of theory and practical skill"; as well as the culture and economic power that Gouldner captures in his notion of cultural capital.

Barbara and John Ehrenreich (1979, 12) proposed a "professional-managerial class" (PMC) emerged in the US in the early twentieth century, consisting of "salaried mental workers" who do not own the means of production, but function to reproduce "capitalist culture and capitalist class relations". The PMC, according to the Ehrenreichs, consists of all professionals and middle to upper level managers. It is not
clear from their discussion whether the Ehrenreichs see knowledge as the basis of their distinct position in society, although this is the implication.

Collins suggests that the new class is not defined by its knowledge base, but by its credentials. He argues that it's the way professionals organise knowledge that confers power - attaching credentials to that knowledge (1979). We recall Haug's argument that the rising levels of public education threatens exclusive professional information control (1975; 1988). Collins suggests that professionals do not monopolise the full range of productive knowledge but a segment of it by making it scarce and controlling who can access it and use it. Haug argues that the professions can no longer control the access side of the knowledge (1988, 51).

Derber et al (1990) argue that professional power is unique in that it combines cultural authority aspects of Gouldner (1979) with the control of skills dimension highlighted by Collins (1979) which are in high demand. Spangler's 1986 book seeks to anchor this discussion of the "new class" in an empirical study of lawyers. Although we are witnessing a change in the professions, as we know them, it is not to say that there is a decline in the power and leverage of expertise over lay people. The expertise of professional people allows them to influence the course of events in their own favour (Spangler, 1986, 176-177). Despite what new class theory states, it is evident that expertise alone is insufficient in protecting one's professional status. The continued strength of professional associations demonstrates the need for collective action. The problem is that many professional employees concentrate on the content of their individual work; their expertise may not be sufficient to protect their goals and interests. Because professionals' interests become self-centred, employers have available a number of strategies to bring them under control. One of these strategies is the implementation of a bureaucratic control system which directs people to better themselves individually rather than collectively (Spangler, 1986, 186).
Spangler's study concludes that when lawyers become employees, they find that their bosses are able to control and to thwart any "new class" goals they may have (1986, 190). Spangler claims to have demonstrated the domination of lawyers by management but she has not made it clear who management is. Are members of the legal profession managing other lawyers? If so, what management strategies are they implementing? Spangler's conclusions do not discuss the supervisory structure within these organisations, which is important in helping us to understand the complexities of professional work settings.

**Collegial Freedom versus Hierarchical Administration**

Study after study has shown that professionals consider their expertise to be beyond judgement by outsiders (Sciulli, 1986; Leitko and Szcerbacki, 1987; Kornhauser, 1962; for example). Their work can be assessed only by their peers. Historically, the state and the public supported the professional view. What kind of supervisory structure develops in organisations to accommodate this phenomenon? Mintzberg (1979) designed an organisational structure specifically to fit the characteristics of professional bureaucracies. His model allows for participative decision making by line staff, with very little hierarchy imposed over them.

Collegial freedom exists when an administrator acts as a participant in organisational decisions-making as opposed to being sole decision-maker. I suggest that there must be a balance between hierarchical control and collegial freedom, even if this balance is continually redefined. Consider an administrative continuum with collegial freedom at one extreme and hierarchical administration at the other.

The greater the number of professional employees, the more the administrative emphasis will fall on the collegial freedom end of the continuum. Since autonomy, use of skills and expertise and control over one's work are the crux of professionalism, this administrative continuum theory becomes extremely important. If a professional does
not maintain the very features that define him/her as professional, then s/he is no different from any other employee.

Another way of conceptualising the balance of authority in professional bureaucracies is through an administrative hierarchy. All professional employees fall into some administrative level, with most at the bottom of the hierarchy. Perhaps all professional employees are not directly involved in administrative decision-making but they feel they (or their interests) are adequately represented. If they become unhappy with their representation, they will enforce a change at the representation level which may affect all administrative levels. Prandy (1965, 62) notes that "those who are low in the authority hierarchy and whose work emphasises their subordination, pursue professional protection". The importance of professional participation in organisations becomes evident. Davidson examined this issue by studying organisations that employ professionals but are controlled by others. In such organisations, management assumes that professionals prefer autonomy to organisational authority as long as those holding power make decisions that do not run counter to the interests of the professionals. If policies change, then professionals become as interested in organisational power as anyone else (Davidson, 1985, 210-220).

Conflict is likely to arise in professional organisations when one's particular area of expertise takes precedence over the organisation's goals or the goals of the profession itself. This conflict was best avoided when professional social or policy researchers took on administrative roles which served to satisfy the employees and administration. Professionals remain autonomous while organisational authority works in the interest of professionals. When authority rests in the hands of professionals as opposed to outside management, the interests of everyone are served. With the development of professional career structures, relationships amongst peers have changed. Colleagues are no longer considered equal in competence, authority and power. This brings us back to the question of where a professional's loyalties lie: with their employer or with their profession? Evidence suggests the latter. For example, professional colleagues remain
reluctant to testify against each other despite political pressure. Disciplinary boards continue to have difficulty reviewing and evaluating practitioners' decisions (Mullis, 1995). Professional recruitment and socialisation processes are designed to ensure this allegiance remains intact.

Waters, using a Weberian analysis of the role of collegiality in professional organisations, argues professionals use collegiality in response to state and commercial corporatism. The consequence of this is a "modification of structures of domination in the professional's favour..." (1989, 471). In other words, collegiality is a form of organisation, established by professional workers, to resist control by bureaucratic, state and commercial interests. Because collegiality is an inefficient form of organisation, according to Waters, its capacity to resist bureaucratic encroachment is limited. The reasons Waters cites for the limitations of collegial authority are twofold. Firstly its reliance on expertise is contestable and, secondly, with regard to the management of material resources, bureaucratic authority is more efficient. Collegiate organisation, therefore, is most advanced in professions such as academia, law and medicine (Waters, 1989).

Mintzberg's professional organisational model features decentralised decision-making, emphasis on professional authority and very little hierarchy. Professionals not only control their own work, but they also seek collective control of the administrative decisions that affect them:

The professional bureaucracy is unique... in answering two of the paramount needs of contemporary men and women. It is democratic, disseminating its power directly to its workers (at least those who are professional.) And it provides them with extensive autonomy, freeing them even of the need to coordinate closely with their peers, and all of the pressures and politics that entails.

(Mintzberg 1979, 371)

Mintzberg gives considerable power and authority to staff professionals, defining them as the "operating core" of the organisations that employ them. Because staff
professionals are so powerful, professional administrators give them considerable indirect power in the structure. The professional administrators handle disturbances in the structure and mediate between professionals inside and interested parties on the outside (like governments and clients associations) (Mintzberg, 1979, 361-362).

Mintzberg's professional-bureaucratic structure fails to include all three types of salaried professional work settings described earlier (autonomous professional organisations, heteronomous professional organisations, service organisations and professional departments). Although he claims to have dealt with the autonomous and heteronomous professional organisations, he has not covered adequately the dynamics of these settings. The important question of whether professional knowledge protects one from outside evaluation and control is ignored.

**Professional Knowledge**

Spangler's study of lawyers stresses that "the nature of legal knowledge" helps protect lawyers from management (1986, 184). Legal knowledge, by its very nature, cannot be standardised; "legal knowledge is cultured - informed estimates about which arguments will be persuasive in specific jurisdictions under particular circumstances". In Spangler's study, the uncertainty of due process is especially important as it serves to protect the staff attorney's freedom to exercise discretion. If expert knowledge is divided into "technical" and "indeterminate" components, the larger the indeterminate element, the greater is the professional's freedom from external control.

The distinction between "technicality" and "indeterminacy" in professional knowledge was introduced by Jamous and Peloille (1970) and elaborated by Child and Faulk (1982). The indeterminate nature of professional knowledge protects one's autonomy by preventing technical means of standardisation and routinisation. This indeterminacy dimension reaffirms the important issue of who can evaluate and assess professional work.
The indeterminacy of professional knowledge helps protect employees from evaluation by superiors only if the superiors do not share the same knowledge. What happens when supervisory positions are held by members of the same profession? Freidson and Rhea did an early study of methods of control in "a company of equals". They looked at the dynamics of a medical clinic with fifty salaried physicians, administrative staff, clerical and paramedical personnel. The hierarchy of this clinic was simple: the Medical Director held responsibility for the conduct of the organisation generally, including the doctors, and the Administrator was responsible for the day to day operation and the conduct of the paramedical and clerical staff. Otherwise there was no vertical division of ranks among the doctors. Physicians were regarded as permanent/tenured and there was no formal subordination or superordination amongst colleagues (Freidson and Rhea, 1963).

Although this setting allows for control over the running of the activities, for example scheduling of appointments, there is no route to gain information on the technical competence of the physicians. Administration could only assess physicians' efforts through reports of support staff or patient complaints. But patients were deemed incapable of assessing technical performance. This meant colleagues had to report on the technical aspects of each other's work. Since physicians believe that the law holds them responsible for the consequences of their work, this gives them autonomy from assessment by others. Accompanying autonomy is the belief that there is no single "right" way to handle a problem. Individual judgement is paramount; so physicians expect mutual trust from colleagues (Freidson and Rhea, 1963). We can see that, even when there are mechanisms which allow one to assess the competence of others, professionals may be unwilling to exercise this option.

Waters (1989), drawing on Parson's position on the link between technical competence and collegial authority, notes three components of organisations operating under collegiality - expertise, equality and consensus. Again in a "company of equals" authority on the sole basis of expertise is paramount. Equality is implied by expert
authority; "each member's area of competence may not be subordinated to other forms of authority." All members of such organisations must participate in decision-making (p. 955). Weber discusses this by way of understanding administrative acts of collegial bodies are legitimated only when they come about under unanimity or majority (Weber, 1978, 278, as cited in Waters, 1989, 955).

Freidson & Rhea (1964), Parsons (1969) and Waters (1989) are discussing the authority structure in organisations where employees are of equal professional standing - "companies of equals". In fact Waters delivers a formal statement of the "collegial principal which draws on this important criterion:

Collegial structures are those in which there is dominant orientation to a consensus achieved between the members of a body of experts who are theoretically equal in their level of expertise but who are specialised by area of expertise.

(1989, 956)

Must we then assume that all physicians, for example, are equals? This is not clear in the discussions. But we will see in the next chapter that many Canadian physicians are not employed as "equals" in medical practices (junior partners, for example). We need to understand their position in these settings as well.

In summary, Freidson addresses the question of whether employment status affects a professional's autonomy and/or economic rewards. He concludes that when one "examines the conditions surrounding self-employment in actual historical circumstances, it is impossible to argue that the self-employed enjoy greater economic security, higher economic rewards and more autonomy at work than the employed":

If one's goods or services are so highly valued on the market that consumers are clamouring for access to them, then one can exercise considerable control over the terms, conditions, content and goals of one's work ... whether one is employed or self employed is beside the point. Given a strong position in the market one can be employed and "write one's own ticket" nonetheless.

(Freidson, 1984:9)
Does bureaucratisation reduce professional autonomy and control? Martin Oppenheimer's (1973; and Oppenheimer et al, 1982) proletarianisation thesis argues that bureaucracy creates, for the professional, factory-like conditions with fixed rules and jurisdictions created by others in a hierarchical command system. These conditions render a professional proletarianised. This chapter has demonstrated that organisations employing professionals are different from typical bureaucracies and professional employees are different from other staff. Oppenheimer failed to analyse the structures of those organisations where professionals are employed.

Derber et al (1990) interviewed over 1,000 salaried doctors, lawyers, scientists and engineers in the United States, discussing their work, their status and influence as professional employees amongst other things. Their findings surprised them considering the theoretical arguments that dominate the current literature on the status of professionalism under salaried employment arrangements. They conclude that "many professionals have maintained and even enhanced key elements of their traditional authority, though in new forms". They found that professionals have created partnerships with their employers, enjoying power and freedom unlike other employees. A great majority of those interviewed claimed to "enjoy great autonomy ... and exercise authority over others" (p. 4).

Weber saw bureaucratisation and professionalisation as complementary processes. He viewed both processes as expressions of the increasing rationalisation of Western societies. The professional is one person in a bureaucratic machine. His expert position and its ensuing privileges and obligations is justified by the bureaucracy. 7

Freidson examined more recent developments in organisational theory which question the assumption that organisations employing professionals are ordered and controlled by strictly bureaucratic means. He cites numerous organisational theorists, the most

emphatic stating that organisations which employ professionals function effectively as loosely coupled systems, not tight bureaucratic linkages and control of units, as conventionally viewed (Weick, 1976 as cited by Freidson, 1984, 11). Professionalism, because it revolves around the principle that members control their own work, operates differently than bureaucracy. Encompassed under professionalism is that the occupational group has obtained power delegated by the state and must, therefore, maintain the conditions that assure its continuation (Freidson, 1994, 173). The professional model is based on the idea that individuals can and do control their work by “co-operative and collective means and ...those who perform professional duties are in the best position to make sure it is well done” (1994, 176). Wilensky and Lebeaux state that a major factor affecting degree of bureaucracy in an organisation is the "proportion of personnel that is strongly committed to a profession" (1965, 245). A professional orientation works toward reducing bureaucratic tendencies:

Professionalism gives one not only the incentive, but also the strength to avoid excesses of bureaucratic proceduralism - for membership in a cohesive group with its own standards...frees the functionary from the fears and insecurity which would lead him to take refuge in fixed rules.

(Wilensky and Lebeaux, 1965, 246)

These theoretical developments raise doubts about Oppenheimer's assumption that bureaucratic organisation puts professionals in a position analogous to the industrial worker. The key issues are whether or not professionals have maintained control over their own work and whether the professions continue to enjoy an autonomous position within the labour force. There may be a decline in the amount of control individual professionals with employee status once had, but one has to question whether this decline is due to becoming an employee or whether it is typical amongst up and coming professionals generally. We are witnessing a decrease in the amount of decision-making power amongst junior partners enjoying self-employment, for example. Spangler's study of lawyers demonstrates that the expertise of lawyers may not be sufficient to protect their individual goals and interests (1986, 186). Barret, on the other hand, concludes
that professionals within organisations are likely to be included in the decision-making rank, which implies greater control over one's own worksite and work life (Barret, 1970). New employees, like new partners, experience a breaking-in period. Whether one is a professional or not, employers test out their abilities, competence, and so on. Once established, professional employees enjoy greater freedom from supervision and greater control over their own work than other employees.

But do the same conditions hold for Canadian physicians? Chapter 5 examines the organisational structures of Canadian physician employment settings to obtain a better understanding of the human organisation literature and the relevance of arguments surrounding the proletarianisation of physicians in the Canadian health care work settings.
CHAPTER 5

THE EMPLOYMENT SETTINGS OF CANADIAN PHYSICIANS

The theoretical literature on the professions has been dominated by the discussions of challenges to the dominant position of professions in society. The proletarianisation of the medical profession position argues that bureaucracy compromises professionalism and undermines the powerful position of medicine through a process that reduces the autonomy of physicians and the object of their labour, revealed through lack of professional involvement in the decision-making apparatus of their employing organisations. The assumption is that there is a natural conflict between professionalism and bureaucratism.

The human organisation literature suggests that this may not be the case. The professional bureaucratic conflict, which has dominated sociological discussion, has left the area of salaried professional employment poorly explored. When we examine the actual structures of professional organisations we see that many professionals have maintained or even enhanced their traditional authority, enjoying autonomy and authority in the workplace (Derber et al, 1990).

In order to better understand the proletarianisation of professionals arguments as well as get a clearer picture of professional work settings, this chapter examines the practice arrangements of Canadian physicians, exploring the dynamics of their employment settings. An examination of the structural features is undertaken in order to determine the range of settings, degrees of bureaucracy and management structures. The position of employee physicians is considered to gain some understanding of the degree of power and autonomy these doctors hold in their workplaces.

Arguments often refer to salaried employment as an indicator of the proletarianisation process (see Oppenheimer et al, 1982, for example), but there appear to be many assumptions about professional labour tied up with this measure. We recall from the
previous chapter that salaried professional employees can and do exercise power and authority in their work places. So it is important to analyse the organisational structures of the workplaces of Canadian physicians. Hafferty and McKinlay (1993) and *The Milbank Quarterly* (1988, Supp. 2) demonstrate through cross country comparative analyses of the medical profession that the historical development and professionalisation process differs for the profession from country to country. We cannot draw on the literature of physicians in other countries as the experiences of Canadian doctors are different from the experiences of doctors in other places and from the experiences of other professional groups, even in Canada. The complexities and variation in workplaces make it impossible to consider the full range of practice settings but this chapter does capture the activity levels of the majority of Canada's doctors.

**Physician Practice Settings**

Williams *et al* (1989) note there are numerous ways in which Canadian physicians can organise their labour (or have their labour organised). It is no longer possible to simply distinguish between group and solo practitioners, as there is an entire range of possibilities. At least six distinct practice types have been identified:

1) **Solo Practice**: physicians predominantly work alone with no income sharing arrangements, no expense sharing or patient sharing with other physicians. This occurs primarily outside institutional settings.

2) **Group Practice**: physicians work primarily with other physicians sharing income arrangements and expenses or partnerships; sharing patients/patient records. This occurs predominantly outside institutional settings.

3) **Associate Practice**: doctors are economically associated, sharing office space, overhead costs but do not share patients/patient records; outside institutional settings.

4) **Hospital**: physicians spend the majority of their work time as hospital and related academic institutions staff.
5) Community Health Clinics / Health Services Organisations: institutionally based employment with remuneration through salary.

6) Hybrid or Mixed Practices: physicians divide their time between solo and group practices.

(Williams et al, 1989)

Each type of practice setting brings with it different remuneration schemes, management structure, kinds of tasks and how they are allocated. Each of these settings will be examined along these dimensions to add insight to the proletarianisation of the medical profession arguments. Other employment arrangements, such as government and industrial employment, will also be included in this discussion, even though they are not included in Williams et al (1989) list of physician practice settings.

As pointed out in the methodology chapter (Chapter 3) the Canadian Medical Association’s Physician Resource Data Bank provides statistical information on the activities of physicians in Canada. The evidence from their 1982, 1986, and 1990 Census reveals the number of physicians in each of the employment settings listed above, as well as other relevant information. The overall picture of Canadian physicians demonstrates some interesting features.

Canadian Physicians: Who They Are and What They Do

A full-time commitment to the practice of medicine remains the dominant trend amongst Canadian physicians despite a growing number of part-time practitioners. Since the number of women in medicine is on the rise, their tendency to practise part-time during certain periods of their career may explain this trend. In 1982, women constituted 14 per cent of the physician population (CMAJ, 1985, vol. 132, 1179). By 1990 the number of women practising medicine in Canada had increased to 19 per cent.

1 All figures have been rounded
If we examine the figures for part-time practice, we note that in 1990, 64 per cent of all doctors who practised part-time were female and 77 per cent of part-timers under the age of 45 were female (citing family responsibilities as the main reason for part-time practice).

The age and sex distribution of doctors in the part-time category was markedly different from their full-time colleagues. Of physicians under the age of 45 who practised part-time, approximately 77 per cent were women, while 57 per cent of those between 45 and 64 years of age were women. 88 per cent of respondents reported full-time practice and 52 per cent of full-time physicians were 44 years of age or younger. Of full-time doctors 34 years or younger, 28 per cent were women.

When comparing the 1982 and 1990 survey results, we note that most physicians practising full-time were under the age of 45, with the proportion of women growing steadily. Physicians, as a group, are working fewer hours. The reduction in hours worked partially reflects the growing number of part-time physicians, but provincial variations suggest other forces at play. Doctors practising full-time in Quebec, for example, report the shortest working week and the greatest amount of time spent in non-patient care: teaching, research and administration. This may reflect a larger proportion of salaried physicians in Quebec, who are more likely to have a structured work schedule resulting in approximately 35 hours per week in practice. Since they are paid a salary, there is little incentive to increase the number of hours spent in patient care but more incentive to become involved in other areas like teaching or research. The corresponding increase in amount of time spent on professional activities beyond patient care may well reflect this development.

Upon examination of the geographic distribution of physicians, we note that four provinces (Prince Edward Island, Nova Scotia, Manitoba and British Columbia) have smaller proportions of full-time physicians than the national average. One important reason for this is the fact that physicians, particularly specialists, are not attracted to
rural areas. For example, only 11 per cent of full-time physicians practise in rural settings. Yet over 30 per cent of Canada’s population reside in rural areas\(^2\). Semi-retired physicians are more likely to be practising in these areas than are full-time or part-time doctors. On the other hand, rural doctors are, on average, younger than their urban counterparts. These statistics reflect the concern the state has with providing quality medical care to all Canadians and incentive plans are being developed to entice doctors to rural areas\(^3\).

The CMA survey, as well as the York University 1986 National Survey of Canadian Physicians\(^4\), determined that general practitioners worked 47 hours per week, on average, while specialists work 50 hours per week. If we compare this to the CMA 1982 survey, specialists are working 4 fewer hours per week in 1986 than they were in 1982; non-specialists, 5 fewer hours per week. This reduction in hours has remained consistent from 1986 to 1993 (CMA, 1993). The reduced work week may be explained by the greater proportion of part-time and semi-retired physicians in the more recent surveys. The greater proportion of women is also a factor. We have already seen that salaried practitioners have a more structured work week and less incentive to increase the amount of time spent in patient care. This, again, may contribute to the decrease in the average number of hours worked per week. We have seen a move toward group practices which, again, contributes to the reduced work hours\(^5\).

\(^2\) Statistics Canada designates all areas with a population of fewer than 10,000 residents as rural and Canada Post assigns the number ‘0’ as the second character in their postal codes. Using this information, the CMA assigned physicians as rural or urban.

\(^3\) For example, a proposal to introduce a one year internship in rural practice is being discussed by the medical training authorities in the province of Ontario.


\(^5\) This will be discussed further under Group Practice Section.
The training of physicians practising in Canada has always been interesting; 27 per cent of the respondents in the CMA survey (1990) were foreign trained and 11 per cent of foreign-trained physicians practised in rural settings. Immigrant doctors in Canada exceeded Canadian trained physicians from 1966 to 1970. So in 1975 the Canadian government and the CMA agreed that physicians would be permitted to immigrate to Canada only if they had a guaranteed position (i.e. one that could not be filled by a Canadian graduate). This helps explain the number of foreign trained MDs in Canada’s north and rural areas. These are positions that Canadian doctors would not fill. It appears that Canada still has difficulty attracting Canadian-trained physicians to rural areas and must continue to import doctors to provide care in this setting.

All physicians were asked to indicate whether they provided patient care for which they received a salary. Of those who responded to this question 25 per cent indicated they were practising full-time and receiving a salary, the majority were working in a hospital or clinic and averaged 31 hours per week in patient care. Fewer than 3 per cent of physicians reported providing salaried patient care in private industry, an average of 13 hours per week, while 1 per cent full-time physicians were federal government employees who reported spending an average of 25 hours per week on patient care. Of the 836 physicians working for provincial government, 26 hours per week were spent on patient care.

As a whole, salaried full-time physicians were slightly younger than non-salaried ones. Of the full-time physicians receiving a salary, over 52 per cent were specialists. Approximately half of the salaried specialists were under the age of 45, compared to 71 per cent of non-salaried physicians. Physicians over the age of 60 accounted for 12 per cent of salaried specialists and 7 per cent of other salaried physicians.

This information provides an overview of the physician population. We now need to determine the differences in activities of physicians based on their practice setting. Remuneration mechanisms and their effect on health care costs and quality of care have
dominated discussions about health care delivery in the last ten years. Chapter 4 of this thesis suggests that remuneration is not the real issue determining a physician’s employment choice but rather the employment context surrounding the method of payment. We need to explore these work settings and their effects on professional labour.

The PMQ data allows to explore the proletarianisation arguments, as a considerable amount of the questionnaire has been dedicated to physicians’ activities. In order to argue that Canadian doctors are becoming (or have become) proletarianised, translating the arguments into measurable indicators suggests that doctors would be spending more time in direct patient care (including on-call hours) and less time acting in a managerial capacity, making decisions or involved in decision-making, and supervising subordinates.\(^6\) This would indicate a decline in professional control over one’s own labour and the labour of others. Again, we must be cautious about these indicators. As was suggested in the previous chapter, physicians may be content to spend their days in direct patient care as long as they feel their interests are being represented in the decision-making process. Many physicians, especially in hospitals, have expressed a complete lack of interest in an administrative role, as it is seen to interfere with patient care, which is all they are really interested in doing (Hassen, 1993, 24).

In order to argue that physicians are maintaining their dominance in the workplace we would need to see evidence of control over their own work, use of their skills and expertise (as measured through patient care) and involvement in managerial decisions and supervision of subordinates. Comparative data helps us to assess changes either over time or between groups. The Hall Commissioner Report (1964) gives us a comparative dimension over time to a limited degree. As highlighted in Chapter 3,

\(^6\) The measure of proletarianisation used in this thesis grows out of Braverman’s (1974) theory of the degradation of professional labour in the twentieth century. Other researchers have used very similar measures; see, for example, Lincoln, 1990 and White, 1988.
there are problems comparing evidence on activity levels of physicians over time, especially when the kinds of issues that dominated medical practice in the early 1960’s (when Medicare was not well established) can be quite different from the issues that come to bear today. But this data bank allows us to draw some conclusions on the questions of whether or not Canadian physicians are maintaining their professional position in the workplace. The 1982, 1986 and 1990 CMA surveys of Canadian physicians give us a further comparative dimension, but the time frame is insufficient to allow us to draw definitive conclusions about the changing nature of medical practice. Perhaps more relevant then, is to compare across groups using the solo, fee-for-service, entrepreneurial physician as the focus group. This has typically epitomised the ideal professional work setting and therefore serves as an ideal comparative base from which to draw conclusions about the proletarianising effects of other practice arrangements. As Freidson (1970, 88) points out, solo practice is “held up as the ideal by professionals ... as the individual is free to do what his (sic) conscience and knowledge dictate.” My own research on medical students in Ontario confirms this opinion; the overwhelming majority of the medical students aspired to work in this setting and argued that this is what they are trained for, although many recognised the financial constraints (Brewer, 1988).

In order to minimise the complexities of this comparative analysis, this thesis examines the work activities of full-time General Practitioners (GPs), both salaried and fee-for-service. There are a number of difficulties comparing across medical specialisations and intra-specialisation idiosyncrasies complicate these issues further. It was felt a more comprehensive picture could be drawn by reducing the sample to this group alone, which still captures approximately 47 per cent of Canadian physicians.\(^7\) We will begin with our focus group – the fee-for-service full-time solo physician in General Practice.

\(^7\) It is important to note that GPs who indicated they receive a salary only and report as full-time are included in the salaried sample. Those GPs working full-time and receiving no remuneration through
Solo Practice

It is interesting tracing the change in nature of solo medical practices from very small (physician and often one other clerical staff member) in the 1950s and 1960s, to larger more complex organisations, with more support staff in the 1990s. Clute (1963) demonstrates that approximately 65 per cent of solo physicians in the early 1960s employed an assistant (typically a nurse or secretary) while the remainder had no formal assistance. In the mid 1980s, over 90 per cent of solo practitioners employ at least a secretary, receptionist and/or clerk, and 50 per cent hire a full time nurse (York University Survey, 1986). There has been a decline in popularity of solo practice; 47 per cent of all Canadian physicians were solo practitioners in the early 1960s (Judek, 1962) compared to 34 per cent in the 1980s (PMQ, 1986).

The solo practitioner in private practice typifies the practice settings of Canadian physicians. This was the dominant mode of medical practice even after the introduction of Medicare and is still the most popular practice arrangement of full-time GPs. But this is changing. Physicians themselves saw the benefits of group practice even back in the early 1960s; Judek's survey showed that the majority of doctors saw improved quality of medical services and working conditions accompanying group practice (Judek, 1962). Despite this view the solo practice continues to survive; its rate of decline is slower than one might have predicted, considering the evidence produced from Judek. The proportion of solo physicians receiving a salary (partially or fully) has remained consistent from the 1960s to the 1980s (14 per cent in the 1960s and 15 per cent in 1980s). The majority of these have combined solo practice with other practice arrangements.

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8 There are suggestions that family members (especially spouses) worked for no formal remuneration.
Fee-for-Service Solo GPs

The fee-for-service solo, entrepreneurial medical practitioner is seen as the ideal medical practice arrangement. Doctors working in this setting are seen to have the freedom to run their practice as they choose, hire and fire employees, make all their own decisions, see patients at the pace they desire. It continues to be the predominant practice arrangement of Canadian physicians.

When we look at fee-for-service solo general practitioners (GPs)\(^9\), they comprise 30 per cent (3374) of all GPs practising full-time in Canada, bigger than any other practitioner group. As mentioned earlier, as this is seen by physicians as the ideal practice arrangement, it will be used as the focal base for this discussion. We need to understand what solo, fee-for-service physicians are doing in their practices, giving us some indication of the overall level of activities for this group, in order to draw comparisons with the other practice arrangements.

GPs in solo practice spend 31 per cent of their work week in direct patient care and 41 per cent on-call. We can argue that the combination of direct patient care with on-call hours constitutes functions of labour (as per the proletarianisation arguments)\(^11\). This group of physicians, therefore, spends 72 per cent of a working week performing functions of labour. (See table 5.1). When looking at the amount of time spent

\(^9\) Unless otherwise stated all figures presented are the results of the CMA’s 1990 PMQ.

\(^10\) As of 1994 all new graduate, non specialist physicians in Canada are required to qualify as family practitioners. The majority of General Practitioners already are. For ease of discussion though I will call them General Practitioners even though the group presented here represents all GPs and/or Family Practitioners.

\(^11\) Like Navarro (1988) I am uncomfortable with the use of the terms functions of labour and functions of capital which are used by the proletarianisation of professions theorists to describe the changing role of professionals in their workplaces from one of power to one of domination by others. I use this terminology throughout this discussion for clarity reasons and for lack of more appropriate terms.
performing functions of capital we are reminded that this is measured by adding the total number of hours spend managing the practice, performing administrative duties, sitting on hospital committees, and formal consultation time with professional colleagues. Solo, fee-for-service GPs spend approximately 4 per cent of their time managing their practice, 3 per cent in an administrative capacity, 1.3 per cent on hospital committees and 1.2 per cent consulting with colleagues. A total of 9.6 per cent of their working week is spent performing functions of capital (See table 5.1).

### Table 5.1
**Full-time, Fee-For-Service Solo GPs**
**Time spent in functions of Labour and Capital**

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR</th>
<th>CAPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time (%)</td>
<td>hrs/wk</td>
</tr>
<tr>
<td>Patient Care</td>
<td>31.0</td>
<td>44.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On Call</td>
<td>41.0</td>
<td>57.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>72.0*</td>
<td>102.0</td>
</tr>
</tbody>
</table>

*Figures do not add up to 100% because time spent in continuing education are not included in these tables.

This constitutes the majority of the weekly activity levels for this physicians group. The remainder of the work week physicians are maintaining and/or upgrading their professional knowledge through continuing education, seminars, conferences, listening

12 Although it appears unrealistic to make comparisons as above, it does paint a clearer picture of *the way GPs see their work week*. Doctors practising in any setting could not work the number of hours they have indicated (up to 129 hours per week). This is partially reflected in the inclusion of “on-call” time, but not exclusively. The hours presented here are the total number of hours GPs have estimated they spend in individual tasks (I have simply totalled these figures - a measure consistently used throughout the thesis so as not to bias any particular practitioner group.
and/or viewing tapes and so on. This will be discussed when we explore the deprofessionalisation arguments. We now turn to the labour activities of salaried, solo GPs to see how this group compares to their fee-for-service colleagues.

**Salaried Solo GPs**

Salaried solo GPs constitute 1.5 per cent (164 practitioners) of all GPs practising full-time in Canada. This is a relatively small group of practitioners and it is impossible to determine their level of salary or source. What we can examine is the activities of this physician group, determining how it compares with fee-for-service solo GPs.

Solo salaried GPs spend approximately 42 hours per week in direct patient care, 30 per cent of their working week and 36 per cent of their time on-call, 51 hours per week. This suggests that this group of practitioners spends 66 per cent of their work performing what proletarianisation theorists term the functions of labour. This is 6 per cent less than our focus group. (See Table 5.2).

Salaried solo GPs spend 3 per cent of their time at work managing their practice, slightly less than the fee-for-service solo group (4 per cent), 5 per cent in administrative role, 2 per cent greater than the benchmark group. These physicians sit on hospital committees 1.5 per cent of the week (slightly greater than the benchmark group) and 1.1 per cent of their time consulting with colleagues (slightly less than the fee-for-service group). All in all, 10.9 per cent of these practitioner’s work is spent performing the functions of capital, slightly greater than the group seen as the ideal medical practice arrangement (9.6 per cent) (See Table 5.2).

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13 The data is void of any determination of income levels for practitioners and, more importantly for this discussion, the source of salaried remuneration. I believe this is an important point which will be discussed further when exploring the deprofessionalisation of Canadian Medicine arguments in Chapter 6 and will be drawn on again in the concluding discussion of this chapter.
### Table 5.2
Full-time, Salaried, Solo GPs

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td>30.0</td>
<td>31.0</td>
<td></td>
</tr>
<tr>
<td>On Call</td>
<td>36.0</td>
<td>41.0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>66.0</td>
<td>72.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Comparative Group</th>
<th>Focus* Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LABOUR</td>
<td>3.0</td>
<td>3.9</td>
<td>Management</td>
</tr>
<tr>
<td>CAPITAL</td>
<td>5.3</td>
<td>3.2</td>
<td>Administration</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10.9</td>
<td>9.6</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

What this evidence suggests is that the solo, salaried GPs group are spending less time in what are seen as proletarianised labour and slightly more in decision-making, managerial, administrative and consultative duties than the ideal medical practice group. We could not argue that salaried solo practice renders physicians more proletarianised than fee-for-service solo practitioners.14 But we need to consider the other practice settings before drawing any general conclusions. We now turn our attention to group practice arrangements.

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14 Unfortunately, there is no comparable evidence from the 1960s: The Judek survey of Canadian physicians delegated all the decision-making, administrative and managerial duties into a category termed “other”, which included other activities not considered functions of capital.
Accompanying the decline in number of solo practices has been an increase in the number of physicians working in group practices. 10 per cent of physicians were working under group arrangements in the early 1960s (Judek, 1962) increasing to 35 per cent in the 1980s (PMQ, 1986).

Certainly one of the explanations for this trend is the financial constraints of solo practice. It appears that physicians are joining a group practice upon graduation (approximately 75 per cent of those aged 30 and under) while more established doctors (over the age of 55) are practising in solo (approx. 62 per cent) (Physician Manpower Questionnaire, 1986). With older physicians, this could be a reflection of the entrepreneurial nature of medical practice of 30 years ago, when these doctors were graduating and this was the expected mode of practice. Or it could be they initially practised in a group arrangement until they established the resources (financial, experience, clientele) to begin their own practice. Williams et al's 1989 survey of Canadian physicians (full-time: ie working more than 30 hours per week) found that approximately 22 per cent worked in a group practice and more than 30 per cent were salaried hospital staff or mixed (solo and group practice). The evidence also suggests that group practices are growing in size not just proportion. Judek shows that for physicians who practiced in groups, the most popular in 1962 was 3 to 5 doctors (74 per cent); this has since changed. In 1986 group practices of six or more attracted the most physicians (54 per cent) (Physician Manpower Questionnaire).

Morton (1992) argues that group practice in Canada began before 1920, accelerating dramatically after the implementation of the Hospital Insurance and Diagnostic Services Act of 1957. Physicians had the view that there would be advantages to practising under cooperative arrangements. Lyon argues that group practice was seen as a way to

---

15 Includes Group Practices and Associate Practices as per Williams et al, 1989
bring doctors trained in different specialties together, giving patients a more rounded opinion on their ailments (1967). Group practice was seen to offer better relations between physicians resulting in higher patient production rates, better financial rewards and improved working conditions through regulated hours (Thorlaskon, 1962).

Despite the perceptions, this is not the reality of group practice. Physicians in group practices work only slightly fewer hours than solo practitioners (Physician Manpower Questionnaire, 1990) and perhaps, more importantly, they report no more satisfaction with working conditions or more leisure time than solo physicians (York University Survey, 1986). Williams et al (1990) argue that women, who we might have predicted would benefit more from the promises of group practice with their career and family commitments, show very similar satisfaction levels as their male counterparts. Yet women physicians in group practice feel more able to maintain good health than female solo practitioners.

Accompanying the increased popularity of group practice is the growth in size of the practices. In the 1960s Judek (1962) demonstrates 26 per cent of doctors practiced in groups of six or more compared to 54 per cent in the 1980s (PMQ, 1986). Again reduced costs, both overhead and maintenance, would be an obvious incentive to larger employment settings.

Management Structures in Group Practices

If we consider the range of supervision provisions in group practice, the evidence presented in Chapter Four leads us to expect that junior partners in a large practice might be more 'supervised' than doctors practising in a setting where a number of physicians are simply sharing space. There would be different structures in between these two extremes. In 1967 the Canadian Medical Association conducted a study of 246 Canadian medical practice groups, arguing that many of these groups began as solo practices, developing as the physician added staff, including doctors. The Association
claimed that the original solo practitioner was in charge of the practice, making upper level management decisions while delegating middle or lower level management decisions to a group manager (1967, 18-67).

McFarlane argues that doctors who were employed rather than offered a partnership would, over time, gain the same privileges as full owners. An employee would gain the status of a full partner, with an equitable share of revenues (1967, 57). On average, becoming a junior partner took less than two years, senior partner, a further two or three years (CMA, 1967, 54). So after a relatively short period of time salaried physicians attain the level of privileges of full ownership with a say in how the practice would operate.

This was the situation in the 1960s. What has changed since then? The evidence from the 1980s suggests that Canadian physicians have entered employment settings where they share expenses yet remain autonomous in their own practices (Williams et al, 1989). This means there is less set up cost and overhead expense. Physicians in associate practices share the cost and maintenance of expensive equipment, support staff salaries, rental or ownership of space and so on. Under these conditions we would have expected individual doctors would spend less time doing the day-to-day paperwork as this would be handled by office staff. Overall, we see that physicians spend about 6 per cent of their day in a managerial capacity no matter what size of group practice they are in. Physicians in large group practices (> 6) are not performing less of a managerial role than those in small group (3-6) practices and only slightly less than those in partnership (Physician Manpower Questionnaire, 1986).

**Fee-for-Service Group Practitioners (GPs)**

Approximately 55 per cent of all full-time fee-for-service GPs work in some group practice, the most popular arrangement is partnerships of 3-5 physicians. 40 per cent of
all group practitioners are practising in a group of this size as compared to 24 per cent in partnerships of 2 physicians and 36 per cent in groups of six or more.

The bigger the size of the practitioner group the less time spent performing functions of labour while more is spent in functions of capital. (See table 5.3)

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Capital</th>
<th>Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group: 2</td>
<td>8.9</td>
<td>71.3</td>
</tr>
<tr>
<td>Group: 3 to 5</td>
<td>10.6</td>
<td>67.0</td>
</tr>
<tr>
<td>Group: 6 &gt;</td>
<td>11.2</td>
<td>64.0</td>
</tr>
</tbody>
</table>

**Table 5.3**  
Full-Time Fee-For-Service GPs  
% of week spent in Functions of Capital and Labour  
Group Practice

Group Practice: 2 Physicians  
GPs practising under this arrangement spend 34 per cent of their week in direct patient care, 3 per cent more than the “ideal” practitioner group, and 38 per cent on-call, 3 per cent less than the ideal group. There is very little difference between these two groups with regard to the amount of time physicians spend performing the functions of labour. (See Table 5.4).

The same argument holds for the functions of capital. Physicians employed in a partnership with one other physician spend 3.5 per cent of their time managing their  

16 Due to the fact that the total number of hours GPs have estimated for their working week often exceeds the number of hours there are in a week (see footnote to Table 5.1), I have included percentages and not number of hours.
practice, 2.7 per cent in administrative work, 1.5 per cent on hospital committees and 1.2 per cent in consultation with colleagues (see Table 5.4).

Table 5.4
Full-Time Fee-For-Service GPs
Group Practice: 2 Physicians

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td>34.0</td>
<td>31.0</td>
<td>Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.9</td>
</tr>
<tr>
<td></td>
<td>2.7</td>
<td>3.2</td>
<td>Administration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.3</td>
</tr>
<tr>
<td>On Call</td>
<td>38.0</td>
<td>41.0</td>
<td>Hospital Committees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>1.2</td>
<td>Consultation</td>
</tr>
<tr>
<td></td>
<td>TOTAL 72.0</td>
<td>TOTAL 72.0</td>
<td>TOTAL 8.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TOTAL 9.6</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

What we conclude from this analysis is that full-time fee-for-service physicians practising in a partnership with one other physician are not significantly different from fee-for-service solo practitioners. Overall those in partnership spend slightly less time performing functions of capital and labour than solo physicians.

Group Practice: 3 to 5 Physicians

Physicians employed in this setting spend 43 hours in direct patient care (38 per cent of their work week) and 32.5 hours on-call (29 per cent). GPs in group practices of 3 to 5 physicians spend 67 per cent of their time performing the functions of labour, 5 per cent less than the focus group. (See Table 5.5).
These physicians spend 3.1 per cent of their week managing their practice, 4.1 per cent in an administrative role, 2.0 per cent on hospital committees and 1.4 per cent in consultation with colleagues, a total of 10.6 per cent of their work is spent in functions of capital (see Table 5.5).

### Table 5.5

<table>
<thead>
<tr>
<th></th>
<th>Full-time Fee-For-Service GPs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Practice:</strong> 3 to 5 Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% Time spent in functions of Labour and Capital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Activity (%) of Time/wk</strong></td>
<td><strong>Comparative Group</strong></td>
<td><em><em>Focus</em> Group</em>*</td>
</tr>
<tr>
<td>Patient Care</td>
<td>38.0</td>
<td>31.0</td>
</tr>
<tr>
<td></td>
<td>4.1</td>
<td>3.2</td>
</tr>
<tr>
<td>On Call</td>
<td>29.0</td>
<td>41.0</td>
</tr>
<tr>
<td></td>
<td>10.6</td>
<td>9.6</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

This group of practitioners spends 5 per cent less time performing functions of labour and 1 per cent more time performing functions of capital than the focus group. Again there is no suggestion from this evidence that this group is proletarianised when compared to the ideal group.

### Group Practice: 6 or more Physicians

36 per cent of all full-time GPs working in group practices are in groups of six physicians or more. These doctors are seeing patients 43 hours per week (40 per cent)
and are on call 26 hours per week (24 per cent). They spend as much time in patient care as the other groups but considerably less time on call. (See Table 5.6) This is, of course, due to the size of the practice and the fact that the on-call time is spread amongst more physicians.

3 per cent of these doctors’ time is spent managing the practice, 5 per cent in administration, 1.9 per cent on hospital committees and 1.4 per cent consulting with colleagues. Just over 11 per cent of their work week is spent performing functions of capital. (see table 5.6).

Table 5.6

Full-time Fee-For-Service GPs

Group Practice: 6 or More Physicians

% Time spent in functions of Labour and Capital

<table>
<thead>
<tr>
<th>Activity</th>
<th>Labour (%)</th>
<th>Capital (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
</tr>
<tr>
<td>Patient Care</td>
<td>40.0</td>
<td>31.0</td>
</tr>
<tr>
<td>On Call</td>
<td>24.0</td>
<td>41.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>64.0</td>
<td>72.0</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

Full-time GPs in practice with 5 or more other physicians are spending 8 per cent less time performing functions of labours and 4 per cent more time in function of capital than the ideal practitioner group.
Overall, we can conclude that the proletarianisation arguments presented in Chapter 2 and developed in Chapter 4 do not hold for fee-for-service full-time GPs in group practice settings. These physicians are, on the whole, spending less time performing labour-intensive duties than the ideal, focus group and more time in capital intensive functions, therefore, maintaining a dominant position in their work settings. The proletarianisation arguments would lead us to predict that this would not hold for salaried group practitioners. Let us look at the activity schedules for these physicians.

**Salaried Group Practitioners**

Looking at the figures over time we can see that the proportion of salaried group practitioners has decreased overall from 23 per cent in the 1960s (Judek, 1962) to 20 per cent in the 1980s (PMQ, 1986). These figures include those who are partially remunerated through salary as well as those fully remunerated on this basis. Those whose income is partially received through salary tend to combine this with fee-for-service arrangements elsewhere.

Looking at the range of group practice types there is only a very small proportion (3 per cent) of all full-time GPs remunerated through salary compared to 91 per cent working on a fee-for-service basis. In both groups (fee-for-service and salaried) the greatest number of full-time GPs are working in group practices of 3-5 physicians (see Table 5.7).
Table 5.7
Percentage of Full-time GPs in Group Practice Settings by Remuneration

<table>
<thead>
<tr>
<th></th>
<th>Salaried</th>
<th>Fee-for-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (&lt; 2)</td>
<td>0.8 *</td>
<td>18.6 (1039)</td>
</tr>
<tr>
<td>Group (3 to 5)</td>
<td>3.7</td>
<td>30.3 (1695)</td>
</tr>
<tr>
<td>Group (6 &gt;)</td>
<td>2.0</td>
<td>27.0 (1508)</td>
</tr>
<tr>
<td>Other</td>
<td>2.0</td>
<td>15.1 (845)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>9.0 (502)</strong></td>
<td><strong>91.0 (5087)</strong></td>
</tr>
</tbody>
</table>

* Number of respondents appears in brackets

Source: PMQ, 1986

What we need to consider now is what these doctors are doing in their respective work environments. Determining this will allow us to draw some conclusions about whether collecting a salary affects one’s position in their workplace and whether there are differences between salaried practitioners and fee-for-service practitioners working in the same types of practices. This will allow us the opportunity to comment on the relevance of the proletarianisation arguments in the arena of Canadian group physician practice settings.

Approximately 3 per cent of all full-time GPs are salaried employees in a group practice. Of all GPs in group practices, this constitutes 8 per cent. Of all salaried GPs, 11 per cent are salaried employees in some form of group arrangement. Compared to fee-for-service group practitioners, this is a relatively small percentage of physicians. Unlike the fee-for-service group practitioners, there is no pattern to the amount of time physicians spend in functions of capital and labour based on size of practice (see Table 5.8).
Table 5.8
Full-Time Salaried GPs
% of time in Functions of Capital and Labour

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Capital</th>
<th>Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group: 2</td>
<td>11.3</td>
<td>71.5</td>
</tr>
<tr>
<td>Group: 3 to 5</td>
<td>17.1</td>
<td>53.0</td>
</tr>
<tr>
<td>Group: 6&gt;</td>
<td>12.0</td>
<td>65.6</td>
</tr>
</tbody>
</table>

**Group Practice: 2 Physicians**

Physicians employed by one other doctor still spend over 11 per cent of their working week performing duties that include management, decision making, administration and professional consultation. This is a greater percentage of time than the focus group, and greater than fee-for-service group of two physicians. 2 per cent of time is put into managerial tasks, 5.7 per cent in an administrative role, 2.3 per cent on hospital committees and 1 per cent consulting with colleagues. (see Table 5.9).

If we compare this with ideal group, practitioner salaried doctors working with one other physician are spending more time in a position of capital, while the same percentage of time is spent in a position of labour. Salaried partners spend 43 hours per week in direct patient care (31 per cent of time) and 57 hours on-call (41 per cent of time). (See Table 5.9)
### Table 5.9
Full-time, Salaried GPs
Group Practice: 2 Physicians

% Time spent in functions of Labour and Capital

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus Group</td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td>31.0</td>
<td>31.0</td>
<td>Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Administration</td>
</tr>
<tr>
<td>On Call</td>
<td>41.5</td>
<td>41.0</td>
<td>Hospital Committees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultation</td>
</tr>
<tr>
<td>TOTAL</td>
<td>71.5</td>
<td>72.0</td>
<td>11.3</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

**Group Practice: 3 to 5 Physicians**

This is the most popular salaried group arrangement with 57 per cent of all salaried group practitioners employed in a group of this size. One obvious reason for its popularity is the reduced number of hours doctors in this setting spend performing functions of labour. These physicians spend approximately 25 per cent of their time in patient care and 28 per cent on-call, a total of 53 per cent, smaller than any other practitioner group, salaried or fee-for-service.

The same holds for the percentage of time these doctors spend in functions of capital, 17 per cent, greater than any other practice arrangement. The majority of this time is spent in administrative capacity (10 per cent), 2.6 per cent in a management role, 2.7 per cent committee work and 2 per cent consulting with colleagues. (see Table 5.10).
### Table 5.10

**Full-Time Salaried GPs**

**Group Practice: 3 to 5 Physicians**

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td>Comparative Group</td>
</tr>
<tr>
<td>Patient Care</td>
<td>25.2</td>
<td>31.0</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Administration</td>
</tr>
<tr>
<td>On Call</td>
<td>27.8</td>
<td>41.0</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospital Committees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultation</td>
</tr>
<tr>
<td>TOTAL</td>
<td>53.0</td>
<td>72.0</td>
<td>17.0</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

Overall, physicians employed in this setting have a workload considerably different from our focus group, almost 20 per cent less time is spent performing the functions of labour and over 7 per cent more spent in functions of capital. This evidence certainly does not support the proletarianisation of professions arguments which would lead us to predict the opposite trend.
Group Practice: 6 or more Physicians

Approximately 30 per cent of all salaried group physicians are employed in partnerships of 6 or more practitioners. Their work activities vary from the other salaried practitioners groups with approximately 65 per cent of their work spent in patient care and on-call and 12 per cent in functions of capital.

This group spend, on average, 41 hours a week in patient care (38 per cent) and 29 hours on-call per week (27 per cent). (See Table 5.11). This is 5 per cent less time than the focus group. Managing the practice takes about 2.4 per cent of the week, administration, 6 per cent, while hospital committee work entails about 2.5 hours a week (2.4 per cent of work week) and consultation time is 1.6 per cent (see Table 5.11).

The 12 per cent time in functions of capital is approximately 2.5 per cent more than our focus group.

Table 5.11
Full-time Salaried GPs
Group Practice: 6 or More Physicians
% Time spent in functions of Labour and Capital

<table>
<thead>
<tr>
<th>Activity</th>
<th>Labour (%) of Time/wk</th>
<th>Capital (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td>Comparative Group</td>
</tr>
<tr>
<td>Patient Care</td>
<td>38.4</td>
<td>31.0</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.9</td>
</tr>
<tr>
<td>On Call</td>
<td>27.2</td>
<td>41.0</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>65.6</td>
<td>72.0</td>
<td>12.0</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs
The evidence presented in this section leads us to conclude that salaried physicians in group practice settings are not rendered proletarianised by receiving a salary. As a matter of fact all of the salaried groups spend less time in functions of labour and more time in functions of capital than the solo, fee-for-service focus group. Overall, salaried group physicians maintain a more dominant position than their fee-for-service colleagues in group practice. The evidence does not support the proletarianisation of professionals arguments. Arguably, the most interesting test of the proletarianisation position is gained from examining the activities of doctors in hospitals and clinics.

**Hospitals/Clinics**

Approximately 15 per cent of all GPs work in a hospital or clinic, the majority of these remunerated through salary. Unfortunately the data does not allow us to examine the statistics on the work settings separately. The literature on hospitals and clinics, though, clearly demonstrate the structures of these workplaces and functions of physicians within them are very different. We will, therefore, review the literature on each settings but examine the data on a combined level.

**Hospitals**

The complexity of hospital structures and functions have lead to increasingly bureaucratic organisation. The implications of this for the activities of physicians is important to understanding the nature of medical practice in hospitals. Coburn (1993, 98) argues that there are limits to the amount of control doctors have in hospitals, because hospital budgets are strictly controlled from outside. Hospitals in Canada are not publicly owned and are not, in the main, profit-making\(^{17}\) so doctors, therefore, suffered penalties from lack of ownership. Yet doctors have always controlled

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\(^{17}\)They are a combination of privately run, publicly funded institutions. The government has a major role to play in budgets and less say over standards and provision of care.
hospitals despite non-ownership. Coburn suggests doctors are losing this control to provincial government bodies concerned with hospital budgets. Physicians are "being co-opted into the administrative hierarchy" as physician administrators whose interests differ from the practitioners.

Although Coburn has examined the structure of hospitals he has not explored the activities of the physicians employed there. Chapter Four has demonstrated the important role physicians have played in the development of hospitals; they are an integral part of the system. Physicians in Canada, today, are dependent on the hospital - the facilities, the equipment and the employees.

As hospitals have changed over time so has the position of physicians within them so that today hospital committee membership has become the most influential tool by which doctors exercise their control in the system. As hospital committee work involves decision making on non-clinical levels as well as clinical, a dual authority structure develops with two separate types of control: administrative and collegial (Blishen, 1991).

According to Leatt et al (1987) a structure of collegial control has developed where doctors are given administrative duties that include evaluating peer performance to determine whether hospital privileges will be granted. Typically annual physician performance appraisals are also conducted. Hassen (1993) argues that hospitals are more and more involving staff in the decision-making process. Hospitals are transforming organisationally to a system of total quality management (TQM). This management strategy develops from within the hospital structure, not outside and reduces or eliminates the tensions between medical practice and hospital administration. This is consistent with the arguments raised in Chapter 4 that professionals are content to do their work as long as it is not compromised by administrators. The minute they feel their work is being compromised they actively seek to become part of the decision-making network, in this case, hospital committees.
Clinics

There are a range of physician work centres that could be captured under this category ranging from Community Health Centres (CHC) to large-scale, after-hour physician-only services. With this in mind it becomes difficult analysing the structure of clinics. Yet the debates between the medical associations and the government over health care facilities such as CHCs and Health Services Organisations (HSOs) has been fascinating and gives us important clues as to the key issues which surround the deprofessionalisation of medicine arguments. This is discussed at length in Chapter 7 so the discussion here is restricted to an analysis of the structure and organisations of community health facilities\textsuperscript{18} The overwhelming majority of physicians working in Community health facilities are fee-for-service (Fulton, 1993, 22). They also tend to be organised in such a way that physicians’ services are but one part of the range of services offered. Burke et al (1989) argued that salaried doctors in Ontario’s CHCs and HSOs have reduced decision-making powers over the operation of the centres, hours of work and hiring and firing of other doctors. Yet they maintain power over decisions in their own area: activities requiring medical knowledge. Burke et al (1989) suggest that physicians employed in these centres are not involved in the management and decision-making structures of the whole organisations, only within their own domain.

It is important to understand the range payment schemes for clinic-based physicians. Community health facilities are not paid, in the main, by fee-for-service or capitation, but financed by the provincial health ministry. The facilities can be physician sponsored, university sponsored or community sponsored and the amount and method of remuneration is dependent on sponsorship arrangements (Birch et al, 1990).

\textsuperscript{18} Health centres have different names depending on the province in which they are located. Ontario has Community Health Centres (CHC) and Health Services Organisations (HSO), B.C. has Health and Human Resource Centres, Saskatchewan has Community Clinics, Quebec has Centre Locale Des Services de Sante or Local Community Health Centres. All of these will be referred to as Community Health facilities.
Interestingly, the three CHC physicians I interviewed agreed entirely with Burke et al’s arguing “why would I work to get involved with the organisation of the whole clinic.” They were content to control their own domain and were surprised and pleased with the level of power and authority they were granted. These physicians organised their work week, supervised their support staff; saw patients at their own pace; they did not see themselves as supervised as they "reported to no one". And finally they all pointed out that ‘if I didn’t like the way things work, I would go elsewhere”.

When I spoke to other workers in the CHCs where the three physicians were employed, there was general agreement that the “doctors are the foundation of the place”. “We wouldn’t have a CHC without physicians on staff”. These doctors were seen to control the “medical side of things” with little or no interference from others. “They’re still up there, while the rest of us are down here”. These comments support the evidence from the PMQ survey.

Let us now look at the evidence of the role Canadian GPs play in the hospital/clinic system. The differences between salaried and fee-for-service medical staff in the hospital/clinic as well as comparative analysis with our focus group will be included. It is important to note that the majority of those in the survey are hospital based GPs.

**Fee-for-Service Hospital/Clinic Physicians**

Full-time fee-for-service Hospital/Clinic GPs comprise only about 111 of all full-time GPs in Canada, and only a very small percent of fee-for-service GPs (1.4 per cent). These physicians spend around 61 per cent of their work time in direct patient care and on call (functions of labour) and 12.7 per cent in functions of capital (see Table 5.12).

The amount of time spent in functions of labour is 11 percent less than the focus group and this is reflected in the number of hours spent on call. Solo, fee-for-service GPs are
spending 41 per cent of their time on call while hospital/clinic based GPs spend 27.5 per cent.

When we compare activities reflected in the functions of capital hospital/clinic-based fee-for-service GPs are spending 3 per cent more time than their solo colleagues, the majority of this difference is captured in administrative responsibilities (see Table 5.12).

Table 5.12
Full-time Fee-For-Service GPs
Hospital/Clinic

<table>
<thead>
<tr>
<th>% Time spent in functions of Labour and Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LABOUR</strong></td>
</tr>
<tr>
<td>Activity</td>
</tr>
<tr>
<td>Patient Care</td>
</tr>
<tr>
<td>On Call</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

As we have seen there are very few full-time fee-for-service GPs working exclusively in a hospital/clinic setting, the most common incumbents of this position are salaried physicians.

Salaried Hospital/Clinic Physicians
Over 40 per cent of all full-time salaried GPs are employed in hospitals or clinics. This constitutes 13 per cent of all full-time GPs in Canada. What role do these physicians play in the hospital/clinic system?

31 per cent of these employed physicians’ work week is spent in direct patient care, which is equivalent to the focus group. 29 per cent of their time they are on call, 12 per cent less time than the solo, fee-for-service physician group (see Table 5.13). Clearly doctors in solo practice will spend more time on-call as there are not other physicians to share this with. Although two solo physicians interviewed pointed out the wide spread use of an after-hours answering service which directs patients to an after-hours clinic or the emergency ward at the hospitals, except in extreme circumstances. So not all solo practitioners have extensive on-call time.

In total, hospital/clinic salaried GPs are spending 12 per cent less time in functions of labour than the ideal practitioner arrangement. But they are spending slightly more time in this position than their fee-for-service counterparts (60 per cent versus 57 per cent).

When it comes to functions of capital, salaried hospital/clinic GPs are spending approximately 4 per cent more time performing these duties than the focus group and about the same amount of time as their non-salaried colleagues (fee-for-service hospital physicians) (see Table 5.13).
Table 5.13
Full-time Salaried GPs
Hospital/Clinic
% Time spent in functions of Labour and Capital

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td>31.4</td>
<td>31.0</td>
<td></td>
</tr>
<tr>
<td>On Call</td>
<td>28.7</td>
<td>41.0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>60.1</td>
<td>72.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>3.1</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>6.2</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>Hospital Committees</td>
<td>2.2</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>1.8</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>13.3</td>
<td>9.6</td>
<td></td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

This evidence does not support the proletarianisation of medicine arguments, which would have lead us to predict that salaried physicians employed in hospitals/clinics would have been the doctors most likely to be working an assembly line of patients with little or no involvement in the decision-making process. The evidence from the surveys of Canadian physicians shows a different scenario.

There are too few respondents in the remainder of the fee-for-service physician employment settings (government and private industry) to include them in this analysis. Respondent numbers of less than five, with not all respondents answering each question means the outcome would distort the actual work activities for these practitioner groups. On the other hand, in the salaried practitioner categories there were 704 full-time GPs working in the government and 455 employed in private industry. Salaried
Government physician employment is the largest category behind hospitals/clinics. We will turn our attention to this group now.

**Salaried Government Physicians**

Over 20 per cent of all salaried GPs are employed in the government; including federal, provincial and municipal levels. The constitutes approximately 6 per cent of all GPs in Canada. Again this group of physicians differs greatly from our focus group and there is no comparative fee-for-service group.¹⁹

Overall, government GPs spend over 15 per cent of their time in functions of capital, 6 per cent more than the focus group. 64 per cent of their time is spent in functions of labour, 8 per cent less than the focus group. When we desegregate the labour activities, the time spent on-call almost directly explains the difference between the government employed physician group and the solo, fee-for-service group. The government group spends, on average, 20 hours less per week on-call, 10 per cent less than the focus group (see Table 5.14).

Examining the capital-intensive activities shows that this group spend 3 per cent of their time in a management capacity, 9 per cent in an administrative role, 2 per cent sitting on hospital committees and 2 per cent consulting with colleagues (see Table 5.14).

¹⁹ Too few responses in the fee-for-service government physician category to draw any conclusions.
Table 5.14
Full-time Salaried GPs
Government

% Time spent in functions of Labour and Capital

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR</th>
<th></th>
<th>CAPITAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(%) of Time/wk</td>
<td></td>
<td>(%) of Time/wk</td>
<td>Activity</td>
</tr>
<tr>
<td></td>
<td>Comparative</td>
<td>Focus* Group</td>
<td>Comparative</td>
<td>Focus Group</td>
</tr>
<tr>
<td>Patient Care</td>
<td>31.7</td>
<td>31.0</td>
<td>2.9</td>
<td>3.9 Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6.0</td>
<td>3.2 Administration</td>
</tr>
<tr>
<td>On Call</td>
<td>31.8</td>
<td>41.0</td>
<td>2.2</td>
<td>1.3 Hospital Committees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.7</td>
<td>1.2 Consultation</td>
</tr>
<tr>
<td>TOTAL</td>
<td>63.5</td>
<td>72.0</td>
<td>15.4</td>
<td>9.6 TOTAL</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs

The evidence presented here suggests that government employed GPs continue to enjoy a position of dominance in the workplace. They are active on hospital committees, consult with colleagues and active in the decision-making operations of their workplaces.

Salaried Private Industry Physicians

Private industry physicians, still often referred to as company doctors, have taken on more and more responsibilities as the nature of their job has changed from annual medicals conducted on employees to involvement in work compensation claims and protection of company interests and maximising profits. We could argue that the increased responsibilities have created a more powerful position for these doctors in their workplaces. The company pressures to increase productivity amongst workers...
Chapter 5

means that doctors are being consulted on the health related issues that affect productivity; corporate level decision-making.²⁰

The data from the Canadian Medical Association’s Physician Manpower Questionnaire (1986) reveals that 13 per cent of all salaried GPs in Canada are employed in this setting, 4 per cent of all full-time GPs. These physicians spend 16 per cent of their time in functions of capital and 62 per cent in functions of labour (see Table 5.15).

The capital-intensive functions see company doctors spending 6 per cent more time in administrative duties than our focus group (9.3 per cent) which almost directly accounts for the difference between these two groups with regard to functions of capital (see Table 5.15).

When it comes to patient care and on-call hours, company doctors fall below the focus group by 10 per cent, almost completely explained by the reduced on-call commitments (see Table 5.15).

²⁰ For a further discussion of company doctors in Canada see Walters, V. 1984, ‘Company Doctors: Standards of Care and Legitimacy: A Case Study from Canada’, Social Science & Medicine, Vol 19, #8, 811-821. There is little information on the changing nature of the role of company physicians in Canada.
Table 5.15
Full-time Salaried GPs
Private Industry
% Time spent in functions of Labour and Capital

<table>
<thead>
<tr>
<th>Activity</th>
<th>LABOUR (%) of Time/wk</th>
<th>CAPITAL (%) of Time/wk</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comparative Group</td>
<td>Focus* Group</td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td>32.4</td>
<td>31.0</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9.3</td>
</tr>
<tr>
<td>On Call</td>
<td>29.3</td>
<td>41.0</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>61.7</td>
<td>72.0</td>
<td>15.5</td>
</tr>
</tbody>
</table>

* Focus Group: Full-time, fee-for-service, Solo, GPs
Source 1986 survey results; not available for 1990.

Discussion

This chapter explores this debate by empirically examining the labour activities of Canadian physicians. Surveys of Canadian physicians were used to help gain some insights and the evidence strongly suggests that medical practitioners have not compromised their professionalism, nor lost power as a result of salaried employment. The solo fee-for-service doctor, which epitomises medical practice in Canada, is used as the focus group from which all other practitioner groups are compared. Every medical practice arrangement sees doctors spending less time performing functions of labour, as measured through direct patient care and on-call commitments. When we examine functions of capital, every group, except fee-for-service group practices of two physicians, spend a greater amount of time in this capacity. (See Table 5.16)
If we compare salaried GPs with non-salaried, overall, we note that 31 per cent of all full-time GPs collect a salary as their only form of remuneration, 69 per cent are remunerated on a fee-for-service basis. The number of salaried GPs has increased, although to what degree is difficult to determine. The 1962 survey of physicians did not distinguish between GPs and specialists with regard to salaried or fee-for-service.

The salaried GPs interviewed commented extensively on the benefits of employment where their income is fixed. They were enticed by paid leave, both sick and annual, and a pension plan that was basically organised for them. “You can’t beat this lifestyle; a lot less pressure and no guilt or worry about actually taking a holiday.” When asked about the perception amongst fee-for-service physicians that those paid by the government have to do as they’re told, this was seen as ridiculous. “The government doesn’t dictate my schedule, patient demand and I do” and “the government has no idea about practising medicine; they pay and I practise.” There was no indication amongst these physicians that they would rather work “for themselves” (in a solo fee-for-service practice) although one felt if she had unlimited resources she may have established her own practice and hired new graduates, but, upon reflection, she added “who has unlimited resources.”

When we examine the evidence we can see the benefits of salaried employment. These physicians are not seeing patient after patient without control or authority. As a matter of fact they are spending 3 per cent more time per week performing these functions of capital than the fee-for-service GPs and 12 per cent less in functions of labour.

Even hospital-based physicians, whether salaried or fee-for-service, find themselves in positions where they are able to perform their duties autonomously with active

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21 Hybrid or Mixed Practices are popular amongst Canadian physicians, seeing them combine solo practice with hospital employment, for example. The combinations of both settings and remuneration schemes is complicated but adds little to our analysis of the proletarianisation of Canadian physicians debates. As a matter of fact, it serves to complicate the issues. Therefore, hybrid/mixed practices are not considered in this discussion.
participation in the decision-making apparatus of the hospital. Hospitals operate through a system of collegial and bureaucratic control and this is a system that doctors are dependent on. The hospital system is bureaucratically structured through a committee network ranging from a credential committee which assesses the credentials of physicians seeking to practice there to the medical audit committee which evaluates the care provided by the physicians practising in the hospital (Blishen, 1991, 127). But many hospital administrators are physicians who are salaried employees, so how do they accommodate these two roles? Chapter 4 suggest they are not conflicting roles and physician administrators are developing strategies that give doctors freedom to control their own domain. We would have expected physicians to be spending more time performing functions of labour and less functions of capital than any other group. This was certainly not the case. As a matter of fact they spend less time in labour intensive duties than any other practitioner group except for salaried GPs in a group of 3-5 physicians. (see Table 5.16).
This chapter delves into the work activities of physicians in numerous settings drawing fairly emphatic conclusions about the lack of relevance of the theories of proletarianisation to medical professionals in Canada. Many were already sceptical about the validity of this position as it difficult to draw analogy between assembly line blue collar labour and physician work. But what this analysis has done is to give us some important clues as to how the medical profession in Canada has been able to protect itself from the encroachment of other interest groups, an argument which is better conceptualised under the deprofessionalisation thesis.

As we will recall, the deprofessionalisation arguments cover a range of levels by which professional power is undermined. Marie Haug is the principal spokesperson for this
position as she argues that medical dominance is threatened by the profession’s inability to exclusively access and understand its knowledge base leading to an erosion of the medical knowledge monopoly. Other occupations, the public (as clients) and the state are revolting against the medical profession’s exclusive nature. What is clear from the deprofessionalisation arguments is that we need to understand the nature of the relations between the interested parties. Chapter 6 takes up this challenge.
CHAPTER 6

THE PROFESSIONALISATION OF MEDICINE IN CANADA

The previous chapter demonstrated the weakness of the proletarianisation of professionals arguments when applied to the Canadian medical profession. Physicians, whether salaried or fee-for-service, continue to maintain control over their own work and the work of subordinates, as well as enjoy continued autonomy in the workplace. I have argued that doctors are not going to become routinised labour until, or unless, the profession itself becomes deprofessionalised. Chapter Two of this thesis brings to light the different levels at which the power of professions can come under threat - the level of individual professionals and the level of the profession as a whole. The individual level threats were addressed in Chapters Four and Five, demonstrating the irrelevance of this level of challenge to the status of medical practitioners in Canada. This chapter and the following seek to understand the significance of the second level of challenge to medical dominance. This is accomplished through an examination of the processes that saw the profession gain its powerful position and how it seeks to maintain it despite the challenges it faces.

Willis (1988, 1989, 1993) argues that in order to understand the medical dominance thesis we need to explore individual professionals' autonomy in the workplace, the profession's authority over related occupations and sovereignty over medicine's area of expertise in the wider society. The authority and sovereignty issues can be captured in an examination of the relationship between the Canadian state and the medical profession, both historically and contemporarily.¹ This historical chapter gives us an understanding of the way in which the Canadian medical profession gained the status it did. Chapter Two takes a closer look at the significance of the second level of challenge to medical dominance.

¹ This thesis does not explicitly address the challenges from competing occupations. Instead it seeks to understand the nature of the profession through the way it addresses challenges from the state. Much understanding can be gained about how the profession deals with individual challenges from specific occupations (or other interest groups) by understanding the important relationship between the state and medicine in Canada. The fact is there are so many groups with an interest in the dominant position of medicine - the media, the public, private insurance companies, other insurers, other health
understanding of the ways in which the Canadian medical profession gained the status it did, while Chapter 7 takes a closer look and how it handles its challenges.

This brief historical look at medicine in Canada is designed, initially, to demonstrate its development into a profession. The concentration lies, therefore, in those areas deemed important to examining and defining a profession: the role of the professional association in helping establish medicine as a powerful force and then protect it from competing occupations, the public and others, the role the state played in granting medicine a monopoly in health care, the role education has played in upgrading the status of medicine, and how these factors have affected the power and status of both the profession of medicine in Canada as well as individual practitioners. It covers the beginnings of the profession until the implementation of national health insurance (Medicare) in the 1960s, arguably the first time the Canadian government took a proactive interest in health care.

Starr (1982, 1-21), upon examination of the medical profession in the United States, argued that the power physicians have gained is through the development of cultural authority rooted within social conditions. In other words, the power of the medical profession was attained by the elite medical establishment through bargaining with the state. The struggles between these two groups were successfully resolved by the profession, allowing privileges such as control over the structure and practice of their work and a base from which political and ideological struggles are overcome. Certainly medicine in Canada established itself in a similar fashion of social closure, including practitioners of similar ideology and excluding others.

Historical evidence reveals an important link between state elites and medicine in establishing the medical profession in Canada. Between the 1780s and 1850s doctors occupations, other professions, hospital associations - to name a few. This thesis concentrates on the state's position, which often reflects many of the other interested parties (or is reflected in them).
struggled to acquire legally binding rights which would give them the power to control their own work as well as the market for their services. Establishing these rights would officially declare them a profession in the eyes of the state, the public, physicians and competing occupational groups. The professionalisation process continued with medicine's gaining autonomy over how health care was delivered by imposing closure over their knowledge which, in effect, restricted access to medical practice (and also meant the state and other groups could not assess their position if they could not access the knowledge) (Hamowy, 1984, 5).

This chapter has been divided into historical periods of importance in understanding how the medical profession in Canada established its position. The Organisational Period covers the struggles of early practitioners in establishing status over other health care providers and non-orthodox medical people and convincing the state they were "experts" worthy of state support.

The Establishment Era was the period when licensing and registration of medical practitioners dominated the agenda of the elite medical societies. Upgrading medical education to university level to improve standards of care, as well as a further exclusionary tactic, came during this period. With the profession established, the period of negotiation between the state and medicine came to the forefront.

The issue of national health insurance highlights the Negotiation Period and a substantial section of this chapter is devoted to discussing this. A careful look at the federal legislation, provincial enactments and the medical profession's responses is undertaken in order to better understand the positions of the powerful actors in the professionalisation of medicine in Canada.

Organisational Period: Unity and Exclusion

The beginnings of "medical" practice in Canada can be traced back to 1639 with the foundation of the Hotel Dieu de Quebec by Duchesse d'Aiguillon and was regulated in
Chapter 6

Quebec from as early as 1660 (MacDermot, 1967, 16; MacFarlane, 1964, 14). By the mid 1700s an elite group of medical practitioners initiated a project to exclude what they considered "undesirables" who were selling treatment. While this elite medical group attempted to influence parliamentarians to create laws in the best interest of their group there were many obstacles to overcome in pushing for professional status. Hamowy (1984) stresses that one of the most difficult obstacles was the lack of interest amongst parliamentarians in the physicians' claims about their expertise and the "undesirables" making services available. Orthodox doctors² therefore had to convince law makers of their claims.

While soliciting state support became the primary concern for early physicians, they could not ignore the added dilemma of those practitioners who refused to comply with "standard" or "regular" medicine. These "irregulars" or non-orthodox practitioners: homoeopaths, herbalists, midwives... were offering services to the bulk of the working class population (Hamowy, 1984). If orthodox medicine was to not only thrive, but to survive, it had to control the irregulars as well as solicit the support of the state. In attempting these endeavours it became clear that the orthodox medical community did not hold a united view. So before the orthodox practitioners could convince others of their “superiority” over competing groups they needed to establish themselves as a united homogeneous medical community.

In the early 1800s a small group of British trained doctors set upon the mission of identifying and excluding "unscrupulous, illiterate and inexperienced practitioners of the art of physic and surgery" (Heagerty, 1952, 152). This group argued that a "gentleman's education" would produce the knowledge, skills and "cultural sophistication" necessary to practise medicine properly. A group of French speaking physicians presented similar arguments to government, suggesting that licensing

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² I have adopted the term 'orthodox' to describe those practitioners who encompassed symptomatic treatment rather than medical therapeutics which were used by non-orthodox or irregular practitioners.
requirements were so relaxed that individuals with "deplorable deficiencies in medical qualifications" were allowed to practise (MacDermot, 1967; Hamowy, 1984).

The notion that scientific knowledge is the basis of medical practice was an important aspect in the development of medicine into a powerful profession. It served as the basis from which orthodox medicine argued its position to legislate against homoeopaths, naturopaths, midwives and others. It served to unite the conventional medical practitioners and exclude others.

**Unity and Exclusion**

Elite medical societies were established consisting mainly of British trained physicians in Canada and “ships’ doctors” employed to see the safe passage of immigrants to Canada. Their mission became the identification and prosecution of those practitioners whose qualifications and skills did not meet the standards set out by these elite medical societies. With this agenda set, a system was established which paid informers who exposed anyone who was not "licensed." This was combined with a campaign to inform the public of the non-credibility of alternative healing practices. The belief was that these alternative practitioners, with little or no scientific training, were giving medicine a bad reputation. What was being overlooked was the fact that a number of allopaths were guilty of unorthodox, if not dangerous, practices. The emphasis on the scientific basis of medical knowledge served as the central bargaining tool used to lobby the government to grant medicine special political and economic treatment. While this was the issue pushed to the forefront, the reality was that "distinct and frequently competing subgroups were active in medicine while an outward demonstration of increasing homogeneity" was being presented to the public and the government (Shortt, 1983, 60).

Despite the efforts of these elite medical groups to present arguments about the illegal, immoral and dangerous practices of alternative healing methods, the early arguments, for the most part, were ignored by the state. Allopathic medicine was viewed as a trade
similar to those occupations it was seeking to condemn and, therefore, any special government treatment was unwarranted. Hamowy reports that in 1827, one member of parliament put forward the recommendation that all those who were practising medicine, midwifery, surgery...without license, would not be liable to criminal prosecution "except in cases of malpractice, gross ignorance or immoral conduct" (1984, 58-59). It was clear that the claims of the elite medical groups were not, at this stage, taken seriously by the government. The Upper Canada Journal published the outrage felt at the parliamentarian's suggestion, proclaiming that any amendment that reflected this recommendation “amounted to the legalisation of quackery” (Hamowy, 1984, 59).

Baldwin argues that the state's initial lack of interest in the demands of the elite medical practitioner groups reflected a lack of interest in health care generally. Health care was not considered a priority in the early 1800's; in fact, the state's involvement was limited to providing marine hospitals and establishing and enforcing quarantine restrictions. Epidemics such as cholera captured the attention of governments as expressed through public health reforms, but this reflected the extent of state interest and concern (1983, 374).

The public was not rallying to support physicians' professionalisation agenda either. The sympathies of the public throughout British North America were strongly opposed to restrictive legislation (Hamowy, 1984, 77). Allopathic practitioners continued their efforts despite the lack of enthusiasm of the public and the state. Gradually physicians infiltrated the state through political positions which saw the medical community make gains towards professionalising (MacDermot, 1967, 21). The push for regulation of practitioners manifested itself in the act that established the College of Physicians and Surgeons of Upper Canada (1839). The College gave the medical community the legal means to regulate the provision of medical licences and diplomas. The College was strongly criticised by the government of England as it was felt it infringed on the jurisdiction of the Royal College of Surgeons of London. The College of Physicians and
Surgeons of Upper Canada was, thereby, disbanded in 1841 and replaced with a previously defunct Medical Board with a similar regulatory function. This board operated until 1865, ending with the passage of the Parker Act (1865). The licensing powers were revised in 1869 under the jurisdiction of the newly created College of Physicians and Surgeons of Ontario. The province of Quebec implemented similar legislative powers in 1847, an Act that was then revised to incorporate eclectics and homoeopaths.

Unable to suppress non-conventional "medical treatment", the elite orthodox medical practitioners revised their strategy on non-orthodox practitioners by incorporating them into their newly founded regulatory body. This was not done because of state pressure or a re-evaluation of the non-orthodox practices but because the elite medical group felt that by including the non-orthodox groups it could then regulate their activities and bring sanctions to nonconformists. McDermot suggests that through this system conventional medical practitioners now had a means of "hugging homoeopathy and eclecticism to death" (1935, 13). As the strategies to exclude non-orthodox practitioners gained momentum, the unification of orthodox physicians took priority with the organisation of a national medical society.

**Medical Society**

The formation of the Canadian Medical Association (CMA) in 1867 demonstrated the desire for a representative national professional body. The primary aim of the Association is to "guard the health of the people by maintaining the highest standards of medical practice." The Association also has a duty to promote the interests of its members and to act on their behalf (MacDermot, 1967, 53). The history of the CMA is interesting as it demonstrates a change in focus over the years as various issues have come to bear on the practice of medicine in the country. As has already been demonstrated, efforts to organise medicine began before 1867 and local medical societies started forming as early as 1826. But the establishment of the CMA was
another crucial component of the advancement of the professionalisation agenda. In 1867 the Conference of the Medical Profession was held in Quebec City to discuss the formation of a national body and resulted in a statement that:

The Canadian Medical Association ... will give a frequent, united and decided expression of the medical opinion of the country, must tend to advance medical knowledge, and elevate the standard of medical education, besides directing and controlling public opinion in regard to the duties and responsibilities of medical men...

(MacDermot, 1967, 54)

The way the Association took on the mission of controlling public opinion was by emphasising that a patient's first point of contact should be "regular practitioners." "Patients should see the doctor even for trivial cases lest fatal results supervene. And a patient should never permit his crude opinion as to their fitness to undercut his obedience to doctor's orders and prescriptions" (CMA Code of Ethics, 1868 as cited by Naylor, 1986, 20).

In the early years, the attention of the Association was focused on uniformity of medical education and registration throughout the Dominion. It was believed that this emphasis would help ensure that a homogeneous occupational group would develop. The CMA did not lose sight of the influence of public opinion so continued its campaign to increase public support by emphasising the scientific nature of medical education and practice and the value of a scientific basis.

In the first half of the century the Association grew slowly and unevenly. It was a long time before the CMA came to be regarded as a body with national interests rather than a group of provincial societies. In 1893 a motion was proposed to disband the association but organisers assured the strengths of the body and the motion was dropped. Later meetings were better attended and the CMA slowly grew. Even 40 years after its formulation, the CMA was not seen as a national body. Since Canada's growth was hindered by its proximity to the United States and the more distant influence of Great Britain, it was easier for Canada to make use of the facilities of these two countries.
rather than develop its own resources. It was felt that a national journal would be valuable to the life of the Association as well as on its own merits. Although there were serious obstacles in cost and organisation, the Canadian Medical Association Journal (CMAJ) was finally brought into being in 1911.

The journal was then put aside at the outbreak of the first world war and even with the end of war, the situation remained uncertain. The Association membership was small, there were heavy debts and the Journal was still poorly organised. But the members were committed and made the decision not only to rebuild but to expand. A full-time secretary was appointed to oversee the rebuilding and expansion (MacDermot, 1967).

As late as 1920, for example, less than 20 per cent of physicians were members of the CMA. But physicians became more politically homogeneous (as per the CMA agenda) and, more importantly, with some early suggestions about government health insurance, membership became more important and beneficial. Membership increased accordingly and by 1935 membership reached 35 per cent increasing to 60 per cent by 1943 (Coburn et al, 1983).

Another important development arising out of this expansion philosophy was the affiliation of the various provincial units of the Association. Each province had developed its own society or association which acted as branches of the central body. Although each branch was an important building stone of the Association, they understandably tended to be concerned with their own provincial affairs. It was not until 1939 that the Association By-laws clearly defined the relationship between the divisions and the parent body.

Geographic and economic factors were major deterrents in bringing the divisions together, but the fundamental distrust of centralisation and a fear of interference in the autonomy of the provincial bodies served as severe deterrents. It was not until each province was convinced that closer organisation would not affect their autonomy that agreement was reached and federation completed in 1939.
MacDermot (1967) argues that by World War II the Association had become closely knit with a strong central organisation. It was able to contribute to the war effort and remain a strong national body. The war helped demonstrate the strengths of medicine in Canada. State and public confidence grew and the CMA worked hand in hand with governmental authorities to meet military and civilian medical needs during this trying period. Riding on the wave of public support that resulted from the war effort, the medical profession prioritised the goal of upgrading its profile.

Establishment Era: Licensing and Registration of Allopathy

The focus of the establishment era was the licensing and registration of practitioners. The strategy used to accomplish this focussed on the education process which was seen to improve the quality of health care. Yet the exclusionary dimension of this endeavour was also evident in the agenda of organised medicine.

Medical Education

The elite medical groups, having organised themselves, never lost sight of their paramount concern - controlling the definition of health and disease and, thereby, who would be licensed to practise. Their method of gaining control, at this stage, was through regulating medical labour power through the medical education system. In general, the course of medical education had been influenced by Canada's small population, slow industrial development, and metropolitan dominance, as well as lags in higher education, generally. Medical teaching began in 1825 at the Montreal Medical Institution in association with the Montreal General Hospital. This was the first medical school formed in Canada and later became the Faculty of Medicine at McGill University. The school immediately attracted students. Unfortunately the Montreal Medical Institution (MMI) had no university affiliation and was therefore denied the right to grant licenses to practise. Within five years things would change. McGill University, although founded in 1819, had not begun any teaching and was in danger of losing the
bequest of its founder. So in 1829, the MMI was "grafted" on the university as its medical faculty and the first Canadian degree in medicine was granted in 1833.

The first attempt to found a medical school in Upper Canada was made in 1825 in St. Thomas, Ontario. But this school closed after just two years. In 1843 teaching resumed at what became the Toronto School of Medicine, then competing with Kings College, later the Medical Faculty of Trinity College. The Medical Faculty was inactive in teaching from 1853 to 1887, although it held examinations and granted degrees. In 1887 the Toronto School of Medicine and the Medical Faculty of Trinity College amalgamated. The same year it was joined by the Medical Faculty of Victoria University. Finally, after further changes, the two Toronto programs merged to become a faculty of the University of Toronto.

A bilingual school had been established in Montreal in 1843 as l'Ecole de Medicine et de Chirurgie de Montréal (eventually becoming the faculty of Medicine at l'Université de Montréal). As mentioned earlier, Quebec City's medical origins began with the founding of Hôtel-Dieu in 1639. Teaching by apprenticeship was well established early in the 19th century and classes were held as early as 1823. Teaching under the auspices of l'Université Laval began in 1853. Changes were taking place in other parts of Canada, and the first stages of a medical faculty at Queen's University in Kingston, Ontario, began in 1854, 1868 at Dalhousie University in Halifax, Nova Scotia, and 1881 at the University of Western Ontario, in London, Ontario. The medical faculty of the University of Manitoba was founded in 1883. Interestingly, this was the first time a Canadian medical school came into being as a direct result of the efforts of interested students. A group of students approached the College of Physicians and Surgeons of Manitoba to consider the organisation of medical education. Their persuasion was obviously successful. Between 1829 and 1867 sixteen university faculties of medicine were established in Canada (See Table 6.1).
Before medical schools came into being in 1823, the only medical training available in Canada was through an apprenticeship lasting three to seven years. With the opening of the medical schools in Montreal and Toronto, good teaching was developed initially by British trained military surgeons. Students were taught to examine and observe the patient directly rather than depend solely on lectures.

Due to the terms of the British North America Act (1867), each province had come into Confederation with control of its own system of medical education. So each province had its own registration system for practice. The political obstacles in establishing uniform national methods of registration became apparent in 1894. After a number of attempts at establishing uniformity, a bill was proposed to form a Dominion Medical Council, composed of representatives from each province. The Council would define the education and medical training required for registration. A diploma, gained by examination, would allow the right to practise anywhere in Canada.

There were two major influences on the growth of the medical schools in Canada: The Flexner Report (1910) and World War I. The Flexner Report, a review of medical education in North America, reported on the state of medical education in Canada, demonstrating need for improvement. Despite considerable resentment at the Report, the findings lead to immediate reorganisation. The Flexner Report gave the medical societies the justification for the continued exclusion of unscientific practitioners as unable to meet the high professional standards (Coburn et al, 1983, 414). One of the major developments implemented to deal with the professionalisation philosophy was the introduction of a five year program at McGill University and University of Toronto. Secondly, Canada moved to putting all medical training on a university basis. World War I, on the other hand, had a much more severe and immediate impact. Large numbers of teachers volunteered for active service, making teaching of medical students over the next four years extremely difficult. When the war ended all the returned medical practitioners had to complete or renew training.
TABLE 6.1

MEDICAL SCHOOLS IN CANADA
by year of establishment

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>McGill University</td>
<td>1829</td>
</tr>
<tr>
<td>University of Toronto</td>
<td>1843</td>
</tr>
<tr>
<td>Université de Montréal</td>
<td>1843</td>
</tr>
<tr>
<td>Trinity College(^1)</td>
<td>1850</td>
</tr>
<tr>
<td>Laval University</td>
<td>1852</td>
</tr>
<tr>
<td>Queen's University</td>
<td>1854</td>
</tr>
<tr>
<td>Victoria University(^2)</td>
<td>1854</td>
</tr>
<tr>
<td>Dalhousie University</td>
<td>1867</td>
</tr>
<tr>
<td>Bishop's University(^3)</td>
<td>1871</td>
</tr>
<tr>
<td>University of Western Ontario</td>
<td>1881</td>
</tr>
<tr>
<td>University of Manitoba</td>
<td>1883</td>
</tr>
<tr>
<td>University of Alberta</td>
<td>1913</td>
</tr>
<tr>
<td>University of Saskatchewan</td>
<td>1926</td>
</tr>
<tr>
<td>University of Ottawa</td>
<td>1945</td>
</tr>
<tr>
<td>University of British Columbia</td>
<td>1949</td>
</tr>
<tr>
<td>University of Sherbrooke</td>
<td>1961</td>
</tr>
<tr>
<td>McMaster University</td>
<td>1965</td>
</tr>
</tbody>
</table>

\(^1\) Amalgamated with the University of Toronto in 1903.
\(^2\) Amalgamated with the University of Toronto in 1891.
\(^3\) Amalgamated with the McGill University in 1906.

Sources: Royal Commission on Health Services "Medical Education in Canada". J.A. MacFarlane 1964; Association of Canadian Medical Colleges, 1984

The weakness in medical education noted in the Flexner report, as well as the shortage of teachers resulting from WWI service, culminated in the closing of some medical schools, the building of new schools and the strengthening of existing programs by integrating them into Universities. Tightening the criteria for qualification to practise medicine in Canada proved to be a valuable strategy gaining positive results for the profession.
The establishment of the Association of Canadian Medical Colleges (ACMC) proved to be an important feature in Canada's system of medical training. It is the only body which can coordinate medical education in Canada. Beginning in 1943 in an advisory capacity to the government, the ACMC was concerned with the provision of medical officers needed for the armed services, as well as with protecting the quality of medical teaching.

The ACMC has an important national role as an educational organisation having official relations with the CMA, the Royal College of Physicians and Surgeons (RCPS), the Medical Council of Canada, the Association of American Medical Colleges and the American Medical Association (AMA). It is the organisation to which the government of Canada appeals on questions of the supply of medical manpower and on the provision of education in the medical aspects of civil defence. The ACMC speaks to the federal government on the effect of social legislation on medical education and on the need for research and training programmes.

The intent of the Canada Medical Act of 1910, which came into force in 1912, was a national uniform minimum qualification standard. The Act was the basis for establishing the Medical Council of Canada. The Council conducts examinations of medical students who have fulfilled registration requirements in the provinces, thereby maintaining uniformly high professional standards throughout Canada.

The Royal College of Physicians and Surgeons of Canada (RCPSC) came into being in 1920 to stimulate and promote post-graduate study in Canada. The intention of the College was to establish a non-teaching organisation which would confer degrees in surgery and other specialities. The letters designated FRCP (Can) or FRCS (Can) are awarded only after specialty training and are held in very high regard by physicians and the community at large.

As specialist training is continually increasing, the role of the RCPSC has become more important. The requirements for training overseas specialists are outlined by the Royal
College. So, although their function may seem passive, in that they have no licensing powers, it has a powerful influence on the trend of specialisation in the country. It has the power to hold special examinations for physicians seeking specialty status, including the power to determine the nature of these examinations and other qualifications. As part of its educational role, the College has the responsibility for approving hospitals for graduate training in medicine.

In order to prevent the deterioration of their professional status in the public eye as well as the eye of their specialist colleagues, general practitioners formed the College of General Practice (CGP) in 1954 with the assistance of the CMA. It was recognised that the prestige of the general practitioner was lower than that of the specialist and competition between the two groups followed. The function of the CGP is to promote the development of curricula suitable for general practice, develop postgraduate programmes and promote the integration of the general practitioner into the hospital system.

Now that we have some understanding of the nature of the relationship between the state and the medical profession in Canada we will be better able to grasp the complexities of the negotiations between theses powerful actors. Up to this point this chapter has set the stage for pursuing the nature of the challenges the state has mounted on the dominant position of medicine, an important aspect of the professionalisation process. By the 1950s the medical profession had developed its authority over medical practice, other health occupations and the public. The profession was established through careful organisation manifested through professional societies, higher education and registration. Up to this time the state was generally uninterested in health matters except in extreme circumstances. This situation changed and the period surrounding the development of national health insurance demonstrates the new position of the state in the health care arena.
Negotiation Period: National Health Insurance

The Constitution Act (1867) formally the British North America (BNA) Act defines the roles and areas of jurisdiction for the provinces and territories in Canada. Initially the provinces had greater responsibility in health services than the federal government which was restricted to maritime quarantine measures and the management of hospital services for marines. The expanding role of the federal government in health came about in 1919 with the creation of the Department of Health. Although their concerns, in the 1920s, lay with the health of armed forces personnel and Canada's indigenous population, it demonstrates an increasing responsibility of the federal government. In the same year (1919) the Liberal Party Convention saw the party, under the leadership of MacKenzie King, make its first commitment to health insurance (50 years before it became a reality).

Several provincial governments initiated talks in the 1920s. British Columbia, for example, had established two Royal Commissions on health insurance by 1932 (Swartz, 1977, 316). Through the 1929-1939 depression and the Second World War, public discontent with lack of affordable medical care grew. Early proposals for health insurance schemes included the plans for governmental control over medical practice. The response of the Canadian Medical Association was sceptical, predicting that loss of control over practice by doctors themselves (via the CMA) would lead to a decline in the quality of health care for Canadians. This put pressure on the Association to produce a health care scheme that protected their control but met the demands of the government and the public (Swartz, 1977; Torrance, 1981). These attempts by the medical associations to formulate an acceptable proposal initially focussed on an insurance scheme for the population in financial need. But as the depression began to take its toll doctors began to see the need for more universal coverage. It became clear that a number of physicians were suffering financially and could not cover their expenses. An article in The Canadian Medical Association Journal estimated that only
about 30 per cent of the population were prepared to pay for medical services (CMAJ, 1934, 51). Attention was drawn to the plight of rural residents by physicians in practice there. It became evident that health insurance was inevitable so the conditions surrounding the insurance scheme became the source of debate.

The government's continued concern with preventative health measures lead to the adoption of laws on the sale of food and drugs as well as establishing a health laboratory to aid in the creation of food and drug legislation. While the government's interests lay in prevention, the medical profession was addressing the problem of accessibility of medical care. In 1934, 27 small local hospitals were established by the CMA in six provinces through sponsored voluntary pre-payment plans (Committee Survey on Group Hospitalisation, 1934).

As more and more doctors cried economic hardship, more and more citizens were making similar cries to the government. The Prime Minister of the day, Bennett, could offer little by way of federal aid so the CMA put forward its own proposal - "Plan for Health Insurance in Canada" in 1934. The position presented in this proposal emphasised emphatically that state health insurance would be funded by the government but supervised by the medical profession, covering only those individuals with incomes below $1200 and family incomes below $2400 per annum (Bothwell and English, 1981).

The emphasis of the CMA proposal was that it was to cover only those in need and that health insurance must be supervised by the profession. What this meant was the medical profession was now proposing a relationship with the state whereby they would now have to negotiate to maintain the current practitioner-client relationship (i.e. fee-for-service). The CMA envisioned an arrangement whereby the state would act as a financial mediator between the client and the physician, not an employer of physician labour. Taylor (1978) documents the difficulty British Columbia (B.C.) doctors had negotiating this arrangement. In 1935 the B.C. government presented an alternative health insurance proposal targeting individuals earning $150 a month or less.
Unemployed, part-time or casual employees and pensioners were not eligible under this scheme. Despite public support, it was condemned by the Medical Association of British Columbia because doctors were excluded from the administrative functions of the plan and had no role in determining fee structures or acceptable methods of payment. This prompted the B.C. Medical Association to adopt a strategy that would insure their administration of health insurance (Taylor, 1978). Other provinces followed suit proposing schemes that would allow Canadians affordable health care while control of medical services remained in the hands of the medical profession.

The federal government's interest resurfaced via the Rowell-Sirois Commission (1938)\(^3\) which laid out the very poor state of public health. A Dominion-Provincial conference was called to discuss the state of health care, specifically the report of the R-S Commission. Again, the issue of health insurance was on the lips of all those in attendance. MacKenzie King believed that Canada needed to look at a social welfare system - individual responsibility for health was no longer affordable or available to a majority of the population (Wallace, 1950, 68).

Government planning for post-war reconstruction produced a committee to investigate Health Insurance (Advisory Committee on Health Insurance, 1942). In 1943, Dr. J. Heagerty, Director of Public Health, Department of Pensions and National Health, presented his report (Report of the Advisory Committee on Health Insurance) which emphasised health promotion through a comprehensive and universal health insurance system. The Report also recommended that the individual provincial departments of health administer the plan in direct consultation with medical practitioners (Bothwell and English, 1981, 486). It should be noted that Heagerty was a trained physician, himself, as well as government employee and consultant. His proposal responded to the

\(^3\) Formally known as the Royal Commission on Dominion-Provincial Relations, this group was appointed to review the divisions of power that should exist between the federal and provincial governments.
concerns of organised medicine by proposing that the provincial Health Commissions be made up of responsible members, "the majority of whom shall be representatives of organised medicine; medical care for indigent paid for by the government; freedom of choice for physician and patient; remuneration according to the method or methods of payment which doctors select" (CMAJ, vol 47, special supp, 3-5, 1942).

Despite Heagerty's main recommendations, no legislation followed. Instead, the federal government shifted focus away from national health insurance to hospital laboratory diagnostic services (a secondary recommendation of the Heagerty report). Large amounts of money were provided by governments to assist in the building and equipping of hospitals. The Federal-Provincial Conference on Post War Restructuring, 1945, saw the federal government demonstrate its very serious position on health insurance through discussion on the actual design and implementation of programs. Several social security measures were proposed, including the recommendation that the federal government pay 60 per cent of the per capita costs. The Department of National Health and Welfare was created with the idea that each of the provinces would implement the health insurance plan and the Department would oversee the implementation. This did not happen in the immediate future.

MacKenzie King's liberal government put forward a proposal in 1948 to offer health grants (National Health Grants Program, 1948) to provinces without the prior condition of health insurance. Hospital construction grants were also proposed and King declared "they represent the first stage in the development of a comprehensive health insurance plan for all Canadians" (House of Commons Debates, May 1948). The federal government increased its role in provincial affairs to encourage more comprehensive health programs through On-Grants Research Funds (established in 1948). The Department of Health and Welfare awarded grants for expansion of provincial public health services, training of medical personnel, research in public health and hospital reconstruction, amongst other things.
The government's Canadian Sickness Survey (1950-1951) revealed the unequal distribution of health services in the country, regionally and socio-economically. The first national study of illness made all concerned aware of the grave inequities in health services. The Federal Hospital and Diagnostic Services Act came into being in 1957 to address the inequities. The Act provided financial assistance to provincial hospital plans, making public hospital coverage universally available with the federal government covering 25 per cent of the average hospital costs.

A change from a liberal government to John Diefenbaker's progressive conservative meant many provinces were questioning whether the federal grants scheme and hospital insurance plans, liberal initiatives, would continue. Diefenbaker's government did honour the commitments bringing the hospital insurance program into effect from July 1, 1958. Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia put programs in place immediately to take advantage of federal cost-sharing. The rest of the provinces eventually joined the ranks: Nova Scotia, New Brunswick and Ontario on July 1, 1959, Prince Edward Island on October 1, 1959 and Quebec began its plan on January 1, 1961 (Taylor, 1978, 233-234).

In effect, the hospital insurance scheme lead to the overutilisation of expensive inpatient hospital care, particularly because of the fact that the benefits did not apply to nursing homes, home-care programs or mental institutions (Taylor, 1978, 235). It also became clear that the fee-for-service method of payment was more expensive than anticipated. This lead the way to the next stage in the history of health care and the role of the Canadian government, universal national health insurance - the Medicare movement.

It was clear that the key legislative lead up to Medicare was the Hospital Insurance and Diagnostic Services Act which spelt out a federal/provincial government cost sharing scheme funded through taxation. In order to secure assistance provincial governments had to assure that hospitals provided budgets approved by provincial authorities.
Hospitals were to be supervised and inspected to ensure they were operating efficiently and effectively.

The medical profession had mixed opinions about hospital insurance. On one hand, the CMA approved of the funding aspect as it became clearer that hospitals were to become the principal workshops of doctors, requiring expensive equipment. On the other hand, the profession was concerned about the political implications of government financed hospital insurance. There were fears that government interest in hospitals would lead to "state medicine", where physicians would become employees of the state.

Hospital insurance increased the importance of hospitals as a medical practice setting which meant that physicians with hospital privileges were subject to administrative and fiscal authority of the state. So organised medicine made the decision to accept the costs of state authority to gain the benefits of having the capacity to use hospitals without charge which would increase their production and, therefore, their incomes (with the added bonus of shedding the burden of collecting patient debts).

The medical profession had attempted to address the need for primary health insurance through a number of insurance plans organised by physicians (Trans Canada Medical plans amalgamated in 1951). The success of the profession's pre-paid medical care prompted insurance companies to enter the field of health insurance. By 1965, a number of companies established plans which covered six million Canadians (MacDermot, 1967, 84). The medical profession regarded this as a "logical development to meet the increasingly recognised need". But the insurance plans did not provide coverage for all medical conditions nor did they cover the entire population. It became clear that a significant number of Canadians were unable to afford medical insurance or health care on a fee-for-service basis. It was the CMA's view that the government should assist these Canadians in need while those who could finance their own insurance be left to do so (MacDermot, 1967, 84).
Legislation in Alberta (1963), British Columbia and Ontario (1965) was enacted endorsing this view. In Saskatchewan, on the other hand, another approach was taken. In 1959 the Premier of Saskatchewan announced his plan to introduce province-wide tax-supported medical insurance. The Saskatchewan Medical Care Insurance Act was passed in 1961 provoking direct and severe opposition by the profession. In July, 1962, private practice was suspended and emergency medical treatment became the only available health care. This "strike" lasted 23 days, ending only with amendments of the Act (the Saskatoon Agreement); satisfying Saskatchewan physicians that their autonomy was not under threat.4

In June 1964, the Royal Commission on Health Services, which was appointed by Diefenbaker's conservative government in 1961 under the request of the CMA, released the first volume of its report (The Hall Report)5. There were numerous recommendations in the Report (Vol 1) all designed to achieve the objective of closing "the enormous gap between our knowledge and skills, on one hand, and our organisational and financial arrangements, on the other (The Royal Commission on Health Services Report, 1964, Vol 1, 10). The stated goal was to be achieved through a Health Charter for Canadians, a national policy with the following objective:

4 This is covered much more extensively under the individual provincial responses.

5 The committee to investigate health services was comprised of Emmett Hall (chairperson), Chief Justice of Saskatchewan, two medical doctors (both English speaking men), one from Saskatchewan and one from New Brunswick (who was also a former president of the CMA, the Dean of the University of Montreal’s School of Nursing (the only woman and the only native French-speaker), a dentist (and former president of the Ontario Dental Association), an industrialist (who later resigned) and an economist (Taylor, 1978, 342).
The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal health services program for the Canadian people.

(The Hall Report, 1964, 11)

The universal health services program was to be implemented in accordance with constitutional arrangement, financed through a prepayment scheme, with the full cooperation of the public, the health professions, all political parties and governments and based on freedom of choice with the assured continuance of free and self-governing professions (1964, 11). The methods of remuneration of health personnel, whether it be fee-for-service, salary or other arrangements and the rates, thereof, should be those agreed upon by the professional associations and the administrative agencies and not by arbitrary decision. There should be an appeal procedure in the event that the parties can not come to an agreement (1964, 12).

The Hall Commission recommendations profoundly influenced public policy in health. It prepared the political, social, professional and economic scene for the introduction of Medicare. It is important to note the Commission's recommended role of the medical profession - continued self-government, remuneration arrangements determined by the medical associations and the encouragement of group practice for the delivery of services.

The 1965 Federal-Provincial Conference under the liberal government of Lester B. Pearson saw the federal government offer 50 per cent of the national per capita cost to provinces if they introduced a health insurance scheme that was based on universal coverage, offering comprehensive benefits and portability, administered by the government. And in 1966 The Health Resources Fund was established to supply financial assistance in the planning, acquisition, construction and equipping of health
care facilities. This developed out of the Hall report's recommendation for increased expenditures on facilities, personnel training concentrating on medical schools and teaching facilities to help pave the way for Medicare (Taylor, 1978, 365).

The *negotiation period*, up to this point, has focussed on the role of the federal government. As was noted, the primary objective of the federal government in health care in the early period was the elimination of infectious diseases. The emphasis, therefore, was on environmental programs and preventative medical benefits. As the demand for the provision of care for immediate public health problems intensified, the government shifted its focus. Gradually through the next phases, the government became increasingly involved in health care matters, although until 1945 the involvement was restricted to public health issues such as epidemics and control of environmental hazards.

After 1945, both federal and provincial level governments became active in hospital construction and subsidisation. This was a response to public demand for a minimal level of social security for all Canadians as well as rising costs of health care. In the early stages of this "welfare state" ideology, 1945 to 1955, health was one of a number pressing social needs which fell under governmental jurisdiction such as mothers' allowance and unemployment insurance.

We witnessed the growth of public and private insurance, attempting to provide a "minimum level of social security". This was marked by the establishment of hospital insurance and the recognition that the state must progressively intervene in the field of public health. Maintenance of the health of Canadians became seen as a collective responsibility rather than the primary responsibility of the individual, and health became defined as a social right. The Hall Commission established the role of the federal government in health as being an active one which assumed responsibility for the health of all Canadians. With this established, the more specific legislative changes within the provinces simply represent attempts to operationalise this concept.
Provincial Legislative Developments

The provinces responded to the changing health care system in different ways. Each provincial legislative change, its objective and significance will be discussed, highlighting the significant events. The purpose for examining the formal responses in each province is that they are reflective of the major trends in the development of health care debates. Initially, the legislative changes up to the point of the introduction of Medicare in each province have been documented. For convenience sake, the analysis moves geographically from east to west in the presentation, which, in no way, reflects the way the legislative changes progressed. The developments in each province are interpreted directly from the legislation and the submissions leading up to their enactment. The submissions include private interests, government proposals, the formal opinions of the medical profession and the arguments from the insurance companies. The legislation is charted to outline significant health policy developments rather than as detailed inclusive analyses. There will be more detail for some provinces, reflecting the fact that these provinces have produced considerably more research.

Newfoundland (Nfld)

By 1935 the Dominion of Newfoundland's government recognised the geographic difficulties Newfoundlanders faced in accessing health care. Arrangements were made for part time medical services in more remote areas as well as both in-patient and out-patient hospital care. This was formally enacted under the Cottage Hospital and Medical Care Act, 1935, which saw 1500 communities receive basic hospital care. The hospitals were provincially owned, staffed almost entirely by General Practitioners who were paid a basic salary supplemented by fee-for-service surgery (Naylor, 1986, 163).

The private Blue Cross Insurance movement entered Newfoundland in 1949 insuring hospital and private medical services. This was part of a national movement seeking to expand private hospital insurance. While the Cottage Hospital and Medical Care Act was responding to the needs of the remote working class rural residents and seasonal
fishing workers, the Blue Cross Insurance Company sought to insure the middle class urban residents. Both groups were responding to public demand for insured services and government interest in adequate health services for all Newfoundlanders.

The Newfoundland government responded to the private health insurance movement with the Public Hospital Insurance scheme (1949), compulsory medical insurance for public hospitals. This appeared to be sending out a message that hospital-based care, whether on an in-patient or out-patient basis, was to become a primary medical practice setting. Blue Cross Insurance and other private insurers as well as the government insurance scheme covered only a minority of medical services.

The health needs of children and the government's view that children should not be penalised under a wage based insurance scheme lead to legislation in 1957 which granted full health insurance benefits to all children under the age of sixteen. The government was beginning to deal with the health care difficulties in their remote and relatively poor province by dealing initially with the most immediate and publicly supported (non-controversial) problems (Concerning Children, Newfoundland, March 1957).

Although the inaugural date for the national Medicare program was July 1, 1968, Newfoundland commenced the program in April, 1969.

**Prince Edward Island (P.E.I.)**

Blue Cross, a private health insurance company, offered coverage to P.E.I. residents from 1944. Again, this was part of a national movement designed to cover private hospital and private medical care fees. The CMA proposal to form the Trans-Canada Medical Services Plan (later called the TCM Plan) was announced in 1951, which offered limited membership and was to be controlled and sponsored by the provincial divisions of the CMA. This competed with the Maritime Blue Cross - Blue Shield program which offered both hospital and medical care coverage. In 1955, with
amendments to the TCM Plan, allowing for provincial variation on sponsorship, P.E.I.
and Maritime Blue Cross became approved members (Taylor, 1978, 336).

A provincial Medical Insurance Plan did not materialise until December, 1970. Prince
Edward Island was one of the last provinces to initiate the federal health insurance plan
for medical insurance coverage for all medical services, including hospital.

**Nova Scotia (N.S.)**

Private hospital and medical care coverage was brought into Nova Scotia by Blue Cross
Insurance Company in 1943. Competition from other private insurers such as Maritime
Medical Care Inc, which was sponsored by the medical profession, solicited N.S.
residents in 1948. This was part of a national movement on the part of the profession to
implement physician sponsored insurance schemes. In 1950, the N.S. government, in
accordance with the CMA's TCM Plan, set up a public assistance health scheme with
Maritime Medical Care as the administrative body. In April 1969, the N.S. government
commenced the national Medicare program.

**New Brunswick (N.B.)**

Blue Cross Insurance Company offered private health insurance to cover hospital and
medical care in New Brunswick in 1944, while the provincial government did not enact
a physicians' services scheme until 1971. So for over 25 years private health insurance
was all that was available to New Brunswick residents.

The New Brunswick government was more concerned with the spiralling hospital costs
in the province. A temporary freeze on hospital construction was put in place until a
comprehensive plan for hospital facilities could be developed. This did not come about
until 1969 with a Hospital Construction report that investigated and reported on these
issues.
The New Brunswick government's attempts to rationalise its province's health system manifested itself in the commission of a private consultative company — Llewellyn, Davies, Weeks, Forrestier, Walker and Bor Consultants — to undertake this task. This committee made several recommendations, the most important being the regionalisation of health services and a de-emphasis on acute hospital care with a commitment to alternative forms of care such as comprehensive home care (Health Care Delivery Report, 1970).

Finally, New Brunswick joined the health insurance program of the federal government in 1971 (it was one of the last provinces to join). This effectively saw all New Brunswick residents insured for medical services and hospital care.

**Quebec (Que)**

Quebec has a much longer and complex history of health care legislation than any other province. The religious influence in this province manifested itself in health care by establishing hospitals, as early as 1639. As health was conceived as an individual issue under the French Government, each family was responsible for the maintenance of its sick. French civilian law acknowledged this responsibility by imposing legal duties on family members for health and protection of next of kin (MacDermot, 1967).

The importance of municipalities as a basic jurisdictional unit became part of health care services. One's personal care was conducted within the jurisdiction of physicians and charitable organisations, particularly churches, except in the case of contagious diseases. This view was reflected in the establishment of municipal health offices which were concerned initially with public sanitation. The first Municipal Health Office fell under the auspices of the provincial government, established in 1840.

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6 L'Hôtel - Dieu, Quebec City, 1639; L'Hôtel - Dieu, Montreal, 1644; L'Hôtel General de Quebec, 1692.
As a result of a small pox epidemic (1885-1886) the government of Quebec increased its interest in and concern with public sanitation. This came about through the establishment of hygiene offices in every locality — the first intervention on the part of the government into public health (Hygiene Act, 1887). The Superior Council on Public Health was formed the same year to help implement the Hygiene Act. The Council was to determine the cause and propagation of diseases, establish anti-pollution regulations and supervise the development of municipal hygiene offices.

From 1900 to 1940 there was increased involvement of individual organisations and religious groups in the development of hospitals. In 1900 thirty non-profit hospitals were established; by 1940 the number had more than tripled. There was an increased role for private philanthropic organisations in health care. The provincial government, on the other hand, continued its interest in municipal health organisations. Reorganisation of municipal centres into health districts became part of the government’s formal agenda, dividing the province of Quebec into ten (10) health districts by 1910 (Municipal Health Organisation Law, 1910).

In 1921, through the Public Charities Act, the province effectively legislated to sustain the actions of private charity and religious groups in financing the cost of operating expenditures of institutions providing care for the indigent. The state decided to aid charitable organisations to adapt to modern hospital techniques, through grants. This marked an important development in Quebec’s move towards universal health insurance. For forty years this legislation provided the only universal means by which the indigent population could access hospital care and treatment. Before this time, care of the sick of all classes was financed by the sick themselves, their families or charitable institutions (except in cases of mental health and victims of work injury). The Public Charities Act brought harsh criticism from some Catholic and social leaders who feared it set the stage for political intervention, marking the beginning of the nationalisation of charity in Quebec.
Chapter 6

The legislation that saw the health districts established through the Municipal Health Organisation Law (1910) was revisited in the early 1930s, resulting in a rethinking of municipal health services in Quebec. "Health Units" were established beginning in 1933 which regrouped municipal offices by county (Health Units Law, 1933). The government demonstrated, once again, its interest in public health. The private charities resurfaced as the government took a more active note in the administration of public charity laws. The Department of Health and Social Welfare was established in 1936 to act in this capacity. Upon recognition that the government subsidies of charitable hospital care was insufficient to cover the growing demand for financial assistance of all health care, the Quebec government began to explore the health insurance scheme put forward by the federal government. The Health Insurance Commission was formed to investigate the question of health insurance and propose a scheme for Quebec residents (Health Insurance Commission, 1943). At the same time an inquiry into hospitals was being conducted (1941-1943); the first commission to recommend universal health coverage. The Report highlighted a number of points. Firstly, accessibility of health care for all Quebeckers, financed by a tripartite system consisting of the state, employer and employee was paramount. More effective control of hospitalisation so as to minimise abuse was also recommended. And interestingly, continued fee-for-service payment to the physician was explicitly stated. The provincial government did not act on these recommendations as there was widespread physician resistance. Instead public hospital insurance was instituted in 1945.

In 1942 the Blue Cross Insurance Company responded to public demand for health insurance in Quebec and the government's reluctance to get involved. The company's campaign concentrated on urban residents in employment. Their insurance scheme had broad community backing and enrolments were high.

Interestingly the name of this department was changed in 1944 to the Department of Health freeing it from the responsibility of social welfare. This also marked the government's move to become more departmentalised.
Chapter 6

The state's concern with abuse of the hospital system led them to enact legislation to organise and develop medical diagnostic centres in 1951. The law was never sanctioned though and focus then returned to controlling hospital use (Act on Diagnostic Centres, 1951). Up to this time the government had only paid hospital costs for the mentally ill, work injured and tuberculosis victims. In 1961 they brought about the Hospital Insurance Act which was an important step toward complete and universal health insurance.

The Medical Assistance Plan (1966) marked another step in this direction. This plan gave allowance recipients (e.g., pensioners, disabled) the right to medical and surgical care without charge. A broader measure to cover all residents, whatever their financial status, was within sight. Taylor (1978, 379) argues that the events leading up to the introduction of Medicare in Que. surpassed in magnitude the 1962 crisis in Saskatchewan. The Que. government wanted complete autonomy in all provincial jurisdictions and the fiscal capacity to finance the health insurance program independent of the federal grant scheme. These objectives ran counter to the federal government's proposals which included a direct federal presence in the program, the necessity of maintaining national standards, retention of federal fiscal control of the economy and the commitment to develop a national health insurance program (Taylor, 1978, 380-386).

The government of Que. initiated its own investigation into health care needs in the province through the Castonguay Commission (1966). The Report of the Commission supported the federal findings, recommending a "complete and universal health insurance plan be established in Quebec." This brought to the forefront the federal offer (with the attached conditions, listed above) of one half the cost of a program that met its four principles; a very attractive financial offer.

The medical profession was not united in its view of the national insurance program. The Federation of General Practitioners showed some encouragement but the more powerful specialists' federation opposed it, a position they displayed through
withdrawing their services. In 1967, 205 radiologists withdrew all but emergency services, an act supported by 2300 specialists who refused to participate in the social assistance medical plan which had begun in the province eighteen months prior. The dispute was resolved when the government agreed to cover payment of radiologists services in their private offices as well as authorising a fee increase. This signalled to the government what might happen if they proceeded with the federal government's national plan (Taylor, 1978, 389).

Que. residents demonstrated their support of the Medicare scheme when a public opinion poll revealed the following. The question read: "As you may know, the minister of finance has announced that taxes will have to be increased to pay for Ottawa's Medicare program. Under these circumstances, which of these statements come closest to the way you, yourself, feel about it?" It was clear that Que. voters supported the national plan.

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(Taylor, 1978, 391).

The federal government offered no flexibility on their program. As a matter of fact they were to introduce a two per cent income tax on all Canadian citizens to help finance it. The federal government was prepared to tax Quebecers to finance health programs outside Que. If Que. did not join the program their people would be deprived of "a lot of money to which they have a right." The lure of the federal 50 percent cost sharing arrangement was too great for the Que. government to turn down (Taylor, 1978, 394-396).

The medical specialists in Que. resented their government's position and refused to operate under the conditions laid out. As the debates heated, the specialists threatened
"confrontation" through withdrawal of services. Media coverage was mixed but tended to side against the specialists (Taylor, 1978, 405-408). In the heat of negotiations the situation was complicated further by the kidnappings of James Cross (the British Trade Commissioner) and Pierre Laporte (Que.'s Labour Minister) by the Front de Liberation de Quebec (FLQ). Threats from other "cells" of the FLQ towards striking specialists and calls for return-to-work from other factions of organised medicine, both in Que. and outside, put pressure on the specialists.

With the murder of Laporte and concerns about increased need for emergency services because of often violent demonstrations over the FLQ crisis, the specialists agreed to return to work, under protest. On November 1, 1970, Que.'s Medicare program came into effect.8

Ontario (Ont)

Attempts by the medical profession to control practice standards in Ontario manifested themselves in the Licensing Act of 1818 (A Medical Act). This ensured that no one could practise medicine without a license and one's license was obtained through examination of a board consisting of five members appointed by the Governor of Upper Canada. This Act was amended in 1827 to cover all those presently practising medicine without a license obtained since the examination process enacted in 1818.9

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9 The only practitioners who did not need a license were midwives.
Chapter 6

The Ontario government's first official involvement in health care came about as a result of a cholera epidemic in 1832. The government established boards of health to guard against the introduction of contagious disease (Public Health Act, 1833). The state only became involved when necessary and only temporarily. Another cholera epidemic in 1845 lead to amendments to the Public Health Act allowing the governor to appoint a Board of Health whenever it was deemed necessary (Public Health Act, 1849).

Again, the medical profession's concern with controlling medical practice surfaced officially in 1865 when a statute was brought in which provided a mechanism for the profession to undertake the education of physicians. The General Council of Medical Education and Registration, composed of elected representatives of licensed practitioners and appointees from the medical schools sought to set the medical education curriculum, grant licenses to graduates only and establish a medical registry. In 1869, the College of Physicians and Surgeons (Ontario) was formed to formally handle the functions as set out by the General Council of Medical Education and Registration.

Revision of the Public Health Act in 1873 saw the authorisation of continuous scrutiny of public health by the state. Local boards of health were established in each municipal council. Public health issues were more frequently on the agenda of the Ontario government leading to the formation of the Provincial Board of Health (1882). The board consisted of seven members, four of which were doctors. This, again, demonstrates an important strategy used by the profession to gain status and privileges - infiltration of the state. During the next twenty years, the powers of the local boards and provincial boards increased so that 1912 the Public Health Act amalgamated all previous legislation into one, representing a new step in government involvement in health care.

This interest spread into hospital construction with the government providing funds for new hospitals (Hospitals and Charitable Institutions Act, 1912) and improvement of
hospital standards (Public Hospital Act, 1931). The establishment of the Department of Health in 1932 demonstrated government involvement was continuing to increase. The Health Department assumed responsibility for administering legislation regarding public health and hospitals.

The notion of health insurance was introduced in Ontario through a number of competitive schemes. As early as 1937 there were voluntary medical services prepayment insurance programs in the cities of Windsor and Toronto. Organised medicine's response was offered the same year in Toronto by the Ontario Medical Association (Associated Medical Services) and ten years later another scheme sponsored by the medical profession (Physicians Services Inc, 1947). Voluntary insurance plans became available in the 1950s through Blue Cross, commercial insurance companies and cooperatives covering varying degrees of services. These insurance groups covered over 65 percent of Ontario residents by 1955 (Taylor, 1978, 112).

The government interest in health insurance was not evident until 1955 when a hospital insurance plan was initiated. A commission was formed to administer this hospital insurance plan in 1957 (Ontario Hospital Services Commission). Interestingly, the Ontario Medical Association's (OMA) response to the Premier's hospital insurance plan demonstrated concerns about the extent of coverage, including diagnostic services such as x-rays and laboratory tests. The Premier stated "it would not be my desire to enter into the medical field in any way. I would prefer to stay out of it entirely, because of the implications and the costs" (Stenographic Report of the Meetings of the Standing Committee on Health, March 14, 1956, 3-7 as cited by Taylor, 1978, 140). The government's interest lay in controlling hospital admissions only.

The Ont. government implemented hospital insurance in 1963. The insurance was available to all uninsured Ontario residents or those who were not eligible under
company standards. On October 1, 1969, fifteen months after its inaugural date, Medicare was available to all Ont. residents.

**Manitoba (Man)**

The first health department was set up by the Manitoba government in 1883 recognising governmental health responsibilities (Department of Agriculture, Immigration, Statistics and Health). This marked the beginning of state involvement in health which then sat idle until after World War II. Meanwhile health insurance agendas were put forward in the province by Blue Cross and the medical profession (Blue Cross, 1937; Manitoba Medical Services, 1942).

The Manitoba government proposed a province-wide preventative health service based on localities in 1945, but no part of the Act was adopted, being revised in 1946. This was designed to increase accessibility of medical services in rural areas by offering free diagnostic out-patient services in a number of rural health units (Health Services Act, 1946).

The province's response to the federal government's insurance scheme was to bring about the Hospital Insurance Act in 1958. Hospital facilities and personnel were established or improved, again responding to federal government initiatives (Hospital Survey Board [Willard Report], 1961). This was followed by the acceptance of the national health insurance scheme which was initiated in Man. in April, 1969.

**Saskatchewan (Sask)**

The early concerns of the Saskatchewan government were with providing health services to remote agricultural communities. Expression of this concern came about through the establishment of geographically allocated localities, called hospital districts, for the purposes of allocating funds for the building and maintenance of hospitals (Rural Municipal Act, 1914). This initiative could not service all areas so a system to employ
doctors on a contract basis in the most remote communities was put in place by the
province (Municipal Doctor System, 1919).

Health insurance was available in Saskatchewan through plans sponsored by physicians
as part of the national insurance wave in 1931 (Regional Medical Services, 1931). The
government took no action until after World War II with the introduction of
comprehensive program of health services including hospital, dental, medical and
pharmaceutical benefits for old age pensioners, those in receipt of a "mother's
allowance" and general social relief benefits (Social Assistance Hospital Care, 1945).
The medical profession responded with a private insurance scheme, initiated in
Saskatoon in 1946 (Medical Services, Inc).

There was no private health insurance company to compete with the physician
sponsored plans offered; the Blue Cross movement never entered Saskatchewan.
Instead, the provincial government put in place the Public Hospital Insurance Plan
(1947) which established compulsory medical insurance for public hospitals.
Saskatchewan was the first province to undertake this scheme leading to the first
universal provincial health insurance plan in Canada in 1962 (Medical Services Act,
1962). This was an extremely controversial move on the part of the government which
warrants a more detailed analysis.

The lead-up to the introduction of a government-sponsored health insurance scheme in
Saskatchewan is important to examine as it illustrates the medical profession's position
on state involvement in "its" arena. The government plans were seen by doctors as
socialising medicine, a system of which they wanted no part. In 1959 the Co-operative
Commonwealth Federation (CCF) government, under the leadership of T.C. Douglas,
announced plans to introduce "Medicare to every citizen." The plans were immediately
opposed by the medical profession principally because they included government
payment of doctors' bills, which runs counter to the laissez-faire system under which
medical services operate. So, essentially, the Saskatchewan doctors were fighting to
maintain their control over the market for medical services (Badgley and Wolfe, 1967, 5).

The government proposal included a number of principles which Douglas reported to the people of Saskatchewan through public broadcast. These principles covered the prepayment nature of the insurance, its universality, the promise of high quality service, government sponsorship and administration in a form "acceptable to those providing the service and those receiving it" (Badgley and Wolfe, 1967, 22). The doctors objected to the administration principle which would give the government the power to control the finances which the doctors saw as leading to the eventual control of medical practices (Naylor, 1986, 198).

The Canadian Medical Association (CMA) was certainly supporting their Sask. colleagues' concern over the administrative aspect of the government-sponsored schemes. The CMA Committee on Economics expressed view was that "a tax-supported comprehensive program compulsory plan for all, is neither necessary nor desirable" (Naylor, 1986, 189). It reiterated its continued position of free choice for doctor and patient; protection of private practice, research and medical education; professional representation on any administrative commission; lack of interference with usual channels of professional self-government; and no infringement on the rights of doctors to choose their type and location of practice or their mode of remuneration (p. 189-190).

Despite the views of the profession, the Sask. MCIC Act (1961) received royal assent on November 17, 1961. The medical profession refused to participate in the commission being established to run the plan. Doctors threatened to withdraw their services but the government assumed that the medical profession, under the laws outlining its authority, had a legal responsibility to treat patients, and therefore, saw these threats as idle (Badgley and Wolfe, 1967, 42-50). So even though Douglas proclaimed, under the final principle of the Medical Care Insurance Commission
(MCIC) Act, that there must be agreement from those providing the services - the doctors - he proceeded without their approval.

On July 1, 1962 the Sask. MCIC Act came into effect and the Sask. doctors went on strike, demonstrating the strength of their resistance to government intervention into medical services. The strike involved the closing of all doctors' offices, no home visits except in emergencies, no telephone consultation, no prescription services and no procurement of medical legal documents (Badgley and Wolfe, 1967, 57). In other words, all but emergency services to patients were withdrawn.

Although the CMA expressed support for the position taken by Sask. doctors, not everyone did. Reports from the media varied greatly. Provincial newspapers put into print pro doctor articles, but other papers argued against the doctors' stance, believing doctors were obliged to accept the legislation because it was brought about through democratic process (Naylor, 1986, 207). The American Medical Association supported the strike, while the British medical groups condemned it (p. 208). The head of the legal medicine department at Harvard University, although opposed to socialised medicine, stated that "it is my opinion that no doctor has the right to strike" (Badgley and Wolfe, 1967, 62-63). The trade union movement, the farmers' union and most cooperative organisations encouraged the government to stand firm (p. 66), while the dental association and pharmacist groups looked to rally to support their professional colleagues (p. 64).

The striking doctors failed to acknowledge the grass-roots support of Medicare by the citizens of Sask. who were actively organising consumer-sponsored medical clinics. This created an added worry for doctors - competing forms of medical practice that may threaten their economic welfare (Badgley and Wolfe, 1967, 69).

It appears the Sask. College of Physicians and Surgeons began to realise that national health insurance was going to be a reality; the doctors' strategy was beginning to lose support. An appointed mediary, Lord Taylor, a physician from Britain's House of
Lords, facilitated a more compromising strategy (Naylor, 1986, 210; Badgley and Wolfe, 1967, 71). An amended version of the legislation (the Saskatoon Agreement) was agreed upon by both parties, a considerable compromise by the medical profession. This ended the 23 day strike.

In the end, the Sask. doctors were allowed to bill patients directly and patients could then claim reimbursement from the insurance commission for up to 85 per cent of the amount charged. The physicians could extra bill patients for the remaining 15 per cent. Doctors could opt to enter the plan directly and get the 85 per cent of the scheduled fee (determined by the Sask. College of Physicians and Surgeons), without billing patients directly. The final option was that doctors could deal with an already existing physicians-sponsored insurance plan at 85 per cent of the full fee, thereby dealing with an intermediary, not the government (Naylor, 1986, 210).

The events surrounding the Saskatoon Agreement illustrate the negotiation strategies used by both the medical communities and the government. The state’s involvement in health care instils real concerns in the profession - concerns that the body that funds health care can and will control numerous aspects of medical work. So it was not the issue of health insurance that caused the doctors to respond as they did but the state’s assumed role in the delivery of services, a role that the medical profession had not witnessed before. The main issue for the profession was the preservation of their freedom to decide how they would be paid. The acceptance of the Saskatoon Agreement meant that doctors accepted that the government now controlled the resources from which they would be paid.

**Alberta (Alta)**

Significant legislation in Alberta did not compare with its Saskatchewan neighbour. It was not until 1944 that the government enacted health care legislation and this was only by way of care for maternity patients. This was funded entirely by provincial general
revenues and lead to hospital-based delivery of babies (Alberta Maternity Hospitalisation Act, 1944).

The issue of health insurance was addressed privately through Blue Cross and the medical profession sponsored Medical Services, Inc (1948) nicknamed the "Edmonton Plan" which established public hospital insurance. The government's alternative was introduced in 1949 based almost directly on Saskatchewan's 1947 plan (Alberta Hospital Services Plan). Alta's response to the federal government's Hall Report saw the Alberta Medical Plan in 1963 granting government subsidies to low income earners and Medicare implemented on July 1, 1969.

**British Columbia (B.C.)**

The British Columbia government, reacting to small pox epidemics, appointed a Provincial Health Officer in 1892 which was the extent of their official involvement in health care until the 1930s. A B.C. Royal Commission on State Health Insurance conducted in 1932 recommended a health insurance program which the government acted on, presenting a draft bill for discussion in 1935. Amendments demanded by the medical profession and the Manufacturers’ Association (both of which sat in opposition to the bill) were integrated and the bill was passed in March 1936 to take effect in March 1937. But in February, 1937 the plan was postponed indefinitely, never again to be introduced (Taylor, 1978,6).

In 1940 the B.C. Medical Association sponsored a prepayment plan (Medical Services Associated - B.C.) which was successful right from the beginning. This fact as well as the bill that rose out of the B.C. Royal Commission demonstrated public need and interest in health insurance. Voluntary and private insurance was being offered by Blue Cross and other insurers from 1940 which provided hospital and medical care coverage. The provincial government hospital scheme was established in 1949 and the province took over all existing insurance programs including Blue Cross.
The provincial health insurance scheme came about in 1965 for low income earners only revised to include all B.C. residents by 1968. July 1, 1968 Medicare was introduced in B.C. to cover all residents, coinciding with its inaugural date in the country.

**Discussion**

Taylor (1978, 379) argues that the lead up to the introduction of national health insurance in Canada was a "thirty year drama" characterised by serious political decisions, complex administrative arrangements with new revenue resources to be found. Saskatchewan and British Columbia qualified with minimal adjustments to their existing programs\(^{10}\) while other provinces struggled with more difficult adjustments, with Quebec's decisions perhaps the most complex and conflict-ridden.

The federal government's health insurance scheme was put in place in every province despite the often emphatic rejection by the provincial medical societies. Yet it took over 50 years to reach the stage of implementation. The negotiation over Medicare was characterised by bargaining strategies between so many different parties - the federal government and provincial governments, the federal government and the CMA, the provincial governments and their respective medical societies\(^{11}\) - making it difficult to draw emphatic conclusions about if or how the powerful position of the medical profession was compromised or undermined in this process. What is clear is that there were a number of "tools" used by organised medicine to gain professional status in the country. This chapter highlights some of these tools, emphasising the processes undertaken in the professionalisation agenda.

\(^{10}\) Although we will recall the controversial situation leading up to the Saskatoon Agreement

\(^{11}\) These are only the official actors in the implementation of Medicare. As was noted earlier there are many interested parties in this health care game.
Uniting medical practitioners into a homogeneous community appears to be the most important aspect of medicine's professionalisation process. This was accomplished through the organisation of orthodox practitioners who adopted symptomatic treatment and the exclusion of irregulars who embraced medical therapeutics. Convincing the state of their "expert" position, granting status over "other" practitioners, was a difficult struggle for orthodox medicine. Its reliance on scientific knowledge was the tool used to solicit state and public support. It served as the base from which organised medicine argued its position to legislate against non-orthodox practitioners. These two important tools - unity and exclusion plus the scientific knowledge base - gave the profession the organisational foundation to build on.

The building of professional status came about in the establishment era when the focus was on licensing and registration of medical practitioners. University-based education was the mechanism used to achieve this goal and by the 1920s all legislation relevant to the licensing of physicians was in place (Hamowy, 1984, xx, 1). Organised medicine had firmly established its dominant position in the health care field. The strategies used to deal with challenges to this dominant position are the maintenance of its knowledge monopoly, continued unity amongst practitioners and, interestingly, the infiltration of the state apparatuses concerned with health.

The history of the medical profession in Canada is rife with examples of medical doctors who act, officially, in the capacity of the state but clearly carry out the agenda of the medical profession (or make sure their interests are well represented). MacDermot (1967, 21) demonstrated the early association between doctors and politics, arguing that "medical men have always been in Parliament..." In 1929 there were 28 doctors in the House; 7 in 1958; 6 in 1962 and 8 in 1965. Boards of Health, Royal Commission Inquiries into health matters and health ministries consistently have had membership that include doctors, often in the majority (Naylor, 1986; Taylor, 1978; Hamowy, 1984).
As a matter of fact, the federal government's Advisory Committee on Health Insurance (1942) appointed Dr. J. Heagerty as chair. At that time Dr. Heagerty was Director of Public Health, but he was also a trained physician and certainly his report reflected the views of the medical profession. He proposed that the provincial health commissions, which would oversee health insurance administration in each province, be made up of members, "the majority of whom shall be representatives of organised medicine...and remuneration according to the method or methods of payment doctors select" (CMAJ, 1942, vol 47, special supplement, 3-5).

If we examine these three key components of medicine's professionalisation strategy—convincing arguments over its scientific knowledge base, a homogeneous practitioner community, accomplished through unity of orthodox practitioners and the exclusion of others, and the infiltration of the state apparatuses overseeing health care - we will be able to determine the extent to which any or all of these components were compromised during the negotiations over Medicare.

Marie Haug (1975, 1988) argues that the general public has become educated to such an extent that doctors can no longer claim a knowledge monopoly. Rising levels of public education, less restrictions on access to medical knowledge and new divisions of labour which disseminate knowledge and practise skills more widely, have threatened professional information control. This was not the case in the 1950s and the 1960s. As we will see in the next chapter, even today it is difficult to make this claim, especially now that continued medical education has become mandatory for practising physicians.

The state was not challenging medicine's knowledge base in this negotiation process. It was challenging medicine's claimed knowledge of the best ways of ensuring the health of all Canadians.

The homogeneity of the medical community is an aspect of professionalism that has come under the microscope particularly during the 1970s and 1980s, resulting from state intervention into professional school recruitment processes which has seen more
women and members of different ethnic groups and socio-economic backgrounds represented in medical schools. During the period under study here, the medical community had not changed distinctively with regard to gender composition, ethnic and socio-economic representation. But what was clear from our analysis of the controversies in Quebec was that, despite this, the medical community in that province was not united in its view on the implementation of Medicare. The General Practitioners supported the federal government's initiatives while the specialists' federation opposed them. This fact as well as Quebec government's reluctance to allow the federal government to take such a dominant role in health matters in its province, complicated by the political strife lead by the FLQ, meant that the government could take advantage of the lack of unity amongst medical practitioners and act on health insurance without support from the medical community. But the implementation of Medicare in Canada was not simply the result of a series controversial issues that worked to the federal government's advantage.

The medical profession was not used to state involvement in health matters. As this chapter has demonstrated, the only time the government showed interest was during crises. The negotiation over health insurance was the first time the state and medicine had to actually negotiate. The state obviously had plenty of negotiating experience and perhaps medicine did not. Certainly their strategy of infiltrating the state did not work as advantageously for the profession as it had in the early period when medicine was granted the power to register and license medical practitioners, and more importantly, to exclude the unwanted.

MacDermot concluded that the implementation of the proposals of the Hall Report places the government of Canada in "effective control of medical services" (1967, 93). The conversion of traditional private practice to government financed health care was unpopular with the medical profession. Yet, at the same time, the provision of public (ie. government) funds for education, research and medical facilities has been welcomed by doctors and was seen as a necessary function of government. Coburn (1988, 105)
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argues that health insurance brought a decrease in the power of Canadian medicine but we need to carefully consider what's happened since this period. We have certainly seen that physicians benefited financially from the new system. There was a rapid increase in doctors' incomes once the assurances of being paid for their services were in place. Doctors' incomes rose steadily, peaking in 1971, with relative declines in the 1970s and increasing steadily again throughout the 1980s (Barer and Evans, 1986). The increased income has appeased many individual practitioners but the profession itself never lost sight of losing the battle with the state over health insurance. It had to revisit its strategies to determine the best methods of protecting further challenges to its dominant position.

It is, perhaps, premature to draw conclusions on how the issues surrounding the implementation of national health insurance have affected the dominant position of the medical profession in Canada. Chapter 7 examines the deprofessionalisation of medicine arguments further, through an analysis of the period following the implementation of Medicare, focussing, again, on the bargaining strategies of the state and the medical profession over health care delivery systems.
C. Wright Mills (1959, 46) argues that social scientists, in order to fulfil their tasks, use the materials of history. So the chronological look at formal legislative history presented in Chapter 6 and this chapter helps us to understand the changing nature of the relationship between the state and the medical profession in regard to health care issues in Canada. This, in turn, allows us to assess the deprofessionalisation arguments.

A number of patterns emerge from the legislative developments. For example, provincial financing problems revolving around medical and hospital services were brought to the federal government demonstrating the complex nature of health care funding and administration at a split governmental level. It became clear, through this analysis, that health policy development reflects broader trends such as the effects of industrialism and the growth of welfare statism.

Overall health care legislation can be divided into phases corresponding to the changing view of health from a private individual responsibility to the responsibility of the state. In the very early phase (approximately late 1800s to 1920s) the programs implemented reflected the state's plans to eliminate contagious diseases transmitted through water and other sources. The interest in prevention (or the maintenance of workers' health and productivity) continued into the 1940s with an increase in programs to locate and target sources of disease - food preparation and packaging plants, water treatment centres and pasteurisation units. Environmental factors were addressed through public health regulations and vaccinations against common contagious diseases were made available. The emphasis on healthy environment and industrial concerns dominated the state's formal agenda until the 1940s. Health was defined through medical measures or
epidemiologically and continued to be viewed as the responsibility of the individual and his/her family.¹

From the 1940s to the 1960s the government addressed environmental issues such as air and soil pollution and the effects of insecticides which were increasingly used in agriculture. There was also a move to making the public aware through consumer education programs (Castonguay-Nepveu Report, 1970, Vol. 4, 14). The responsibilities of the state for the health of Canadians gradually increased during this period. Maintenance of one's health came to be seen as a collective responsibility, and policy eventually moved to acknowledge this. This was also the period when Canadians experienced public and private hospital insurance schemes. State involvement in providing social services, generally, increased and health became defined as a dynamic concept, seen as a civic and social "right". Accompanying this right was the federal government's Medicare program which gave universal coverage for all medical services to all Canadian residents. Although the medical profession was content to see the government become involved with health matters on the level of preventative measures, it was concerned about state interest at the level that affected doctors' relationships with their patients. So while government subsidy for patients in financial need was welcomed, universal coverage was not.

It was clear that the implementation of the federal government's national health insurance scheme was a blow to the medical profession which argued hard against it. But did the loss of this battle leave the profession in a vulnerable position? Did the implementation of a government initiative, unsupported by physicians, serve to depprofessionalise medicine? This chapter examines additional government initiatives with a view to gaining more information to assess the professional status of medicine in Canada.

¹Charitable organisations and government intervention came into play in the cases of the mentally disabled, industrial injury or those in economic need.
As was noted, doctors benefited financially from the implementation of Medicare, even though the profession, as a whole, saw it as a loss to its powerful position in the health care arena. Once Medicare was well established, debates over health care costs surfaced, leading many to argue that there was a fiscal crisis in health care (Barer and Evans, 1986). Until recently physicians have been reluctant to accept that health care costs are out of control; instead there have been frequent cries of underfunding. Increases in health care costs sparked both the federal and provincial governments to initiate cost-cutting measures. The strategies used range from imposing structural limits on health care costs through imposing global budgets for hospitals to the transfer of costs to new payers such as employers.

Since the recommendations of the Hall Report were released in 1964, the federal government had not organized another official inquiry into health care. This was about to change. We are reminded that the Hall Report marked the beginning of formal state intervention into health services in Canada at the national level. As the first major federal royal commission on health, it established guidelines for health care that really sought to change the system. The Report defined health as a "right" of all citizens and attempted to institutionalise this right through the establishment of a Health Charter. It also endorsed a universal health insurance scheme, promoted freedom of choice for both patient and physician, and continued existence of self-governing professions (maintaining a fee-for-service payment system) and the establishment of new professions.2 Since the 1960s the government's interests have expanded beyond the enactment of hospital and general health insurance policies to the issues of delivery of medical services: the quality, the availability, accessibility and costs.

2The Report also emphasised a change in philosophy from curative health care to preventative. Although this change in ideology has important implications, it is beyond the scope of this thesis.
Legislative Developments

In response to the spiralling cost of hospital services, the government unilaterally put a halt to issuing grants for hospital construction in an effort to slow down the increased use of costly hospital services across the country. This reevaluation of federal policy came about in 1968-1969 when a task force was nominated to explore health care costs. The focus of the appointed committee was on alternative, less expensive forms of health care delivery. Once Medicare was established, the public and profession's opinion was that health care delivery needed to be examined; medical and hospital insurance was not the remedy to all health care inadequacies. The task force recommended a variety of approaches to curtail escalating costs without compromising quality of care. One significant proposal was that national health grants continue to be available for the development of health centres, advocating, particularly, community health centres (Task Force on Costs of Health Services Report, 1969).

In October 1969, the federal government initiated the First National Health Manpower Conference. The primary objectives were for all levels of government to create planning and health councils to promote alternative health care delivery systems with a view to the future, to address the need for education in the area of administration to ensure there would be sufficient health services administrators and undertake research in the delivery of health services. The initiative came about in response to provincial health issues and signified moves toward federal government influence over provincial health policy.

The Economic Council of Canada produced its Seventh Annual Review: "Patterns of Growth" in 1970, recommending various approaches to reduce costs, including health care costs. This demonstrated the new orientation of federal policy with regard to health and its emphasis on costs, not just accessibility. The 1971 National Conference on Assistance to the Physician (Boudreau Commission) included both federal and provincial representatives. The outcome of this conference was the recommendation
that effective community involvement in health care delivery be immediately established, as well as the development of a program to encourage and recruit educational practitioners. The future role of nurses in health care was discussed, seeing their role expanded in the health care delivery arena. In October of the same year the Second National Conference on Health Manpower sought to redefine the role of all health workers, expanding some and reducing others, and establishing Canadian physician licensing standards. More research into health policy was signalled, making clear the state's growing interest in health care at all levels.

The Community Health Centre Report (Hastings Report) was released in 1972 after a committee had been appointed by the federal liberal government in 1971 in response to the recommendations of the Task Force on Costs. The emphasis of the Hastings Report was the immediate establishment of community health centres, exploring this concept extensively, detailing its agenda. This Report identified that problems associated with the promotion of innovative health delivery systems lay with the Federal-Provincial cost sharing formula (The Hastings Report, 1972).

A new federal cost-sharing formula was designed for implementation in 1972. The old formula was a 50/50 arrangement for specified hospital and medical services. This was seen as too rigid, concentrating expenditures on costly services, thereby inhibiting the development of new approaches. The new formula consisted of an annual federal payment on a per capita basis to each province, adjusted annually. A very large trust fund ($640 million over five years) was established and was made available to finance the reorganisation of health care delivery according to provincial needs (Federal-Provincial Cost Sharing Formula, 1971-1972). This new formula opened the door for more innovative delivery models. The alternatives which were recommended and implemented by the governments were, again, not well received by the medical community. Analysis of the situation revolving around one of the innovative delivery models, the Community Health Centre (CHC), and government attempts to introduce,
expand and protect these centres gives us more clues in determining the current status of medical professionalism.

**Community Health Centres**

Following the Hall Commission there were several provincial reports examining the health needs of Canadians. In 1970 the Task Force on Costs of Health Services in Canada was initiated to examine the rising costs of health care. The briefs submitted covered a number of areas, for example, the utilisation of services, efficiency, salaries and wages, facilities, methods of delivery, price of medical care, and costs of public health service. The most interesting recommendation stressed the establishment of health centres as an alternative delivery system, although the hospital was still seen as the focal point of medical services. Research into health care delivery was also emphasised, recognising that growing costs could not continue. The medical profession was still seen as a self governing body, with fee-for-service remuneration continuing.

However, in the same year (1970) the Committee on the Healing Arts (Ontario) saw a different role for the medical professional, including reduced powers for the profession. It recommended that certain powers of the College of Physicians and Surgeons be removed, most importantly the right to determine rules and regulations, admission requirements, and curricula. The Committee on the Healing Arts was composed of lay members only, while the Task Force on Costs of Health Services had numerous medical representatives. It is, therefore, not surprising that the role of the medical professional was seen so differently by these two bodies. The Report of the Committee on the

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3 There is provincial variation in the names attached to community health facilities. In Ontario, they are called Community Health Centres (CHC), in B.C. they are Health and Human Resource Centres (HHRC), Saskatchewan has Community Clinics (CC), in Manitoba they are Health and Social Service Centres (HSSC) and Quebec has Centres Locale des Services de Sante (CLSC) or Local Community Health Centres (LCHC). When these are being discussed in general terms they will be referred to as Community Health Centres.
Healing Arts serves to highlight public opinion about medical delivery of services, as well as the profession itself.

The White Paper on Health Policy (Manitoba, 1972), which included equal numbers of lay and medical personnel, opposed fee-for-service and promoted a new form of physician compensation. The Commission of Inquiry into Health and Social Welfare (Quebec, 1970) composed of eight lay persons and two medical people also criticised fee-for-service and professional monopolies, recommending the establishment of control mechanisms with lay members on boards of directors of Professional Orders. All these commissions proposed alternative health care delivery systems. The Quebec Commission (The Castonguay-Nepveu Report) conceived of the state "as the only body capable of reforming the health field because it possesses the economic and social resources and acts for the welfare of the people, while professional monopolies may not". The Report concluded that health care must be subject to the authority of the state in areas directly involving the consumer. While the province of Quebec was extreme in its recommendation for increased state control, the other provinces reflected on a new role for the medical profession. One such scenario that reinforced the idea that the profession's mandate is given by society and they are therefore required to respond to public demand (Committee on the Healing Arts, Vol 3, 29). Government should act as a "guarantor of payment rather than as employer" and should "help define standards of health service which are to be universally available and to identify and fill in gaps in the service" (Ontario Council of Health, Supplement no 53, 1970, 67). Manitoba and Nova Scotia, the two other provinces supporting provincial inquiries into health care, viewed the relationship between the government and the medical profession much the way Ontario did (White Paper on Health Policy [Manitoba], 1972; Health Care in Nova Scotia: A New Direction for the Seventies, 1972).
As a result of the numerous reports and recommendations, the provinces of Quebec, Manitoba, Saskatchewan, British Columbia and Ontario began experimenting with CHC\(^4\) alternatives in the early 1970s. This interest did not stem solely from cost-cutting pressures but this was certainly an important motivating factor. In British Columbia, Saskatchewan, Manitoba and Quebec the interest was also associated with alternative political philosophies. In Quebec, for example, the *Quiet Revolution* produced a new view on the social aspect of health and, therefore, health care. This new philosophy resulted in a significant interest in Centres Locale des Services Communitaires (CLSC), Quebec CHCs.

This *quiet revolution* which was taking place in the 1960s and 1970s propelled Quebec into the field of community health. The system of church domination of health care was coming under scrutiny as a result of challenges by the new middle class technocrats (Lesemann, 1984; Renaud, 1981). A new generation of GPs was demanding a reorganisation of the health care system, one that would put an end to control over medical practice by the elite associations (Lesemann, 1984, 57). The roots of this new ideology can be traced to the medical school at the recently established University of Sherbrooke which was actively teaching social medicine. Accompanying this, a group of radical social workers (calling themselves "animateurs sociaux") emerged in the mid-1960s with the agenda of organising social action committees in low socio-economic areas, in order to improve conditions by addressing specific community needs. The social work mission combined with the new ideology of social medicine being taught, lead to the establishment of a number of community health facilities in Quebec.

\(^4\)A CHC provides clinical, diagnostic, therapeutic and preventative services to regular, special care and transient patients as well as participatory health promotion to a defined geographical or demographic community. The facility is paid, in the main, by fee-for-service or capitation (Birch et al, 1990). A CHC contains no in-patient beds and functions on the basis of ambulatory care. It provides comprehensive medical services and includes health personnel such as General Practitioners, Medical Specialists, physiotherapists, occupational therapists, lab technicians, nurses and social workers (Mandell, 1974, 198).
Quebec's Union Nationale government commissioned a study of health and social services in 1968, resulting in *The Report of the Commission of Inquiry on Health and Social Welfare (The Castonguay-Nepveu Report)*, published in 1970. The Report recommended drastic far-reaching changes to health and social services in the province. The reasons for the recommendations stemmed from the recognition of poor distribution of services leaving many areas under serviced, the lack of communication between the different components of the health care system (which was seen to have resulted from the church-sponsored and private hospital system) and the rising costs of health care in the province generally. The duplication of services which resulted from the development of separate health care systems for the French and English was identified as well as the absence of regional planning bodies to accommodate the needs of rural communities (Lee, 1979, 5).

The government's interest was also connected with Quebec's hopes of developing a different social philosophy from that which was developing in the rest of the country under the negotiations over Medicare (Renaud, 1976; Tsalikis, 1982a) Although the reasons may not have been immediately apparent, the reorganisation strategy outlined in the Castonguay-Nepveu Report was. A complete reorganisation and rationalisation of the health care system including decentralization of power, a holistic approach coordinated through teams of health professionals (broadly defined) and regionalisation of the province into health districts in order to consolidate and rationalise resources and needs were all recommended. The health districts were to operate on three separate levels. The first level of entry into this newly designed health care system was through Local Health Centres (or Centres Locale des Services Communitaires) which would provide health care and other related social services to the residents in that community. The next level, the Community Health Centre, was conceived as the general hospital while the third level was the University Health Centre, specialised hospitals connected with medical faculties at the provincial universities. Each of these three tiered health
regions would be accountable to the Quebec government's Ministry of Health and Social Services.

Castonguay, who had chaired the government inquiry, joined the Quebec liberal party in 1970 and later that year the party was elected into power. He was thereby appointed Minister of Social Affairs (an amalgamation of two separate ministries: Health and Family and Social Welfare). Upon taking up this ministry Castonguay was free to put in place those changes recommended in his previous report. His reorganisation of the Quebec health care system was formalised under Bill 65 which was passed in 1971, meaning the new system, in effect, was implemented "from above."

The way the local CHCs were conceptualised involved numerous criteria laid out in the report:

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

(Castonguay, 1971, 193-197)

The development of CLSCs in Quebec continued through the 1970s and 1980s under both the Liberal and later, Parti Quebecois governments. Their development has not been without problems and setbacks, but, as we shall see, the CHC movement in Quebec has been more successful than any other province.

Quebec was not the only province to experiment with change to health care delivery through CHCs. But the experimentation in other provinces was brought about through left of center political governments, often initiated "from below". The election of N.D.P. governments in Manitoba and British Columbia brought with it alternative
approaches to health care delivery. Manitoba released its *White Paper on Health Policy* in 1972 which recommended the development of CHCs. Six Health and Social Service Centres were funded initially and were established in under-serviced areas with a large proportion of elderly and Canadian Indians and in rural and far north regions. Initially the centres were informally administered until 1975 when legislation was enacted to unify health and social services, giving centres a legal basis for providing comprehensive care (Ryant, 1977; Hepworth, 1977). Swenger argued that traditional medical practices divide societies' problems but the new CHC concept is directed at the whole person or family, including the total environment in which they operate (1972,13).

The British Columbia government, through the commissioned report of the *Health Security for British Columbians* (or the Foulkes Report), recommended the CHC as the "ideal mechanism for entrance into the health care system at the community level" (Smart and Stotsky, 1981, 33). This report, released in 1973, was also critical of conventional health care delivery and the new N.D.P. government moved to initiate its own group to develop the CHC concept. Initially five Health and Human Resource Centres (HHRCs) were funded as pilot projects, providing health and social services to fit the needs of targeted communities. Salaries were paid to board members who held responsibilities for the administrative duties of the centre, hiring and firing staff and general decision-making (Smart and Stotsky, 1981, 33).

The re-election of the N.D.P. in Saskatchewan came about in 1971 and the ramifications for the CHC movement were great. Under the terms and conditions of the Saskatoon Agreement the CHC movement had become dormant. But, under the new government numerous groups - universities, unions, women's groups and nurses associations - were active in lobbying the government for a resurgence of community health facilities with an emphasis on preventative ideology and comprehensive integrated services (Globe and Mail, July 5, 1972). The response from the government was promising, introducing a funding scheme which would see Community Clinics paid global budgets with community boards controlling the allocation of funds as well as overseeing the
Following the Hastings Report it became obvious that alternative health care would not be implemented without state interest and support. The medical profession, predictably, resented state intrusion and state support for innovation in health care delivery. Although the CMA was initially enthusiastic about the recommendations of the Hastings Report, it immediately withdrew its enthusiasm as its implications became clearer (Crichton 1978, 8). The medical profession's objections seem to have come on a number of different levels. The profession was not convinced there was a relationship between CHC development and economic saving. The argument was that alternative delivery systems would simply be add-on in nature and would, therefore, simply increase demand which would increase costs. Secondly, if there was any economic gain to be made it was at a very high price - the loss of physician autonomy. Thirdly, the CHC philosophy on the teamwork approach to delivering health and social services ran counter to the training and experiences of physicians. The doctor, as the only decision-maker and senior member of the medical staff, was compromised by the equalising approach of the Hastings Report. And finally, the CHC could be used as a tool by which the government could gain complete control of medical practice:

Whereas the medical profession cannot be overly critical of the concept of community health centres as a means of health care delivery it should be very clear that in the context that the concept is presented the health centre might become but an administrative device to ensure absolute control of the pattern of medical practice.

(Ontario Medical Review; 1972, 667-668)

To the medical profession Community Health Centres (CHC) meant state control and payment by salary. Their fears may have been legitimate in that the government had taken a greater and more direct interest in health care during the last decade. If the state's role in welfare and education were any indication, the field of health was certainly under threat of increased bureaucratisation and state intervention. But the fact remained that the medical profession itself was doing little to implement change in
either in their own best interest or in the best interest of consumers. Somebody had to do something to improve the availability of health care, as well as to control its rising cost. The profession argued that there was no economic crisis in health care and CHCs were not the only or the best way to address accessibility.

The profession developed a number of mechanisms to thwart the development of the CHC movement. Saskatchewan and Ontario refused to grant hospital privileges to health centre physicians. In Quebec private polyclinics, set up and operated by doctors themselves, were established alongside the Centres Locaux de Services Communautaires (CLSCs) in order to encourage a second class image for CHCs (Tsalikis, 1982, 151). So every time a CLSC went into the planning stage, a private polyclinic was set up in the same neighbourhood in direct competition. Over 400 of these private physician-sponsored clinics were established compared to approximately 150 CLSCs (Tsalikis, 1982, 151). In addition, Crichton (1978) documented less direct tactics employed by the profession, such as medical journals refusing to review or publish positive studies of alternative health facilities. Referrals were not made to, or received from, health centre doctors (Lomas, 1985, 73). The organized medical societies in both Ontario and Saskatchewan and in Canada more generally, strongly discouraged CHC growth. And their attempts were quite successful. The inability of CHC associations in Saskatchewan to attract doctors can be attributed, to some extent, to the intense pressure exerted on medical colleagues to conform to the views of their medical association. Lomas (1985) argues that the high turnover rate of physicians in Sault Ste. Marie (Ontario) was a direct result of the pressure placed on CHCs by the Ontario Medical Association. Despite the view of the medical association, it became clear that curtailing the costs of health care by exploring alternative health delivery systems was to become the focus of government activity in the 1970s. The provincial and federal health reports of that time indicated regional organisation in the form of Community Health Centres (CHC) were to be the trend of the future.
Why did the state suddenly become so interested in health care delivery? We noted earlier that until the 1960s the government had played a very passive role in the delivery of health services. But the state of health care was now seen to be in economic crisis. Federal and provincial expenditures on health were already high and the implementation of universal Medicare caused drastic increases in federal spending on health. Economists were predicting sky-rocketing health care costs and the Economic Council of Canada reported that if expenditures continued at the present rate then spending in health and education would take all of Canada's GNP by the end of the 1970s (Economic Council of Canada, 1969). The Task Force on the Costs of Health Services (1970) highlighted and documented these concerns.

Many studies of the early CHCs were conducted, with particular emphasis on relative costs. These studies concluded that CHCs were more cost-efficient than fee-for-service practices (using hospitalisation rates as the focus of cost saving). These conclusions provided a basis for recommending further development of the community health alternative.

While the governments of the western provinces and Quebec were willing to intervene in the health care sector by way of reorganising how health care was delivered, the Ontario government was more reluctant. Intervention in the west was certainly less radical than that coming from Quebec. But the willingness to intervene at any level when the medical profession so strongly objected was precipitated by both political ideologies and economic considerations. We must remember Ontario did not share the same recent history of radical alternative politics and had not launched experimental projects based on the ideology of co-operatism. So Ontario did not share the commitment to the CHC movement. As a matter of fact, this province had demonstrated a reluctance to get

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6 See, for example, the World Health Organisation in conjunction with the Ontario government which conducted a four year study of the Sault Ste. Marie Centre (1966) and the Saskatchewan Department of Public Health, Community Health Association Clinics (The McPhee Report), Regina, 1973.
involved in the health care system beyond its funding despite the fact there was a relatively strong alternative health movement in the province and the increasing health care costs shared by all provinces.

The Ontario government has shown some tentative interest in alternative arrangements along similar lines to the CHC. Several advisory bodies and task forces on health had, indeed, recommended a de-emphasis of the curative medical model, but a sustained state interest in community-sponsored health facilities and a commitment to the social movement has alluded the Ontario government. For these reasons it was deemed important to look more closely at the relationship between the Ontario state and the medical profession over the issue of community health. Policy in Ontario, the most populous province, often influences developments in other provinces as well as reflects these developments, so drawing conclusions about Ontario has important implications for understanding the nature of the relationship between two very powerful interest groups in the health care debates generally, not just for Ontario.

The Ontario State and Health Care Alternatives

Despite the level of interest in CHCs being generated in other provinces, the government of Ontario was conspicuously absent from such enthusiasm, despite the interest expressed in the community. There was, of course, similar disinterest from the Atlantic provinces and Alberta, but unlike Ontario, there was not a lot of public demand for such services. The reports produced for the Ontario Ministry of Health in the early 1970s did not reflect the public sentiment that the communities themselves should determine their own priorities in health.

So, the only interest the government showed in CHCs or any other delivery alternatives was if they demonstrated cost-cutting potential. Evidence was accumulating in both Canada and the U.S. suggesting that CHCs did present the possibilities for reductions in health care costs, targeting both primary and secondary care as the source of cost saving
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(Soderstrom, 1978; Donabedian, 1969; Roemer, 1973; Anderson and Crichton, 1973; McPhee, 1973). Despite this evidence the government was slow to show interest and it was not until 1973 that the Ontario government arranged to develop and evaluate health care alternatives when the Ministry of Health created the Project Development and Implementation Group (PDIG). The PDIG, which began operating in 1974, was interested in promoting numerous alternatives in order to compare and evaluate and then make recommendations in the government's formulation of health care policy. The guidelines set out by the PDIG suggested a political environment conducive to CHC development. Specifications were layed out indicating that health centres could be sponsored by any group, individual or organisation, as long as the following criteria were met:

1) Continuity of care would be emphasised rather than volumes of episodic care;

2) Care would have a basic health rather than disease orientation;

3) Economy and effectiveness would be achieved by use of the services of other health professionals such as nurse practitioners and community workers in place of physician services, where appropriate;

4) The resources of the public health system, already publicly financed, would be used;

(Program Development Branch, 1981, 6-7)

Despite these goals several of the guidelines imposed by the funding branch of the Ministry of Health suggested it was not interested in encouraging community-sponsored health facilities. No capital operating funds nor start-up funds were made available to group-sponsored CHCs. Even in severely under-serviced areas, no initiative was made by the health ministry to promote CHCs. There would be no publicising of available funding. This meant that physician-sponsored health clinics were more likely to be set up under these restrictions because a clientele and physical resources would
already have been established.\textsuperscript{7} CHCs would have to attract their own clientele as well as staff, with no financial assistance to establish a location to practise. Further restrictions were put in place specifying that alternative health care delivery systems would be supported only if they required no more government economic commitment than conventional fee-for-service medicine, regardless of the type or number of services provided. There was little incentive for groups or organisations to establish this type of alternative under the funding restrictions laid out.

The PDIG was made responsible for the diverse range of \textit{community health care facilities} that had been previously funded from a number of private and public sources. These included physician-sponsored and run solo practices and group practices under capitation, a range of health facilities that employed nurse practitioners to carry out initial consultations with patients, hospital- and university-sponsored clinics (both with and without community involvement), community-sponsored centres providing conventional primary medical care only, community centres offering a range of services (including multi-medical specialties and preventative programs) as well as other alternatives. It did not include, however, the union-sponsored CHCs set up in Sault Ste. Marie and St. Catharines. The PDIG, although responsible for funding arrangements for the approximately 26 existing health service facilities, could not actively encourage health centre development. However, in April, 1975, before the PDIG's funding arrangements were complete, a freeze was placed on any further development. The interim per capita funding arrangements were to continue for the existing centres; no further development would be funded. So the PDIG's mandate of establishing and evaluating diverse range of health care delivery systems was shortlived. And a new method of evaluation was announced by the health minister to be carried out on the existing centres only.

\textsuperscript{7}Physician-sponsored health centres called Health Services Organisations became a more successful alternative in Ontario; see following section for a more in-depth discussion.
The termination of the PDIG in 1975 put a halt to any further development of the CHC concept. To call for evaluation after such a short trial period for a small number of heterogeneous health organisations certainly signalled apprehension on the part of the government. What brought about this sudden halt in innovation? The ministry defends its termination of the PDIG's mandate because it claims that the evidence on the effectiveness was lacking as was a method for evaluating the alternatives. Yet evidence cited earlier in this chapter had indicated that cost savings could be expected from CHCs. A statement found in the PDIG's history points to a more politically strategic reason for the freeze:

As the number of projects increased, so did criticism and opposition from proponents of the traditional health care system. Within the ministry itself there was not full agreement on the project and opposition from internal and external sources seriously impeded the development task.

(Program Development Branch, 1981, 10)

So what were these sources alluded to in this document? This was certainly not made any clearer in the document itself. The answer to this question lay in examination of the political arena in the country and the specific actors involved.

As we will recall, the medical profession was not supportive of arrangements along the lines of CHCs. As a matter of fact, the profession set out to limit the success of alternatives to traditional fee-for-service practice. The Ontario College of Physicians and Surgeons published a notice warning physicians expressing an interest in CHCs and other alternatives that they could have their licenses suspended if:

...any form of advertising, canvassing or promotion by, or on behalf of a medical insurance or prepaid medical plan that recognises for payment only the medical services provided by the members of a limited or restricted group of physicians is, in effect a form of indirectly advertising or promoting the services of the group, and it is considered unethical for a member of a College to be a member of such a group.

("Warning Notice and Special Notices", 1973, College of Physicians and Surgeons of Ontario, p 2)
This warning had, in effect, seriously limited the spread of information about CHCs. It has made it difficult for CHCs to make the community aware of the services provided. According to some reports the strength of the medical profession’s lobby was the major factor influencing the state's decisions to stop development of health care alternatives.8 Numerous accounts of the CHC movement agree that the profession was instrumental in swaying the government's decision to halt development.9 The Ministry of Health was fragmented in its views. There were several branches within the ministry responsible for various areas of health reform, with conflicting ideas about implementing changes and the Ontario Medical Association as well as individual physician protests were successful in lobbying the Ministry to halt development (Lomas, 1985, 110).

The statement from the PDIG also identifies internal forces which acted to deter the development of alternative health care delivery systems. In order to determine the internal opposition we need to understand that the health ministry, with its many bureaucratic branches, was not in agreement about its desirability. There were groups with varying opinions, as one member of the ministry noted:

There was a lot of internal resistance to the whole notion of community centres. There was a general belief that fees-for-service was what we understood, what we paid for and that some of this other stuff was really for the birds.

(Greer, as cited by Lomas, 1985, 110)

Lomas (1985) argues it was the Special Projects Branch, which had been given responsibility for the two union-sponsored centres discussed earlier, that lead the opposition to the exploratory approach of the PDIG. This Branch wanted a more rigorous approach which would see the alternatives under examination aligned with conventional medical practices for comparative evaluation; an approach that appears to

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8 See Smart and Stotsky, 1981; Lomas, 1985, for examples.

9 Lomas, 1985; Metro Toronto Health Services Organisation Working Group, 1978; Smart and Stotsky, 1981.
have run out in the end. What Lomas does not address is who the key figures in the Special Projects Branch were. As Chapter 6 highlighted, the medical profession had developed a strategy to gain an upper hand in bargaining with the state by placing physicians in the state apparatuses concerned with health care. We need to question whether this had been a strategy developed to thwart the development of CHCs in Ontario.

Coburn (1993, 844) argues that the introduction of Medicare in Canada lead to a decline in physician control over provincial and federal health organisations. Bureaucrats (who are also physicians) were replaced in the state health authority positions by “health bureaucrats, planners, managers and accountants...at all levels”. In the province of Ontario, for example, up until 1968 (and again in 1971-1972) all health ministers were physicians. After that period they have all been laypersons. Coburn highlights the major impact this has had on medicine’s influence on the state and health policy. But it doesn’t help us explain how and why this strategy of physician domination in the state health apparatuses failed to thwart the national health insurance movement yet managed to stifle the CHC movement.

There were also important global and national considerations that would have influenced Ontario’s decisions. As health care costs were levelling off in Canada as compared to the dramatic increases over the previous few years since the implementation of Medicare (Statistics Canada, Consolidate Government Finance, 68-202), there was no longer the economic pressure there had been. So radical reorganisation (and the changes being recommended by the PDIG were considered radical by the medical profession) to get health care costs under control may not have been so demanding. But, at the same time, the message sent around the western world was that there was a general need for economic restraint in the mid 1970s. Inflation and unemployment were on the rise and the federal government was entering discussions with the provinces about limiting transfer payments in health, education and welfare. It had already promised the provinces that they would never again be coerced into accepting expensive cost-sharing
programs such as Medicare. It appears then that the promises of welfare statism were to give way to restraint on government subsidy on services which signalled a shift away from collectivism and toward individualism (A New Perspective on the Health of Canadians, 1974). In the health sector this view was clearly reflected in Lalonde's Report, a federally commissioned report; this position on individualism which was being pushed federally were bound to affect the provinces. The Ontario government must have reflected on this.

The White Paper received incredible attention both in Canada and outside. For example, Illich's famous Medical Nemesis addresses it in the introduction (1975). Its implications were discussed by academics and governments alike.\textsuperscript{10} It was seen as an example of the new holistic view of health and illness which appeared to be promoted in Lalonde's report. But upon closer examination it was more likely to have been a reflection of the declining federal government support for change in the health care system. The Report was critical of the biological causes of illness as the sole focus of health care in the country and, instead, suggested that illness and, therefore, health care, involved other important components such as the environment, lifestyle and health care organisation.

One would have predicted that the views expressed in Lalonde's report would have signalled a battle to refocus the whole health care system. It was critical of the system's refusal to view health more widely and the continued insistence on placing preventative responsibility on the individual. But the conclusion to Lalonde's analysis was pessimistic, citing the huge health care expenditures as detrimental to the implementation of any change. The Report stated the desirability of community based health care but no federal funds for research and development were to be made available.

\textsuperscript{10}See Navarro, 1976; Ham, 1982 for example.
The rhetorical value of this document lay in its success at shifting responsibility for health care and illness prevention to the individual despite the admission of forces beyond individual's control at play in the health care game. The federal government, through this report, signalled its lack of commitment to anything but the status quo - a health care system that addresses symptoms only with curative care and individual prevention. It provided a popular and non-challenging alternative to change which, for the most part, has accomplished what it set out to do - maintain the status quo.

It was in this atmosphere, one of shifting responsibility away from the state and on to the individual, that a number of the provinces were attempting to deal with their provincial health care reforms. It was in this environment that the Ontario government put a freeze on CHC development.

Following the Ontario government's freeze on CHC development, the Ontario Council of Health, the senior advisory body to the health ministry, appointed Dr W.O. Spitzer of McMaster University Medical Centre to develop a methodology for evaluation. He was to assess alternative organisations in relation to “Normative Practice Units” with a view to reaching evidence that could be used to direct policy formulation in the development of future health care arrangements.

Evaluative studies had already been done in Ontario, reaching contradictory conclusions. The World Health Organisation’s study of the Sault Ste. Marie Health Centre (Hastings et al, 1973) found hospital utilisation by health centre patients to be 25 percent lower than those of a matched population under conventional care. A 1974 evaluation which focused on the quality of health care received under per capita funding arrangements in the St Mary’s Medical Clinic concluded there were only minor improvements in quality of the care patients received (Sibley, 1974). Two 1975 studies demonstrated that health centres reduced costs and increased efficiency due to the utilisation of nurse-practitioners. This reduced the use of expensive physician time in routine tasks which, subsequently, lead to the expansion of the practices (Ontario Council of Health, 1975;
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Batchelor et al, 1975). An update of Hasting and Mott’s World Health Organisation analysis of the Sault Ste. Marie Group Health Centre was funded under contract by the Ontario Ministry of Health in 1975 (see Badgley, 1979). This study compared Ontario’s two union-sponsored clinics with six unnamed fee-for-service group practices in northern and southern Ontario. Although the report noted fewer hospital admissions in the union-sponsored centres, the clinics were found to be “somewhat disappointing ... and the government would be justified in terminating its capitation contracts with the clinics ... as they had not achieved “...the utilisation patterns which their founders had anticipated” (quoted in Badgley, 1979, 365-370). The Special Projects Branch, responsible for the Sault Ste. Marie and Ste. Catharines’ clinics, was conducting its own evaluation which matched the union health centres with similar fee-for-service group practices in Oshawa and Brantford. The results, published in 1976, demonstrated that with regard to the volume, quality and costs of care for the two practice types, the Sault clinic saved about twenty percent in the utilisation of hospital days and costs, while the St. Catharines clinic, which was still new and struggling, was not financially viable.

There was obvious ambiguity of these finding but these studies lacked an agreed upon frame of reference or a set of evaluative tools and the primary focus was on costs. Measuring the costs was often done only in the very short term, using a narrow range of criteria. Quality and appropriateness of care, the accessibility of that care to the community, the benefits accrued from extra-medical services and activities, and the long term benefits to health that could only be measured over time were not taken into account. An attempt was made to address some of these issues. The report contained a number of indices that would theoretically allow evaluation of such things as utilisation of health services and financial performance, accessibility and quality of care. Although fine in theory, the construction of these indices was extraordinarily biased against alternative health facilities. The government received many complaints from community groups and health professionals over the extent to which the framework, if used, would discriminate against alternatives. By attempting to reduce “health” to a question of
costs, that could somehow be compared to simple fees-for-services, evaluations meant overlooking many of the less obvious benefits of alternative health arrangements. These benefits include the non-medical services provided such as nutritional counselling and health promotion programs, the benefits of diagnostic services and treatment being available in one facility, the absence of extra-billing and other charges for a number of patients in fee-for-service care, and the overall benefits to the health of the individual and the community of a holistic and preventive approach to health practised in many alternative health organisations.

Spitzer’s report did receive applause from the alternative health movement for its recommendation that at least fifty alternatives needed to be developed for effective evaluation. A “Primary Care Unit” was subsequently set up in the ministry to develop Spitzer’s recommendation but nothing concrete developed out of this. The Ministry of Health may have recognised the difficulties it would face in implementing Spitzer’s scheme. A decision still had to be made about the alternative health organisations already in existence. In June of 1976, the problem was passed on to the Program Development Branch but alternative health facilities would wait another three years before a concrete policy was determined.

Between 1976 and 1979 the Program Development Branch was developing a system whereby eligible alternatives would be paid a per capita rate equivalent to fee-for-service monthly patient rates, for all enrolled patients whose health insurance premiums were paid up without consideration of the community profile. This was met with protest from alternative health organisations as many health centres had patient populations that included a disproportionately large number of elderly, which are heavy users of health services. The ministry conceded and the capitation rates would be adjusted to take into account the age and sex profile of the clinic’s patients. However, there were no adjustments in recognition of the levels of illness in the population being served. This has remained a funding problem to the present, as health centres servicing the
communities which are economically disadvantaged do not get an adjustment for the greater health costs incurred (Association of Ontario Health Centres, 1985, 8).

It was not until the spring of 1979 that the Program Development Branch’s funding scheme was approved by the Ontario government, providing for capitation funding as described above. It also included a funding device to encourage clinics to be responsible for all primary care to enrolled members. This was called capitation-negation, and under this scheme the ministry would deduct from a clinic’s monthly payment the individual capitation rate for any patient who, in that month, used the services of duplicate practitioners outside the organisation. Although this was punitive enough to health centres, it was definitely an improvement over the system of charging back the full costs of services rendered outside the organisation. The funding arrangements also offered an incentive for decreased hospital use, called the Ambulatory Care Incentive Payment (ACIP). This program would pay to qualifying organisations a percentage of their hospital savings over the year. This has proved successful for healthier patient populations, but obviously, when the patient population is elderly, for example, and hospital care may therefore be more appropriate, it is much more difficult to qualify for the ACIP benefits.

According to the ministry’s calculations, only thirteen of the twenty-six alternatives that existed in Ontario would be viable under such a system (Program Development Branch, 1981, 24). These were officially called Health Service Organisations (HSOs) and only two of these (one being the Sault Ste. Marie CHC) were community-run alternatives. The rest were physician- or hospital-owned and operated. For these thirteen there was an assured, stable, committed funding base. For the other category, into which most CHCs fell, the assurance of future support rested on their ability to build sufficient rosters of patients (sufficient in size and stability) to be admitted into the program.

It was not until 1982 that community based health organisations received official word on their status when the Task Force to Review Primary Health Care (1982) released its
recommendations. Existing CHCs were guaranteed funding under the Community Health Centre program (completed in 1985) but the requirements for the establishment of new CHCs were so strict that they effectively closed the door on new developments. CHCs were seen as service centres for under-serviced rural and urban areas so any group requesting funding under the new funding scheme would have to demonstrate the need for services, determining that the need was not being met by conventional practices; a very difficult task for community groups. Submissions to the Ministry of Health by community groups affirm that all the administrative hurdles necessary to establish a new CHC make it virtually impossible to proceed. Carrying out an acceptable needs survey has precluded much in the way of further development.

The Ontario government has shown no interest in developing community sponsored health organisations. The PDIG established in the early 1970s to explore alternatives was short-lived. The state has tried to decide what to do with those health organisations that did develop out of the PDIG experiment. In contrast to the other provinces discussed, the Ontario government's position has always been that it did not intervene in the organisation of health services; it simply paid for services (Lomas, 1985, 112). The state has tried to maintain a free-market environment. CHC development was to serve areas the existing system was not interested in serving: rural communities and under-serviced urban populations. Ontario's policy reflects this attitude: no encouragement for the development of CHCs.

In February 1990 the Ministry of Health of Ontario employed 52 full-time equivalent general practitioners at CHCs. The physicians were employees of the CHC where they practise and the Ministry paid the Health Centre a global budget. How the budget is distributed within the Centre is determined by the individual CHC boards. But physician salaries are set by the Ministry based on the average general practitioners take-home pay

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11The following is based on information provided by the Ontario Ministry of Health through a telephone conversation with the Coordinator of the Community Health Centre Program, January, 1990.
($92,050 annually in 1990). The individual centres are free to add to the minimum salary set by the Ministry. Pension plans, annual leave, sick leave and other benefits are determined by each Community Health Centre. The Ontario government employee guidelines must be followed to set a minimum benefit package, otherwise the Centres can determine their own scheme. Physicians work a 35 hour week on average, with some on-call hours. Although one's work schedule is flexible, most Centres are open evenings and weekends.

Despite what appears to be an attractive employment package, the Ministry of Health has difficulty attracting general practitioners. According to the Coordinator of the CHC program within the Ontario Ministry of Health it is a continuous task to find physicians. Physicians who are employed appear content with their work environment (to judge from the low turnover rate).\(^{12}\) An earlier chapter suggested that doctors are trained to be entrepreneurs and not employees. So this is perhaps one difficulty in attracting GPs to this work setting. Another reason stems from the fact that the Ontario Medical Association frowns on state employment and discourages physicians from seeking employment in state-financed or community-run centres.

The medical societies and associations in Canada were generally, and still remain, opposed to alternative forms of primary health delivery, especially when controlled or regulated by the consumer or the state. To join a CHC meant becoming the salaried employee of a community board, setting a precedent that might mean loss of autonomy and control over the definition of health care as well as the health care process. Organized medicine discouraged doctors from joining CHCs and most of the clinics had to close because they were unable to attract physicians (Badgley and Wolfe, 1967). The medical society even placed a warning in the Canadian Medical Association Journal concerning the Sault Ste. Marie Community Health Centre in Ontario:

\(^{12}\)Although the Coordinator of the CHC Program within the Ministry claims there is a low turn-over rate, evidence cited later in this chapter suggests the opposite to be true.
The Sault Ste. Marie Medical Society has established an information service to advise doctors contemplating practice in the area on matters of local importance. The establishment of a consumer sponsored clinic in the "Soo" has given rise to certain misunderstandings within the profession, and newcomers, in their own interests, should investigate the situation before making commitments.

(December, 1963)

Qualified doctors employed by CHCs were refused or delayed hospital privileges and referrals were not made to or received from Health Centre doctors (Badgley and Wolfe, 1967, 103; Gruending, 1974, 8; Lomas, 1985, 73-74). Health Centre doctors were ignored, snubbed and often refused entrance into local medical societies. This lead to high turnover rates at some centres, as many doctors were unable to deal with the intense alienation from their colleagues (Lomas, 1985, 73; Griffith, 1974, 5).

Pressure from the medical association of Ontario had a number of repercussions for CHCs. The government supported the profession and made substantial changes to funding arrangements. For example, doctors in health centres were no longer salaried employees of the centres but independent partners on the board. The legislation "confirmed the view that doctors, not consumers, were the primary decision-makers in health care and thus helped legitimise doctors' demands for more control" (Lomas, 1985, 88).

A statement issued by the Special Committee on Group Practice (Canadian Medical Association, 1967, 34) captures the national medical feeling about groups other than physicians organising and directing health care:

It is the overall impression of the Special Committee on Group Practise, however, that everything else being equal, there appears to be no advantage to the public or the profession in outside sponsorship of groups. The profession, by accepting positions in such groups, are tending to put their destinies into the hands of others - while it would be undoubtedly in their greatest interest to establish their own group practices where at all possible. In conclusion, therefore, the committee would most strongly recommend against this type of arrangement.
A number of physicians heeded this suggestion and another alternative health care delivery system developed alongside the CHCs, Health Services Organisations (HSO).

**Health Services Organisations (HSO)**

The Project Development and Implementation Group (PDIG), set up in 1973 by the Ontario government to study the feasibility of alternative health care settings, set the following goals for the establishment of health facilities:

1. Continuity of care would be emphasised rather than high volumes of episodic care;
2. Care would have a basic health rather than disease orientation;
3. Economy and effectiveness would be achieved by use of the services of other health care professionals such as nurse practitioners and community workers in place of physician services where appropriate;
4. The resources of the public health system, already publicly financed, would be utilised; and
5. The resources of the social services system would be utilised by establishing cooperative managements.

(Program Development Branch, 1981, 6-7)

Under the guidelines imposed by the government, physician-sponsored health clinics could be established more easily than community-sponsored health organisations. Physician-sponsored groups already had fairly stable and well-developed clientele as well as existing physical resources. Most importantly, perhaps, HSOs were not as problematic to the Ontario government or the status quo in health care. They could be established with substantially less state involvement and cost. Negotiations with the Ministry of Health over capitation payments and the notification of patients regarding the changes in funding are the only formal government-HSO arrangements.

A Health Service Organisation (HSO) is a health care facility which provides clinical, diagnostic, therapeutic and preventative services to a roster of regular patients and to
transient patients and is paid (in the main) by capitation (Birch et al, 1990). Hence, on
the surface, the main differences between HSOs and CHCs are the payment scheme
(capitation versus global funding) and the community served (CHC have a defined
geographical or demographic community). But the differences between these health
care facilities, especially in terms of the physician responsibilities, are far reaching.

Although HSOs are funded by the Ontario Ministry of Health they are mainly physician-
sponsored and the money given by the Ministry is handled by the physicians who
sponsored the Organisation (not a Board of Directors).13 What this means is that the
physicians are not considered employees of the Ministry nor of the HSO where they
practise.

In March 1990 there were 76 HSOs in Ontario with 308 general practitioners as
members (not all full-time) and 70 specialists. The Ministry of Ontario spent $70 million
on HSOs in the 1989-1990 fiscal year but how the money was distributed is impossible
to determine. Doctors are not paid a salary but share in the profits of the HSO where
they practise. The more patients an Organisation attracts, the more money the Ministry
pays. The money is paid per patient/per month and does not depend on visits or medical
procedures performed. Because of the payment scheme, some have argued that there is
no incentive for a HSO to attract patients requiring long term regular care, or any
incentive for physicians to pursue in-depth medicals or refer to specialists. This problem
has lead to a number of evaluations of HSO performance by health economists as well as
the Ministry of Health.

Birch et al (1990) looked at a number of studies of HSO performances, notably those

13 Health Service Organisations can be university or community sponsored but in Ontario (in 1990), for
example, of the 76 HSOs, 5 were university sponsored and 4 were community sponsored; the remainder
were physician sponsored.
the clinical and economic performance of Ontario's Health Service Organisations. Most important for our discussions is that payment mechanisms can affect the cost and quality of health care, but the differences within modalities are as great or greater than the differences between modalities.

It appears that the government is searching out cost-saving health care alternatives but is unable to evaluate the plans it promotes. The Ontario Medical Association and the Ontario Ministry of Health are at odds when it comes to the delivery of health services. In lieu of the present situation with CHC and HSO alternatives, the government is now proposing a non-profit corporation option in health care delivery: the Comprehensive Health Organisations (CHO).

**Comprehensive Health Organisations (CHO)**

The Ministry of Health of Ontario is proposing yet another health care delivery system in the hope of cutting health care costs and improving access to medical care. Their new approach emphasises community-involvement, illness prevention and health promotion programs. The CHO alternative is in the pilot stage and the Ministry is optimistic that the program will satisfy all parties involved: the public, the physicians, the Ontario Medical Association and the Ontario state.

A Comprehensive Health Organisation (CHO) is a non-profit corporation which assumes responsibility for providing or purchasing the delivery of a full range of vertically integrated health and related services to a defined population. The CHO is formed from existing health delivery elements including physicians, hospitals, other provider groups and the community. Services are provided under the direction of a single unified administration responsible to a community board consisting of CHO members, key providers, community and other health representatives. Clearly-defined mechanisms for quality assurance and program measurement are combined with health promotion and illness prevention strategies. These activities support an emphasis on
achieving the highest degree of independent living for CHO members (Ontario Ministry of Health, 1990).

Criteria, guidelines and standards for several required components are being developed by the Ministry and include the following basic requirements necessary to establish a CHO:

1. administrative and financial expertise,
2. ability to provide primary and speciality response to both illness and injury,
3. a formal program of quality assurance, program measurement and evaluation,
4. commitment to programs of health promotion and illness prevention strategies,
5. willingness to develop alternative practice patterns using a wide variety of health professionals,
6. commitment to community participation both in governance and delivery of CHO services.

(Ontario Ministry of Health, 1990)

It is obvious that the cost-saving criteria will result from the use of ambulatory and community-based care rather than institutionalisation, as well as from substituting other health professionals, such as nurse practitioners, for physicians. As predicted, physicians and the Ontario Medical Association have been cautious in their response to this planned alternative.

CHO annual funding is based initially on the sum of the existing cost of providing all services for which the CHO will assume responsibility and liability. This total is divided by the CHO population to give a per-member payment (i.e., annual hospital plus physician plus other costs divided by the population to determine a per member payment). Subsequent annual increases will be based on a combination of inflation, demographic shifts, acuity changes, and program requirements in a formula to be developed by the Ministry.
The CHO will receive this combined funding as a single flow of dollars on a monthly basis based on the number of members. Funding will increase or decrease during the year as new members are added or as existing members leave. The organisation and funding of corporate divisions and its providers are the responsibility of the CHO and its corporate partners. The CHO will assume responsibility for the payment of services which it is unable to provide on its own but can purchase for its members. The CHO will be charged the cost of the service billed to the Ministry by a provider, for a self-directing member who seeks a service outside the CHO which could have been provided or purchased by the CHO (Ontario Ministry of Health, 1990).

What appears to be a complicated organisation and funding scheme is simply an innovation on the present HSOs. The fee-for-service format for private physicians and global budgets for hospitals froze health delivery and organisation style. The CHO is designed to restructure the organisation by introducing flexibility in payment methods and encouraging innovation. "The joint-partnership of the various delivery elements will have the capacity to decide how to best allocate the single-stream payment to best service the patients and the community in a quality driven, cost-effective manner" (Ontario Ministry of Health, 1990, 6).

According to the Ministry, doctors in a CHO area will not be required to join, but will have the right to join, or leave, a CHO. Their privileges at local hospitals would not be affected by their membership or lack of it.\textsuperscript{14} A CHO can be flexible in the funding of its physicians, maintaining a fee-for-service payment scheme or implementing sessional or salaried payment or any combination or other payment approach. It is hoped that the flexibility and incentives that this funding approach provides for the CHO will result in a shift of financial and human resources from the present emphasis on institutional care

\textsuperscript{14}According to one specialist presently completing a residency at Kingston General Hospital, the Ontario government has threatened to refuse billing numbers to doctors who do not join a CHO. Understandably, the doctor wishes to remain anonymous and the Ministry has no comment. The issue would be worth exploring once the Ministry has established operating CHOs in various locations.
a greater focus on community-based response to the needs of patients/members. Since
CHO costs are based on existing costs for an identified population the Ontario
government is initially putting out the same amount of money. But future flexibility to
shift costs to more appropriate and less costly care is hoped to generate savings.

It is interesting to note that the Ministry is targeting northern and rural areas as places to
receive special consideration for the initial development of CHO projects. Reflecting on
the Community Health Centre alternative discussed earlier reminds us that they were
focused on these same areas. These are areas where Ontario physicians, especially
specialists, are reluctant to locate their practices. The government offers little incentive
to encourage doctors to move to remote areas. Perhaps the suggested threat of refusing
billing numbers to new doctors will be the tool the Ministry can use as an "incentive".

It appears that the public can only benefit from this program. Members will be able to
have access to a wide range of community and medical services in modern facilities with
extended hours. They will have a say in how their CHO is run through representation
on the CHO board and committees. A grievance procedure is also expected to preserve
patients' rights. Membership at a CHO is voluntary and members can seek outside
medical care even if they belong to a particular CHO. There are no enrolment or
membership fees. Membership is automatic when one elects to receive care at a
particular CHO. Ontario residents are guaranteed the right to see the physician of their
choice. The CHO is required to pay for outside services received by a member (Ontario

There are some concerns on the part of the public. What prevents a CHO from signing
up healthy, low risk members only? The Ministry feels this is not likely to be a problem
"because of the large size of CHOs and the wide cross-section of the population they
will embrace" (1990, 14). But it appears difficult for anyone to monitor or regulate
membership, making this a viable concern. And what prevents a CHO from giving
favoured treatment to members over non-members? Again the Ministry states that "all
insured services must be available on the basis of medical need to members and non-members alike" (1990, 14). But what kind of checks in the system could ensure that this is the case?

This new scheme has not yet been tested to its fullest. The Ontario Medical Association has said it is willing to assist doctors wishing to become involved in CHO development. It does not appear they will encourage physicians to move to this new practice setting nor promote this alternative enthusiastically. It is left to time to see what develops.

The Success of the CHC in Canada

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

In the western provinces, CHCs are no longer paid any attention by governments, as the New Democrats in those provinces were replaced by conservative governments. In British Columbia, a change back to the Social Credit government in 1975 could have brought the termination of the program, as the Socreds had soundly criticised the program while the N.D.P. was in power. Political pressure exerted on the new
government to maintain the program, however, prompted the B.C. government to set up an evaluation team to study its economic viability. This team, made up of representatives of the B.C. Medical Association, various government representatives from the health and human resources ministries, and a University of British Columbia Commerce professor surprisingly made a favourable judgement on the CHCs, noting decreases of 20 to 25 percent in hospital utilisation for areas containing CHCs. Lower costs per capita of provincial spending were also noted, prompting a recommendation that the program be expanded in B.C. However, CHCs have not been expanded; four continue to exist as established, but aberrant, components of the conventional health care system.

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

In the case of Quebec, the reality of reform has not matched up to the rather grandiose plans for complete reorganisation of the health sector (Lesemann, 1984; Renaud, 1981). Although changes have been brought about in other aspects of Quebec's health care system, the CLSC, envisioned as the vehicle that would transform primary care and become the basis of a new primary care system, has been relegated to a very secondary role. CLSCs have become primary care centres for the poor and for rural areas unserved by the mainstream health care system. Community participation, seen initially as the cornerstone of effective reform, has been abandoned in practice, in favour of
government control and centralisation of decision-making power. The state quickly learned that community control of health centres meant diversification, as community groups focussed on very different aspects of health care organisation and delivery. Furthermore, community control often meant vocal left-wing radicalism - an embarrassing position for the state to be in, considering it was financially responsible for these health organisations. The Quebec government moved to take control of the CLSCs in 1974 and 1975, drastically reducing the role of the community, standardising programs, and deciding priorities for further development (Renaud, 1981).

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

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

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

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

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

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The above summary of the success of the CHC alternative might lead one to conclude that the CHC concept is not a workable one - that it has not deserved place in the health sector in Canada. Indeed, CHCs have been given a very secondary role in the health care system, assigned only the responsibility for taking care of those the conventional system does not want to serve. Yet it is clear that CHCs have, and continue to, provide valuable and necessary functions. In the studies that have been done on cost effectiveness, they have shown lower hospitalisation rates for their patients, although it is difficult to assess whether this is a result of the care given in CHCs or the type of self-selecting populations they may serve\textsuperscript{15}. They are in the forefront of health promotion, offering many programs stressing lifestyle changes, nutrition, and the like, very much in line with the “new perspective” on individual responsibility for health. And finally, to a lesser degree, they have been active in pointing out the economic, social, and environmental causes of illness, stressing occupational health, pollution concerns, and housing issues.

Community health centres have had an impact, however limited, on the organisation of primary health care. In Saskatchewan in the 1930’s, in Sault Ste. Marie in the 1960s, and in Quebec in the 1970s, the threat of consumer organisations has prompted change in the medical profession. The conventional primary care system has been forced to respond to the new approaches of the alternative health organisations. It has done so in two ways, one, by bullying, threatening, and legislating against the emerging movement, 

\textsuperscript{15} As statistics on health at the individual level is not accessible it is difficult to determine whether lower hospitalisation rates result from care received from CHCs or reflect a self-selected clientele inherently more interested in health promotion.
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and two, by directly competing with it and offering more accessible and responsive care in the medical marketplace. In this sense, although CHCs have not been quantitatively successful, they have to a small degree influenced the quality and accessibility of the conventional medical system.

Discussion

Coming back to the case of Ontario, the evidence demonstrates that HSOs have been a much more successful health care alternative, more successful than CHCs. We have also seen the majority of HSOs are physician-sponsored, operated and run. They are also supported by the Ontario Medical Association as is the CHO concept. The same cannot be said of CHCs. This leads us to explore the depth of the state’s lack of support for the CHC movement. We have seen no more supportive evidence that HSOs are more cost-efficient than fee-for-service practice than the evidence that exists for CHCs. So the Ontario government’s decisions have not been based on economic rationalist arguments alone.

The only province that has been relatively successful with the CHC alternative is Quebec and this is the only province where the medical profession was not united in its opposition. We are reminded there was an active cohort of GPs trained under the social medicine philosophy who supported the CHC concept. Chapter 2 highlights the importance of unity within the profession in the professionalisation process. The previous chapter demonstrated how the orthodox medical community united to exclude non-regular practitioners and then proceeded with their own agenda of dominating health care in Canada. If membership of the medical associations is used as a measure of unity and support, as suggested by Taylor (1978) and Naylor (1986), we can see there
was not a united medical stance against CHCs in Quebec. Provincial medical association membership in Quebec is at an all-time low, declining gradually over the last twenty years. Only 40 percent of Quebec physicians are members of the Quebec Medical Association. This is far lower than any other province, including the other provinces where CHCs were experimented with. Despite this the physician run polyclinics have grown at a faster rate than the community sponsor CLSCs. This leads us to delve further into the profession’s rejection of CHCs, giving us a greater understanding of the relationship between government policy making and medicine’s influence.

As noted earlier, the medical profession objected to CHCs on many different levels. They felt that the funding arrangements and location of clinics meant that doctors would lose their opportunity to choose their own clientele. This was seen as restricting their rights as physicians as they would be remunerated on a capitation basis. This means they would have to treat whoever requests to see a physician as opposed to being paid a fee for the number of patients seen and the types of treatment required. This is seen as impinging on medicine’s economic and technical autonomy (Williams, 1987, 17). All provincial governments have tried to deal with the poor distribution of medical services in their province by proposing numerous schemes to move physicians from over-serviced urban centres to under-serviced rural communities. Some of these have been supported by the medical community. The CMA’s 1993 survey of physicians revealed that 66 percent of respondents support reducing the number of foreign trained graduates

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16 1996 provincial medical association membership figures: Nfld/LAB:100%, PEI:100%, NS:100%, NB:100%, ONT:80%, MAN:100%, SASK:75%, ALTA:80%, BC:68%*, NWT:80%, YUKON:95%. Interestingly 5 provinces/territories see membership as a condition of practice (those with 100 percent membership). *91% of all practising doctors in BC.
who can practise in Canada. Fifty-four percent agreed with reducing medical school enrolments into both general practice and specialties. The belief expressed amongst physicians here is that controlling the number of practising physicians will reduce over-servicing in busy, popular centres. But it ignores the problem of under-servicing in other areas. Only 27 percent support government threats to restrict billing numbers as a way of redistributing the physician population. This suggests that the medical profession will not support policy that sees the government control who practises where. CHCs were seen to dictate this.

Although the circumstances surrounding the introduction of Medicare tend to be the focus of the deprofessionalisation of medicine in Canada arguments, we must remember this is not the only significant encounter between these two powerful groups. What this chapter emphasises is that the two decades of failed CHC experimentation is also significant. Taylor (1978) points out the implementation of the national health insurance scheme by all the provinces lead to a “Medicare Pact”: if physicians join the Medicare scheme, the government would not interfere with either the profession or the practice of medicine. Government support and funding of CHCs was seen to break this pact. This was not what the profession had anticipated from the government and the government was certainly reluctant to push on this issue despite public pressure.

Physicians were also reluctant to accept public scrutiny of the medical definitions of health and disease; definitions which ignore social issues like poverty and types of

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17 There are a number of significant events that could be included in this study. See Coburn, 1983, 1988, 1993, for examples of others. This study had to be limited so focuses on comparing the outcomes of these two significant movements as it was deemed a good way of gaining more understanding of the deprofessionalisation thesis and its relevance to the medical profession in Canada.
employment (Rachlis, 1989). Comparing the 1993 PMQ results with York University’s 1982 survey of physicians shows a decline in physician support for training in the social and environmental aspects of disease from 61 percent approving of increased training in 1982 compared to 49 percent in 1993 (CMA, Sept. 1994). Bolaria (1988, 540) argues that the focus on a “mechanistic - individualistic conception of disease... is pervasive in medical practice and research, absolving economic and political systems from the responsibility for diseases, and denying its social foundations”. This view of health and disease is learned in medical school, which socialises physicians to view it in these terms.

This type of medical education runs counter to the CHC concept that views health and health care more widely and socially. So, in Quebec, when the Sherbrooke Medical School was educating its students in the social-environmental aspects of health, the reception to CHCs was warmer. And in Ontario, for example, where the socio-environmental bases of disease were not adopted throughout medical training, graduating physicians are less likely to adopt this philosophy and accept employment in practice settings that do encompass it. The three physicians interviewed from CHCs in Ontario shared their views on the centres’ philosophy on health, the patients’ role, effects of environment, lifestyle and so on. All agreed that this was not a large or important part of the medical school curriculum where they had trained, but it was a big part of the CHC where they worked. Two of the respondents had worked as junior

18 All three had trained at different medical schools in Ontario. None trained at McMaster University but all mentioned that it was an important part of medical training there and that they would have expected more graduates from McMaster to be employed in CHCs. It is important to note that this was the physicians’ view of the medical program at McMaster’s University. Other researchers have noted that the perceived “physico-social” orientation of McMaster’s medical education program is, simply, a myth.
partners in fee-for-service practices previously and noted the differences between the two environments in this regard. As one respondent noted:

in the other practice [fee-for-service] the stats we took on new patients, dealt with previous ailments, family history of disease and stuff like that. Here we look at these as well as living conditions, place of employment, kind of job, family life....

They all agreed that most of the socialising they received in socio-environmental health issues came once they were employed at the CHC. They were aware of the issues beforehand but their significance was not as clear as it was at the CHC.

We need to look more closely at the medical education system and its effect on the physician attitudes toward state involvement in health care delivery generally. Blishen (1967, 1991), Shapiro (1978) and others point out that doctors’ attitudes are developed through formal medical education. N. and J. Parry (1976, 59) emphasise the importance of education, particularly its manipulation, as the source of the profession’s control of the market. This is typically accomplished by selective recruitment into the profession. Chapter 2 demonstrated this important professionalisation strategy used by the elite medical doctors in Canada, accomplished by moving medical education to university training where curriculums and, therefore, practices become regulated. Of course, medical schools are less able to recruit students of their choice as the government has intervened in the selection criteria which has seen more women and members of disadvantaged or ethnic groups entering medical schools. But as Hall (1946, 1949) Hughes (1971), Freidson (1970) and Blishen (1967, 1991) have argued, the professional
socialisation process is such that medical schools, despite selective recruitment, still socialise students into the kind of practitioners the profession wants.²¹

Ann Daniel, examining the professional socialisation process, notes that values about intellectual excellence, teamwork, self-discipline and long hours of study and practice as well as an arrogance toward subordinate workers are an integral part of professional training (1990, 42). She cites Anderson and Western’s (1968, 1972) longitudinal study of professions as support for her arguments and further observes “these effects are reinforced throughout the professional’s working life” (p 42). This process solidifies the relations amongst students and continues as they become colleagues.

Blishen (1991, 85-86) argues that since the medical students’ role models (their teachers) stress values of independence and autonomy in medical practice, then graduating students adopt these values as well. Novice physicians, thereby, “filter their perceptions of the prevailing socioeconomic conditions of practice through this ideology”. The medical education system still promotes a disease-based, curative medical model combined with a business-centred solo-practice orientation. This means graduating physicians have difficulty working in teams, especially when the team consists of non-medical personnel who define health and health care in a much broader sense. The structure of CHCs runs counter to the physicians’ attitudes and values gained through their training.

²¹ This may be why separate medical faculties, such as those at McMaster University in Ontario and Sherbrooke in Quebec, develop to attract a different type of doctor rather than broadening the curriculum in all medical schools.
Related to the source of rejection of CHCs explained above is the perceived threat of other health occupations to medicine’s dominant position in the delivery of health care services. Again, this can come from occupational groups which share a different health philosophy - a more socio-environmental focus (such as naturopaths). But it still comes about when the related occupations share the same view on health and disease. We are reminded that the government health care reports were recommending expansion of the role of allied health workers in health care generally and in CHCs particularly. The Boudreau Commission (1971), for example, saw the role of nurses in health care expanded. Studies of existing CHCs in Ontario concluded that use of nurse practitioners for initial consultation with patients at centres was an effective cost-efficient approach to health care (Ontario Council of Health, 1975; Batchelor et al, 1975). Medicine’s aversion to competition for “medical services” from numerous health occupations has been documented. Coburn (1993) looks at the changing role of nursing and chiropractic in Ontario, examining the medical profession’s attempts to thwart their professionalisation and expansion. The PMQ 1993 survey of physicians reveals that doctors do not support the training of nurse-practitioners nor midwives. When asked to rank areas to be given priority for health care funding from the government budget, training of nurse practitioners was ranked ninth out of twelve possibilities. Non-medical obstetrical care was ranked eleventh. These ranked behind such things as primary medical care, hospitals and chronic care facilities and medical research and development. HSO and CHCs were ranked tenth (CMA, Sept, 1994). These figures compare with York University’s 1982 results which saw nurse practitioner training ranked last (10th), and HSOs/CHCs ranked ninth (midwifery was not included in the survey) (CMA, Sept, 1994).
Challenges to physician dominance of the medical knowledge have always existed and continue to date. As demonstrated in Chapter 5, doctors were successful in excluding competition from their knowledge base and practice skills.\(^{20}\) As Chrichton et al (1990, 59) demonstrate, most of the allied health professions are directly controlled by doctors in the guidance of their work. Physiotherapists, for example, cannot prescribe without physician permission and supervision. And midwives who practise in hospitals must do under the *general supervision* of a physician. The medical profession has expressed the doctrine that physicians are the leaders in a health care team:

...physicians recognise the importance and independence of nursing care, but under the overall supervision of a doctor because nurses can only describe .... physicians evaluate.... physicians are the leader of the team. The essential contribution of other health care team is recognised but the principle of physician leadership is emphasised.

(CMA, 1986).

Understanding this means we can see the lack of attraction of the CHC philosophy. When I interviewed the CHC doctors about the leadership aspect and how it operated in the clinics where they worked they were mixed opinions. One doctor argued that each of the “health care sections really operated independently. I fulfil my responsibilities with patients and the centre and other employees do their bit”. He did not see it as a team effort but worked independently as he felt the others (like the nutritionist and psychologist) did as well. Another physician at another clinic saw his responsibilities to his “own patients” (not clinic patients) and wasn’t sure how the other health workers handled their responsibilities. The only female CHC physician interviewed did feel that

\(^{20}\) Some occupations have gained ground in the competition, see Coburn, 1993 for discussion on midwifery, nursing and chiropractic in Ontario.
the “Centre’s health team” worked as a team, discussing patients with each other, trying to reach the best therapy for individuals. But she also commented that the team “almost always” deferred to her opinion and although happy to comment, insisted she, as the doctor, lead the discussion and, ultimately, make the decision.21

As noted earlier, there were questions raised by medical authorities about the value of lay persons on the boards of CHCs. We have seen that lay representation on government health commissions gave very different outcomes to the overall recommendations of those commissions (see Committee on Healing Acts [Ontario, 1970], White Paper on Health Policy [Manitoba, 1972]). So the medical profession was aware of the kinds of proposals that were coming from lay members. The kind of arrogance toward subordinate workers Daniel (1990) argues, physicians acquire as part of their training could also be said about lay members of the boards of CHCs.

The idea that lay boards undermining medical decision-making was raised as a concern by the profession during discussions and negotiations with the health ministry over alternative health delivery systems (Lomas, 1985). As argued in Chapter 2, the medical profession believes its scientific knowledge base cannot be grasped by the lay community and this is reflected in physicians’ frustrations over patients’ behaviours and requests. The PMQ 1993 physician survey reveals that physicians believe patients are demanding more information on diagnosis and treatment than is reasonably required”, and they are “simply shopping around for advice on treatment” (CMA, 1994). This

21 One has to question whether the team approach to health care was better received by the female physician because of the nature of the clinic or because she was a female. There was insufficient evidence to draw conclusions.
reflects the greater issue that Haug (1975, 1988) raises in her deprofessionalisation of medicine arguments.

Haug argues that experiential professional knowledge and academic training in domains of professional expertise are now more widely disseminated through books, magazines, TV and so on. Computer storage and retrieval of academic knowledge means that knowledge need no longer be "packed into the professional's head", or in a specialised library where it is relatively inaccessible. It is now available not only to those that know, but to those who know how to get it (1988, 51). She demonstrates the increased patient questioning of physicians and demands to be included in the diagnostic and treatment decision-making processes (1988, 52-53). This erosion in the trust in physician opinion stems from the increased awareness and knowledge (p 51). Perhaps in recognition of the perceived threats to their knowledge monopoly Canadian doctors are extremely active in continuing medical education. Chapter 5 highlights the percentage of time physicians, no matter what their employment setting, spend in functions of labour and capital. As was mentioned, but not discussed, was that the remainder of physicians' time is spent in continuing medical education (CME) as measured through classroom instruction, listening to tapes, viewing videos, reading, conference attendance, and workshops and courses. The PMQ surveys since 1982 demonstrate an increased amount of time spent in CME by Canadian physicians (figures compared from 1982, 1986 and 1990 census). Doctors are taking steps to maintain and upgrade their medical knowledge and practice techniques which should, in effect, protect their knowledge
effect, protect their knowledge from the increasingly aware public. \(^{22}\) We will also recall that Haug was reluctant in her 1988 paper to draw any conclusion on her 1975 predictions that increasing lay education levels would erode the professional knowledge monopoly, deferring to more time before drawing any conclusion.

Despite Haug’s deprofessionalisation arguments, Hastings and Vayda (1986, 347) point out that even though federal and provincial reports were recommending increased community and consumer participation in policy formulation and decision-making in the health care system, there have been relatively slow changes in lay membership on advisory bodies, hospital boards, public health and voluntary agency boards. Even in Quebec where lay membership is mandated, many have noted the relatively weak position of consumer members compared to health professionals and bureaucrats (See Begin et al, 1978; Godbout, 1981 and Hastings, 1984, for examples). Perhaps physicians face more threat from consumer-based self-help and advocacy groups or voluntary organisations which focus on patients with particular diseases than they do from consumer participation in decision-making bodies (Hastings & Vayda, 1986, 347; Kelleher, 1994).

My own membership on Ottawa’s Centretown CHC board as a community representative as well as my discussions with the current Boards of Directors of this centre and one other demonstrates the primary role physicians play in the decision-making apparatus of the centres. Meetings were not held unless the staff doctors could

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\(^{22}\) GPs, who perhaps would have faced the greatest threat under Haug’s assertions, must now be certified as Family Practitioners (as of 1994) so that all new graduate, non-specialist physicians are required to obtain this certification which requires more education and training.
attend and the items on the agenda were ranked according to physician preference. As one board member remarked, “we couldn’t run the Centre without the physicians and they and us are very aware of that”.

Although the medical profession has expressed resentment at lay boards undermining medical decision-making, this in fact, has not been the case. Government and third parties (for example consumer groups and lay boards) attempt to control the non-clinical aspects of medicine in the “best interest of the public” (Blishen, 1991, 144). There has been a decline in public support of medicine, leaving doctors in a difficult situation when it comes to justifying their position in the health care arena. It appears the profession’s success in deterring the growth and popularity of the CHC philosophy stems from its ability to continue to protect the clinical aspects of their work - the disease-based, curative medical model which requires physician diagnosis and treatment (or supervision of treatment) (Chrichton, 1990). Medicine’s status has been eroded as public opinion polls have demonstrated (see Reid, 1986, for example). However doctors still command a great deal of power based on the possession of knowledge that the majority of Canadian society still considers valid. Their rejection of CHCs was couched in terms of this. The profession was not convinced there was any cost saving through the CHC concept. And, as we will recall, cost saving was what the government was focusing on in provinces such as Ontario. The numerous evaluations of CHCs reached conflicting conclusions about the cost saving benefits. This combined with medicine’s reluctance to embrace the CHC concept which, in effect, ran counter to their training and their knowledge base, led to the failure of the movement.

Why were the outcomes of the CHC movement and the Medicare movement so different? And what do the outcomes of each of these movements tell us about the
deprofessionalisation of medicine in Canada? Pluralist and elitist, as well as Marxist theories of the state are some of the many conceptual tools that help us understand the nature of the health care system in Canada and the roles of the actors in health care policy decisions; these are discussed in Chapter 8.
A number of explanations have been put forward in an attempt to explain the nature of the health care system. One body of theory directs us to the major actors in the health care arena - those who control it and those who challenge - as instrumental in understanding and maintaining the nature of the system. Pluralist and elitist theories operate along this premise. Another body of theory, neo-marxist thought, goes beyond the nature of the health care system alone and looks to the nature of capitalist society generally as a means of explaining the nature of the health care system. These sets of tools will be used here to help us to understand the Canadian health care system - how it operates, who the powerful actors are and how decisions are made. This in turn will allow us to draw conclusions on whether the depriorisation of medicine arguments are valid in the context of the Canadian health care system.

Pluralist and Elitist Theories Of Health Care

Health and social scientists have examined the pervasive and entrenched health system in western societies through the motives of the actors, the interest groups or ‘elites’ who make or influence health care policy. This body of theory is particularly useful in understanding some of the aspects of the CHC movement especially those that led to its failure in Canada.

In examining health policy, the simple pluralist would identify interest groups which basically have equal access to a neutral decision-making apparatus of the state. Each of these groups has the opportunity to influence policy in their best interests (see Anderson, 1972, for example). This approach may help provide an explanation of the policy-making process, but ultimately it is too simplistic to take us any further. A more sophisticated variant of the pluralist approach, elitist theory, takes us beyond the process
itself to the complexities of the health care system, through an analysis of the discrepancies in the power and influence of the interest groups.

Elitist theories of the state recognise that certain groups in society exercise more power than others in influencing the state, often to the extent of dominating the relevant sectors. One adaptation of the elitist model, put forward, most profoundly, by Ivan Illich (1975, 1976) sees the real power elite in the health sector as the technocratic and bureaucratic medical establishment. Illich argues that industrialisation has changed western society such that health care, as well as most areas of life, is increasingly removed from the hands of the people and placed in the hands of a technocratic elite which possesses the skills and knowledge needed to operate medical bureaucracies. Medical bureaucrats control and manipulate medical resources and ideology. The medical bureaucracy has perpetuated its power by creating an addiction to medical and technological care. The channels of government influence are not always necessary to establish or operate the system. Illich argues that the medical bureaucracy creates over-medicalisation leading to iatrogenic (doctor-caused) disease and medicine dependency rather than self-care, self-reliance and less bureaucratised forms of health care.

Using this variant of the elitist model, the failure of preventative and/or community based health care can be seen to result from the increasing power of medical elites or dominant structural interest groups. The dominant medical establishment relies on the continued emphasis on medical and technological diagnosis and care to maintain the status quo.

Robert Alford (1975), in his analysis of the American health care system, examines the “structural interests” in society which are involved in policy making and identifies three major structural interest groups. Dominant interest groups seek to maintain their acquired position of dominance, challenging interest groups attempt to reorganise social structures in hopes of attaining dominance while repressed interest groups seek to change the system as well but their interests are typically deemed unimportant by policy
makers due to the disorganised and weak nature of their group and/or concerns. Therefore, repressed interest groups need to develop strategies which see their interests adopted by more powerful groups.

Applying his analysis to New York health centres, Alford identifies the dominant structural interest group as “professional monopolists”, the medical profession and hospital administrators, who seek to retain their dominant position in the health care arena. Alford argues that maintenance of their dominance is not difficult if we consider they are a politically strong and professionally well-organized group. The challenging structural interest group Alford identifies as “bureaucratic rationalisers”, health bureaucrats who seek to dominate what they describe as an irrational and illogical health care system under the control of the medical profession. Their attempts, through cries of crises in health care, seek to alter the system in their favour. Repressed structural interests, on the other hand, are represented by social movement activists advocating consumer control and equality of access to health and health care through significant changes in the system.

Alford argues there is a constant battle in the health care arena between the dominant and challenging interests who seek to maintain or attain control. Neither group fights for a change in the structure of the system. Clearly, the dominant group wants to maintain the status quo while the challengers seek to modify the existing system to make it more rational, less costly, or more competitive and, in the process, gain control over the “medical establishment”.

The repressed interest groups, who have limited resources, power and political influence have very little opportunity to dictate policy in health care. So unlike the pluralist theories, Alford recognises the unequal power, access and influence on policy decisions of the groups involved. However, occasionally changes are brought about to the benefit of repressed structural interests, often through the encouragement and support of those in power. As Piven and Cloward argue:
Ordinarily...elites do not support efforts to form organisations of lower class people. But when insurgency wells up, apparently uncontrollably, elites respond...to cultivate those lower-class organisations which begin to emerge in such periods, for they have little to fear from organisations which have come to depend on them for support. Thus, however unwittingly, leaders and organisers of the lower classes act in the end to facilitate the efforts of elites... these organisations usually fade, no longer useful to those who provided the resources necessary to their survival.

(1977, xii)

Alford demonstrated that attempts to implement community-based health centres in New York met with outright failure or extremely limited success. Projects aimed at establishing Neighbourhood Health Centres failed as the social movement was co-opted by more powerful structural interests which were able to influence development in their best interests (Alford, 1975, Chpt. 6).

Alford’s Elitist Theory And Health Care In Canada

Applying Alford’s theory on health care politics to the two movements in health care in Canada, the Medicare and CHC movements, we are able to identify some inadequacies in the theory, but, more importantly some differences between the movements. We are reminded that Alford was particularly concerned with barriers to health care reform and in neither of these cases was reforming the system universally accepted.

As we saw in Chapter 6, Medicare in Canada grew out of the labour and western agrarian campaigns which protested against a health care system which made individuals responsible for medical costs either directly or through one of the existing private insurance plans. These groups voiced their concerns and desire for some kind of insurance against illness even before the economic depression of the 1930s (Torrance, 1981, 22-23). Employers in many remote areas of Canada set up their own health plans and/or facilities in an effort to attract labourers (Lomas, 1985, 16-18; Swartz, 1977, 316). In Saskatchewan, as early as 1914, municipalities pooled their resources through taxation, to ensure access to medical care. We are also reminded that many provinces
contemplated the idea of health insurance especially where labour unrest was high (Robin, 1972; 1973; Swartz, 1977, 316).

As discontent grew numerous militant strikes emerged and the federal government initiated action (Granatstein, 1975, 276), with most political parties in the 1945 federal election endorsing the ideal of health insurance. Using Alford’s approach it is clear that the medical profession represented the *dominant* structural interest in this movement, the federal government represented the *challenging* structural interests, and the workers represented the *repressed* structural interests. Alford makes clear the enormous amount of political and organisation energy required by the repressed interests to offset the huge disadvantage they begin at (1975, 211).

We have seen that the dominant group, the medical profession, did not oppose health insurance for the economically disadvantaged and actively supported subsidies for this group. The profession was encouraging the state to take an active role on behalf of the repressed interest group. But in the end, the repressed interests were aligned with the challengers (the state) in challenging the profession. The alignment between these two parties stems from the fact that the state was not interested in providing health insurance for select groups or select treatments and the repressed interests sought to have all treatment insured for themselves. The medical profession sought to protect its position by insuring or billing, on a fee-for-service basis, those who could afford to pay while acknowledging the role the state should play in addressing the needs of the economically disadvantaged.

While Alford’s theory helps us to understand who the interested parties are and the complexities of changing the system, it falls short in explaining why the state (challenging structural interests) looked to change the health care system to the extent it did. Why wouldn’t the federal government restrict its insurance scheme to those groups who expressed discontent with costs and access? Although the difficulties with Alford’s theory become obvious upon application to the health insurance movement in Canada, it
highlights for us the complexities of trying to implement change and the nature of role of the groups involved. His theory is more applicable to the CHC movement.

The early health centre movement in Canada was part of a more general movement demanding increased access to health care (the same movement the Medicare program grew out of). The same groups of workers were demanding health care in remote and medically underserviced areas. Occupational groups, competing with medicine, as well as middle class social activists gave a bigger voice to the demands of the underprivileged. Politically and organisationally repressed interest groups tried to solicit the support of the medical profession and the state. Although some branches of the health authorities in some provinces were supportive of the CHC initiative, the medical profession was not.¹

The repressed interests and challenging interests tended to be at odds with regards to both motive and strategy. Generally, the states were concerned with cost-cutting delivery alternatives so were not prepared to move forward unless there were clear indications that CHCs were going to reduce health care costs. The repressed structural interests lay with access, type of care and a change in medical philosophy from a curative emphasis to a preventative one which recognises socio-environmental factors.

So we could argue that the lack of unity in motive and strategy served to undermine the movement, giving the dominant interests more opportunity to attack. As the greatest threat to the dominant group comes from the challenging interests, the profession attacked the cost-cutting claims of the state. In the wake of this, the interests of the repressed groups got left behind.

As Alford (1975, 204) notes, challenging structural interests defend their position and mount their challenge on the claim of “rational, efficient, cost-conscious, coordinated

¹ Except for a minority group of GPS in Quebec, see Chapter 7.
health care delivery”. In order to prove CHCs accomplished this, numerous evaluations of centres were conducted, reaching contradictory conclusions. This highlights one of the principal differences between the two movements. The CHC movement was tried on the basis of clinical aspects of medical care, the area the medical profession can protect and defend most ably. The Medicare movement challenged the political power of medicine and, as the results indicate, this is where the profession can best be challenged.2

Alford’s theory also highlights the complexities of the health care system and the interest groups involved. The Medicare movement involved more actors, especially at the state level. Although health insurance schemes were being discussed provincially the federal government initiated the debates. They had to convince (or in some case coerce) all provinces to support the scheme and this was accomplished using a number of strategies. With the obvious support of the public and eventual agreement from the provinces, the state had a very strong base from which to challenge the profession. It becomes clear that state unity is as important as professional unity in bringing about change. There is an abundance of literature examining the importance of professional solidarity in maintaining dominance but little has been written about the power of unity within the state.

Professional associations are dependent on a sense of solidarity amongst all members of the profession, not just members of the association. This solidarity begins with shared education and training, continues and is strengthened by mutual work experience and the necessity for referrals and respect (Becker et al, 1961; Merton et al, 1957). Professional associations command practitioner allegiance to the profession and, in return, represent the professionals’ interests. When there are struggles between the association and

2 As demonstrated in Chapters 4 and 5, the profession continues to protect the clinical aspects of its work no matter what setting they are employed in. Challenges on this level have been strongly met and resisted. Physicians are united in their defence of their knowledge base and clinical skills as demonstrated.
outside interests, like the state, the solidarity of the practitioner group is “critically important if the profession is to maintain its dominance over contending interests and constraints” (Daniel, 1990, 63).

As the state expands, it becomes more complex, decentralised and competitive. This means it is more difficult to get a united view from this bureaucratic giant. We saw in Chapter 7 that there were differing views within the Ontario Ministry of Health, for example, with regard to the implementation of the CHC alternative. Ultimately, this fragmentation led to mixed evaluations of CHCs, evaluations that, ultimately, have to assess the clinical aspects of medical care.

Although there are weaknesses in Alford’s approach to gaining understanding of the success and failure of health care movements in Canada, it, like all elitist theories, is a valuable tool for highlighting the complexities leading us to a better understanding of the developments in the Canadian health care system and the professional status of medicine in Canada.

Neo-marxist theories of the state and health care argue that the pluralist and elite approaches to understanding health are inadequate as they do not explore how and why health care policy is made extensively enough. Neo-marxists argue that these theories ignore the bigger picture in the society and do not have much value in helping us understand the nature of health care policy beyond community health.

**Neo-Marxist Theories Of Health Care**

Another tool which helps us to grasp the nature of the medical dominance debate is the work of neo-marxist theorists such as Navarro (1976, 1978), Doy et al (1979) and Renaud (1976, 1981). Their analyses of the health care system in western societies looks to the economic base of society and the accompanying structures such as the political system, the judiciary and the welfare system. They define the state as a
capitalist state, which is not neutral, and acknowledge economic classes as important in shaping society.

This study will draw primarily on the work of Navarro (1976a; 1976b; 1986) to exemplify this theoretical perspective. Navarro condemns the pluralist and elitist approach for its lack of consideration of class struggle and the role the state plays in maintaining the relations of productions that exist under capitalism. He examined the health care system in Britain and the United States, including an analysis of the functions of the state and its inescapable tendency toward fiscal crisis, and the implications of this. His understanding is drawn on the work of O’Connor (1973) and Miliband (1970), bringing it into the realm of the health care sector.

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

According to Navarro (1976b, 452-453), the state must attempt to address this fiscal “imbalance”, and does so through a number of mechanisms. Initially, it attempts to cut the social costs of accumulation and legitimation by decreasing social programs and by instituting cutbacks in spending. In effect, the least productive of the state’s social costs are targeted for cutbacks - welfare services, programs for the elderly, health care programs, and day care - which must make sacrifices so that the “economy can be put back on its feet”, an aim synonymous with the desire to boost capital accumulation. Numerous strategies are used to legitimate these cutbacks. In the health care field, for
example, an ideology of individualism is put forward in order to shift the blame for illness and the responsibility for health to the individual. Accepting this ideology means individuals accept the costs for their own individual health care.

Secondly, the state increasingly centralises its bureaucratic apparatuses and institutes a system of regionalisation - regional councils, for example, over which a centralized body is responsible. This regionalisation is important in that it bypasses local levels of government thereby providing a buffer zone between the centralized authority and the different components of the system.

Thirdly, the state calls for a rationalisation of the system in order to decrease unnecessary waste and pare down the costs of administering and providing social programs. In the health sector, this rationalisation includes utilisation of cheaper forms of health care delivery, as well as less expensive medical personnel, both of which lead to reduction of costs. It may also involve cutting back the wages of health workers.

According to Navarro, these are the mechanisms employed by the state in the face of increasing fiscal crises. However, within the capitalist state there are contradictions which strictly limit the alternatives and the strategies which can be employed successfully. State spending in the health sector serves two often contradictory functions. First, it serves a direct *accumulation* function; the state provides for the capitalist class the "...infrastructure of production, i.e., the development of those goods and services that are the preconditions for the working of the capitalist system" (1976b, 443). This includes, among other things, programs to maintain a healthy labour force. This type of economic consideration underlays the creation of Canada's Medicare program, for example. So, despite pressures to cut back on social programs, it is in the direct interest of capital for the state to maintain spending on social programs which assists in the maintenance of a healthy labour force.

In addition to this, the class nature of the medical sector and of society itself serves to hinder state attempts at implementing change in order to rationalise the system.
“...[R]eforms must take place within the set of class relations prevalent in capitalist societies” (Navarro, 1976b, 448). Reforms in the health sector cannot challenge the basic free-market ideology underlying capitalism.³ For the medical profession, and for wider capitalist interests, class relations cannot be drastically disturbed without the state appearing interventionist. Furthermore, Navarro points out that, not only is professional dominance in the medical sector based on class location, but the existence of other economic interests in the present health care sector follow class locations. Since corporate capital has invaded all spheres of the economy and private life, including medicine, there has developed an increasingly profitable health industry, based on the commodification of medical care. Its profitability in the U.S., for example, is evidenced by the fact that stock in the health sector is a highly remunerative item. According to Wohl (1985), it is one of the surest ways to realise profits; the demand for medical care is endless in capitalist society.

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

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

³ By free market I mean a situation where the state has intervened by way of funding health care but seeks to maintain a situation where medical entrepreneurs decide the content of medical care and the way it is delivered.
consumerism exacerbates the problem, creating more illness through the marketing of unsafe and harmful products. Furthermore, the ravages to the physical environment caused by industrialised development are major contributors to the level of illness. According to Navarro, the large majority of illness is collectively caused by capitalist development, while an ideology of individualism is perpetuated by medicine in order to conceal the true nature of health and illness (1978, 91-93).

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

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

...medicine is indeed socially useful to the degree that the majority of people believe and accept the proposition that what are actually politically caused conditions can be individually solved by medical intervention.

(Navarro, 1976b, 447)

A prevalent response to this contradictory dilemma faced by capitalist state caught in a fiscal crisis is the perpetuation and support of individual alternatives to health care. Because individuals have been blamed for creating their own illness, individuals are urged to modify their behaviour and maintain their own health.
As we have seen, the aim of capitalist medicine is to reduce a collective phenomenon to an individual one. In this respect ... the present self-care strategies, far from conflicting with the ideology so long as they remain at the level of individual responses. (my emphasis)

(Navarro, 1976b, 448)

**Navarro’s Neo-marxist Theory and Health Care in Canada**

Navarro’s theory recognises that there will be significant change in the health care system unless it is “preceded by a broader realignment of society itself” (Badgley & Wolfe, 1992, 221). Monique Begin, a former Canadian Minister of Health, argues that the key actors in the health care field are the provincial governments, the medical associations and the federal government. Any of these players, according to Begin, can block the operation of the system, change the rules or the nature of the game. None, she argues, is above or below the others, they all have equal power (1984, 188). But, as we have seen, as the health field has grown the state has had to expand, become more complex, decentralised and competitive. The same can be said of the medical profession. So although the three key actors have remained the same, the complexities of the actors has grown as have the rules of the game.

Navarro would not support Begin’s view; the players in the health field are not equal in power, according to Navarro. He argues that, “contrary to widely held belief, it is not the medical profession that dominates medicine, it is the bourgeoisie” (1986, 243). The medical profession is the administrator of medicine and serves two functions in society: it contributes to the care and cure of health and disease, and is the control function over the working class and popular masses (1986, 242). Then how would Navarro explain the success of the Medicare movement which was not endorsed, promoted or supported by the medical profession?
Walters (1982), using Navarro’s neo-marxist perspective, argues that the implementation of Medicare in Canada rose from a combination of government fears of the potential actions of an increasingly powerful and radical labor movement, demands from capitalists who supported legislation that removed expensive fringe benefits, such as healthy workers, from their domain and the role states play in capitalist societies, a role that assists capital accumulation and legitimises contradictions that develop in capitalist societies.

Both federal and provincial governments stood to gain by discussing and implementing a health insurance scheme that covered all Canadians, not just those who can afford it. They stood to gain political capital by introducing legislation that minimised the costs of reproducing labour power, under the guise of “the general interest of the nation”. By addressing the health care needs of all Canadians the state not only gained a healthier workforce but secured political capital. As was highlighted in Chapter 6, the health status of the population became a central concern to governments as reports (such as Canada’s Sickness Survey) revealed the unacceptably low levels of health and fitness.

The government also had reasons to be concerned about anti-capitalist sentiments that were being pushed by the CCF party. Taylor (1978, 35) documents the concern of Health Minister Ian MacKenzie who argued in a letter to the Prime Minister (August 1943) that the Canadian public was dissatisfied with the government of the day over the lack of social security measures.

Navarro argues that the state, which also serves two functions, is caught between two contradictory demands - the demands for accumulation from the capitalist class and demands for a healthy workforce necessary for accumulation. This, combined with the ability to accumulate political capital, lead the state to proceed with their Medicare scheme. Why were the decisions surrounding Medicare so different from those surrounding CHCs?
As documented in Chapter 7, once Medicare was established in Canada health care costs increased. The extent to which they have increased are continually debated between “spiralling out of control” to “small relative to the proportion of taxes spent on health care in other countries”. The debate has lead to a perception that there is a fiscal crisis in the health care which the state must address.

So the public perception that medical services are “free” under the Medicare system, means the demand for services grows. Under this system, fee-for service remuneration flourishes as physicians can prescribe more and more medical services in order to meet the demand that they, in effect, help to create. This, in turn, increases doctors’ incomes. As Evans (1984) and Barer and Evans (1986) demonstrate this is exactly what occurred in the years following the implementation of Medicare. We also saw that government views on the relationship between Medicare and health care costs differ from the views of the medical profession. The costs of social programs have escalated significantly as have demands for social programming.

Canada’s health care system has come under increasing fiscal pressures (Barer and Evans 1986, 79). Transfers of federal revenue to assist health care programs provincially was substantially reduced through the creation of the Established Programming and Financing Act (1977). This Act allowed the federal government to gain greater control health service costs, establish equity between rich and poor provinces and allow provincial governments more flexibility in dealing with their own health care concerns. It is in this context that governments have attempted to control health care costs and one of the strategies to do this was alternative health delivery systems such as CHCs.

Again the governments are caught between their two functions - maintaining political capital by maintaining the principles of Medicare and facilitating capital accumulation in a declining economy. The capital accumulation function is gained through the maintenance of a free-market environment, ensuring the state the general support of the
capitalist class. The critical factor in the state’s intervention into the free-market health field beyond funding was the economic imperative, gaining control over health care costs and maintaining the "health" of the capitalist economy.

We are also reminded that the neo-Marxist approach sees medical care as dominated by a particular understanding of health and illness, an understanding rooted in the class base of the capitalist mode of production. The failure of alternative health organisations should not, therefore, be seen only as a product of the unequal power of interest groups but as a result of the capitalist state’s lack of interest in anything other than the curative medical model. To embrace an alternative conceptual understanding of health and illness would mean undermining the dominant position of capitalism and the capitalist state. Stressing social and economic factors as important aspects of health, as opposed to individual and organic ones, would expose the state to another crisis, one that would involve addressing these socio-environmental influences.

**Conclusion**

Two important health care movements were analysed in this study in order to come to a better understanding of the relevance of the deprofessionalisation of Canadian medicine arguments. Both of these were opposed by the medical profession. The Medicare movement was successfully implemented but took fifty years from its inception to reality, due, in no small part, to medicine’s reluctance to endorse it. The CHC movement was thwarted almost before it got started and certainly before it had the opportunity to demonstrate its benefits. Again, the medical profession was instrumental in deterring its success.

The elitist and neo-Marxist theories of the state offer important insights into the outcomes of these movements, the nature of the Canadian health care system and the debates over the status of the medical profession in Canada. The elitist approach, a micro-level analysis looks primarily at individual and group level actions and outcomes.
Chapter 8

The Marxist analysis of health is a macro-level approach which minimises the importance of individuals and interest groups and focuses on class issues and the overall nature of the state.

The Medicare movement, unlike the CHC one, focused on non-clinical aspects of medicine. Attacking the clinical aspect of medicine and medical delivery would not only be met with severe opposition from the profession but it’s an aspect of the health care system that is most difficult to access and assess. We saw the difficulties encountered in attempts to evaluate cost efficiencies at CHCs. As we have seen in Chapters 4 and 5, the Canadian medical profession continues to successfully protect the technical, clinical aspects of their labour no matter what setting they are employed in. So the success of CHCs needed to be proven before they would be accepted and endorsed whereas the success of Medicare was explicit in the scheme itself.

The Medicare movement was very much a political campaign, unlike the CHC crusade. The governments stood to gain extensively by implementing a health insurance scheme for all Canadians. They stood to secure political capital while gaining a healthier work force. The CHC movement was much less political as the governments could foresee fewer gains from implementing a health care alternative which addressed a minority of the population. There were fewer provincial governments that even initiated CHCs and there was far less federal pressure than there had been in the lead up to Medicare.

There was more public support and interest in Medicare despite its grass roots beginnings which mirrored the beginnings of the CHC campaign. Medicare was seen to affect all classes of people and every citizen would gain from a universal health insurance scheme. The CHCs were targeted at remote areas and lower-class urban areas.

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4 Badgley & Wolfe (1992) successfully demonstrate that twenty-five years on this had not been the case. The greatest beneficiaries have certainly been the middle class.
communities whose interests tended to be represented by a small group of radical middle-class social workers or labour unions.

The profession’s attack on CHCs was personalised and directed at individual doctors who embraced the CHC philosophy. The penalties were high for these physicians, too high for many physicians to cross the line. Opposition to the federal government’s health insurance scheme was not directed at physicians in support as there was a united stance, presented by the profession, against the Medicare movement.

The unity of the profession’s stance against Medicare is important to understand. The arguments presented in this thesis suggest that this unity should have served to thwart the Medicare campaign while the lack of unity amongst physicians in their views on CHCs should have made them a more viable alternative. But we will recall that during the campaign to promote and implement the health insurance scheme, the federal government solicited (bribed or coerced) all of the provinces’ support. So the united stance of the state appears to be more powerful than that of the profession in bringing about change in the health care field. As the state and the medical profession become more complex and specialised we have to question whether there will be unity amongst the actors.

The profession’s early strategy of infiltrating the state (see Chapter 6) to ensure its interests are properly represented becomes more and more difficult. As the state expands it becomes more competitive and impossible to have adequate representation of all interested parties. As the medical profession becomes more disjointed it becomes more difficult for the profession to put forward one stance or even ensure that the profession’s dominant view is well represented. Physician infiltration of the state will be insufficient as there will be no guarantees that these physicians share one view.

As Daniel (1990, 63) reminds us, the solidarity amongst medical practitioners is essential in the maintenance of power, authority and autonomy. Professional associations are dependent on a sense of community which begins with shared training and continues
with mutual work experience, the necessity for teamwork, referrals and respect. The association commands practitioner allegiance in return for representation and protection of members’ interests. Solidarity is essential if organized medicine is to maintain its dominance over contending interests and constraints.

So even though the elite medical association memberships are high (see Chapter 7) in all provinces but Quebec, Coburn (1993, 845) argues that there are “vicious internal struggles over control of the provincial and federal medical associations between various political factions within the profession,” leading to the development of sub-groups. With this in mind, we need to seriously question whether the Canadian medical profession will be able to continue to protect its powerful representation in the state as it has protected the clinical aspects of its work.

As the power elite theorists have empirically shown, different organs of the state are heavily influenced and often dominated by specific power groups (see Olsen, 1977, Clement, 1983, 1990, for examples). But with the state equally or more fragmented than the profession the battles between these two players will become more complex. The outcomes of these battles will be less predictable with the profession perhaps losing as many as it wins if it does not develop new strategies to contend with the challenges on all levels. The continuing separation of the profession into sub-groups demonstrates the tension which leads to a lack of unity amongst doctors and, therefore, increasing deprofessionalisation.
CHAPTER 9

CONCLUSION

The debates over the status of the medical profession typically follow three paths: medical dominance, deprofessionalisation or proletarianisation, the latter two focus on challenges or threats to medicine’s dominance of the health care system. Freidson (1970, 1985, 1994), Willis (1988), Illich (1976) and Arney (1982) argue that the medical profession maintains a dominant position in both practice and in organisation. Other, such as McKinlay and Arches (1985) and McKinlay and Stoekle (1988), argue that physicians are being reduced to a proletarian position in society, resulting from bureaucratisation which logically grows out of capitalist expansion. Still others (Haug, 1973, 1988; Light and Levine, 1988; and Hunter, 1994) claim that the medical profession is losing its monopoly over knowledge, public acceptance of the service ethic and authority over clients, all part of the deprofessionalisation process.

Despite definitional biases in many of the arguments, which, in part contribute to this debate, many of the theoretical positions lack empirical evidence. This study sought to overcome some of the drawbacks of the status of medicine arguments through an examination of the historic process which determined the relationship between the medical profession in Canada and the Canadian state. Policy analysis, with a focus on the key players, helped to understand the role of the state and the profession, both historically and contemporarily. Bureaucratic threat to medicine’s control over the nature of its practice arrangements are addressed through empirical examination of professional work settings, generally, and Canadian physicians employment settings, specifically. Through these processes we gain a greater understanding of the status of the medical profession in Canada today.

There have been a number of studies on the status of the medical profession in Canada, reaching varying conclusions. The problems of conceptual and definitional clarity run throughout the studies. Little evidence is offered in support of arguments which suggest
that the employment of physicians in bureaucratic settings compromises professionalism. It becomes clear that the debate operates on, at least, two separate levels: the level of the individual practitioners and the level of the profession. The proletarianisation arguments tend to focus on the former, deprofessionalisation claims, on the latter. Those who support the medical dominance thesis, must defend their position on both levels.

Chapters 4 and 5 of this study focused on the individual level arguments: the proletarianisation of professions position. The literature on professional employment in bureaucratic settings is explored initially. Upon examination of the structures of numerous types of professional organisations it become clear that the bureaucratic-professional conflict, assumed in bureaucratic organisations, is not inherent in professional employment settings. As a matter of fact, the human organisation literature suggests professionals meld their personal/professional goals with those of their employer, leading to a mutual partnership (Spangler, 1986; Guy, 1985). Derber et al (1990) conclude that professionals have maintained, or even enhanced, their traditional authority through the creation of partnerships with their employers, which sees them enjoying greater power and freedom than other employees.

The dynamics of professional bureaucracies has changed over time as more and more professionals seek employment in organisations and as more and more employers seek professional employees. These organisations differ in structure, in organisation, in administration and in orientation. The literature suggests that the nature of professional knowledge is what helps protect professionals from typical bureaucratic management styles (Spangler, 1986; Freidson and Rhea, 1963; Child and Faulk, 1982 and Walters, 1989). The indeterminate nature of professional knowledge help defend employees against evaluation, protecting their autonomy by preventing technical means of standardisation and routinisation.
In order to pursue the proletarianisation thesis further, an examination of the workplaces of Canadian physicians was undertaken (Chapter 5). This helps us move from the more general evidence about salaried professionals to the specific evidence on Canadian physicians. Insight is gained through an empirical investigation of the work activities of physicians in a range of employment settings including solo practice, group practice, hospitals, clinics, government and private companies. The evidence is drawn from a series of census of Canadian physicians done by the Canadian Medical Association. A historical dimension was added, when appropriate, using evidence drawn from Judek’s 1962 survey of doctors (See Chapter 3).

The proletarianisation of medicine position argues that bureaucracy compromises professionalism and undermines the powerful position of medicine through a process that reduces the autonomy of physicians and the object of their labour, revealed through lack of professional involvement in the decision-making apparatuses of employing organisations. While the human organisation literature suggests this is not the case, we cannot draw conclusions about Canadian medicine from the general findings of Chapter 4 alone.

In order to argue that Canadian doctors are experiencing the proletarianisation process, we need to see evidence that they are spending more time in direct patient care (including on-call hours) and less time acting in a managerial capacity, making decisions or involved in the decision-making process, as well as supervising subordinates. This would indicate a decline in the professionals’ control over their own labour and the labour of others. Conversely, in order to argue physicians have maintained their dominant position in the workplace, we would need to see evidence of control over their own work, use of their skills and expertise (measured through patient care) and involvement in managerial decisions and supervision of subordinates.

Chapter 5 combines physician questionnaire results with interview data, suggesting that salaried physician employment in bureaucratic settings does not compromise
professionalism. Using the solo fee-for-service doctor, the epitome of medical practice in Canada, as the focal comparative group, every other practice arrangement sees physicians spend less time performing functions of labour. For every type of practice arrangement, except fee-for-service group practices of two physicians, we find doctors spending a greater amount of time in functions of capital than the focus group.

Salaried GPs, overall, spend more time in capital-intensive activities than fee-for-service GPs and approximately twelve percent less time in labour-related activities than their fee-for-service counterparts. Doctors commented on the benefits of employment in facilities where their income is fixed. Enticed by paid leave (sick and annual), a pension plan organised by their employers and decent working hours with less on-call time, physicians are not seeing patient after patient without any control or authority. (See Table 5.16)

Even hospital-based GPs, whether salaried or fee-for-service, find themselves performing their duties autonomously, while actively participating in the hospitals’ decision-making structures. It appears hospitals continue to function through a system of collegial and bureaucratic control - a system doctors have become dependent on. The bureaucratic structure of committee networks tend to be monopolised by physicians acting in the role of hospital administrator (Blishen, 1991). Chapter 4 suggested that these are not, necessarily, conflicting roles and physician administrators develop strategies which give doctors the freedom to control their own domain. Hospital-employed physicians spend less time in functions of labour than any other practitioner group with the exception of salaried physicians employed in groups of three to five doctors. (See table 5.16)

 Chapters 4 and 5 draw fairly emphatic conclusions about the weaknesses of the proletarianisation of the professions arguments in accounting for the activities of Canadian physicians in their work settings. Both employee professionals and the management in physician workplaces develop strategies that combine productivity with
autonomy and control. The ability of professionals to maintain their dominance in the workplace is carried further in order to gain understanding of how the profession deals with its challenges in the wider society - challenges from the state, the public and other interest groups. This is accomplished through an examination of the processes which saw the profession gain its powerful position and how it rises to the threats it faces.

As was noted in Chapter 2, Willis (1988, 1989, 1993) argues that we need to understand medical dominance on three levels. The individual professionals’ autonomy in the workplace was dealt with in Chapter 4 and 5, consumed under the proletarianisation thesis. Autonomy and sovereignty issues are captured through an examination of the relationship between the Canadian state and the medical profession in order to test the relevance of the deprofessionalisation arguments. Chapters 6 and 7 gave us an understanding of the ways the medical profession gained the status it did and how it handles its challenges, also an important aspect of the professionalisation process.

The deprofessionalisation of the medical profession was pursued primarily through analyses of the legislative developments (both federal and provincial) surrounding the introduction of Canada’s national health insurance scheme (Medicare) and the experimentation with Community Health Centres (CHCs). A comparative analysis of these two movements proved a valuable method for gaining insight into the nature of the relationship between the medical profession and the state. As the outcomes of these movements were different, despite similar beginnings, we dissect the developments, noting the important strategies used by the key players.

Although the principal source was the official legislation and the official views presented to government inquiries into health matters, the unofficial views of the many interest groups were also included using social accounts, newspaper articles and physicians’ views as gained through physician questionnaires conducted in 1982 and 1993 (see Chapter 3). The Canadian Medical Association’s Physician Resource Databank was used to determine the role of continuing medical education in the protection of the
medical knowledge monopoly, an issue highlighted by Haug’s (1975, 1988) deprofessionalisation position.

Taylor (1978, 379) argues that the lead up to the introduction of Medicare in Canada was a “thirty year drama”, characterised by serious political decisions, complex administrative arrangements with new revenue resources to be found. It was put in place in every province despite the often emphatic rejection by provincial medical societies, the CMA and the majority of physicians. But it took over fifty years from inception to reality. Chapter 6 highlights the key events leading up to its implementation with a particular emphasis on the medical profession’s role in this process. But, in order to understand the profession’s position on national health insurance, we need to understand medicine’s professionalisation process.

The early period of the profession’s history - the organisational period - saw the elite medical community unite orthodox practitioners (those who adopted symptomatic treatment) into a homogeneous community, while excluding the non-orthodox. Once united, the orthodox group lobbied to convince the state of its “expert” position in hopes of being granted status over “other” practitioners. This difficult struggle was accomplished by soliciting the state and the public to accept the orthodox practitioner community’s reliance on scientific knowledge. This served as the base from which organised medicine argued its position to legislate against non-orthodox practitioners.

The building of professional status came about through the regulation of practitioners, which saw the profession focus on licensing and registration of medical practitioners. University-based education was the mechanism by which this was accomplished. By the 1920s all legislation relevant to the licensing of physicians was in place (Hamovy, 1984, xx, 1); organised medicine had its dominant position in the health care field firmly established. Challenges to this dominant position were met by the profession with strategies that included maintaining its knowledge monopoly with convincing arguments over the value of its scientific base, a homogeneous practitioner community gained
through the unity of orthodox practitioners and the exclusion of others, and the infiltration of the state apparatuses concerned with health. Chapter 6 sought to determine if all, or any, of these components were compromised during negotiations over Medicare, arguably the first major challenge to medicine’s dominance over health.

As was discussed in Chapter 2, Marie Haug (1975, 1988) argues that as the general public becomes better educated, access to medical knowledge less restrictive and knowledge and practise skill more widely disseminated, doctors can no longer claim a knowledge monopoly. But the early period of the development of the profession and during the negotiation stage when Medicare was high on the agenda, this was not the case. As a matter of fact, we have seen that, even today, it is difficult to make this claim, especially since mandatory continuing education for physicians in Canada has been put in place. The negotiations over implementing Medicare did not see the state challenge medicine’s knowledge monopoly. The state challenged medicine’s claimed knowledge of the best ways of ensuring the health of all Canadians.

The homogeneity aspect of professionalism has been heavily scrutinised particularly during the 1970s and 1980s when the state intervened into the recruitment policies of professional schools. This lead to higher enrolments of women and members of different ethnic groups and lower socio-economic backgrounds in higher education generally, including medical schools. During the period when national health insurance was under heavy negotiation, the medical community make-up had not distinctively changed with regard to gender composition, ethnic and socio-economic representation.

What became clear from the analysis of the situation surrounding negotiations over Medicare implementation in the province of Quebec was that the medical community in this province did not present a united stand on the national health insurance scheme. This was an extremely controversial period and while other provinces struggled with difficult adjustments, Quebec’s was perhaps the most complex and conflict-ridden (Taylor, 1978). The General Practitioners (GPs) in Quebec supported the federal
governments’ plans while the Specialist’s Federation bitterly opposed them. This division within the profession, combined with Quebec government’s reluctance to agree to the federal governments’ plan to dominate health matters in the province, complicated by the FLQ crisis, lead the federal government to move on its initiative without medicine’s support.

Chapter 6 demonstrates the difficulties the medical profession has with state involvement in health care matters. Since establishing its dominant position over health, the issue of national health insurance was, perhaps, the first serious negotiation the profession had faced. The state would obviously have had plenty of negotiating experience while medicine was, perhaps, more novice at the game. The profession’s earlier strategy of state infiltration did not work to its advantage, as it had in the period leading up to its dominance.

Coburn (1988, 105) argues that the implementation of Medicare lead to a decrease in the power of the Canadian medical profession. But examining this event alone is insufficient to draw conclusions about a reduction in medical power and, if reduced, the permanence of this position. What is clear is that individual practitioners benefited financially from this new system. Incomes increased rapidly, once physicians were assured all their services were paid for (Barer and Evans, 1986). So, while the rise in incomes would appease practitioners, the profession itself had to recover from this battle, re-evaluate its strategies in order to protect itself from future threats to its powerful position. These strategies were put in place during negotiations over the experimentation with Community Health Centres.

The circumstances surrounding the introduction of Medicare tend to be the focus of the depprofessionalisation of medicine in Canada arguments, even though this is not the only significant encounter between state and the profession. Chapter 7 emphasises that the twenty years of failed CHC experimentation is also significant. The CHC movement grew out of the labour and western agrarian campaigns, the same groups who
Chapter 9 is not shown in the image.
When we examine the central tenet of the CHC movement - community participation - it appears unattainable. As the real enthusiasm for community involvement came from the middle class reformers (only marginally supported by the community at large), it often became more symbolic than real. The Community Health Centre became simply another place to go for health care.

The only province to demonstrate any success with the CHC alternative was Quebec, the only province where the medical profession was not united in its opposition. An active cohort of GPs, trained under a social medicine philosophy, supported the CHC concept. This leads us to conclude that change appears to be more easily made in the health care field when there is lack of unity within the medical community. Quebec has a lower medical association membership than any other province (40%); it is also the province that has most radically challenged conventional health care.

Taylor (1978) points out that provincial acceptance of the federal government’s health insurance scheme lead to a “Medicare Pact.” If physicians joined the Medicare scheme, the government would not interfere with either the profession or the practice of medicine. Government support and funding of CHCs was seen, by the profession, as breaking this pact. The government was, therefore, reluctant to push the CHC concept under this agreement. Perhaps the reluctant acceptance of the Medicare scheme has, in effect, given the medical profession some form of reassurance that their position in the health care system would not be threatened further.

Physicians are also reluctant to accept public scrutiny of the dominant medical definitions of health and disease, definitions which ignore social issues (Rachlis, 1989). There has been decreasing physician support for training in the social and environmental aspects of disease (61% in 1982; 49% in 1993) (CMAJ, Sept, 1994). As mentioned earlier this has not been a significant part of their professional training and socialisation. So the medical education system certainly contributed to physician attitudes which condemned the CHC alternative before it even had a chance. The medical education
system and its effects on physician attitudes toward state involvement in health care generally, demonstrates the importance and resilience of a united medical stance.

The professional socialisation process is such that medical schools, despite restrictions or selective recruitment, socialise students into the kind of doctor the profession wants (Hall, 1946, 1949; Hughes, 1971; Freidson, 1970; Blishen, 1967, 1991). Ann Daniel (1990, 42) notes that values about intellectual superiority, teamwork (amongst physicians), self discipline and an arrogance towards subordinates are important aspects of the medical training process. All of these attitudes would contribute not only to the failure of the CHC movement, but to the profession’s attitude toward other health related occupations.

Medicine’s aversion to competition for “medical services” from a number of occupations has been well documented (See Coburn, 1993; CMA, 1994, for examples). Crichton et al (1990, 59) argues that most of the allied health professions continue to be controlled by doctors in the guidance of their work. The medical profession sees physicians as the leaders in a health care team (CMAJ, 1986). This would, again, contribute to the reluctance of physicians to accept CHCs and the underlying philosophy.

Daniel’s (1990) comments about physician attitudes to subordinates can be extended to include lay community representation on the Boards of CHCs. Lomas (1985) points out that the idea that lay boards undermine medical decision-making was raised as a concern by the profession during discussions with state health officials about alternative health delivery systems. As argued in Chapter 2 the medical profession believes its knowledge base cannot be grasped by the lay community, whether as lay member of CHCs or as patients. We have seen Haug (1975, 1988) challenge this notion but even she was reluctant to draw any conclusions about the effect of increasing lay education and accessibility to medical knowledge on the medical knowledge monopoly. Evidence from the 1982, 1986 and 1990 CMA’s PMQ suggests physicians are taking steps to insure
they continue to upgrade their knowledge and skills, making modern medical knowledge and skill unattainable to non-physicians.

The outcomes of the CHC movement and Medicare campaign were so different, leading us to explore more fully the nature of the health care system. Two tools which aided in this endeavour were the Elitist and Neo-marxist theories of health care. The elitist approach, a micro-level analysis, primarily looks at individual or group level actions and outcomes. The marxist analysis of health is a macro-level approach which minimises the importance of individuals and groups, instead focusing on class issues and the overall nature of the state.

There were important differences between the two movement under study here. The Medicare movement was a political campaign initiated from below and adopted by the Canadian government. The governments, both federal and provincial, gained enormous political support through the implementation of a health insurance scheme that covered all Canadian residents, not just those who could afford it. The governments stood to gain political capital while ensuring a healthy, productive workforce.

The CHC movement attacked clinical and technical aspects of medical services and medical ideology. Not only is this the aspect of medicine that the profession is most likely to severely oppose, but its also the most difficult for the state and other interest groups to access and assess. There were tremendous difficulties encountered when attempts were made to evaluate CHCs, for example. The Canadian medical profession has been successfully able to protect the technical and clinical aspects of their labour as we saw upon examination of the proletarianisation of medicine arguments in Chapters 4 and 5. So the success of CHCs (which was measured on many different levels) had to be demonstrated before they would be accepted and endorsed, yet, their success was, fundamentally, based on long term measures; the success of Medicare was inherent in the insurance scheme itself.
There was certainly more public support and interest in the government’s national health insurance plan despite the same grass roots beginnings of the CHC campaign. Medicare was seen to affect all Canadians, with everyone benefiting, whereas CHCs were aimed at a certain class of people whose interests were represented (or misrepresented) by middle class social workers.

The medical profession’s attack on the federal health insurance scheme was united in presentation whereas the opposition to CHCs was manifested in direct attacks on individual physicians who adopted the CHC philosophy or directly at the clinics themselves, especially in Quebec. All arguments presented in this study suggest that the unity of the profession’s stance on Medicare should have been too great to allow the scheme to continue. But we recall the state’s tactic - solicit, bribe or coerce all of the provincial governments. This combined stance of the state appears to be a more powerful strategy than unity within the profession in challenging the dominant position of medicine in the health care field. But as the state and the profession become more complex, expansive, departmentalised and specialised, will the issue of unity amongst the key players be a possibility any longer?

Medical association memberships are high in all provinces except Quebec (see Chapter 7), but this may be camouflaging the true nature of physicians’ sense of solidarity. As Coburn (1993, 845) points out, there are “vicious internal struggles over control of the provincial and federal medical associations between various political factions within the profession.” This has, in effect, led to the establishment of sub-groups of physicians united in their opposition to the dominant medical society. So, although we will continue to see medical representation on government inquiries into health and health care, representation will no longer bring assurances of the elite medical society’s views. We need to question whether the profession will be able to continue to protect even the clinical/technical aspects of medicine under these circumstances, although the political grievances between the factions or subgroups of the medical profession do not appear, at this stage, to include this aspect of medicine.
Then we have the issue of at least, if not more, subgroups of opposition within the health branches of the state. The power elite theories of the state have empirically demonstrated that certain organs of the state are dominated by specific power groups (Clement, 1983, 1990, for example). With the continued fragmentation of the state, which of the power groups will dominate, becomes very complex and unpredictable.

Although it appears that the Canadian medical profession has become depprofessionalised as a result of losing the battle over Medicare, its position may have been only temporarily challenged, not irrevocably eroded. The profession’s success at thwarting the CHC movement certainly indicates its continued powerful position in the health care field. It is insufficient to look solely at the implications of the implementation of Medicare on the profession, as this was but one battle. The strategies of all interested parties’ have changed and been adapted, as they do as the political and economic climate change. But the strength of medicine in Canada can be seen in its continued protection of the clinical and technical aspects of its work - defying the proletarianisation challenges associated with capitalist development in Canada. The profession’s opposition to the government’s national health insurance scheme grew out of fears that a state funded and administrated health insurance plan would transform the health care system, making physicians civil servants to the state. Acceptance grew out of the recognition of the benefits for Canadian residents and its inevitability. So physicians reluctantly accepted the terms and conditions of Medicare, while assuring their clinical/technical autonomy remained intact. We have seen there are a number of ways by which the practitioners have accomplished this. Two of the more important are, firstly, through continuing medical education which secures the physicians’ level of expertise over the rest of the community and, secondly, through the creation of stable practice forms - institutional and collective - seen through the growth of group practices.

In order for the state to gain control over physicians’ labour in their work settings, it will need to open the indeterminacy component of the medical knowledge base. It is
certainly the case that since Medicare was brought into being the state has played a more active role in the health field, but, perhaps, more importantly it has contributed to sustaining medicine's power. The state has guaranteed the profession a dominant position within the health division of labour through the licensing legislation and also assuring that they are paid for their services. These types of guarantees help keep the profession in a very powerful position.


Advisory Committee on Health Insurance Canada, 1943 *Health Insurance*, Printer, Ottawa.


Auer, L. 1987 Canadian Hospital Costs and Productivity, Study prepared for the Economic Council of Canada. Minister of Supply and Services, Canada.


Ball, N. 1972 Some Thoughts on the Community in Community Health Centres, study commissioned by the Community Health Centre Project, Ottawa.


Batchelor, G.M., et al. 1975 The Burlington Randomized Controlled Trial of the Nurse Practitioner, McMaster University Faculty of Health Sciences, Hamilton.

Battle, K., & Torjman, S. 1993 Federal Social Programs: setting the record straight, Caledon Institute of Social Policy, Spring.


Bell, N. 1972 Some Thoughts on the Community in Community Health Centres. Paper commissioned by the Community Health Centre Project, Ottawa.


Bigelow, W. 1969 *Forceps, Fin and Feather*, Altona, Manitoba


Blishen, B. 1991 *Doctors in Canada*, University of Toronto Press, Toronto.

Blishen, B. 1969 *Doctors and Doctrines: the ideology of medical care in Canada*, University of Toronto Press, Toronto.

Boan, J.A. 1964 *Group Practice*, Submission to the Royal Commission of Health Services


Brewer, L. 1988 Report to Queens University’s Medical School Curriculum Review Committee, Kingston, Ontario


Brosseau, B.L.P. 1967 *Manpower Problems in Canadian Hospitals*, Conference Manuscripts, Health Insurance and Medical Manpower, 203-213.


Bull, W.P. 1934 *From Medicine Man to Medical Man: a record of a century and a half of progress in health and sanitation as exemplified by developments in Peel*, George McLeod, Toronto.


Bibliography

— 1964 *Royal Commission on Health Services*, (The Hall Commission), Vol. 1, Queens Printer, Ottawa.

— 1943 Health Insurance, *Report of the Advisory Committee on Health Insurance*, Queens Printer, Ottawa

Canada, Department of National Health and Welfare 1988 Unpublished Data, Health Information Division

— 1984 Community Health Centres in Canada: inventory. Community Health Services Division.

— 1975 Community Health Centres in Canada. Directorate of Community Health


— 1976 Community Multi-Service Centres: Summary of Recent Developments in the Delivery of Personal Health and Social Services and Report of the meeting on Community Multi-Service Centres, Vancouver.


— 1986 *Perspectives on Health Occupations*, CMA, Ottawa

— 1985 *Minutes of the Conference on Negotiations Policy*, CMA, Ottawa


1985a 'Medicine in the 21st Century.: will computers replace physicians?', vol. 132, April 15, 895.

1980 Message from the President, October.


1942 No title, vol 47, Special Supplement, 3-5.

1935 No title, September, no. 31, Supplement, pp. 51.


Canadian Public Policy 1980 The Implications of Established Programs to Finance for National Health Insurance, Summer, 521-532


Caplow, T. 1964 The Sociology of Work, University of Minnesota Press, Minneapolis.


Bibliography


Bibliography


Crichton, A., Hsu, D., & Tsang, S. 1990 Canada’s Health Care System: its funding and organization, Canadian Hospital Association Press.


— 1982 Professionals as Workers: mental labour in advanced capitalism, G.K. Hall and Co, Boston.

Dickinson, H. 1989 *The Two Psychiatries: the transformation of psychiatric work in Saskatchewan, 1905-1984*, Canadian Plains Research Center, University of Regina, Regina, Saskatchewan


Elliot, J.L. 1972 Citizen Participation in the Community Health Centre: Consumer Constraints upon the Emergence of New Forms of Ambulatory Care. Paper commissioned by the Community Health Centre Project, Ottawa.


Frechette, 1975 ‘Emergency Care and Hospital Centers: a new system in Montreal’, *Dimension of Health Services*, vol. 52, 45-47.


Bibliography


Gruending, D. 1974 *The First Ten Years*. Saskatoon.


——— 1964 *Report of the Royal Commission on Health Services (Canada)*, Queen’s Printer, Ottawa.


Hamowy, R. 1984 *Canadian medicine: a study in restricted entry*, The Fraser Institute, Toronto.


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Heagerty, J.J. 1940 The Romance of Medicine in Canada, MacMillan, Toronto

Heagerty, H.H. 1928 Four Centuries of Medical History in Canada: and a sketch of the medical history of Newfoundland, MacMillan, Toronto.

Health and Welfare Canada 1984 Earnings of Physicians in Canada, Health Information Division, Table B1.1


Holzner, Burkart & Marx, John, H. 1979 Knowledge Application: the knowledge system of society, Allyn and Bacon Inc., Toronto.


— 1982 ‘What is to be Known? The structural determination of social class’, *Economy and Society*, no. 6, 194-233


Judek, S. 1964 *Medical Manpower in Canada*, Royal Commission on Health Services, Ottawa.


Kleinberg, B.S. 1973 *American Society in the Post-Industrial Age: technocracy, power and the end of ideology*, Merrill, Columbus, Ohio.


—— 1978 ‘The Local Community Service Centres and the Democratization of Health’, *Canada’s Mental Health*, vol. 26, no. 1, 14-17.


McFarlane, A.B. 1967 ‘Distribution of Income in Medical Groups’, *Group Practice in Canada: report of the special committee on group practice (with additional guest articles)*, Canadian Medical Association, Ryerson Press, Toronto.

MacFarlane, J.A. 1965 *Medical Education in Canada* Royal Commission on Health Services, Queen’s Printer, Ottawa.


McKeown, T. 1979 *The Role of Medicine; dream, mirage or nemesis*, Princeton University Press, Princeton, N.J.


Ontario College of Physicians and Surgeons 1973 *Warning Notice and Special Notices*.


—— 1976 *Evaluation of Primary Health Care Services* (the ‘Spitzer Report’), Toronto.

—— 1975 *The Nurse Practitioner in Primary Care*, Toronto.


--- 1964 Ontario Medical Services Insurance Inquiry, (the ‘Hagey Report’), Queen’s Printer, Toronto.


Prandy, K. 1965 Professional Employees: a study of scientists and engineers, Faber and Faber, London.


Robillard, R. 1970 Medicare, the M.D.'s and You, self published.


Rosen, G. 1974 From Medical Police to Social Medicine, Neale Watson, New York.


Routley, T.C. 1943 Letter to the Executive Committee of the Canadian Medical Association, February 6th, Canadian Medical Association Archives.


Saskatchewan 1963 Report of the Honourable Mr. Justice Mervyn Woods on Hospital Staff Appointments, Regina.

Saskatchewan 1973 Department of Public Health, Community Health Association Clinics (the ‘McPhee Report), Regina.

—— 1944 Health Services Survey Commission: report (the ‘Sigerist Report’), King’s, Printer, Regina.


Shapiro, M. 1978 *Getting Doctored*, Between the Lines, Kitchener.


Sibley, J.C. 1974 Community Health Services Project, Quality of Care Appraisal, St. Mary’s Clinic, McMaster University Faculty of Health Sciences, Hamilton.


Smart, A.M., & Stotsky, K. 1981 ‘Community Health Centres: can they become the agents of change needed to reform health care?”, Perception, March/April, 32-34.


Task Force Reports on the Cost of Health Services, Canada 1970 National Health And Welfare, Ottawa.

Taylor, M. 1978 Health Insurance and Canadian Public Policy, McGill-Queen’s University Press, Montreal.


—— 1987 Health Insurance and Canadian Public Policy, the seven decisions that created the Canadian health insurance system and their outcomes, 2nd ed., Institute of Public Administration of Canada, Toronto.

—— 1978 Health Insurance and Canadian Public Policy, the seven decisions that created the Canadian health insurance system and their outcomes, Institute of Public Administration of Canada, Toronto.

Taylor, M., Stevenson, M., & Williams, P. 1992 Medical Perspectives on Canadian Medicare: attitudes of Canadian physicians to policies and problems of the medical care insurance program, Institute for Behavioural Research, York University.


Thorlakson, P.H.T. 1962 Provision of Medical Services Through Group Practice, Submission to the Royal Commission on Health Services.

Tollefson, E.A. 1963 Bitter Medicine, Modern Press, Saskatoon.


Van Loon, P.J. 1980 ‘From Shared Cost to Block Funding and Beyond: the politics of health insurance in Canada’, *Medical Care*, vol XV, no. 5, 382-389.


Walters, V. 1984 ‘Company Doctors: standards of care and legitimacy - a case study from Canada’, *Social Science and Medicine*, vol. 19, no. 8, 811-821.


____ 1989 Medical Dominance: The Division of Labour in Australian health Care (2nd edition), Allen and Unwin, Sydney.


Wynward Community Health Centre 1979 Brief to Health Services Review ’79, Public Archives of Canada, RG 29, Acc. 84-85/099, Box #6.


