

How Can We Improve Canada's Public Health System?

This paper aims to explore the issues within the Canadian public health system and suggest effective policy changes to address them. It will focus primarily on inequality and various shortcomings of the healthcare system that create and exacerbate health disparities. Through reviewing scholarly articles about the Canadian healthcare system, I found that it is built mainly for emergency physical care, but it does not efficiently treat chronic diseases or provide less urgent services such as dental care, nor does it consider the social determinants of health (SDOH). Much of the care citizens do receive is unnecessary or ineffective, and many people experience difficulty accessing care to begin with, especially rural and Indigenous Canadians. To improve Canada's public health system, lawmakers should implement policies that focus on increasing the effectiveness of spending, improving the comprehensiveness of care, and including SDOH to improve health equity, especially for Indigenous Canadians. I investigated strategies implemented in Canadian, foreign, and small-scale health systems to determine which methods work best to accomplish these goals. This is increasingly important as the prevalence of chronic diseases rises, especially in racialized and marginalized communities, and as the racial prejudices built into Canada's socioeconomic system come to light in the current health and sociopolitical climate.

Keywords: healthcare, public health, public policy, health inequity, Indigenous health, social determinants of health

INTRODUCTION

Canada's universal health care system is a major source of pride for Canadians because of its implications for the equality of our society. The primary aim of the Canada Health Act upon its implementation in 1984 is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Government of Canada, 2020, para. 2). However, as evidenced by extensive research, Canada's healthcare system is not fully achieving this objective, and it often ranks poorly



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compared to other countries in the developed world (Dhalla & Tepper, 2018). Notably, the system focuses on emergency biomedical care but does not sufficiently address the social determinants of health (SDOH), which are “the conditions in which people are born, grow, work, live, and age” that influence health outcomes, including socioeconomic, cultural, political and environmental circumstances and the broader systems that shape them (Magnan, 2017, para. 1). For several marginalized groups, especially rural and Indigenous Canadians, their demographic characteristics and geographic location are barriers to accessing health and healthcare (Public Health Agency of Canada [PHAC], 2018). The Canadian healthcare system is rife with inefficiencies and does not sufficiently provide care for chronic and mental illnesses. Significant changes are necessary to make the system truly universal—to accomplish equitable access to high-quality healthcare for all Canadians (Dhalla & Tepper, 2018). This paper will analyze the available literature to evaluate issues within the Canadian healthcare system—primarily those that exacerbate health inequalities—and suggest possible policy-based solutions based on strategies utilized in other health systems. This is of particular importance now, as the COVID-19 pandemic strains Canada's health system and intensifies socioeconomic-based health disparities.

HEALTH INEQUITIES

The universal healthcare system was intended to remove socioeconomic barriers to accessing healthcare—providing equal access for all—but several marginalized communities still face obstacles. Because Canada's healthcare system is not truly comprehensive, and systemic and interpersonal racism still exist, health inequities due to race, gender and socioeconomic status are stark (PHAC, 2018). Recent immigrants often struggle with language barriers, unfamiliarity with the health system, and discrimination, which results in a distrust of healthcare professionals (Browne, n.d.). Implicit bias against people of colour, especially Indigenous people, women, and LGBTQ+ people is also prevalent among healthcare professionals. This bias is correlated with poorer healthcare, therefore worsening health disparities (FitzGerald & Hurst, 2017). Additionally, specialized health services are often few and far between in rural and remote areas. Residents of these areas thus have to travel for hours to access these services. This travel is costly and stressful, especially due to separation from friends and family (Browne, n.d.). These disparities in access to healthcare are further exacerbated by the system's disregard for the SDOH. To address systemic bias, the health and social service sectors should be integrated. This would allow for the consideration of SDOH beyond what the health services system is capable of on its own (Magnan, 2017). Health disparities should be routinely monitored with corrective policies being enacted based on the findings. To address interpersonal bias, awareness of health disparities could be increased through creating training opportunities for health professionals, improving curricula for

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healthcare students, and providing awareness programs for the general public (PHAC, 2018).

INDIGENOUS CANADIANS

Indigenous Canadians are a particularly disadvantaged group. They have traditionally “viewed health in a balanced and holistic way, with connections between spiritual, emotional, mental and physical dimensions,” but colonization destabilized their culture and put them at a drastic disadvantage (PHAC, 2018, p. 7). The process of colonization involves “cultural genocide, the spread of deadly diseases, the banning of Indigenous languages, forced assimilation, and the illegalization of social, cultural, and spiritual practices” (Mitchell et al., 2019, p. 78). In Canada, colonization also involved the alienation of Indigenous people through forced displacement from their traditional territories and the removal of Indigenous children from their families and their culture, first to Indian Residential Schools—in which children were abused and Indigenous culture and language were forbidden—and then through the Child Welfare System (Phillips-Beck et al., 2020). These practices severed Indigenous people from their spiritual, cultural, and physical connections to their land and traditional way of life (Ayo, 2012).

These factors have negatively impacted the SDOH of Indigenous people, including education, income, and food security (Mitchell et al., 2019). As a result, when compared to the overall Canadian population, Indigenous people have worse health outcomes including a higher prevalence of various physical and mental illnesses and a significantly lower life expectancy (Phillips-Beck et al., 2020). Many Indigenous communities currently “live in situations comparable to third world conditions,” including lack of access to adequate water and sanitation, despite being citizens of a developed country (Mitchell et al., 2019, p. 76). The colonization of Indigenous people has also led to systemic social exclusion and racial discrimination against them that persists to this day. Indigenous people are often faced with interpersonal racism when they do try to access healthcare. The case of Brian Sinclair, an Indigenous man who died in a hospital waiting room because the staff assumed he was drunk, is an extreme example of the consequences anti-Indigenous racism can have (Blackstock, 2012).

The Canadian government has attempted to lessen the health disparities between Indigenous and non-Indigenous Canadians by implementing Indigenous-specific health programs. The Non-Insured Health Benefits (NIHB) program was created to provide health care for Indigenous people, but it does not cover non-status or Métis people (Blackstock, 2012). Jordan's Principle was created to provide necessary health services to Indigenous children before the resolution of jurisdictional disputes between federal and provincial governments over which party should cover the costs (Blackstock, 2012). It was named after Jordan River Anderson, a 5-year-old Indigenous boy who died in hospital after waiting over two years for the federal and

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Manitoba governments to decide who would pay for his at-home care. The Principle is incapable of achieving its purpose, however, because the program has strict requirements for eligibility that very few cases meet. More children like Jordan continue to be denied care because the federal government states that Jordan's Principle is "procedural and nonbinding and does not create a right" (Blackstock, 2012, p. 370). These policies should be corrected to ensure that healthcare is equitable in access and quality for all Canadians, Indigenous and non-Indigenous alike. To reduce interpersonal and systemic racism against Indigenous people, more healthcare delivery programs that are led by, and/or specialized for, Indigenous people should be implemented. Awareness programs should also be created to inform the general public about Indigenous culture and anti-Indigenous racism, and health service providers should be trained on how to identify and counteract their implicit bias (Mitchell et al., 2019).

NEOLIBERAL AND BIOMEDICAL APPROACH TO HEALTH

In contrast to the Indigenous holistic approach to health, the Canadian healthcare system takes a neoliberal, biomedical approach (Mundel & Chapman, 2010). Neoliberalism views health as a matter of individual responsibility (and, thus, poor health as a personal failure rather than a social issue), and biomedicine treats health at the biological level within the context of a physician-patient relationship. Combined, these approaches neglect the underlying SDOH that shape population health, and thus fail to make meaningful improvements (Horton, 2020). In contrast, health promotion from a holistic lens conceptualizes health, focuses on prevention, and calls for the improvement of social and economic conditions. As a result, this approach "holds greater potential for promoting Aboriginal health than relying solely on biomedicine" (Ayo, 2012, p. 99). However, most attempts to implement health promotion frameworks, such as the Ottawa Charter for Health Promotion, have been overridden by an individualistic approach. For example, rather than urging investment in the determinants of good health such as education and employment, most highly endorsed Canadian health promotion frameworks "suggest that all will be well if individuals simply exercised 30 minutes a day and ate more fruits and vegetables" (Ayo, 2012, p. 101).

This strategy deepens inequalities, which worsen population health. This has been illustrated by the COVID-19 pandemic, which has most adversely affected marginalized groups including women, people of colour, and poor people (Horton, 2020). For example, women, immigrants, and racialized groups (especially Black and Filipino people) disproportionately work in occupations such as nursing and meat processing that increase COVID-19 exposure and infection risk. Consequently, in Toronto, racialized groups constitute over 80% of all COVID-19 infections (PHAC, 2020). Indigenous communities are also particularly vulnerable to COVID-19 due to "exacerbating conditions, such as limited access to clean water, lack of health

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professionals/services, a high prevalence of chronic diseases and crowded living conditions" (PHAC, 2020, p. 12). Although the PHAC acknowledges these inequities (and the role of SDOH and Canada's history of colonization and systemic racism in creating them), most of Canada's COVID-19 control efforts have been focused on biomedical approaches (PHAC, 2020). However, as stated by Horton (2020), the vulnerability of minorities and poorly paid workers indicates "that no matter how effective a treatment or protective a vaccine, the pursuit of a purely biomedical solution to COVID-19 will fail. Unless governments devise policies and programmes to reverse profound disparities, our societies will never be truly COVID-19 secure" (p. 874).

INSUFFICIENT HEALTHCARE COVERAGE

As a result of Canada's neoliberal and biomedical approach to healthcare, the health system is not adequately comprehensive. While hospital and physician expenses are covered, many other health services that are crucial for overall well-being must be paid for by private insurance or out-of-pocket. This makes services such as out-of-hospital pharmaceuticals, dental, and eye care unattainable for low-income Canadians who do not have employer-provided insurance and cannot afford to pay out-of-pocket expenses. Consequently, these patients often go without essential treatments (Dhalla & Tepper, 2018). This is a widespread issue; according to a 2016 Canadian Institutes of Health Research (CIHR) study, nearly one-third of Canadian primary care doctors thought their patients often experienced difficulty paying for medications or other out-of-pocket costs (CIHR, 2016). This can cause their health issues to persist or worsen, thus increasing costs to the public health system due to repeated doctor or hospital visits. Insufficient coverage also exacerbates the health inequity between races and genders, because women and people of colour are significantly more likely to be of a lower socioeconomic class (PHAC, 2018).

The Canadian healthcare system also focuses on treating illnesses rather than preventing them and facilitating holistic health. To be truly comprehensive, a health system should invest heavily in preventive health measures through an emphasis on primary health care. Among developed countries, health systems centred around primary care have better health outcomes, lower expenditure, and greater patient satisfaction. Leslie et al. (2016) found that the integration of family-focused preventive programs into primary healthcare settings can reduce several negative behavioural health outcomes and produce widespread public health improvements. These interventions also result in "more economic benefits to society than they cost, because of their effects in preventing future behavioural health problems including depression, violence, crime, and drug abuse" (Leslie et al., 2016, p. 107). Primary care should be reformed to be more team-based, with a group of healthcare professionals—for example, physicians, social workers, nutritionists, and counsellors—working together in one location to accomplish holistic patient health.

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Team-based practices increase the accountability of providers and prevent burnout by lessening the workload of each provider. Interdisciplinary healthcare teams have been shown to enhance overall patient health and reduce readmission rates (The Canadian Foundation for Healthcare Improvement, 2017). The shift to primary care may also correct the issue of physician-dominated healthcare provision (Jacobson, 2012). Canada has also failed to implement programmes and policies that incorporate a health promotion approach and address the SDOH. A more comprehensive healthcare system would represent more effective and culturally appropriate care for all Canadians, especially Indigenous people (Phillips-Beck et al., 2020).

PROBLEMATIC PHYSICIAN PAYMENT SYSTEM

The fee-for-service (FFS) model is used to pay doctors in Canada. Under this model, the amount of payment is determined by the number and complexity of treatments. As a result, FFS incentivizes doctors to perform more procedures—especially those that incur high fees—and to increase the frequency of consultations, even when this is unnecessary (Hewak & Kovacs-Litman, 2015). Additionally, to cycle through patients quickly and garner additional visits, FFS doctors often restrict patients to mention only one issue per visit. This practice is unsuitable for the many patients who have chronic or complex health issues, and forces them to determine which of their symptoms is most urgent without the knowledge needed to do so. In an extreme case, a patient died of a heart attack one week after a doctor dismissed her concerns about chest pain because she had already brought up a different issue (Adhopia, 2019). The Colleges of Physicians and Surgeons of both Manitoba and British Columbia have discouraged this policy since 2012 and 2016, respectively, but the federal government needs to impose a stricter ban (Adhopia, 2019). The physician remuneration model should be changed to a fixed payment scheme such as capitation or salary. Doctors paid by capitation are motivated to contain resource use and expenses; thus encouraging them to provide effective disease prevention and treatment so that fewer patient visits are necessary. The salary system may not be ideal for most doctors, but it is valuable for certain cases such as rural doctors who have a small patient base. Doctors paid by salary have no deterrent to investing more time and resources into patients that require it, so they are three times more likely to accept complex enrollees (such as Indigenous, poor, mentally ill and/or homeless people) compared to doctors paid using FFS (Hewak & Kovacs-Litman, 2015). As a result, payment by salary would help to reduce socioeconomic-based health disparities.

CONCLUSION

As stated in a 2018 Canadian Medical Association Journal article, high-quality healthcare is “safe, timely, effective, efficient, equitable and patient-centred” (Dhalla & Tepper, 2018, p. 67). All of these factors need to be improved in the Canadian healthcare system. Despite being generally appreciated by residents, the Canadian

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public health system is far from ideal. Many issues today stem from the flawed history of Canada's health system, including the effects of colonialism and neoliberalism that continue to undermine the quality of healthcare practices as Canada tries to operate in a global market dominated by these forces. These factors have created and exacerbated health disparities, which have been further intensified during the COVID-19 pandemic, as evidenced by the differential rates of infection between racial groups (PHAC, 2020). In order to achieve the tenets of good healthcare proposed by the Canada Health Act, policies should be implemented to correct the numerous shortcomings in comprehensiveness, accessibility, and effectiveness. The Canadian government should also ensure that tax dollars are used as effectively as possible, that healthcare is equally accessible for all citizens, and that healthcare is fully comprehensive. In particular, the SDOH need to be considered in the healthcare system, and the harmful policies that put Indigenous people at a disadvantage must be reformed. This can be achieved by implementing a health promotion approach that prioritizes primary and preventative health and addresses the SDOH and socioeconomic disparities. The successful implementation of these changes would result in a health system that more efficiently and equitably serves its population, resulting in a healthier and happier Canada.

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