Psychological Services and the Future of Health Care in Canada

ROY J. ROMANOW
Former Premier of Saskatchewan, Former Chair of the Commission on the Future of Health Care in Canada, and Senior Policy Fellow
University of Saskatchewan and University of Regina

GREGORY P. MARCHILDON
Former Executive Director of the Commission on the Future of Health Care in Canada and Canada Research Chair in Public Policy and Economic History
University of Regina

Abstract
The implications of the Commission on the Future of Health Care in Canada’s (CFHCC) recommendations extend beyond the necessarily limited scope of its report. This article explores the potential role of psychologists in a restructured public health care system that goes beyond hospital and physician care to home care and a revamped primary care system. Public plans would also benefit from the use of psychological alternatives to prescription drug therapies. Such evidence-based extensions to the existing Canadian model would improve both health and medical outcomes. They could also introduce new cost-savings to provincial health plans that are presently under immense financial strain.

The Commission on the Future of Health Care in Canada (CFHCC) was created to address some very specific problems facing Canada’s public health care system. These included escalating costs, timely access to certain services and procedures, and shortages of some types of providers. Questions had also been raised concerning the quality of health care as well as the range of services that should be offered by the public sector and the role of the private sector in the delivery of those services. Beyond these specific challenges was the question of whether the governance of the health system was failing. There was also a growing dysfunction within the federal system as each order of government attempted to blame the other for the shortcomings of the public system and its perceived lack of adequate funding. These issues had already precipitated a number of arms-length government studies. In April 2001, when the CFHCC was established, the governments of Québec (2000) and Saskatchewan (2001) had already been provided with their own Commission reports. Moreover, the Alberta government (2001) was about to receive its report. Given the provincial context of these studies, however, the reports barely touched upon the national dimensions of health care.

As for the federal government, it had already decided to reduce its social (including health) transfers to the provinces before receiving the recommendations of an earlier commissioned study. As a consequence, the recommendations of the National Forum on Health (1997) were initially sidelined as the federal and provincial governments began to debate their respective roles and responsibilities in the funding, administration, and delivery of public health care. By 1999, the Senate Standing Committee on Social Affairs, Science and Technology had begun to study the federal role in health care, but it was not perceived as acting on behalf of the federal government, nor was its mandate considered, at least initially, to be directly relevant to the provinces.

Unlike previous Royal Commissions that had three to five years to complete their work, the CFHCC was given a mere 18 months. The debate concerning the sustainability of public health care was then reaching a crescendo. Federal-provincial conflict in particular had escalated to the point of destabilizing the health care system itself. The sources of this conflict were varied, but the main fault lines were constitutional, institutional, financial, and ideological in nature. The debate that this conflict triggered was confusing, and it was unclear as to whether the fundamental values of the system were in question. Moreover, it was unclear whether governments agreed or disagreed as to the general framework within which change and reform could take place over the coming years. As a consequence, it was believed that any report released beyond the 18-month time period might be too late to provide answers directed to these basic questions and provide the recommendations that would help shape the policy outcome in the country.

In addition, the CFHCC was required by its original order-in-council to deliver an interim report, which
was released in February 2002 (Canada, 2002a). This left nine months to conduct one of the most extensive and intensive public consultation processes ever engaged by a Royal Commission in Canada and to write a final report with a broad range of recommendations on the future of health care. This report was delivered in November 2002, amidst saturation-level media attention and at the peak of federal-provincial conflict over the future of public health care (Canada, 2002b). Although the recommendations went beyond at least some of the immediate issues that were of concern when the CFHCC was created, the extremely short time frame meant that the recommendations could not cover the entire waterfront of longer-term issues, including the role of psychology in the health of Canadians (Allon & Service, 1999). Instead, the report delivered a limited package of fiscally and politically feasible recommendations, many of which would be capable of implementation within a short period of time. Particular emphasis was placed on lancing the federal-provincial boils because of the difficulty of achieving positive health care change on the ground without addressing the malfunctions at the highest governance level. Moreover, contrary to most recent health care reports in Canada, much time was spent on how to achieve change, most significantly on how to create new intergovernmental structures and processes, such as the establishment of a Health Council of Canada, to replace existing intergovernmental processes and institutions (see CFHCC implementation plan, Canada 2002b, 255-256).

There was a price to be paid for this focus in the CFHCC’s final report. Professional psychologists were not alone, for example, in wishing that the CFHCC had gone further into the issues of greatest interest to them (Canadian Psychological Association, 2002). As a consequence, the purpose of this article is to explore at greater length the implications of key recommendations in the report for the future of psychological services. We begin by summarizing the principle features of the Canadian model of medicare as it has evolved over time in order to understand why psychological services are largely outside the core of public health care. We then review the major systemic changes recommended by the report – home care and primary health care – and the role that psychological services could potentially play in their organization and delivery in the future. This is followed by an examination of prescription drugs, the most significant cost-driver in health care today, and the alternatives to physician-directed drug therapies. Finally, we look at some of the more immediate challenges in Canadian health, in particular, rural, remote, and aboriginal health and health care.

The Canadian Medicare Model

Canadian medicare is, first and foremost, a historical construct. The first pillar of our contemporary public health care system was initiated by Saskatchewan in 1947, followed by other variants of hospitalization in Alberta and British Columbia. With the passage of the Hospital Insurance and Diagnostic Services Act by the federal Parliament in 1957, and the offer of federal cost-sharing transfers, the Saskatchewan model of universal public hospital insurance was adopted in all the provinces and territories by 1961 (Boychuk, 1999; Taylor, 1987, 1990). Psychiatric health services were, however, excluded from the definition of hospital services, and federal government inspectors actually counted the number of psychiatric beds in general hospitals to exclude them from the federal share of provincial hospital expenditures. This encouraged the pre-existing tendency to keep long-term mental health facilities such as psychiatric hospitals separate from the “regular” system. Nonetheless, some emergency mental health services were covered under hospitalization, and this meant that psychiatrists and psychologists could provide critical care mental health services under the rubric of hospitalization. These services would expand over time but even by the mid-1980s, no Canadian hospital offered admitting privileges to psychologists, nor would most hospital patients be assessed and/or treated by psychologists except after physician referral (Arnett, Martin, Streiner, & Goodman, 1987).

The second phase of medicare was the implementation of universal public health insurance for primary medical care services outside hospitals by Saskatchewan in 1962. Despite the existence of other models, including a targeted subsidy approach in Alberta, it was the Saskatchewan model that was recommended for national implementation to the federal government by the Royal Commission on Health Services – the Hall Commission – two years later (Canada, 1964). It took another 50:50 cost-sharing offer by Ottawa, plus years of negotiation, but all the provinces and territories had implemented universal medicare by 1972 (Naylor, 1986; Taylor, 1987, 1990). There were two significant factors in this phase. First, the family/general physician was seen as the centre of the primary care universe. Second, the fee-for-service (FFS) methods of physician remuneration that predated medicare were continued, except that the government rather than individuals or private insurers paid the physicians’ bills. In the beginning, therefore, other professions, including professional psychologists, were largely excluded from the FFS medicare system.

This changed little over time, in large part because
of the desire by governments to limit their expenditures of public funds on new services and new providers. A few other professions such as chiropractors were occasionally, and temporarily, let into the FFS public system by particular provincial governments, but professional psychologists provided primary care services in the private sector. This was despite the replacement of shared-cost funding schemes for both medicare and hospitalization with a block funding transfer known as Established Programs Financing (EPF) in 1977. One of the reasons behind the change was the provinces’ desire for greater flexibility in their use of federal health transfer funds, which was triggered in part by an interest in new organizational models of primary care delivery (Canada, 1972) and population health through the Lalonde Report (Canada, 1974).

By the end of the 1970s, provincial health care plans were covering or subsidizing health services well beyond hospitals and primary care physicians, including prescription drugs, as well as home/community care and long-term care. At the same time, advances in drug therapy and changes in mental health treatment modalities had resulted in the “de-institutionalization” of many patients previously resident in provincial psychiatric hospitals. Despite these changes, the medical model of treatment, with the physician at the centre, remained the norm. Most primary care continued to flow through general/family practitioners who referred patients with serious mental disorders or difficulties to psychiatrists while attempting to cope with less serious cases on their own or, very occasionally, by sending them to a psychiatric nurse or psychologist.

In 1984, the federal Parliament passed the Canada Health Act (CHA, 1985). The motives for passing the Act were varied, although the chief preoccupation of the federal Minister of Health at the time was to curtail the practices of extra billing by physicians and user fees by hospitals in parts of the country. These were contrary to the operating principles of the original federal legislation underpinning the federal transfers but made almost unenforceable through the EPF changes (Bégin, 1987). On this count, the CHA was a great success, rolling back almost $247 million in extra billing and user fees within three years. However, the CHA also entrenched the hospital and physician-centred model of medicare by limiting insured health services covered by the five governing principles of the Act – public administration, universality, accessibility, portability, and comprehensiveness – to medically necessary hospital and physician services.

Although the CHA has never blocked the provinces from providing a broader range of services under their respective health plans, it has meant that both hospital services and primary care physician services are historically privileged. Moreover, given the focus of general/family physicians on physical ailments, this has resulted in a lack of emphasis on mental health services, other than mental disorders that can be easily identified and referred to a psychiatrist by other physicians. The result is that almost 80% of consultations with psychologists – the majority of which likely involve mental health issues – occur within the private rather than the public system (Canadian Psychological Association, 2001). Of this 80%, a portion is covered through private insurance (largely employment based) and the remainder is paid out-of-pocket.

The enormous burden of mental disorders in Canada is one of the more unfortunate legacies of the Canadian medicare model. Without a doubt, mental disability has a major impact on the health status of the population. Despite this, our public system invests disproportionately on addressing physical diseases, particularly those associated with death (Bland, 1998). One estimate of the economic cost of mental disorders in Canada was $14.4 billion in 1998, a little more than 25% of the total invested in public health care that year. This is a consequence of the fact that approximately 3% of the Canadian population suffers from serious mental disorders in any given year, while about 1 in 5 Canadians suffer a less serious, but nonetheless potentially disabling, mental condition (Canada Mental Health Association, 2001). Canada is not alone in terms of this burden and the fact that it is inadequately addressed. As the World Health Organization (2001) recently pointed out, mental health remains one of the most neglected areas of public health care throughout the world.

In Canada, there is a gradient of services. Within the core medicare system, most serious mental disorders are treated by psychiatrists. Unfortunately, less serious mental conditions are often not being diagnosed much less treated within the existing system. Finally, the systematic pursuit of mental health, as opposed to the treatment of mental disorders, is poorly resourced and rarely done in Canada. Each of these categories will be examined in turn.

Serious mental disorders are now mainly addressed through drug therapies under the supervision of psychiatrists. Drugless therapies are much less common for two reasons. The first relates to the major advances in psychotropic drugs over the past 30 years and the fact that drug therapy has become the treatment of choice among psychiatrists. The second is that clinical psychologists, who are not permitted to prescribe medication, are rarely consulted in such cases, in part because they are not part of the
Canadian medicare model, unless hired by hospitals or community mental health clinics. Both psychologists and psychiatrists can provide psychotherapy but in most provinces, psychotherapy is only funded publicly if provided by physicians, a consequence of a traditional FFS system, discussed earlier, in which physician services are automatically covered but psychologists’ services are not. This is despite the fact that PhD-level clinical psychologists receive far more extensive training and education in psychotherapy than physician-trained psychiatrists (Ontario Psychological Association, 2001). Although Canada is similar to many Organization for Economic Cooperation and Development (OECD) countries in this respect, there are exceptions. In Germany, for example, psychoanalytical services provided by either psychologists or psychiatrists are covered in the public system (Canadian Psychoanalytic Society, 2001).

If diagnosed, less serious, but nonetheless debilitating, mental disorders are addressed both inside and outside the public system. For such ailments, drugless therapies provided by psychologists play a correspondingly larger role. Although the economic benefit of psychological services has not been fully studied, the initial results are very encouraging (Hunsley, 2002, 2003). Indeed, treating depression and various addictions, as well as anxiety, conduct, mood, and personality disorders through cognitive behaviour therapies (CBT) and other empirically supported psychological interventions holds considerable promise for the future (Hunsley, Dobson, Johnston, & Mikail, 1999). In addition, psychologists have been central in treating stress-exacerbated physical conditions such as hypertension and ulcerative colitis. Psychologists also play a recognized role in treating the psychological dimension of physical diseases such as cancer, through group and individual therapies. In addition to their clinical effectiveness, some of these therapies are also proving to be cost-effective. In a recent study of female breast cancer patients in Calgary, for example, the availability of group therapy lowered health care costs by 24% (Ontario Psychological Association, 2001).

Each of the treatment modalities for mental disorders and the psychological dimensions of physical illness or disability, including drugs, psychotherapy, CBT, as well as family and group therapies, have their inherent advantages and disadvantages. Moreover, treatment effectiveness will also depend on the unique needs of the individual being treated. Nonetheless, for both financial and quality-of-outcome reasons, there should be, in theory, a far greater availability of psychological therapies within the public system in the future. It needs to be emphasized, however, that it is extremely difficult to overcome institutional rigidities that are, to a considerable extent, the historical legacy of the Canadian medicare model.

In practice, it is much more feasible to target those parts of the model that governments have now agreed can, and should, be changed as part of an agreed-upon plan of health system reform. Some of this consensus was reflected in the common recommendations of recent health commission reports in Canada. The CFHCC went a step further in attempting to determine what the general public desired and supported in terms of directional change through an innovative “citizen’s dialogue” involving a representative sample of Canadians in 12 day-long deliberative sessions (Maxwell, Rosell, & Forest, 2003). To better understand what would be within the realm of politically possible, the CFHCC kept in touch with all provincial and territorial governments as well as aboriginal organizations through a formal intergovernmental liaison as well as informal but high-level contacts with first ministers. The CFHCC final report reflected a judgment on not only the changes that needed to occur but the reforms that had the most chance of success given the level of public support in the context of what was politically and fiscally feasible. The next step was for governments to act on the basis of the existing consensus, and a little more than two months following the report, federal, provincial, and territorial first ministers agreed to a basic package of reforms through the Health Accord of February 5, 2003 (Canadian Intergovernmental Conference Secretariat, 2003). We now turn to the key areas of health system reform (relevant to the future of psychological services) that were an integral part of the 47 recommendations made in the CFHCC final report.

Home Care

Home care has never been part of the basket of “insured health services” under the Canada Health Act. In many instances, however, health care provided in the home can be less expensive and more appropriate for an individual than hospital or institutional treatment. In fact, since the 1970s, provinces have been adding home care services to their respective health plans in an effort to improve the continuum of public health care services and to contain acute care and long-term institutional care costs. The provinces were encouraged to continue down this track by the relaxing of federal transfer conditions with the introduction of EPF in 1977. This was more formally recognized when Ottawa expressly permitted federal transfer funding to flow to “noninsured health services” such as home care and long term care as defined under the Canada Health Act (1985).
Today, every province has its own unique set of home care services in place. Unlike hospital and primary physician care services, the absence of federal funding tied to legislated conditions or principles permits enormous variability in the quality and quantity of home care programming, as well as the conditions of access, across the provinces and territories. Moreover, most jurisdictions have little in place to support home and community care for individuals with mental disabilities. This stands in stark contrast to the provincial infrastructure for institutionalized patients with chronic physical and mental disabilities.

Indeed, mental asylums, psychiatric hospitals, and similar institutions were a familiar part of the health care landscape in most of Canada long before hospitalization and medicare. In many cases, these served to “warehouse” a small group of individuals with serious mental conditions but did little or nothing for the many more with less serious conditions. Moreover, in terms of the institutionalized patients, the existing system fell short of acute care hospitals in having curative objectives. This led the Hall Commission to state: “Of all the problems presented before the Commission, that which reflects the greatest public concern, apart from the financing of health services generally, is mental illness” (Canada, 1964, p. 21). In a bid to put mental disorders on the same level as physical illness in terms of the organization and provision of services, Hall recommended that mental health care be integrated into the hospital system by adding psychiatric wards and wings to hospitals and replacing the larger, segregated mental asylums. His commission also recommended that the majority of children with mental disorders should be treated at home or in the community rather than placed in long-term institutional care (Canada, 1964, p. 24). However, these recommendations were bypassed to some extent by a major societal shift that would have been difficult to predict by the Hall Commission.

In the 1960s and 1970s, the deinstitutionalization movement took hold in Canada and other advanced industrial countries (Trainor, Pape, & Pomeroy, 1997). New psychotropic drug therapies and a new vision of community psychiatry, along with the cost advantages of treatment outside expensive long-term mental institutions, led to the release of many patients back to home and community environments. But while provinces invested heavily in paying for the drug therapies for these individuals, little was done to improve the home and community care infrastructure for individuals with mental disorders in most provinces despite the fact that this should have also been part of deinstitutionalization (Gatz & Smyer, 1992). By the mid-1970s, the negative side of deinstitutionalization was becoming clear, as described by the Canadian Mental Health Association (2001, p. 8) in its written submission to the CFHCC:

For many former hospital residents, the new system meant either abandonment, demonstrated by the increasing numbers of homeless mentally ill people; ‘trans-institutionalization’: living in grim institution-like conditions such as those found in the large psychiatric boarding homes; or a return to family who suddenly had to cope with an enormous burden of care with very little support. In addition, fears and prejudices about mental illness, in part responsible for the long history of segregation in institutions, compounded the problems in the community.

The current system has some perverse features associated with it. In a recent study of Ontario, for example, the Canada Mental Health Association (2001) discovered that people with serious mental disorders are generally not eligible for home care in the province unless they have previously been admitted to a hospital: this, despite the fact that effective home supports for such individuals may be able to prevent a hospital admission in the first place. Moreover, even serious mental disorders are not the chronic, incurable, conditions once believed, and our knowledge base concerning appropriate and effective interventions is growing rapidly (Trainor, Pomeroy, & Pape, 1997).

For a broad range of mental disorders, professional home care is much more than simply an alternative to institutionalization. It is often an essential element in ensuring that a treatment regime (drug or nondrug) is strictly adhered to in order to avoid periodic relapses and destructive behaviours as well as repeated readmissions to hospital. According to Hollander and Chappell (2002), very large savings to the public health care system can be realized by focusing home mental health services on individuals who generally live well in their communities, but who may have occasional problems. This is particularly true for individuals who only rarely exhibit violent behaviour during these problem periods but, when they do, are then hospitalized or institutionalized to protect the caregivers around them. Currently, intervention, generally by the police and emergency response units, only takes place after the situation boils over and causes damage to both patients and caregivers. This form of emergency intervention is costly to society while doing little or nothing to improve the quality of lives of those most directly affected.

To address this situation, the CFHCC recommended that two types of home mental health care services be the planks in a new national floor. The first was case
management and the second was behavioural intervention. In the former, a case manager would work directly with the patient and a range of health care providers and community agencies to monitor the individual’s health and ensure continuity and coordination of care with the appropriate supports in place. The latter category would involve more systematic intervention services to assist and support clients and their caregivers during periods of disruptive behaviour that pose a threat to themselves or their caregivers. Clearly, the two services are directly connected in the sense that it would be almost impossible to have timely and effective intervention without the case management infrastructure in place, an infrastructure which is largely absent in most provinces. As a consequence, of the estimated $568 million annualized cost for mental health home care, almost all ($528 million) would be needed to create a case management infrastructure in Canada (Canada, 2002b).

This reform involves more than a timely crisis response, diverting individuals from inpatient hospitalization. It involves comprehensive monitoring and evaluation by skilled health professionals, at least one of whom has built up a trusting relationship with the mental health patient and this individual’s caregivers. It is a methodology that strives to improve clinical status by preserving, promoting, and restoring mental health. It also involves the active participation of both clients and caregivers in treatment and care.

In the 2003 First Ministers’ Accord on Health Care Renewal, the Prime Minister and the Premiers all agreed to provide full public coverage for “short-term acute home care,” including “acute community mental health” services and case management within the next three years (Canadian Intergovernmental Conference Secretariat, 2003). Although the word “acute” may end up limiting what governments do or provide, this commitment by all governments likely marks the first major step in addressing mental health services since the introduction of medicare decades ago. The question remains, however: What role will psychological services play in this reform?

The simplest response by provinces may be to layer onto the existing physician-centred approach by allowing the provision of professionally accredited psychological services that are already well recognized by the medical professions in the U.S. and Canada. In this regard, Dobson (2001) identifies three specializations: clinical psychology, including clinical child psychology; clinical neuropsychology; and clinical health psychology. Such an approach could fill in some obvious gaps in the current system. It could also be a substitute for specialized physician services that are in short supply. There are, for example, very few child psychiatrists in Canada despite the growing demand for such services. Even in Ontario, which has more than the national average of psychiatrists, there are 7,000 children waiting an average of 6 months for psychiatric services (Canadian Mental Health Association, 2001). This waiting list could be reduced or eliminated over time if clinical child psychologists could become an integral part of the public system.

Whether home care will trigger major changes in the public utilization of psychological services ultimately depends on the precise range of specialized services that provincial governments and (where delegated) regional health authorities (RHAs) will pay for with public funds. If provinces automatically privilege psychiatrists, psychiatric nurses, and nurse practitioners for home-based mental health care, this will leave only limited space for specialized clinical psychology services. If, on the other hand, provinces or RHAs fundamentally reassess the membership of the home care team, or allow case managers a significant amount of discretion in selecting the professional services most appropriate to an individual home mental health client, then much more space for psychological services will be created.

Part of the solution may lie in determining who the home mental health case managers of the future will be and how much they will be paid. There are a number of possibilities that range from nurse and nurse practitioners to social workers and psychologists. Although the nursing professions have much training in health care, social workers are experienced in case management and the business of co-ordinating a diverse range of services. Psychologists, in particular those clinical psychologists with a broad knowledge of the health system, should also be considered. At the same time, it must be admitted that there is no perfect professional background for such a role and that no one provider group has all the skills necessary for a home mental health care case manager. In this new home care landscape, we require case managers, irrespective of label, who are aware of the full breadth of psychological services, including the advantages and disadvantages of alternative therapies (Service, Allon, & Mikail, 2001).

That said, clinical psychologists may be in the best position to work on a regular basis with such clients if they can gain expertise in the nonmedical health care aspects of case management and service co-ordination. Moreover, this may be a very cost-effective approach from a provincial government’s (or RHAs) perspective as well, given the already demonstrated savings gained through psychological treatment of anxiety disorders, depression, and borderline personality disorder (Hunsley, 2003).
ample opportunity for large-scale pilot projects in home care that can be used as a comparative benchmark for both cost-effectiveness and quality in home mental health case management.

In reality, the amount the public system is willing to pay home care case managers will determine the range of possibilities. If case managers are perceived to be at the very low end of the skilled professional continuum (as they are now), they will be paid accordingly. In such a situation, they are not likely to attract more highly educated professionals such as psychologists. If, however, such positions are reconfigured as high-skill occupations, new possibilities will open up not only for psychologists but also for other well-educated professionals. The question is whether we, as a society, are willing and/or able to make the public investment necessary for this to occur.

The aging of the Canadian population will increase the demand for home care for the simple reason that the incidence of brain disorders – dementia and delirium – increases with age. Alzheimer’s alone now accounts for over 50% of dementia cases. The financial burden imposed by this disease is already sizeable in advanced industrial societies (Heston & White, 1991; LaRue, Dessonville, & Jarvik, 1985). One Canadian study estimated the cost to be $3.9 billion in 1991, slightly over half of which was for long-term institutional care (Ostbye & Cross, 1994). A recent study using 1994 Canadian data, found that the average annual cost of care for an individual suffering from Alzheimer’s ranges from $9,451 for a mild case, $25,724 for a moderate case, and $36,794 for the severe type (Hux, O’Brien, Iskedjian, Goeree, Gagnon, & Gauthier, 1998). Another Canadian study found that delirium was associated with 51% of older patients who had been admitted to hospital, and that patients suffering from both delirium and dementia were at much higher risk of being moved into expensive long-term institutional care (McCusker, Cole, Dendukur, Belzile, & Primeau, 2001) than older patients suffering neither condition.

At present, this age group, and those that support their care in the home, do not receive the public services they require (Gatz, Karel, & Wolkenstein, 1991). For years now, brain disorders of the type described above account for more admissions and hospital inpatient days for older individuals than any other condition in advanced industrial countries (Christie, 1982). Although only a small percentage of people under the age of 60 suffer from dementia, approximately 30% of individuals over 80 years of age do (Heston & White, 1991). This is a concern given the ever-growing percentage of the population exceeding that age. We can prepare for Canada’s graying population by ensuring home care policies and programs are in place that will forestall hospital and institutional care, including psychological assistance for caregivers (Grunfeld, Glossop, McDowell, & Danbrook, 1997). Providing care for older individuals suffering mental disabilities can exact an enormous psychological toll on family and loved ones. Much of the support for home care can actually become support for the caregivers to facilitate their ability to continue to provide high-quality care to loved ones. Moreover, it must be recognized that, at some point, because of the severity of the disabilities and the difficulty and high cost of continuing to provide care in the home, the individual may need to be transferred to an institutional setting.

The CFHCC recommendations on home care went beyond mental health services to include post-acute home care and palliative, or end-of-life, care (Canada, 2002b). These services are also part of the 2003 First Ministers’ Accord on Health Care Renewal, slated for implementation by 2006 (Canadian Intergovernmental Conference Secretariat, 2003). In the case of post-acute home care, the CFHCC recommended that the 14 days covered following release from hospital be extended to 28 days if rehabilitation is involved. Psychologists who specialize in rehabilitation work with patients to speed up recovery, prevent relapse, and help with the adjustments necessary in the case of chronic disability could be critical in the delivery of this service if the recommendation is adopted by the provinces (Canadian Mental Health Association, 2001). Services that improve the quality of care while saving the public system money will be the most immediate impetus for change.

In the case of palliative home care, end-of-life patients and their loved ones may benefit from psychological counseling. This is often the time when unresolved issues come to the fore and may cause more suffering if not addressed constructively. More importantly, as in the case of mental disorders, the emotional toll on palliative caregivers is often enormous, in many cases heavier than that faced by a dying patient. As Grunfeld, Glossop, McDowell, and Danbrook (1997) point out, the percentage of caregivers suffering anxiety and depression is often greater than the percentage of terminally ill patients suffering the same difficulties. Thus, for palliative home care to be a viable option in the future, the psychological burden of caregivers must be addressed. Given their education and experience, clinical psychologists may be in the best position to provide this type of support.

For some patients dying from cancer or other diseases, pain management is a major concern. Although drug therapy assists greatly in alleviating
pain, patients might also benefit from some evidence-based psychological therapies aimed at managing chronic pain. These may also prove to be cost effective. Jacobs (1987, 1988), for example, found that treatment of chronic pain conditions produced a saving of $5 for every dollar invested in psychological treatment. Here again, psychologists have researched the impact of chronic pain and have pioneered some of the most important treatment methodologies to cope with such pain.

Home care is an important illustration of how to build on the existing medicare model while redefining public health care beyond hospitals and primary care physicians. By targeting public resources towards three very specific aspects of home care – mental health, post-acute health care, and palliative care – the result can be a catalyst for even more profound and long-term change in the future. In other words, this change is a financially and politically feasible first step that is built upon a public consensus. What remains missing, however, is for such change to be “locked-in.” The CFHCC recommended that the Canada Health Act be amended to include these particular home care services so that they become permanently protected under the principles and conditions of the Act (Canada, 2002b). If the federal government takes this step, medicare will forever have to be defined beyond hospitals and primary care physicians. Until then, any progress on the home care front is more easily reversed. In this sense, the CFHCC judged that the risk of opening the CHA was less than the opportunity of using the legislation to reshape the Canadian model of medicare.

Primary Health Care Reform

Changes in the organization and delivery of primary health care services are pivotal to the future sustainability and quality of the public system in Canada. The concept is simple. As a society, we should invest more in front-end health services aimed at reducing the demand for illness care services at the back end. As well as early detection of illness, these services involve health promotion and disease prevention, which, in turn, should include managing stress, anger, and chronic disease, improving parenting and caregiver skills, and ending addictions such as smoking (Ontario Psychological Association, 2001).

Although there has long been agreement among health policy experts on this proposition, most government efforts over the last three decades to change the nature of primary delivery have had limited impact. The purpose of most of the reforms was to move from a physician-centred, fee-for-service, delivery model to one in which a multidisciplinary health care team provides a range of broadly defined treatments as well as disease prevention and health education services. As the first point of contact with the health system, such services would ideally be available 24 hours a day, 7 days a week, with the expertise and co-ordinating capacity to refer individuals quickly and effectively for acute and other care when necessary. As the first line of contact, primary care units, rather than acute care hospitals, should be the central focus of the health care system (Mikail, McGrath, & Service, 2000).

As Hutchison, Abelson, and Lavis (2001) note, however, this is easier said than done in a public health care system that was historically built upon publicly insuring an existing pattern of physician-centred primary care. As the current primary health gatekeepers to the public system, physicians currently deal with a host of psychological conditions. According to one estimate, 60% of the “conditions presented to primary care physicians are psychological, have a psychological component,” or are “highly influenced” by psychological factors. In addition, although about 40% of high-end primary care users suffer from some form of depression, well over one-half of these individuals receive no treatment for their condition (Ontario Psychological Association, 2001). Stress and other conditions that substantially increase medical costs often go untreated (Saskatchewan Psychological Association, 2001). This focus on physician care in the Canadian model reduces quality for patients and may be costly for provincial health plans.

Aside from the Canadian system’s focus on hospital and physician care, other barriers to primary care change include: increasing professional specialization and protection of turf; fragmented health care delivery; marginalized health promotion activities and illness prevention services; limited patient empowerment; and a lack of health information (Canada 2002, p. 119). Consistent with recent provincial and federal reports (Alberta, 2001; Québec, 2000; National Forum on Health, 1997; Saskatchewan, 2001; Senate, 2002), the CFHCC recommended a less fragmented approach to primary health care. Given the vast and diverse nature of the country, as well as the very different needs, organizations, and providers available in different communities, the CFHCC did not propose a single model or approach as the final solution to achieving a reformed primary care system. Instead, it proposed, in order of priority, four essential building blocks that must be put in place for any given approach to succeed: 1) continuity and co-ordination of care; 2) early detection (including prevention) and action; 3) better information flow concerning needs and outcomes for both providers and patients; and 4) new and stronger
incentives so that providers are encouraged to provide more comprehensive and integrated care. These four building blocks were also accepted as the “key” to an “effective primary health care system” in the 2003 First Ministers’ Accord on Health Care Renewal (Canadian Intergovernmental Conference Secretariat, 2003).

The first building block would, as in home care, likely require case managers to guide individuals through the health care system and co-ordinate their care services. Although a truncated version of this role is currently occupied by primary care physicians, one recent Health Transition Fund project in primary care demonstrated that the case manager of the future need not be a physician or nurse as long as access to those providers can be assured (Durand, Tourigny, Bonin, Paradis, Lemay, & Bergeron, 2001). Whether some psychologists could ever work as case managers in a reconfigured primary care setting would depend on factors similar to those discussed above in relation to home care. This would certainly require knowledge and experience beyond a narrow specialization. Unlike home care, however, remuneration for case managers should be less of an issue given that primary care physicians currently act as de facto case managers in the current system, and most receive incomes that exceed those of the majority of practicing psychologists.

The more plausible scenario is for psychologists to become full-fledged members of the multidisciplinary primary health care teams of the future. In this regard, the Prime Minister and the Premiers have committed their governments to provide all Canadians with access to 24-hour a day, 7 days a week, care from “multidisciplinary health care organizations or teams,” with one-half of their respective populations to have access to this reconfigured type of primary health care within 8 years (Canadian Intergovernmental Conference Secretariat, 2003, p. 3). In this respect, psychologists already enjoy a comparative advantage due to their “specific training in interpersonal, group and workgroup dynamics that help them work collaboratively with colleagues as team members” (Canadian Psychological Association, 2001, p. 2).

Going beyond the referral system, which lies at the heart of the curative medical model, the future primary health care team will not only diagnose, treat, and rehabilitate a given roster of patients, but will take proactive steps to prevent illness or disease, provide public health services, and promote health through education. Although team members gain entry into such teams by virtue of their specialized education and training, they work as general health care practitioners providing the advice and services most appropriate to the individual. In this sense, the current trend towards increasing professional specialization within psychology may actually work against the feasibility of providing primary care through such a methodology. In addition, the tendency to jealously guard the “scope of practice” within any old (e.g., psychiatry) or new (e.g., clinical psychology) specialization can be a formidable barrier to change. To create the primary health care teams of the future, it will be essential to draw on the broadest possible range of health-provider skills and knowledge.

Prescription Drug Therapies and Future Options
As in other OECD countries, prescription drug therapies have become a major part of the Canadian health care system. As is the case with home care, prescription drug therapy is not an insured health service under the CHA. Nonetheless, because of the growing importance of drugs in medical treatment, every province and territory has created its own drug plan to provide public coverage for defined prescription drugs to certain classes of individuals. For the most part, these plans supplement existing private insurance plans, which are primarily employer-based in Canada. As is the case with home care, provincial and territorial drug plans vary considerably by jurisdiction.

Scientific breakthroughs, combined with intensive research and development activities by pharmaceutical companies, have produced a wealth of prescription and over-the-counter (OTC) drugs that now accompany medical treatments, as well as substitute for older treatments and interventions, including surgery. Based on Québec data, the following six categories of pharmaceuticals now account for over 50% of total spending in provincial drug plans: lipid reduction, antihypertensives, antiinflammatories (analgesics), gastrointestinal, antiinfectives, and psychotropic (Québec, 2001).

These pharmaceutical categories are largely responsible for the surge in public and private drug spending in Canada, the fastest growing sector of health expenditures for the last two decades. In 1980, prescription drug expenditures represented 5.8% of total (public and private) health expenditures in Canada. By 2001, this prescription drug share had risen to 12% (Canadian Institute for Health Information, 2001, 2002). Combined spending on prescription and OTC drugs now surpasses total spending on physician services in Canada. Inferring again from Québec data, prescription drug costs have grown by almost 60% from 1997 to 2000. By far, the fastest growing pharmaceuticals are psychotropic drugs, which grew by an astounding 115.4% during the same period (Québec, 2001).
Many would argue that such rates of growth are unsustainable for the provincial drug plans that have been underwriting 44% of total prescription drug costs based on a national average of 1999 data (Canadian Institute for Health Information, 2002). They may also be unsustainable in the long run for private insurance plans, which cover approximately 34% of total prescription drug outlays, as well as for individual Canadians, who pay out-of-pocket for 22% of these drugs. Concerns have also been raised about inaccurate prescribing and inappropriate utilization behaviours that are detrimental to the health of Canadians.

The more fundamental question is whether the existing health care system is, as a general rule, overly weighted toward drug therapies as opposed to drugless alternatives. There is some evidence to support the proposition that some nondrug psychological therapies may be just as effective as drug therapies. In one study of severely depressed outpatients, nondrug cognitive behaviour therapy (CBT) was directly compared to antidepressant medication, the most common therapy recommended by psychiatrists. The outcomes associated with the use of CBT for very severely depressed individuals were as positive as antidepressant drug therapy (DeRubeis, Gelfard, Tang, & Simons, 1999). This points out the need for more research in light of the fact that Canada may be on an unsustainable prescription drug trajectory if current prescription and utilization patterns persist. In terms of cost, virtually every provincial drug plan is under immense strain due to growing demand and the rapid introduction of new and costly prescription drugs. Some provinces have responded by reducing public coverage. In terms of patient safety and health quality outcomes, serious concerns have been raised about the knowledge base of some primary care physicians as well as the medical profession’s overall emphasis on drug treatment versus drugless alternatives. Psychological services may provide one part of the solution to the future sustainability of prescription drug plans – both public and employment-based plans – as well as providing treatment modalities that actually improve patient safety and health outcomes.

At a minimum, patients should be made aware of alternative treatments in such cases. These will generally come down to three options: first, drug therapy alone; second, psychological (including cognitive behaviour therapy and other psychotherapies) treatment combined with drug therapy; and third, psychological treatment alone. There is supporting evidence concerning the effectiveness of psychological treatment for anxiety, depression, panic disorder, anger, and stress, as well as for coping with cancer and major physical illnesses and disabilities (Canadian Psychological Association, 2001).

The profession of psychology seems to be divided on a related issue. Some would like to see clinical psychologists receive prescription privileges in Canada. They point to the efforts in certain American territories and states that have resulted in some psychologists being permitted to write prescriptions for their patients or clients. Others oppose the idea of the profession having prescription privileges, emphasizing the efficacy of drugless treatment modalities (Dozois & Dobson, 1995). Given the cost pressure of current drug plans, however, it is almost inconceivable that any provincial government would allow another profession to write prescriptions for fear that this would drive up consumption and costs. The stronger argument in an environment of scarce resources is that the drugless therapies provided by psychologists are both less costly and more effective than the prescription drug alternatives. Research in this area should take on greater importance. As a society, we allocate enormous resources to pharmaceutical research, mainly through the private sector. This could be offset by a combination of increasing public and private funding for research into drugless therapies. Moreover, this research must include cost effectiveness as well as clinical effectiveness.

Rural, Remote, and Aboriginal Health and Health Care

The CFHCC also proposed major change in terms of rural, remote, and Aboriginal populations that could have some bearing on the future deployment of psychological services. Canada has an immense geography with a rural and remote population dispersion that is more extreme than any OECD country by a considerable margin. Not only is it expensive and difficult to provide health and health care services within reach of these populations, but many types of health providers are in chronic short supply. In addition, the needs of Canada’s rural and remote populations are greater than their urban counterparts. Both physical illness and mental disorders are more prevalent in the rural, remote, and northern parts of Canada, an unsurprising result given the high correlation between the two (McIlwraith & Dyck, 2002).

Despite the prevalence of mental health problems in rural and remote regions, there are very few psychiatrists practicing outside urban areas. Of the 3,600 psychiatrists in Canada, for example, not one resides in the Yukon, according to the Canadian Mental Health Association (2001). Drawing from a larger pool of psychologists to provide mental health services in rural and remote communities could potentially
address the chronic shortage of psychiatrists. However, psychologists are also concentrated in urban areas, generally in close proximity to university and health-related research infrastructures. As is the case with all health provider professions, the ability to attract individuals who have grown up in such rural and remote communities into the psychological profession may be the determinative factor. One example of such a successful program for recruitment and retention is provided by the Rural Psychology and Post-Doctoral Residency Program at the Health Science Centre in Winnipeg (Saskatchewan Psychological Association, 2001).

Sixty-five per cent of aboriginal people live in areas defined as rural by Statistics Canada. More significantly, the rate of suicide among Aboriginal peoples is eight times the national average (Canada, 1994). Clearly, there is a need for services that could be provided by psychologists with some broader cultural understanding and sensitivity. More importantly, this should indicate the need for psychologists of Aboriginal ancestry and the great opportunity to be obtained by university psychology departments to attract Aboriginal students in a very proactive way. Funding here should not be an issue given ongoing federal funding that is available to universities, colleges, and other organizations that establish programs and processes to increase the participation of Aboriginal students in courses leading to professional health careers (Canada, 2002b).

In the CFHCC consultations, many Aboriginal people expressed their belief in a more traditional, spiritually based and holistic approach to health and health care. The approaches suggested – from healing circles to the use of native herbal therapies – are worth careful examination by psychologists. Through such research, many non-Aboriginal Canadians might benefit from this Aboriginal knowledge.

Conclusion

The future sustainability of public health care in Canada depends on the effective marshalling and allocation of scarce public resources. Costs must be managed while constantly working to improve outcomes in both population health and health care. To avoid a fate similar to many managed care organizations in the United States, it is not enough to simply contain costs without regard to outcomes. Instead, provincial health plans should be focused “cost-efficient interventions with demonstrable outcomes” (Hunsley, Dobson, Johnston, & Mikail, 1999). Certain psychological services meet this criterion but the decisions concerning public coverage, and the priorities within public coverage, remain based on service categorization, often by location (e.g., hospital) or the profession delivering the services (e.g., primary-care physicians). Reconstructing health care for the 21st century requires moving away from this simple categorization approach to a more complex assessment of alternative treatments based upon proven evidence of quality and cost outcomes, the ground work for which has now begun (McEwan & Goldner, 2001).

One potential area to begin with is for one or more jurisdictions to experiment with limiting public funding to empirically supported treatments. For psychologists to be “in the running,” as Hunsley, Dobson, Johnston, and Mikail (1999) point out, this would require psychologists to develop treatment lists and practice guidelines for a host of mental health services. Without doubt, there are public health care services offered by psychologists that are substitutes for the services offered by other professions. But there are many more unique services offered by psychologists, some of which can play a critical role in improving the quality of the system and ensuring its sustainability into the future.

Correspondence concerning this manuscript should be addressed to Gregory P. Marchildon, Faculty of Administration, University of Regina, Regina, Saskatchewan, Canada S4S 0A2 (E-mail: greg.marchildon@uregina.ca).

Résumé

Les répercussions découlant des recommandations issues de la Commission sur l’avenir des soins de santé au Canada (CASSC) vont bien au-delà de la portée, par nécessité limitée, du rapport qui en a émané. Le présent article explore le rôle possible que pourraient jouer les psychologues dans un système de soins de santé public restructuré, qui déborderait les soins hospitaliers et médicaux et permettrait de gagner les soins à domicile et un système de soins primaires remanié. Les régimes publics de soins de santé pourraient également bénéficier du recours aux approches psychologiques comme solutions de rechange à la pharmacothérapie. Un tel élargissement du modèle canadien existant, fondé sur l’expérience clinique, pourrait améliorer à la fois les résultats cliniques et les résultats médicaux. Ces résultats pourraient à leur tour permettre aux régimes de soins médicaux provinciaux, qui sont soumis à des pressions financières énormes, de réaliser de nouvelles économies.

References

[D. Mazankowski, Chair].
Canada (1964). Royal commission on health services, volume I. Ottawa, ON: Royal Commission on Health Services [E.M. Hall, Chair].
Canada Health Act (1985). R.S.C. 1985, c. C6. [Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services].
Canadian Mental Health Association (2001). Written submission to the Commission on the Future of Health Care in Canada.
Hunsley, J., Dobson, K. S., Johnston, C., & Mikail, S. F. (1999). Empirically supported treatments in psycholo-
Psychological Services and the Future of Health Care in Canada


Les services de psychologie et l’avenir des soins de santé au Canada : un résumé

ROY J. ROMANOW
Ancien Premier ministre de la Saskatchewan, ancien président de la Commission sur l’avenir des soins de santé au Canada et supérieur de recherche en politique publique
Université de la Saskatchewan et Université de Régina

GREGORY P. MARCHILDON
Ancien directeur général de la Commission sur l’avenir des soins de santé au Canada et titulaire de la Chaire de recherche du Canada en politique publique et en histoire économique
Université de Régina

En novembre 2002, le rapport final de la Commission sur l’avenir des soins de santé au Canada (CASSC) était rendu public; ce rapport était publié à un moment où les régimes d’assurance-maladie financés par les deniers publics qui, selon plusieurs, se trouvaient en pleine crise financière et politique, suscitaient la controverse. Tous s’attendaient à ce que le rapport de la Commission clarifie le débat et donne une orientation aux mesures gouvernementales possibles, tant à l’échelon provincial que fédéral. En raison du caractère imminent de la question, la Commission a disposé d’une période inhabituellement courte pour mener la recherche et tenir les consultations publiques – 18 mois plutôt que les 3 à 5 ans réservés normalement à une commission d’enquête parlementaire; par conséquent, le rapport qui en a émané porte exclusivement sur des plans d’action réalisables pouvant être mis en œuvre de façon relativement rapide pour réagir au tollé croissant du public face à l’inaction du gouvernement.

Les répercussions des recommandations de la Commission dépassent, néanmoins, la portée limitée de son rapport final et il importera d’approfondir davantage les recommandations lorsque viendra le temps de discuter de leur pertinence pour des disciplines professionnelles précises. Le présent article examine le rôle que pourraient jouer, dans un système de soins de santé restructuré, les professionnels offrant des services de psychologie. On aborde les nouvelles conceptions en ce qui a trait aux soins à domicile et aux soins primaires, ainsi que les questions liées aux traitements à l’aide de médicaments sur ordonnance et à la prestation des services de santé mentale en régions rurales ou éloignées et auprès des populations autochtones. Enfin, un aperçu préliminaire du modèle d’assurance-maladie canadien dresse une esquisse du contexte qui pourra contribuer à cette discussion.

Le modèle d’assurance-maladie canadien
Les régimes publics d’assurance-hospitalisation universelle ont été adoptés par toutes les provinces et territoires au début des années 1960 et la tendance qui existait alors, voulant qu’on sépare les traitements psychiatriques et psychologiques du système « régulier », supposait que ces services n’étaient dispensés que dans certaines situations, peu nombreuses et très précises. Pendant la décennie qui a suivi, l’assurance-maladie s’est étendue jusqu’à couvrir les services médicaux de première ligne offerts ailleurs qu’en milieu hospitalier. En vertu d’un accord de partage des coûts à 50/50 pris avec Ottawa, toutes les provinces ont mis sur pied des modèles de soins primaires fondés sur les services d’un médecin et se sont mises à utiliser les deniers publics pour payer les professionnels de la médecine d’après la formule de rémunération à l’acte. Les autres professions, y compris les psychologues professionnels, ont continué à exercer leur profession à l’extérieur du système public.

Bien que l’élargissement de la protection des régimes d’assurance-maladie et des subventions au-delà des hôpitaux et des installations de soins de santé primaires ait été observé dans les années qui suivirent, les provinces ont continué à s’appuyer sur le modèle de soins primaires fondés sur les services d’un médecin en tant que moyen principal de dispenser des services médicaux. Cette situation a fait des omnipraticiens le point d’accès principal du système de soins de santé, à une époque où les progrès en matière de traitement pharmacologique et les changements apportés aux modalités de traitement en santé mentale entraînaient la « désinstitutionnalisation » de nombreux patients psychiatriques hors des établissements provinciaux. Les cas graves ont continué à être orientés vers des psychiatres, tandis que les omnipraticiens se chargeaient des cas les moins graves. L’adoption en 1984 d’une loi fédérale, la Loi canadienne sur la santé, a fixé encore davantage le modèle d’assurance-maladie fondé sur les services d’un médecin et est parvenue à limiter la
surfacturation des médecins et des hôpitaux dans certaines régions du pays. Même si cette Loi n’empêche pas les provinces de prodiguer une vaste gamme de services, elle renforce le statut privilégié du médecin offrant des services de première ligne et elle fait obstacle à l’élargissement des services dans le domaine de la santé mentale. C’est ce qui explique que 80 % des consultations auprès de psychologues se déroulent en cabinet privé plutôt que dans le système public, où sont traités, exclusivement par des psychiatres, les troubles mentaux les plus graves, les cas les moins graves demeurant souvent non diagnostiqués et les préoccupations générales et systémiques en matière de santé mentale étant rarement examinées.

Quelques projections prometteuses quant à l’utilisation de la psychothérapie sans le recours à la pharmacothérapie laissent croire que les psychologues cliniciens devraient jouer un rôle plus important dans le traitement des troubles mentaux, graves et moins graves, ainsi que dans la prestations d’un complément psychologique au traitement conventionnel des maladies physiques. Tout en reconnaissant que l’inflexibilité qui marque l’histoire des soins de santé persiste encore aujourd’hui dans le système de soins de santé, l’accessibilité des psychologues à domicile ne renforce le statut privilégié du médecin offrant des services de psychologie et l’avenir des soins de santé au Canada. Les recommandations de la CASSC insistent sur l’importance de faire passer l’actuel modèle de soins de santé primaires à un système qui fera appel à une diversité de disciplines, ainsi qu’à des gestionnaires de cas qui coordonneront le traitement et faciliteront la collaboration entre les professionnels dans les soins à domicile, des soins primaires et de la pharmacothérapie.

Soins à domicile

Au fil des années, les provinces ont élargi leur couverture aux services de soins à domicile dans le but d’améliorer le continuum intégré de soins mis à la disposition des personnes qui ne nécessitent pas expressément une hospitalisation. Malheureusement, les soins à domicile n’ont pas réussi à régler adéquatement les problèmes associés aux nouvelles approches adoptées par les soins de santé mentale au cours des dernières décennies, problèmes qui pourraient s’aggraver avec le temps en raison du vieillissement de la population. Pour accroître l’efficacité de l’aspect « communautaire des soins de santé » dans le traitement des troubles mentaux, la CASSC a recommandé la création d’une infrastructure globale qui assurerait la gestion des cas (qui est, à l’heure actuelle, à peu près inexistante dans toutes les provinces) et la mise sur pied de services d’intervention afin de détourner les patients d’une hospitalisation automatique.

De plus, les provinces pourraient décider d’ajouter à la liste des services assurés dans le cadre des soins à domicile les services généralement reconnus et dispensés par les psychologues. L’éventail des services psychologiques offerts dépendrait des orientations prises par les provinces ou par les autorités régionales de la santé afin de déterminer la composition des équipes professionnelles chargées des soins à domicile. Tout comme pour la coordination des cas, les compétences des psychologues cliniciens doivent être prises en considération lorsque viendra le temps de définir le rôle de coordonnateur/gestionnaire des cas et la personne qui assumera ce rôle, et ce, même si la rémunération financière deviendra un déterminant décisif du niveau de compétences de la personne qui occupera ce poste.

Nous proposons ici que le rôle des psychologues professionnels dans les soins à domicile en phase post-aiguë, les soins palliatifs à domicile et les soins de fin de vie à domicile devrait consister en des consultations psychologiques auprès des patients et des membres de la famille, le contrôle de la douleur et la réadaptation. Ces services de psychologie pourraient être codifiés et intégrés à une approche, nouvelle et efficiente, de prestation globale des soins de santé (dont découlera possiblement des économies) que permettra une Loi canadienne sur la santé remaniée.

Soins de santé primaires

Les soins de santé primaires, en tant que point d’accès de première ligne qu’empruntent les patients qui ont recours au système d’assurance-maladie, sont encore fondés sur les services d’un médecin. Les recommandations de la CASSC insistent sur l’importance de faire passer l’actuel modèle de soins de santé primaires à un système qui fera appel à une diversité de disciplines, ainsi qu’à des gestionnaires de cas qui coordonneront le traitement et faciliteront la collaboration entre les professionnels de la santé. Ce nouveau modèle engendrerait un continuum de soins, disponibles 24 heures sur 24, intégré et homogène, qui compléterait la diversité des problèmes de santé et des préoccupations des patients qui accèdent au système. Les psychologues professionnels pourraient agir à titre de membres à part entière, aux côtés des autres professionnels de la santé, des équipes de soins de santé primaires de demain et se pencher, non seulement sur certains problèmes et préoccupations de santé précis que vivent les patients, mais également œuvrer dans le cadre d’une démarche plus globale.

Traitements par médicaments
d’ordonnance et choix d’avenir

Au Canada et partout ailleurs dans le monde, la pharmacothérapie a pris une place de plus en plus prépondérante dans le traitement des maladies, tant mentales que physiques. Les coûts liés aux médicaments sont en augmentation, en particulier les médicaments de caté-
gorie pharmaceutique, tout spécialement ceux de la sous-catégorie des psychotropes. Pour les régimes d’assurance-médicaments publics qui sont, au Canada, administrés exclusivement par les provinces et souvent avec le concours des régimes d’assurance privés personnels, cette réalité s’est traduite par des pressions financières. Les préoccupations croissantes au sujet des coûts et de la viabilité financière de la pharmacothérapie s’accompagnent d’une certaine méfiance laissant croire que le traitement des troubles mentaux a donné, au détriment des traitements parallèles, trop d’importance à la pharmacothérapie. Qui plus est, des inquiétudes sérieuses ont été soulevées quant à la base de connaissances de certains médecins offrant des soins de santé primaires en ce qui a trait aux pharmacothérapies qu’ils prescrivent.

Les patients devraient être informés des traitements psychologiques de rechange pouvant être employés avec la pharmacothérapie ou pouvant remplacer la pharmacothérapie. Compte tenu des pressions croissantes exercées par les coûts associés à la couverture des médicaments, il est peu probable que les psychologues obtiennent l’autorisation de prescrire des médicaments de peur que cela entraîne une augmentation de la consommation de médicaments – en revanche, le recours accru aux psychologues professionnels pourrait devenir une approche moins coûteuse et, peut-être, plus efficace pour améliorer la santé mentale. Il est nécessaire de mener des travaux de recherche supplémentaires à ce sujet, possiblement financés par des fonds publics et privés, afin de faire le contrepoids des ressources abondantes investies actuellement dans les recherches pharmaceutiques.

Régions rurales, régions éloignées et santé autochtone

Les psychiatres et les psychologues professionnels qui, au Canada, sont répartis en majeure partie dans les centres urbains, se trouvent très loin des populations les plus gravement touchées par la maladie. Soixante-cinq pour cent des populations autochtones du Canada vivent en région rurale et les peuples autochtones présentent en général un taux de suicide de huit fois plus élevé que la moyenne nationale. On doit se pencher sur la nécessité de doter les régions rurales et éloignées de services de psychologues professionnels, peut-être en mettant sur pied des programmes ciblés qui mettraient à contribution les collectivités dans la formation des psychologues (par exemple, le programme de psychologie rurale et le programme de résidence post-doctoral offerts par le Health Science Centre de Winnipeg). Les professionnels qui possèdent une vaste compréhension des variables culturelles et une grande sensibilité aux différences culturelles pourraient contribuer à l’intégration de certains aspects de la guérison traditionnelle à la réadaptation de ces collectivités extrêmement défavorisées.

Conclusion

La viabilité des soins de santé au Canada nécessite une restructuration de la prestation des services afin d’y incorporer un éventail plus vaste de compétences professionnelles. L’intégration de ces compétences au système public repose sans aucun doute sur des résultats concrets et des économies. Les services propres à la profession de psychologue doivent être pris en compte dans une évaluation plus complexe de l’efficacité et de la perspective globale des traitements et de la prévention. La recommandation de la CASSC, qui prescrivait, en premier lieu, d’offrir des soins assurés par l’État aux personnes qui nécessitent des soins de santé mentale à domicile et communautaires, a été adoptée par les premiers ministres en février 2003. Il s’agit là d’une véritable impulsion qui constitue le cadre parfait à l’intérieur duquel d’autres services de psychologie et d’autres programmes pourront s’intégrer au nouveau modèle canadien d’assurance-maladie.