The future of health care in canada

Countries, Canada

Raphael (2003) pays particular attention to policy issues to retrace the policy studies demonstrating how Canada had once the foremost place in setting out specific policy issues and leading public debates in this area, only to have fallen behind in advancing policy initiatives in the areas of the social determinants of health. Once again, the promotion of biomedical interventions and lifestyle choices as the remedy overlooks the evident social determinant sources for a policy of individualism without credible evidence That matters might redressed by creating a task force and setting aside the $1. 5 billion targeted for diagnostic services in the Romanow Report on the Future of Health Care in Canada by " allocating an equal amount towards two essential determinants of health for children and families:

1. affordable, safe housing
2. a universal system of high quality educational childcare..."

That seems far-fetched given the present conservative trend across Canada. Reutter and Kushner (2010) call upon nurses to be especially sensitive to iniquities and to battle by advocacy and political engagement social conditions that result in and perpetuate health inequities whose key dimensions involve a ' critical caring approach' within a social, political, economic and historical context of health inequities that " policy advocacy" would address allowing is to " move forward". After a hard day of nursing, policy advocacy seems beyond what may be expected though.

Moore et al. (2015) do not make that assumption in focusing on early childhood years, seeking specifically the impact of inequities upon health and development and again for ways to reduce inequities by " policies and

practices that work” accomplished through working what they called “ layers of influence” by which they means the broadest possible proposals, each drawn from a specific instance when that worked as in employing a texting system in one Australian jurisdiction to a community effort geared to early issues in another. It is not clear why what worked in one place in Australia at one time would work well in another place in Australia at another time, still less in Canada where we are urged to follow the evidence-based examples that were provided. nCrammond and Carey (2017) dispute that, though they too call as others have for urgent political action outside the specific area of health delivery, in varied government sectors that are to be lobbied.

Their proposal is extremely simple and relies on making ethical considerations, not evidence-based data the basis of that appeal. While the direction of the above articles was away from relying on individual responsibility and the role of education when confronting inequalities in the social order that affects public health, Adler et al. (2014) by contrast suggests that increased funding on programs to erase inequality has very little real impact, so that the less expensive self-help model may be preferable. In sum, money should not be wasted, but rigorously targeted to health promoting behaviors. This work is worth noting as extending and defending by monetary investment what would be dispersed in health care, a view that is surely a great political barrier to eradicating inequality in Canada’s health sector.

Finally, Garg et al. (2016) thinks to combine better health, improved health care delivery, and reduced costs while overcoming social and environmental

barriers to good health by targeted screening for social determinants which “ can detect adverse exposures and conditions that typically require resources well beyond the scope of clinical care. Screening any condition in isolation without the capacity to ensure referral and linkage to appropriate treatment is ineffective and, arguably, unethical.” Where the links to services may be found is left unmentioned.