CANADIAN PSYCHOLOGICAL ASSOCIATION

SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

Psychology Specific Analysis of the Report of the Royal Commission on the Future of Health Care in Canada

December, 2002

I - INTRODUCTION

The one and a half year odyssey of the Commission on the Future of Health Care in Canada, known as the Romanow Commission, is at an end with the tabling of the Commission's report in the House of Commons on November, 28, 2002. The report is a comprehensive template for the future development of health care in Canada. It is important for psychology to identify the directions, opportunities and obstacles for the discipline outlined in the report.

Psychology made the Romanow Commission an advocacy priority during 2001 and 2002. These advocacy activities included the following:

1. CPA, the majority of provincial associations and a couple of regional associations submitted letters and briefs.

2. Many individual psychologists wrote letters.

3. Many individual psychologists contributed money to support the advocacy effort.

4. CPA organised a meeting with Lillian Baine, Associate Executive Director of the Commission and Special Advisor to the Commissioner in Winnipeg that included representatives from CPA, the Council of Provincial Associations of Psychologists (CPAP), the Canadian Register of Health Services Providers in Psychology (CRHSPP), the Canadian Council of Professional Psychology Programs (CCPPP), the Manitoba Psychological Society (MPS) and the Psychological Association of Manitoba (PAM). A news conference was held.

5. CPA appeared before the Commission during the Sudbury, Ontario public hearings.

6. A number of psychologists appeared before the Commission.

7. CPA attended one of the Experts/Stakeholders workshops chaired by Lillian Baine and Bob McMurtry, Special Advisor to the Commissioner.

8. CPA had several informal discussions with Dr. McMurtry.

9. The Group of Seven Health Professions (also known as the G 7 including psychology, pharmacy, physiotherapy, occupational therapy, social work, dietetics, and speech pathology and audiology) invited Mr. Romanow to meet with the group. Unfortunately the invitation was not accepted.

10. CPA invited the Commissioner to meet with psychology. Unfortunately the invitation was not accepted.

11. CPA supported briefs from other organizations such as the Health Action Lobby (HEAL), the Canadian Institute for Child Health and the National Children's Alliance.

12. CPA was one of the few professional associations invited to the pre-budget briefing (lock up) two and one half-hours prior to the tabling of the report in the House of Commons.

13. CPA's goal was to attempt to make contact with the Commission in some form or another on a frequency of two times per month.

As you can see, this was a major advocacy effort by the psychological community. Many thanks go to the many organizations and individual psychologists who donated their time, energy and money to further the cause. The process drew the discipline closer together and produced some very important documents that are part of the foundation for further advocacy work.

Unfortunately, when all is said and done, psychology has seen better days. The psychology specific issues will be looked at in some detail later in this analysis. To begin with, however, the report makes recommendations that can be supported by psychology and/or by each of us as Canadian citizens. The next section briefly summarises some of the positive macro issues. The final section looks at some of the specifics of the report from a psychologycentric perspective.

II - FIRST THE POSITIVES

The Commission made some important recommendations that psychology and we as Canadians can support. These include, for example:

1. Increased funding for health in a long-term, stable and predictable manner.

2. A health specific cash transfer to the provinces for health.

3. Targeted funds for a Primary Health Care Transfer, Rural and Remote Access Fund, Home Care Transfer and a Catastrophic Drug Transfer.

4. The development of a Canadian Covenant on health to outline the entitlements and responsibilities of Canadians, providers and governments.

5. The development of a Health Council of Canada to improve co-operation and collaboration and to have good data drive decisions concerning services. There is a major focus on improving information collection and use.

6. The creation of Centres for Health Innovation to research issues related to rural and remote health, health human resources, health promotion and pharmaceutical policy with mental health recommended for the second round of Centres.

7. Expansion of scopes of practice and flexibility of practice to better meet the needs of Canadians. The report recommends a broader range of services that need to be available to patients. Needs assessments should be locally sensitive and practice should be empirically based.

8. Education and training needs to be more interdisciplinary in nature with a focus on rural and remote issues to attract and maintain practitioners. Strategies must address recruitment and retention issues.

9. There is a strong emphasis on primary health care reform to provide 24/7 physician coverage, to include a broader mix of necessary professionals, to ensure incentives are in place to recruit and retain professionals and to focus on health promotion and disease/injury prevention. The Commission outlines what it calls the essential building blocks of primary care as continuity of care, early detection and action, better information on needs and outcomes and new incentives for health care providers to participate in primary health care.

10. There is an attempt to improve physical health diagnostic access and a reduction in waiting lists.

11. Recommendations call for improved services in the official languages and culturally sensitive services.

12. Three main pillars of the report relate to an improvement in services to rural and remote communities, an expansion of home care ($500 million to be allocated to home care for the mentally ill) and pharmacare.

13. The report makes recommendations to improve Aboriginal health.

The report is replete with inclusive and permissive language that provides opportunities for the profession of psychology to develop within the Commission's vision of health care in Canada.

Based on the language, it is likely the Commission would argue that the report positively addresses psychology's recommendations and concerns. It is likely Commission staff would underscore the value of psychology's many individual and organizational submissions. At a macro level, the profession can feel satisfied with the job done. Psychology has not been excluded and much of the report's language can be interpreted positively for psychology.

III - PSYCHOLOGY SPECIFIC ANALYSIS OF THE REPORT

With all this positive, what is the problem? The Devil is in the details or the lack of same.

The Commission report did not put human behaviour at the heart of health care in Canada, the title of CPA's brief and our advocacy goal. The best that can be said is that the report advanced our cause through its vague, permissive and inclusive language.

Unfortunately, the report is almost exclusively focused on physicians, hospitals, nurses, diagnostic machines, pharmaceuticals, etc. It is really a physical medicine vision. It takes us back to the struggles psychology had in the 1960s and early 1970s concerning a broadening of the health care vision to include the biological, cognitive, affective, social/cultural and environmental determinants of behaviour across the continuum of care from wellness to palliation. As a discipline and a health system we have moved well beyond this vision.

Using time as a marker, much of the dialogue around partnerships, scopes of practice, interdisciplinary care, primary care reform etc has taken place in the 1990's and is already occurring. Again, the profession has moved on from the perspective of the practitioner on the ground and the various associations representing the health professions. Our work with our partners on interdisciplinary collaborative care in mental health, in mental health and primary care, and in health human resources and primary care are the most recent examples.

The goal of the Romanow advocacy effort was to broaden the focus of the Commission and ultimately of the health and health care debate from an almost exclusive preoccupation on cells, organs, tissues and blood to encompass the contribution of human behaviour across the continuum of care. It appears we were not nearly as successful as we would have liked to be. This is deeply disappointing. Our vision, although enabled by the report's permissive language, was not embraced or even referenced. In fact, the word psychology or any of its derivatives appears only once in a chart on page 93.

As mentioned above, in spite of the bittersweet result, the profession performed admirably. Individual

psychologists contributed money, wrote the Commission and appeared at public hearings. Associations wrote letters and briefs. Meetings were held with Commission staff. CPA was invited to an experts workshop and to appear before the Commission in Sudbury. The co-ordinated effort left the discipline with valuable policy documents, a higher profile in the health policy and health research sector and a Commission report that will be useful in further advocacy efforts. Perhaps most importantly, the eighteen-month advocacy effort helped the psychology community become more cohesive as we worked together on this project. Many colleagues and associations became partners in the process.

The following analysis directly examines many aspects of the psychology relevant issues of the report. It is understood that none of us expected the report to respond positively to each and every one of the issues below. That it responded to none directly is telling. However, the analysis draws attention to the many opportunities available to the Commission to comment on our issues and it underlines some of the disciplines opportunities and vulnerabilities.

It is interesting to note that data collected from conversations and press releases to date indicate generally positive responses from nursing, hospitals, public health, health executives, pharmacy, medicine, long term care and the Health Action Lobby (HEAL).

So, what do we do with a good news/bad news scenario?

What follows is a brief commentary on Building on Values: The Future of Health Care in Canada (November 2002).

Chapter 1: Sustaining Medicare (page 1)

Services: The point made by the report is that the range and nature of treatment options in medicine have changed dramatically. From this broad perspective, the report then quickly narrows the field by only citing hospital and physician services, pharmaceuticals, home care and rural care.

This position completely misses the point that many other health services are provided by a wide range of providers. In fact, in the second paragraph on page 3, the spectrum of health services is essentially restricted to physical medicine.

There is permissive language in the chapter but it is not clear who it is intended to include.

Medicare and Beyond

There is no mention of the services such as psychological services that are not covered by medicare plans nor is there a discussion of ways of adding or linking these services to the public system.

Use of Private Insurance and Out-of-pocket Payments

There is limited discussion (page 24) of this important issue yet there was no meaningful exploration of the pros and cons nor the links of the private sector to the public sector. The report strongly supports public, tax based health financing yet ignores the already thriving private sector in professional services. It is difficult to believe this could have been missed. Likely it was ignored for political reasons. It appears the Commission decided to put "their money" into the more traditionally funded areas of health care.

Chapter 2: Health Care, Citizenship and Federalism (p. 45)

The establishment of a Canadian Health Covenant (p. 48) is an interesting concept. However, based on the overwhelming physical health orientation of the report, this recommendation may not bode well for the inclusion of psychological services in a meaningful way. The Aefficiency and value for money@ point (p. 49) may hold some promise as research shows psychological services work and are cost effective.

There are many laudable points in the proposed Covenant (p. 50). The problem for the profession is whether public sector psychology will have a voice and whether private sector psychology is involved at all. The language of the report is permissive but not encouraging in its ambiguity and bio-medical focus. The inclusive language allows for change and provides opportunity for dialogue and advocacy. The lack of specific attention to psychology=s positions, based on the massive amount of material provided the Commission by psychology, speaks volumes to the historical and vested interests orientation of the Commission=s position.

Achieving the Vision (p. 52): Recommendations 3 and 4 have a lot of positive potential. The problem for psychology is there is no indication in the report that psychology is considered an important part of the system. Establishing performance indicators, benchmarks to improve quality, access, etc. are laudable indeed. However, if data on psychological activity is not captured or information systems are not developed that effectively capture this information, these recommendations will work against the profession. CPA surveyed each ministry of health in 2001 only to discover what we already knew, data systems do not capture public and private psychology activity. The record of the Canadian Institute for Health Information is another disappointing example. It has very poor information on mental health and little to none on psychology.

A New Approach to National Leadership (p. 52): We can agree with more inter-governmental co-operation and less intergovernmental fighting.

Role of the Health Council of Canada (p. 55): The Health Council is designed to report to Canadians on the effectiveness of the health care system. Again this could be an opportunity or a liability for psychology depending on the data used psychology's access to the Council, the orientation of the Council etc. On page 56, under Reporting on issues…, the report suggest getting comprehensive and reliable data on health care workers from the National Steering Committee on Patient Safety and the Canadian Council on Health Services Accreditation, two organizations that have very little helpful data on psychology in general and two organizations that do not have representation from psychology. In addition, the suggestion that the Canadian Institute for Health Information will be a valuable source is highly problematic. As mentioned above, CIHI

has little to no data on psychology except that which it collects annually from regulatory bodies. CIHI's most recent report on health care in Canada (an annual report) had nothing on mental health or psychological services. CPA continues to meet with CIHI concerning these data issues. The meetings are congenial but little progress occurs because much of the CIHI data is provincial health system data, with all its limitations. This does not bode well for the profession.

The Health Council of Canada is intended to look at primary care and the supply, distribution and changing roles of health care workers, issues dealt with later in the this analysis of the Commission's report.

A Possible Model for the Health Council of Canada (p. 59): It is designed to be a small organisation of 14 members with 4 representatives from the provider and expert community. This leaves little room for psychology or representation from the majority of health professions. There is no process outlined to ensure meaningful interaction with the Council that could mean access is restricted, as is currently the case with the Federal/Provincial/Territorial health committee structure. No representation and limited access would be problematic.

Modernising and Updating the Canada Health Act (CHA) (p. 59): CPA's brief advised against this action out of fear that the Canada Health Act would be very vulnerable to being weakened through the political process of compromise. The Commission's report suggests opening up the CHA and adding to it.

Recommendation 5 is laudable by confirming the five principles of the CHA, updating portability and adding accountability. However, their vision of updating comprehensiveness is to add targeted home care and prescription drugs. This is not the view of expanded comprehensiveness put forward in our collective briefs. There is nothing wrong with these suggestions in and of themselves. They do not go far enough and they miss the mark in terms of psychology.

On page 62, the report puts psychology in the comprehensiveness game once again, but not by name but once again by inference. There is an obliquely defined opportunity in the recommendation to expand the continuum of care in the future as money allows. However, it recommends starting with home care and medically necessary diagnostics (read MRI not psychological assessments). Later, the report emphasises mental health service expansion in home care, which is a positive point. However, mental health should read services for the mentally ill, a much more narrow field of interest than was suggested in our briefs. Again, it is a masked or oblique opportunity. No door is closed but no hand of invitation is extended.

Providing Stable and Predictable Federal Funding (p. 65): Recommendation 6 is once again good and promising at the macro level but there is no beef for psychology in the details.

A specific, predictable and stable health transfer from the federal government to the provinces is a good idea.

Building Canada's Health Information Technology Infrastructure (p. 76): This is an excellent idea. However, the devil is in the details.

Recommendation 8: The personal electronic health record is a good recommendation. As defined in the report, it would apply to patients accessing the public system. However, will private practitioners be able to access the information (confidentiality issues, technological capability etc.)? If not, will the inability to access the information compromise their ability to treat patients due to a lack of information and could this result in liability and malpractice issues? Will those providers that can=t access the personal health record system be marginalised over time? How will this system work with the private insurers? Will private practitioners be able to or be required to participate in the system by adding patient information to the electronic record? Will the government pay the expenses or will the necessary equipment and the time needed to fill out the record be expenses borne by the practitioner?

Recommendation 9: A Canadian Health Infoway, code for the local, regional and provincial data systems being able to measure and report data that is meaningful across jurisdictions, is an excellent idea. It is one CPA has been championing for years. However, since psychological services in both the public and private sectors are not currently available but are reported under other categories or not directly collected, this effort to build a mega system will in all likelihood involve working with the most basic and readily available data sets. In other words, the system might include only those data sets currently reported by agencies and institutions and physician billing data. The problem then becomes, once again, if psychology is in a data driven system and psychology doesn't appear in the output data, then psychology is invisible which could lead to psychology being in trouble.

Expanding Health Literacy (p. 81): This is an excellent idea. The CPA Fact Sheet series is a good example. (http://www.cpa.ca/factsheets/main.htm)

Building Canada=s Health Research Knowledge Base (p. 86): There is support for more health research with a focus on applied research. The report suggests the creation of four Centres for Health Innovation (p. 87) to study rural and remote health, interprofessional collaboration and learning, health promotion, and pharmaceutical policy. Later on, if this work, it is suggested new centres are developed to address patient safety, mental health, telehealth, genomics and proteomics, and chronic disease management.

There is great potential for meaningful involvement by psychology in these centres because of our research skills and knowledge base. It is an interesting prioritisation with interprofessional collaboration and learning coming before mental health even though the latter is widely acknowledged as a huge and unmet health issue.

Chapter 4: Investing in Health Care Providers (p. 91)

The Current Situation for Canada=s Health Workforce (p. 92): This is an important moment. This seems to be the one and only place the word psychology or any derivative thereof that refers directly to the discipline appears in the report. It can be found in the chart on page 93. A moment of silence please. Perhaps it should be framed.

There is little discussion of substance of the human resource issues of any other profession or group other than nursing and medicine in pages 91 to 103. This was the identical tack taken by the Kirby report on healthcare in Canada released in October 2002.

In the section entitled Allied Health Care Providers and Managers, Allied Health Care Providers get 7 lines and the rest of the section focuses on managers for 12 lines. That is it. That=s all they wrote to cover 57% of the healthcare workforce.

The use of the term "Allied" belies a serious lack of knowledge of the sensibilities of the majority of health professions. It is a demeaning and marginalising term. Frankly, we don=t like it, we don=t use it, and we discourage its use by others when referring to psychology, a regulated health profession in all provinces and a primary care provider in independent practice. There is some reference to a few other health professions (i.e. technicians, pharmacists) outside of the section. We are not allied to that which is important in health. We are an equal partner in what is important and we call ourselves a health profession. It is simple terminology once the issue is correctly reframed. If the Commission had clearly understood the sector, they would not have used the Allied Health Care Providers descriptor as they did. Secondly, we, as a group, merit more than 7 lines of text.

A National Effort is Needed (p. 104): From the dregs of disappointment, once again, springs a glimmer of hope. The report suggests an examination of the distribution, scope of practice, practice patterns, and the right mix of skills of various health practitioners. It indicates that primary care needs networks of qualified providers and that new approaches to education and training are needed. Again, some oblique enabling clauses appear after being shut out of most of the section. It is much like a drive by compliment or opportunity.

Immediate Investments in People and Change (p. 105): Again there are some optimistic points. The first bullet on page 105 suggests immediately securing the supply and distribution of providers in rural and remote areas. This could be advantageous to psychology. The second bullet suggests transforming the skills and roles of providers. This could be both an advantage and a disadvantage. The report then goes on to say that increases in funds for rural and remote healthcare and primary care should not be spent on salaries. Not good news to the many psychologists in the public system who are significantly underpaid. That presents an interesting dilemma in terms of recruitment and retention. In addition and once again, there is no discussion of the role of the private sector. It is also not clear if there is any real support for disciplines other than medicine, nursing and those professions directly aligned with physician services.

Changing Roles and Responsibilities (p. 106): Again the pattern continues. The section focuses on physicians and nurses and suggests we need case managers. The latter is probably a good idea and could result in appropriate referrals to psychology, or it could not. It is unclear from the report how the system would work but, based on the rest of the report, it is more likely psychology will remain marginalised and case managers will not have the ability to get the right practitioner or service to the right patient at the right time, a quote from Recommendation 1 of the CPA brief to the Commission.

The third and fifth paragraphs on page 107 bring some hope. They discuss flexible provider mixes for primary care and home care. Again, the references are oblique and of little comfort within the broader physical health context of the report.

Planning for Change over the Longer-Term (p. 108): The three recommendations 16, 17 and 18 are very interesting and relate to duties of the Health Council of Canada. Sixteen suggests collecting good information on the workforce. This could be good if psychology is included.

Recommendation seventeen suggests the Council review education and training programs and provide recommendations to government on their relevance for preparing professionals for primary care. This could mean governments might exercise some direct control on program content, internships, accreditation and regulation. This would be of significant concern to the discipline.

There are more details available on 109 and 110. They suggest a shift to evidence based health care, more relevant skills mixes needed by providers, new provider roles etc. Presumably governments would/could force changes on professions through changes to education and training programs. The government might also provide additional money to increase the number of students in training programs. This could be positive if it meant more faculty and negative if it meant higher student/professor ratios or the withdrawal of money when the government thought it had enough psychologists or when money is tight.

Recommendation eighteen suggests the development of a comprehensive plan to deal with the issues identified in Recommendation 16 discussed above.

It is important to examine Table 43 on page 112 entitled Policy and Planning which outlines responsibilities across Canada related to education, training, accreditation, regulation, immigration etc. The strengths and weaknesses for psychology in this schematic are obvious and important.

Chapter 5: Primary Health Care and Prevention (p. 115)

The recommendations in this section could be very promising. It suggests taking the overwhelming focus off hospitals and medical treatments, breaking down the barriers between providers, facilities and sectors, increasing the focus on prevention, developing a community focus with responsiveness to particular community needs, more provider networks and 24/7 coverage. There is an inferred focus on behaviour change in terms of prevention. We can hope psychology is a partner in this new vision of primary care and prevention, but it is not explicitly recommended.

One glaring problem with the model is the lack of discussion about the primary care providers outside of the public system. This omission is significant for private psychology practice.

The report encourages the use of case managers, service integration and case networks. These ideas could be very interesting for psychology or could leave the profession out in the cold. There are no details and the overwhelmingly physical health orientation of the report leaves only tempered optimism.

The notion of early detection (p. 122) is one psychology strongly supports yet, once again, the example is very physical health oriented.

The report recommends more information on needs and outcomes (p. 133). This is a no brainer. It could also mean more involvement for psychology=s scientists. On the other hand, the information provided will be the information funded and vetted for dissemination, and, as noted above, psychology is all too frequently a data phantom in terms of tracking service provision. The question remain, will psychology data be available for research, will research on psychological services be seen as a priority and thereby funded and how will this information be disseminated?

New and Stronger Incentives (p. 123) indicates that remuneration mechanisms for physicians A... and other health professionals in primary health care settings are obstacles.@ Earlier we noted the report suggested new money not be used for salaries.

The report also wants stability in primary care so there is not constant change with the resulting negative consequences. Work-life conditions call for less rigid scopes of practice and shared responsibilities for patients. It is hard to know if this is advantageous or not. The point the report makes is that quality of care should improve. We would all agree with that. That would result in a broader use of psychological services, a point not mentioned in the report.

Building National Momentum (p. 126): The report calls for a summit on primary care to include key stakeholders. If psychology is included, and if psychology=s position receives voice and standing, then this could be an important opportunity. The problem is inclusion and voice. Since the best predictor of past behaviour is future behaviour, it is not clear that psychology would be included, or, if included, have meaningful representation that results in some influence. National health summits over the past ten years have had large representations from specific groups such as managers, medicine and nursing. We will have to follow this initiative carefully.

The report lists many potential positive aspects of primary care improvement on pages 126 and 127.

Strengthening the Role of Prevention (p. 128): Again, these recommendations and the emphasis on prevention are easily supported. However, there is no mention of mental health or psychology. The report again uses exclusively physical health examples. This pattern covers several pages under topics such as Promoting Good Health, Addressing Leading Causes of Major Health Problems and A National Immunisation Strategy. This physical health focus is disappointing considering the well-documented role of psychology in prevention, the plethora of health issues involving psychological factors and the central role of mental health and mental illness.

Chapter 6: Improving Access, Ensuring Quality (p. 137)

The first issue is waiting lists. This is entirely physical health oriented. It states that waiting lists are managed

by physicians. There is no mention of other providers who manage waiting lists. There is an emphasis on diagnostic services which means MRIs and CT scanners. The report is concerned with access to specialists (likely medical) and surgical procedures. Pretty thin soup that covers pages 137 to 150.

Improving Quality (p. 150): The Health Council of Canada is encouraged to develop a national framework for measuring and assessing quality and safety. There is much of interest and worthy of support in this concept. Again, the devil will be in the details. Inclusion, access and voice will be among the important issues for the profession.

Improving Access for Official Language Minorities and Addressing the Diverse Health Needs of Canadians (p. 154): There is much to be supported in these sections.

Chapter 7: Rural and Remote Communities (p. 159)

At a macro level, there is much to be supported. However, the section is almost exclusively physician and nursing focussed. There is passing reference to the broader group of health care providers. The use of telehealth is supported. The report does talk about trying to attract and retain health care providers, but the underlying message seems to be attracting and retaining physicians and nurses. Recommendation 31 (p. 166) calls for support for innovative training programs that give health care providers a rural health experience in order to recruit and retain professionals in rural areas. This sounds like the Manitoba psychology rural internship model.

Chapter 8: Home Care: The Next Essential Service (p. 171)

Looking Ahead (p. 175): The first bullet on the top of page 176 ties home care to networks of primary care providers. This is one of CPA=s recommendations and offers the possibility of significant involvement by psychology practitioners, both public and private. The question is how realistic is the possibility of success for psychology.

Home Mental Health Case Management and Interventions (p. 178): There is a strong commitment to home care services for the mentally ill which includes the recommendation of over 500 million dollars of new funding for this initiative. This is a very important recommendation and should be vigorously supported.

The downside is that this is virtually the only recommendation for improved mental health services and relates only to the mentally ill. This group of patients certainly needs the support and so the recommendation should be strongly supported.

However, it is very telling that this is the only specific reference to mental health issues except for the recommendation for the eventual development of the previously discussed Centre for Health Innovation for mental health (p. 88). This demonstrates a very narrow view of mental health, mental illness and psychological factors in health. It should be noted that the reports use of mental health should read mental illness. It also demonstrates a lack of appreciation of the psychological components of health across the

continuum of care. The report places little importance on these critical issues for the health of Canadians.

It is interesting that this is the same position taken by the Kirby report. Senator Kirby's Senate Committee was unable to deal with mental health in its six volumes and so relegated the issue to a separate investigation to occur in the future. This is very damaging. This is the centuries old tradition of separating psychological factors in health, mental health and the mentally ill out from "real health", adding to marginalization and stigma. Our briefs and information demonstrated to both Senator Kirby and Commissioner Romanow how to effectively integrate mental health and psychological factors in health across the continuum of care. Neither body was willing to take this necessary step. As a result, we continue to have the orphan of mental health, to use Mr Romanow's words, whose orphan status is unwittingly reinforced by both reports. This conceptualisation of mental health, mental illness and psychological factors in health is deeply rooted in the past and completely misses the current reality.

The rest of the chapter is strictly physical health oriented under such topics as Post-acute Home Care, Palliative Home Care, Informal Care Givers, Human Resources, Contiguity and Co-ordination of Care, etc. Again, there is no reference to psychology or our issues.

Chapter 9: Prescription Drugs (p. 189)

This Chapter has many good ideas and yet completely ignores the contribution of psychology. There is no discussion of the efficacy of the combination of medications and psychological interventions or the superiority of psychological interventions. This is a major oversight. Ironically, the bullet on page 192 entitled Substitution for Other Medical Interventions talks about the substitution of medications for other medical procedures and not the more current framework of the substitution of more efficacious and cost-effective interventions in place of medications.

The section Medication Management and Primary Health Care (p. 206) talks about an interdisciplinary approach to medications, alternatives and medication management. Again the focus is physical health oriented but we should seize upon this point to underling the meaningful involvement for psychology.

Chapter 10: A New Approach to Aboriginal Health (p. 211)

This Chapter discusses Aboriginal health with no mention of psychology. There are, however, many opportunities whether or not they are mentioned in the report.

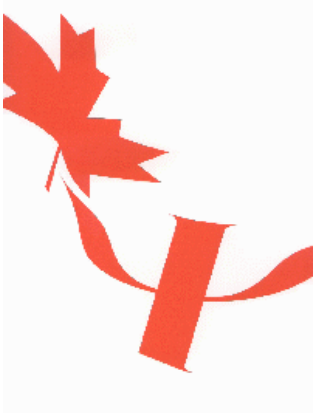
IV - SUMMARY

In summary, although the report is very disappointing from a psychological health, mental health and mental illness perspective, it offers many oblique opportunities that we will use in our advocacy efforts in the future.

Psychology made the Romanow Commission a major advocacy effort. Many associations and individuals supported the effort on behalf of the science and practice of psychology. To one and all a heartfelt thank

you.

As was discussed above, the results from this high level and excellent effort were disappointing. However, the many oblique positives and the enabling language provide important opportunities for psychology. The advocacy effort was effective in this regard. In addition, the lack of clarity in regards to the profession and the physical health focus of the report mean we must be vigilant. We must ensure decisions are not taken that compromise either the public or private practice of psychology and thereby the quality of care and the health of Canadians.



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Prepared by the Clinical Section of the Canadian Psychological Association

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