CONVERSATION ON HEALTH: MY VIEWS

Executive Summary
My starting point is the five principles on which the Canadian health care systems are based: public administration, comprehensiveness, universality, portability, and accessibility. To these I would add a sixth principle which is in the preamble to the provincial Medicare Protection Act and appears to have stimulated this conversation: fiscal sustainability. What did these principles mean to Canadians when first formulated in 1960 in Saskatchewan (for the medicare plan on which the Canada Health Act was later based), and what do they mean to Canadians now?

Public administration
Forty-seven years ago, ‘public administration’ meant the exclusion of insurance companies and medical organizations from control of the medical system. Those were the existing private-sector interests that strongly opposed the introduction of any publicly administered medical system although they favoured the idea of ‘prepaying’ medical care. The notion that private-sector corporations other than insurance companies might be able to profit from selling health care to individuals was hardly on the horizon at this time although there were a few highly specialized service centres with medical ownership.

So in the general form, each provincial government established what is now a customary model: an arms’ length commission including government representatives which is responsible to the government for administering the medical/hospital system. The commission may contract with another or other bodies to administer the various aspects of its operations.

The objective behind ‘public administration’ was to keep ‘profit’ out of decisions relating to an individual’s health care. The essence of this is that no one should have more, or less, or different care of his health because some-one within the health care system would benefit financially from a decision on the health care he is to receive.

This very clearly seems to be still the objective of Canadians. We will not let go the principle of public administration. ‘Public administration’ permits a government to pay the bills at a considerable distance from the health client, usually through one or more layers of private-sector administrative intermediaries which are entitled to be paid for their service.

But in the vastly more complex health care system of the present it is no longer so easy to determine how to keep the profit motive out of influencing an individual’s health care. Each layer of intermediary private contractors between the payer - that is, the government - and the client receiving health care introduces the potential for profit considerations to influence the health care given. To preserve the non-profit principle of public administration, therefore, the number of private-sector ‘layers’ must be minimized. Moreover, the government must set and administer strict guidelines for the contractor or contractors and must fully accept responsibility for the actions of the contractor or contractors.

The argument used for placing private-sector intermediaries (or more of them) between the government-payer and the client-beneficiary is that the private sector is more efficient at administration than government is. ‘Efficiency’ is equated with ‘cost savings’. How to assess this argument? Does the private sector spend less to get the same result? Not necessarily, and perhaps not even often. Where cost savings follow privatization it is often because service has been reduced or employees are being exploited or both. On the other hand, it is possible to save money through private contractors if the private-sector management is of better quality than the government’s or improves efficiency through well-judged capital improvements which the
government has refused to finance. So every case must be judged carefully on its specific merits. My own conclusion from these considerations is that governments should retain the principle of public administration and implement it more whole-heartedly. Therefore, whenever government contemplates contracting out a function in the health care system, it should first:

- ensure its own health administration is of top quality, with particular emphasis on first-rate management information systems including financial and statistical information;
- examine the relative costs and benefits of improving its own systems in comparison with the costs and benefits of policing those of a potential private contractor;
- set strict, detailed and enforceable guidelines for the actions of contractors; and then
- accept government responsibility for a contractor’s actions

‘Public administration’ does not require or imply public ownership of physical facilities. That had been clear since the introduction of the national hospital insurance plan well before medicare. However, once health care became a full-blown industry, the established pattern of hospitals owned by public trusts and religious orders was augmented by the appearance of for-profit hospital companies. These provoke some controversy in the same way that non-hospital institutions for personal care do (extended care homes, seniors’ residences, nursing homes): do the facilities generate profits through low standards of care and exploitation of their employees rather than through higher standards of administrative ability?

**Comprehensiveness**

This principle, that insured persons should receive all necessary medical and hospital (and even dental) services, was initially stated in a very general and even circular way to avoid interfering with either professional judgments on patients’ needs or the specifics of provincial health service plans. The phenomenal changes in medical, pharmaceutical, hospital and other aspects of health care in the past forty-seven years confirm the prudence of being non-specific in the statement of the ‘comprehensiveness’ principle. For one thing, planners in the sixties did not contemplate any need to ration health care. It was not supposed that people would seek care they didn’t need. Advertising about health conditions and treatments was basically limited to well-known patent medicines. Diagnostic procedures were few, and surgical interventions were regarded with great caution. Hospitals were where people went for care, to be discharged when they were better. Retrospectively it could be said that medicare was framed in the dark ages. Had the legislation contained detailed specifications it would have required continuous updating so its flexibility has been a continuing advantage. The financial demands of an expanding health care universe have been making heavy fiscal demands. Formally speaking, the only path provincial governments might have taken in attempting to rein in costs would be to ‘delist’ medical services - that is, characterize some as no longer ‘medically necessary’. But the participation of medical professionals in medicare administration ruled out that kind of approach. Instead, provincial governments have tried to constrain medicare costs by limiting the supply of what might be called the factors of production (hospital beds, equipment and health professionals) and by bargaining hard, sometimes even unfairly, with various kinds of health care personnel. As a result of many factors, patients’ stays in hospital beds are now astonishingly shorter than they used to be for equivalent conditions or procedures. One consequence is that some of the cost of sickness initially borne by the public system has been transferred back to the sick individual: namely, medication and what used to be considered nursing care. Out of hospital
after three days, the sick person provides his own medication and nursing and personal care where previously he might have stayed in hospital three weeks receiving all of these through public care. Thus new non-insured health care needs appear. They join a group of health care needs that for mostly institutional reasons never have been wholly included in national health care systems: the long-term pharmaceutical and care needs of the mentally and physically impaired.

Fiscal sustainability and accessibility are major aspects of the comprehensiveness issue. Personally, I am disappointed that provincial governments have not tried - as they might have done - to move in the direction of a national health plan providing broadly similar services to all Canadians, but this issue seems to raise little public discussion.

**Universality**

Universality - coverage of basically the whole population - has never been an issue in the health care system and does not seem to be now. In the fifties and sixties, insurance interests campaigned vigorously to continue using individual or employer-based insurance premiums to cover the well-to-do and institute provincial government payment of the insurance premiums for the others, but this option vanished when public administration won out. In provinces which require the payment of a premium for coverage, arrangements are readily made for the inclusion of those unable to pay. However, status Indians are excluded from the covered population and instead receive separate and different coverage directly from the federal government. In my opinion, the long-term goal of Canadian health systems should be to incorporate status Indians, while providing whatever separate targeting their health needs require. I have to recognize, however, that nobody feels it in his or her interest to advocate the integration of status Indians into the general Canadian health systems. Perhaps that time will come.

**Portability**

True portability will not be reached until Canadians can get much the same health services when travelling within the country as when at home. It is not going to happen for a long time; provinces are not motivated to move on this front. It is worth considering, however, whether some of the fraudulent use of health cards occurs when residents of one province want to obtain service in another, whether because of waiting times or views about the relative quality of services. If services were more portable within Canada, would the administrative costs of the provincial health plans be thereby reduced?

**Accessibility**

This principle bundles together two interesting ‘sub’ principles. One has to do with payment for services from the health client’s point of view: all insured persons must have access to insured services on uniform terms and conditions and the services must be paid for “in accordance with a tariff or system of payment authorized by the law of the province” (Canada Health Act, s12 (1)(b)). The other principle has to do with payments from the provider’s point of view: medical practitioners or dentists (but not other health service professionals!) must receive reasonable compensation. Compensation is considered reasonable if it results from negotiations between the province and provincial medical (or dental) organizations and if the dispute resolution therefor is appropriately constituted in accordance with the Canada Health Act. Both of these two main principles are in issue currently. A third provision in the accessibility principle, respecting federal hospitals, is not of interest in the present health care conversation.
Looking first at accessibility from the client’s point of view, the principle has a financial component and a non-financial component.

The financial component is essentially that the fee for a service rendered to A must be the same as the fee paid for the same service rendered to B. Clearly the government plan must not pay differential fees for the same service: but then why would a patient be interested in topping-up the payment to a practitioner? The answer is obvious at the present time though not at all times: to receive service sooner. This leads directly to considering the two-tier proposals emanating from some specialists in the medical profession, perhaps predominantly particular kinds of surgeons and imaging specialists who have long waiting lists. Adopting a two-tier system means either that some specialists are underemployed or else that though fully employed in the public system they are willing to adjust their patient waiting lists on the basis of financial benefit to themselves. The second possibility reintroduces the profit motive discussed above under **Public administration** and is clearly inadmissible as a breach of fundamental principle in the national health plan. The first possibility, that some skilled resources are underemployed, will be touched on below under **Fiscal sustainability**.

The non-financial component of the first accessibility principle, from the client’s view, is that insured services must be provided on uniform terms and conditions and on a basis that must “not impede or preclude (access to those services), either directly or indirectly whether by charges...or otherwise...” (Canada Health Act, s12 (1)(a)). The big difference between some groups of residents and others is their place of residence. People who live in the larger cities have much better access to most health care facilities than people who do not. This difference exists for most facilities, not just health care, and to a great extent reflects lifestyle choice. People living in cities have better access to theatre, cinema, cable television, high speed internet, cell phone service, libraries, shopping, employment opportunities, and so forth, and they pay for their advantages in money (the higher cost of living), lack of privacy, exposure to noise, traffic and dirt, and so forth. People living in small towns or the country forfeit a lot of the advantages listed but they benefit from lower living costs and many compensating social and recreational advantages. It is not feasible to provide rural dwellers with the same access to health services as city dwellers have, but good access to primary care and emergency care must be considered basic and essential. There is always much to be done here; every province struggles with the problems of health services in low-density and remote areas. The Conversation on Health has provided a lot of good suggestions.

The other main ‘accessibility’ principle has to do with the compensation paid to health service providers, specifically medical practitioners and dentists. The reasonableness of their compensation is judged by the manner of arriving at their fee schedules, including provision for dispute resolution. The Canada Health Act deals only with compensation for these specified professionals, but in the Conversation on Health we should make it an explicit goal to achieve reasonable compensation for all types of health service workers. Technicians of many types are required to provide a full range of diagnostic and health care, not doctors alone. Provincial governments have willy-nilly assumed the major responsibility for ensuring that the provincial supply and distribution of all types is optimum. They do this by a combination of training offered and salaries or fees paid to practitioners. On the whole, no province seems to have achieved a satisfactory way of arriving at reasonable compensation for health professionals, including doctors - certainly not if harmony and satisfaction were desired outcomes. Several provinces including British Columbia have seen bitter disputes between medical associations and the provincial government on amounts paid for
medical services. Some feelings of grievance on the part of the professionals may have been justified. Leaving the allocation of provincial fees among specialties within the medical profession may not have led to the best overall allocation of medical specialties from the point of view of the public well-being. (As an example, the worrying decline in the availability of primary care providers, family doctors.) But this area is not one I feel competent to comment much on.

**Fiscal sustainability**
The Government of British Columbia started the Conversation on Health because of its fiscal concerns. I think the provincial health plan does an outstandingly good job and I do not see signs of the ‘failing’ and ‘at risk’ health system that some people are shouting about in newspaper headlines. I would rather improve the system by enlargement to meet our national objectives more fully than restrict it out of fiscal fears. (I recall the fearful alarm of the Economic Council of Canada in the early seventies that in so many years the two responsibilities of Health and Education - particularly Education - were going to consume the whole GNP. It didn’t happen. But then, maybe it was prompt provincial reaction that saved us from the peril. Provincial governments attacked both serpents by restricting the number of health care professionals they would educate and allow to immigrate. That accounts for our personnel shortages now, but is it what saved us from bankruptcy twenty years ago?)

Fiscal considerations must not be allowed to stampede us into making changes to a comprehensive, almost universal, almost portable, accessible and publicly administered health system which works pretty well and only needs to be rounded out. A major rounding out I support would be inclusion of pharmaceuticals to some extent. This is a cause in which B.C. could join other provinces to press the federal government for leadership and financial support. Another would be the integration of mental health services more successfully into the general health portfolio.

I also suggest division of the current health care budget into two main parts, to differentiate between the system of ‘insured services’ (medical, hospital and pharmaceutical services) and other elements currently in the health budget which are for personal or residential care or home services. This differentiation should probably be accompanied by a redefinition of ‘insured services’ so that the term includes all services which are narrowly health services according to current practice, rather than following the historical accident of how the services came to be publicly administered. I recognize that all provincial governments and the federal government have waffled back and forth over time on how to manage these programs, sometimes putting all government activities related to human well-being into one department and sometimes putting them in two or even three different departments.

In the Conversation on Health’s “Pressures on the Health Care System” you describe health spending as totalling $12.8 billion. Medical Services and PharmaCare together cost $3.75 billion and $4.6 billion for Acute Care is contained in the large Regional Health figure. Putting these three together I arrive at a total of $8.35 billion (no doubt understated) for what I would consider ‘insured services’ - that is, hospital and medical services and the pharmaceutical program as it currently exists. It seems to me that the systemic issues about money which are now being fought out under the headings of ‘privatization’ and ‘two-tier health care’ play out differently with respect to insured services than they do with respect to other health care institutions which are more
precisely described as welfare services. (By welfare services, I do not mean payments to the indigent but rather services to improve residents’ well-being.) Splitting the health budget as it is now presented doesn’t at all reduce expenditure, but it could clarify for public discussion what portions of provincial responsibility it is that the insurance industry and medical bodies are attempting to bring into the private i.e. the insurance realm.

This brings us to the major question of efficiency within the health care system. Adopting ‘two-tier’ health care, i.e. allowing insured services to be provided to persons outside the health care plan at differential (higher) fees, would increase the total of dollars spent on health care and also the proportion of GNP spent on health care. Is that what the health care system needs? Back to the question raised in the Accessibility section: are there medical practitioners who are now underemployed and can only be fully employed if they are allowed to practise both within and without the plan? If so, are they prevented from full employment within the plan because the fee schedule in some way caps their total earnings from it? Are they prevented from full employment because the physical facilities they require for their work are not available? Are they prevented from full employment because their catchment basin doesn’t provide enough patients for their highly specialized capacity? Is there something else that could be impeding their full employment?

I don’t know the facts here, and knowledge of the facts is essential to finding solutions. If a radiology specialist (let us say) is forced to work less than she wants to because the province or the medical association has imposed a cap on her income, I would disapprove of such a technique of limiting provincial expenditure, especially when waiting lists are long. If the radiologist cannot work because the radiology equipment is not available, the provincial plan is functioning at poor efficiency by failing to provide needed equipment or, perhaps, by failing to allow full utilization of equipment. (Shortage of ancillary staff, say). Again, if waiting lists are long it would be poor management to create or permit deliberate inefficiency in the use of provincial resources in order to restrain total expenditure. Or is there a specialist unable to work full-time because there is a shortage of insured residents requiring his or her services? In such a case, which is conceivable, the province should attempt to make arrangements for a highly specialized professional to work in two or three jurisdictions.

It’s useless to speculate without knowing what it is that prevents doctors from using their time fully on insured patients and insured services, but it is certainly possible to imagine institutional inefficiencies that create such a situation. And if this is the case, the provincial government should be working on eliminating those inefficiencies. Of course, clients who have more money than most people are naturally ready or eager to spend some of their money on preferential health care access, but there is no reason why the public health care plan should be structured to facilitate this.