

20 YEARS OF HEALTH CARE IN POLICY OPTIONS

POLITIQUE SANTÉ : 20 ANS DANS OPTIONS POLITIQUES

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This year marks Policy Options' 20th anniversary. To celebrate, we are running excerpts from the archives. In this issue, to go along with our cover story, we feature past analysis of and recommendations for health care policy. Lots has changed in 20 years, but, alas!, as you'll see, lots hasn't.

Notre revue célèbre cette année son vingtième anniversaire. À cette occasion, nous publions divers documents tirés de nos archives. Nous reproduisons ce mois-ci des analyses consacrées au régime public de soins de santé. Les auteurs discutent des problèmes qui sévissaient à l'époque et proposent des réformes qu'ils jugent nécessaires. En vingt ans, certes, bien des choses ont changé. Mais beaucoup d'autres, hélas, sont restées en l'état.

The high cost of malpractice Following a pattern well established in the United States, charges of medical malpractice have become more frequent in Canada, and the courts have made large awards against doctors found guilty of improper practice. All doctors carry insurance against this risk: The considerable increase in the number of such awards and the huge increase in their size has enormously increased the payout by the insurance companies, moving them in turn to raise their premiums drastically...

If indeed we want the victims of medical mishaps to receive large financial awards we could adopt a different procedure. We could simply set up a kind of "no-fault insurance" system under which all such victims would be given awards, in something like the manner in which employees are given awards by provincial Compensation boards, for work-related injuries. Since absolutely everyone would be a potential beneficiary the system should be financed by a levy on everyone. The arrangement would have its own drawbacks, but these might be less severe than those being experienced now.

Innocent doctors are being maligned; wasteful medical practices are being followed; courts of law are resorting to deceitful subterfuges to achieve worthy ends.

Ruben BELLAN

September 1988

The sickness lobby Health as a movement has no natural leaders, no lobbies or pressure groups promoting a policy. Sickness, on the other hand, was named by Sir William Beveridge (*circa* 1942) as one of the major scourges of mankind, along with ignorance, poverty, squalor and war. Before that time the poor, the ignorant and the sick were always to be with us to appeal to our charity. Since then they have no longer been acceptable. Consequently sickness has many champions: the medical profession; consumer lobbies; patients; and the victims of social pathology. But health has none. Therefore policies deal with sickness, not health...

Physicians are dedicated to the sick. The few notable exceptions, to a degree, are obstetricians, pediatricians and medical officers of health. Medical education consists of loading the mental computers of medical students with clinical facts and honing their hands for medical skills; whereas health education should be a novel trans-disciplinary synthesis of health, environmental and sociopolitical studies...

Though physicians know more about normal physical functions than the laity, they don't know enough about health to assume real leadership. And health is far too important to be left to doctors alone.

Daniel CAPPON

March 1983

Medicare controls costs The Canadian experience has had two distinct periods: an initial rapid expansion of facilities and services, followed by a much more constrained expansion. In 1951, Canadian expenditures on hospital and physicians' services respectively were 1.5 percent and 0.7 per cent of Canada's GNP. By 1985, expenditures on hospital and physicians' services, as a per cent of GNP had about doubled, reaching 3.5 per cent and 1.4 per cent of GNP. The number of hospital inpatient days per 1,000 population increased from 1,419 in 1951 to 1,958 in 1982. Hospital services per patient day more than doubled over the same period. The number of physicians per 1,000 population rose from 1.0 in 1951 to 2.0 in 1985. On average, each physician nearly doubled the services he or she provided over this period. Physician services per capita rose even faster, more

than four-fold between 1951 and 1976, and another 70 per cent by 1982. The number of nurses has also increased dramatically, from 104,635 in 1971 to 242,000 in 1988.

Nevertheless, the Canadian experience also provides the lesson that with universal public insurance, a government can impose remarkably effective ceilings on cost escalation. Since the government is the sole payer for hospital and physician services, it can impose cost ceilings without the continuation of cost escalation through supplementary private payments or extra-billing. Each province has imposed limits on hospital budgets, physician fee schedules, and the number of new medical students and interns.

David CONKLIN

May 1990



Raeside, May 1991

Hard decisions need to be made In a time of economic restraint, hard decisions need to be made and all the players need to be aware of the costs of their decisions. Does the average taxpayer know the cost of each trip to his doctor or to the emergency department? Do doctors realize the cost to the government and hence themselves as taxpayers of each unnecessary referral or blood test?

People must be made aware that ultimately they are responsible for their own health. If they choose to smoke, drink, drive dangerously, statistics prove that they will have medical problems and hence medical costs. Should everyone pay the price of another's carelessness? Life insurance and automobile insurance companies are now differentiating rates for their customers. The government must undertake a public awareness program.

Anne CRICHTON

November 1986

Taking responsibility, taking control What is needed is a discussion which encompasses a balanced and cooperative approach to the development of health care policy. Certain European countries have already started to embrace a more holistic approach to health care involving a more humanistic view toward the care and maintenance of the sick and elderly.

At the root of this approach is the belief that the individual patient should have more control over the life and death decisions surrounding the treatment of terminal diseases or extreme aging. Indeed, the continuing control of these decisions by the medical profession is being challenged in the United States on legal grounds.

In Canada, we can take comfort from the growing emphasis on personal responsibility for health care. The increased focus of attention on the prevention of disease through the combination of a healthier living environment and healthier lifestyles, as promoted by the federal Lalonde Report in 1974, has the long-term potential to improve the health of the community substantially, at a lower cost.

John CHURCH

July/August 1989

Cost control is number one Cost control has now replaced access as the primary objective in the health care system. Access objectives involved choosing the services to be provided; cost control is more problematic because it means choosing to eliminate less beneficial services. It means saying “no.”

Cost control at best incites “your money or your life” arguments, and at worst means state-sanctioned death. Health cost control is also income control ... This mobilizes a powerful lobby against spending control, access limits or elimination of those services that convey a marginal benefit at an immense cost.

Central cost control through physician fee schedules, facility availability, technology acquisition and finite hospital budgets, has had limited success in containing health expenditure growth, especially when utilization *per se* remains uncontrolled.

Cost control does not mean moving from the present state of no rationing to rationing; it means a change in the way rationing takes place and who is affected by it. It is ludicrous and naïve to think any nation can provide all the care that is technically feasible. Up to now, we have been able to postpone any decisions about who gets what care by accommodating demand and supply through increased resources. What happens when we can no longer increase resources?

Susi M. DERRAH

October 1993

The new orthodoxy One thing has remained constant about our shifting array of health concepts: They have never been immune to manipulation by the ideologues of the prevailing social order. Medieval church-states blamed disease on demons and prescribed the burning of witches. With industrialization came the discovery of germs, and the marketing of allopathic medicine and mass-produced drugs.

The most recent conceptual chicanery is the notion of “lifestyles.” Disease in the industrialized first world is considered the outcome of such bad personal habits as smoking, drinking, overeating, lack of exercise, high stress, promiscuity and plain old carelessness. Atonement carries an unacceptably high price tag (over 7 per cent of the GNP) and curbing health care costs means spreading a new health promotion gospel of personal restraint and individual responsibility. If you get a head cold or a backache or have high blood pressure, you can add guilt to your misery, stop smoking and take up stress management.

As with all new efforts to wrap up our irksome reality into a neat package, this new health philosophy contains both truth and con; but the key health promotion assumption that unhealthy lifestyles are the fountain of contemporary disease is specious, and government interest in “preventive medicine” suspect at best.

Ronald LABONTE

Jan./Feb. 1982

The Polish/Canadian model Recurring sources of public dissatisfaction identified in the past include: uncaring health care professionals, queuing for service, inadequate and outdated institutions, lack of access to service, no free choice of physician, lack of facilities, and so on. The response of previous Polish governments had been quite consistent, irrespective of the government in power — communist or democratic. Health Care Commissions, made up of government appointees, were established and they all recommended similar remedies: more funding, organizational restructuring and consolidation.

Malgorzata FIGURSKA and Jacek HOLOWKA

October 1993

The uses of crisis There is a “crisis” in Canadian health care. But this should come as no surprise: there has always been a crisis in Canadian health care. The corresponding rhetoric — cut-backs, shortages, unmet needs, in general “under-funding” alleged by the providers of care, with the counterpoint of “spiralling costs” or “cost explosions” threatening to bankrupt the country or at least its governments — should be quite familiar after decades of repetition.

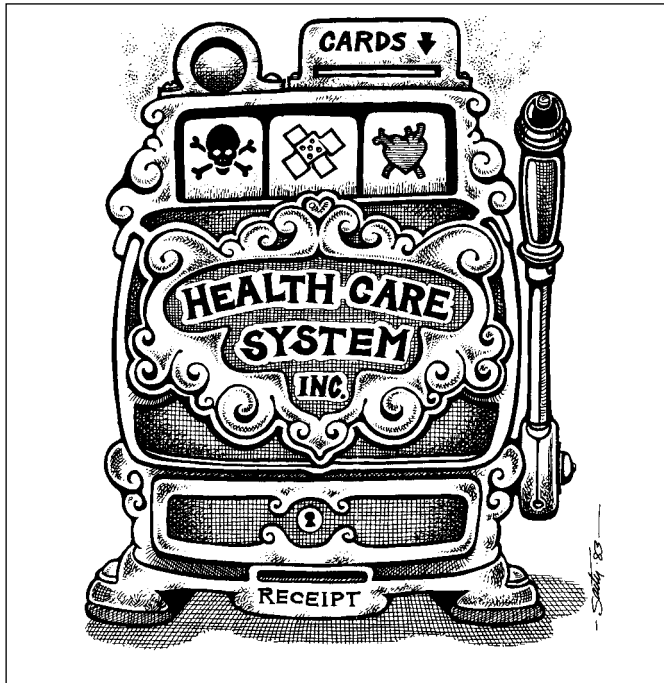
In the last thirty years, Canadians have almost doubled the share of our national income used to pay for health care, from 5.4 per cent in 1960 to 9.9 per cent in 1991. Per capita expenditure has quadrupled, from about \$500 to just over \$2000 (in constant, 1986 dollars), and has increased 50 per cent in the last ten years. And throughout, the Canadian health care system has been the most richly supported in the

world — always excepting the US. Yet despite this massive expansion, the rhetoric of “crisis” and “underfunding” continues — with claims both of “unmet needs” and inadequate provider incomes.

The rhetoric is in fact unrelated to actual levels of funding, since no finite level of support will ever meet all imaginable “needs” or satisfy all income aspirations. Claims of “crisis” are part of the on-going process of political bargaining through which providers of care negotiate for their share of national income in a public system. They are advanced through what Jonathan Lomas has described as “orchestrated outrage” — which also, of course, makes for alarmist newspaper headlines and dramatic sound-bites.

Robert G. EVANS

July-August 1993



Saitu, March 1983

Health costs have not risen Health care costs in Canada are not rising faster now than over the past twenty years; and on average have risen considerably less fast since the completion of universal coverage in 1971 than in the previous decades. What has happened, is that since 1980 the growth of the overall Canadian economy (and that of most other western economies) has slowed markedly. Health care costs are not “exploding,” just continuing to rise at the same rate they always have. But our ability or more accurately our willingness to pay these ever increasing amounts, in our more straitened circumstances, is now less.

This does not mean that there is not a problem of limiting the growth of our health care system to fit within our more limited capacities — there is, and it is a serious problem. But it has not been created by some change in the behaviour of the health care system itself, let alone some change resulting from public financing.

Robert EVANS, Morris BARER
and Greg STODDART

October 1993

The Singapore model Singaporeans recognized a decade ago that, if trends continued, they would not be able to afford to finance the system. In 1984, the government introduced a compulsory saving plan, the “Medisave Scheme,” under which an amount equivalent to 6 per cent of an employee’s wages is set aside every month. The Medisave funds can be withdrawn to pay for hospital care but cannot be used for ambulatory or out-patient services ... On reaching the retirement age of 55 years, the account holder can withdraw the accumulated savings, minus \$10,000. The philosophy behind the Medisave scheme is that people must be rewarded for staying well.

The system is the main means of paying hospital care: about 70 per cent of Singapore General Hospital’s in-patients use Medisave funds to pay for services ; 10 per cent depend on employer-funded coverage and 20 per cent pay out of their own pockets.

Ron MARSTON

October 1993

MRIs vs. school lunches Decisions in health care are rarely taken in isolation. Funding an MRI would more than likely mean not funding something else like perhaps an expansion to the renal dialysis program. Ethical decisions also have to take into consideration what course of action leads to the greatest good for the greatest number. The decision-making process so far has, once again, only looked at doing things right. From a societal perspective, this issue may take on a different outlook.

Expenditures on health care should be justified by evidence of a benefit to the health of society. Health is much more than health care. The Lalonde commission several years ago pointed out that health is a function of environment, lifestyle, genetics and health care facilities. As Aaron Wildavsky notes in *Doing Better and Feeling Worse: The Political Pathology of Health Policy*, “The best estimates are that the medical system (doctors, drugs, hospitals) affects

about 10 per cent of the usual indices for measuring health: whether you live at all, how well you live, how long you live. The remaining 90 per cent are determined by factors over which doctors have little or no control, from individual life style, to social conditions, to the physical environment.”

In a world of limited resources we must look for activities that provide the greatest impact on the health of a community. The interest on the funds required to purchase, house and run an MRI in a community would likely fund a school lunch program for that community. The impact of these two courses of action on the general health of the people though is quite different. One good nutritional meal daily to all the children in Canada would probably do much more for the general health of the population than would the operation of an MRI in every large hospital.

Kenneth J. FYKE and Barbara POOLE

October 1991

For a health care payroll tax Premiums are a form of regressive taxation levied in equal amounts on all people regardless of ability to pay, except in the case of the very poorest in society. Taxing middle- and lower-income earners at percentages greatly in excess of upper-income earners is unacceptable...

A more efficient and potentially more progressive and humane method of raising revenues for health care exists and it has been adopted, with variation, by Quebec, Ontario and Manitoba — the Employers' Payroll Health Levy. This tax, as the name implies, is a levy on the salary roll of all employers in the province...

The advantages of this tax are obvious. First and foremost it guarantees that everyone who lives in the province has a right to receive medical treatment, regardless of whether they can afford it. In effect, a payroll tax secures universal health care: a right for all people to be treated for sickness, the only criteria being personal ill-health, not financial well-being...

The payroll tax can be relatively progressive as between corporations if the tax is levied on a graduated scale as payroll costs increase. Generally speaking, the larger the corporation, the more profitable it is and the more easily it is able to absorb costs. Furthermore, because the tax is based on gross payroll rather than the number of employees, the tax falls most heavily on those corporations or other employers who have the highest paid employees. Indirectly, therefore, the payroll tax ought to be progressive though there are some counter indicators.

Maureen A. MALONEY

May 1991

The crisis this time Is the Canadian health care system in crisis — again? Many would agree that fiscal constraints have become more widespread and more firmly entrenched in our health care system than ever before. This period of "budget famine" and cost control coupled with the unrelenting pressures for high quality and technologically advanced services lead many health payers and providers to conclude that, this time, the system is indeed in a crisis.

William G. THOLL
and Claudia A. SANMARTIN

October 1993



Frampton, October 1991

Don't copy the Canadian model In Britain, it is impossible for those over the age of 65 to get hemodialysis unless one goes to a private medical facility, which one has to pay for. In Canada, the determination of whether one gets dialysis is even more complicated. If you happen to have multiple ailments, the government may leave you out entirely and since no private parallel system is permitted in Canada that person is sure to die unless they can get to the US and pay.

While those over age 65 are technically eligible for dialysis in Canada, unlike those who reside in Great Britain, there are very few who actually get it.

Notice that Harold Ballard, the 86 year-old former owner of the Toronto Maple Leafs, was flown to Miami in late December 1989 rather than to Toronto for dialysis treatment as he could afford care in the US and there was a certainty that he could receive immediate treatment, whereas in Canada, that would not always be possible if the dialysis unit for a region is already booked.

Isn't refusing someone dialysis euthanasia by another name? Also, in the Canadian system, if the allocated spaces for a region are already allocated, the newly approved person has to go to another region or do without, a sure sentence of death.

There is another system which can be used to allocate resources. That system is a lottery, which is also claimed to be fair since it does not depend on one's wealth or status in society. Some people feel we have reached that now, as some people seem to get services while others do not — the elderly, for instance, do not always get services that others get (they are quietly told that there is no space or it would not do enough for them to make it worthwhile) and yet it seems to be a lottery as to whether the services are available when illness or accident strikes. It is surprising when a hip transplant can be done on an 85-year old woman on Easter weekend, one week after a fall broke that hip, when others can wait three years for the same operation.

Douglas J. MCCREADY

October 1991

DOCTORS' LOVE-HATE RELATIONSHIP WITH MEDICARE

Louis B. Sherman

Doctors are ambivalent about Medicare. Many of them like it. They like it because they get paid; moreover, they get paid on time. More than a few enjoy incomes far exceeding anything they could have hoped to achieve under the old pre-Medicare system, in those good old days when doctors had to chase their patients for their bills. But they dislike themselves for liking it. It is an egalitarian system, implying conformity and standardisation. It reflects a philosophy substantially unsympathetic to the classic image of the North American physician as free-wheeling, independent professional-cum-businessman, making his own decisions.

It is hard for many doctors to accept this perceived erosion of their professionalism and their autonomy; this wound to the profession's self-esteem. They live with it, rationalizing their acceptance by reminding themselves that it not only provides them with assured accounts, it also provides all Canadians with financial peace of mind where personal health is concerned. And that is something the profession endorses.

But the nagging sense of surrender is there, and the result is a deep-seated neurosis in the doctors' collective psyche. It explains part of the professions' demonstrated restiveness with Medicare, and with the fee schedule. Dissatisfaction with fees and with the stubbornness of provincial governments is part real, part gesture. In its latter capacity it is a catharsis for the guilt complex.

This does not mean that the widespread medical expression of disenchantment with Medicare is insincere. Nor does it offer any excuse to government to pass it off as unimportant. On the contrary, it builds an even stronger case for sensitive response from politicians to the profession's discontent.

There is nothing abnormal about a person's or a group's resentment when he, or it, has suffered a reduction in stature, particularly when that reduction is the product of external influences over which he had less than complete control. It is human nature to feel some bitterness in such circumstances. Since politicians themselves are particularly vulnerable to the possibilities of such a fate every time they

face the electorate, they, above all others, should understand this human frailty.

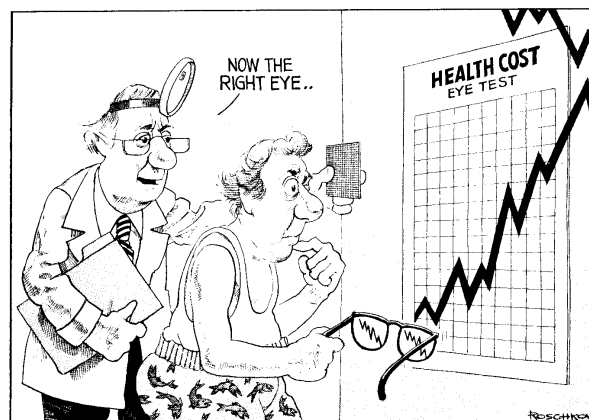
Any way you want to slice the melon, doctors have suffered a reduction in stature under Medicare. That some perhaps do not care is of little moment. Many do; and what's more important, the profession as a lobby group does. It is hard for them to say so, just as it is frequently hard for political parties to state their feelings in direct terms. Candor can leave one terribly naked, and a target for unfair and uninformed ridicule. It is impossible to imagine the doctors complaining publicly that they don't like Medicare because it has diminished their profession. It is totally unrealistic to expect them to do so; just as it would be totally unrealistic to expect a defeated politician to say he doesn't like the voters because they diminished his.

Thus, quite understandably, the doctors say other things. They carry on their battle by complaining about the fee schedule, about the "bureaucracy" of Medicare, about the need for more "flexibility" in billing privileges, and about the desirability of binding arbitration as the means of fixing their annual or biennial increases. All of these complaints are genuine in their own right. But they also serve as a smoke screen for the deeper grievance: the

regimentation that they have seen imposed by Medicare upon a great and once free science.

They do not believe that Medicare takes fairly into account either the long years they expend on study in achieving their expertise, or the long days and nights they put in at operating theatres and emergency departments in their practice. They resent the fact, for example, that under Medicare medicine has become one of the few occupations in "free-enterprise" North America that offer no financial recognition either of excellence or of experience. The fee schedule pays a fixed amount per procedure, regardless of whether the doctor performing it is an acknowledged leader in his field or run-of-the-mill; oblivious to the question of whether he has spent twenty years at his craft or one.

They do not believe that Medicare makes for very good medicine. Many of them despair, sincerely, of the effect that Medicare has had upon the style and substance of



Roschkov, November 1986

medical practice in Canada, insidiously and inexorably reducing it, in their view, to little more than a counterpart of the industrial assembly line. They see it as destructive of true professionalism: the catalyst in the rise of a new kind of treadmill medicine which implies high volumes and mass production.

The patient becomes a unit, rather than a person. Technological procedures and expensive tests replace the doctor's personal time and attention. The doctor must move on, to another unit of production, and another. The fee schedule is built that way. The system, by its very nature, generates high through-put; and once having established that environment, it demands obedience from those who would survive within it. The net result is a general style of medical practice that frequently leaves both doctor and patient feeling unfulfilled and unrewarded.

The profession is bitter that Medicare, to a large extent, has shut its practitioners out of the decision-making process in medicine and health care, and reduced them to functionaries where basic health policy is concerned. This is inevitable in any system where government is paying the bills; but the doctors' point is that there remains a role for relevant professional opinion, even in such circumstances, while the system in this case treats such opinion as a nuisance.

Finally, a great many doctors truly hate the annual or biennial round of fee-schedule negotiations which their

respective associations must carry on with provincial politicians. They find demeaning the adversarial, union-style bargaining atmosphere that accompanies those negotiations. They find uncomfortable the vivid confrontations that frequently occur between their profession and their government. And they find unfair, and embarrassing, the inevitable and often unrepresentative public discussion in the media of their so-called average incomes, and the comparisons with other provinces.

All of these deep dislikes, and perhaps even some others, lie behind the medical profession's current disenchantment and its continuing struggle against the restraining leashes of the system. There is, no doubt, genuine professional conviction that the fee schedules are too low, and that billing procedures are too rigid; but the carefully chosen rhetoric in those cries tells only half the story. It is an outlet, and a cover, for much of the real pain.

In short, the real crisis of Medicare is not so much a crisis of the fee levels as a crisis of the spirit. It is a billowing professional gloom, engendered by the perceived effects that Medicare is having in a multitude of ways upon both the artisan and the art; and if it is allowed to spread it will do inestimable damage to the quality of medicine in this country.

Louis B. SHERMAN

July/August 1982

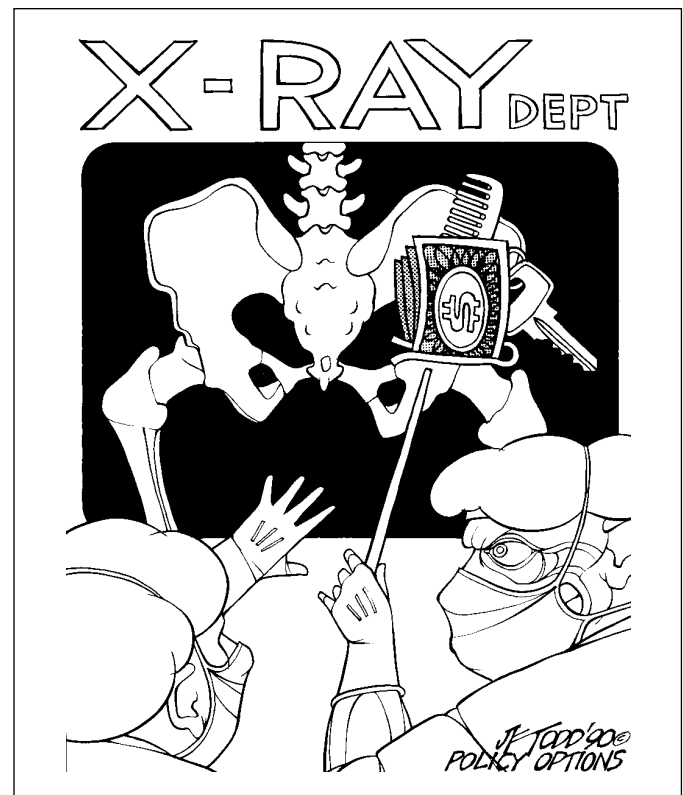
Our system is better The Canadian health care system has eliminated most market signals. Instead of responding to price changes and profit incentives, it is driven by political and regulatory decisions. As a result, many feel that the Canadian health care system has not responded or adjusted rapidly enough to basic changes in health care. In adopting new technologies, for example, Canadians often have to look to the US experience as a guide...

Canada's system is general subject to far more government direction than is US health care. Yet, in Canada, individuals generally do have freedom in regard to choice of physician. In the United States, the growth of Health Maintenance Organizations (HMOs) and other prepaid plans may have restricted some patients' choice among health care providers, particularly if the patient is a member of an employer-sponsored plan with specified providers.

Each country's experiences will likely provide useful insights for the other country. Nevertheless, at this point in history Canadians are able to state with confidence and with self-congratulation that Canada's health care system is both cheaper and better.

David W. CONKLIN

May 1990



One vision of US health care

Todd, May 1990