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HEALTH CARE DEVELOPMENTS IN CANADA

The situation in Canada is somewhat similar to that in the United States, although it differs in a number of ways. One way in particular is that in the States, at the moment at least, the interest is on provision of medical care for people over 65—that is, both hospital and medical care—and one of the concerns there is that, if that becomes part of the Social Security system, some people think it would be relatively easy to extend that downwards to cover the entire population. In Canada, the situation is a little different. The hospital field is already fully occupied by the Government at the provincial level—every province has a Provincial Hospital Plan—so that the issue in Canada is not what to do about the aged but what to do about medical care versus hospital care for the entire population. In other words, we are already at the point of the whole population being covered for hospital care, and the question is one of extending by coverage rather than the United States problem of extending by age.

In Canada, as in the States, there is a Federal Provincial distribution of powers, so that this discussion is current in Canada at both levels. In the States the most exciting discussions these days are at the federal level, but in Canada they are at both the federal and the provincial levels.

At the federal level a Royal Commission has been appointed to look into the whole question of health care for Canadians. This is not specifically health insurance, it is anything to do with health care. Are there adequate facilities, hospital facilities, medical facilities? What is to be done about the mental institutions, tuberculosis? Anything to do with health care is the subject of this Royal Commission. It has a very broad directive. Of course, one of the very important issues is, should there be a Government health insurance program?

This Commission seems to be approaching its task on a very objective basis. Its reports receive the widest possible discussion and distribution, and I personally am convinced that they do not have preconceived ideas but are open to ideas from all. The insurance business certainly intends to present its views to the Commission. I will come to that a little later.

Now, at the provincial level, Saskatchewan is the C.C.F. Government—it is what would, in the States, be called a socialistic government, I guess. They started the hospital scheme on the provincial level, which spread across Canada, so that what happens in Saskatchewan is very important, as a matter of precedent. They have already had two readings

of a bill that would introduce compulsory medical care insurance in Saskatchewan at the provincial level. It is a very interesting document. I would like to read to you four of the subjects of regulations that can be made by a commission appointed under that Act. This will be a commission of, I believe, eight members, only two of whom would be doctors. I think this will give you an idea of what is going to happen to the medical care of you and your grandchildren if general medical care at the government level is adopted on anything like this basis. This nonmedical commission has the power, the delegated authority, to make regulations on the following subjects:

1. Providing for the establishing, maintaining and altering of lists of persons entitled to receive payment under this Act for providing medical services;
2. Prescribing the rates of payment to be made under this Act to physicians and other persons and the method of assessing accounts;
3. Prescribing the terms and conditions under which physicians and other persons may provide insured benefit.

Just think that one through! This is the Government commission determining the terms and conditions under which doctors can provide medical care.

4. The standards respecting the maintenance and improvement of the quality of services provided under this Act.

Again, it is a nonprofessional Government commission which is determining how to maintain professional standards.

Adjacent to Saskatchewan we have Manitoba, and Manitoba is currently, by propinquity, much concerned about what to do about medical care in the Province of Manitoba. We have a peculiar situation there in that Manitoba Medical Services, the prepayment plan of the doctors, has a very large percentage of the population already covered, so that just what will happen in Manitoba is anybody's guess at the moment. But they seem to be exploring the private enterprise approach.

Now we come to Ontario, the most populous province, and they are interested in developing a plan based primarily on voluntary insurance. They had a recent contest for the party leadership. The Progressive Conservative Premier of Ontario recently resigned and his Party came out with a new platform for the new Premier. In their new platform they have the following plank on the subject of medical care. This I find encouraging. I hope you do, too, because this is the Administration, this is now the party in power in Ontario.

". . . A high proportion of the residents of Ontario have secured medical care insurance through existing carriers.

"The Convention recognizes the special need of those in poor health of older ages, living in isolated areas and with hazardous occupations. The Convention urges the Government to devise, in association with insurance carriers, a plan to meet the needs of these less favoured groups and to extend the existing medical welfare program on behalf of those in distressed financial circumstances."

Now, that sounds a lot more like our language, it seems to me, and I hope reflects what may be done in Ontario when the proper time comes.

Well, now, what has the insurance business been doing? Obviously we have seen this development coming for some time and the Canadian Health Insurance Association appointed a committee over a year ago to devise, if possible, a plan of voluntary health insurance that would make it unnecessary for Government to extend its services in this field.

We have the same problem there as was mentioned in the United States, that government abhors a vacuum and if we do not do the job, somebody is going to do it for us. So this committee was appointed, of which I happen to be the chairman, to try to devise a voluntary plan that insurance companies can offer the public to extend services to all these presently uncovered groups at a price they can afford, so it can no longer be said that some groups in Canada cannot get insurance at a reasonable price.

This committee, in commencing its deliberations, started with the premise that neither we nor the doctors are going to decide what the final basis of providing medical care for Canadians is. That is going to be decided by the people of Canada through their elected representatives. Our job is to try to come up with a program that will appeal to them. No matter how good it is, if it can't be sold to the people through their representatives, the plan is not going to be effective.

We also started from the premise that government insurance is not inevitable. There is a large part of the population in both countries, I am afraid, that feels, "Well, we are going to lose this battle anyway. Why waste time?" So one of the objectives was to try to convince people that, provided voluntary insurance has a satisfactory alternative to offer, it is not inevitable that the Government will take over this field.

Another premise was that only doctors can provide medical care. There is a lot of smoke screen around about insurance companies trying to get into the medical care business and interfering with the doctor-patient relationship. I don't have to tell this audience that that is the furthest thing from our minds. We know perfectly well that only doctors can provide medical care, but we do think that insurance companies have something to offer in the field of providing a mechanism for paying and dis-

tributing the cost of medical care. But before you can get very far talking to doctors you have to get it across to them that we are not trying to enter the medical care field.

Voluntary insurance in Canada, as in the States, has done a good job. About 8 million Canadians already have some form of voluntary medical insurance, and that is almost half the population of Canada. About half of those 8 million are covered by prepayment plans of the doctors and half of them by insurance companies' plans, so that, while either insurance companies or the doctors separately might not have too much voice, if we can get together with the doctors on the prepayment plans we can speak for practically half the population of Canada and say that they are already covered. Let's see if we can't find some way of extending that coverage rather than bringing in the Government. We think it is good for the people of Canada that there are these two types of mechanism. If any one carrier, whether it is a doctor-sponsored plan or an insurance type of operation, covered the entire population it would be a sitting duck for the Government to come in and take it over. Governments do not like private monopolies.

Now, despite this steady expansion of private health insurance in Canada and the United States, there are and always would be, under the present system, I am afraid, several small segments of the population who cannot or will not meet their personal responsibilities in the area of health care. The question is, is it necessary because of these minorities to sweep all of the Canadian people into one big compulsory plan? We do not think so. Such a step would be irrevocable and we think it is surely sensible to try first of all to modify the present system.

Our committee was asked to do just that—not to work out necessarily what we thought *should* be done, but what *could* be done, on the assumption that something *must* be done, and what changes in the present operation of voluntary plans would be required to accomplish this purpose.

We were directed to keep as much of the voluntary systems as we thought it was practical to do, and in particular to maintain the freedom of choice both ways between patients and physicians, to maintain the independent doctor-patient relationship, to fit in readily with the practice of fee-setting by doctors and not by third parties, to maintain the principle of competition, to avoid any semblance of monopoly, to give the Canadian people a wide variety and choice of plans and, of course, to accomplish a minimum of Government regulation, recognizing that probably some Government regulation was necessary if we were going to cover this field.

So we said, "What are the gaps in the existing programs?" That, of course, is obvious as soon as you start thinking about it. It is easy to list them:

First are the uninsurables, the people that, as private insurers under the present method of operation, we cannot insure at any price;

Second, the substandard groups, to whom we can offer insurance only at relatively high cost;

Third, the older age group, which, if you like, could be classified in the same group as the substandard for health care purposes;

Fourth, those in isolated areas where it is difficult to get to them; and

Fifth, what we started out calling the indigents, the medically indigent.

I learned something very practical from the Ontario Medical Association, that they had had difficulties over this "medical indigent" term and said it has been subject to a great deal of confusion because it has been used for two different purposes. Accordingly, they have separated it into the two different types. One is the marginal income group, those who can't afford medical care, or can't afford the full cost of it; and second, what they call the "high-risk group." Both of them have been sort of interchangeably mixed up in the term "medically indigent" and it is essential, if we are going to make progress in this area, to think of those two groups as entirely separate categories.

Of course, the cost of any such program must be acceptable. There is no point in offering to the people of Canada a program which is more than they could afford. That just leads the Government to move right in.

Well, after spending a lot of time on it, we came to the inevitable conclusion that the Government must participate for the marginal income groups—what we used to call the indigent before we learned to distinguish between the two terms—because insurance companies cannot create dollars. We cannot provide money to provide medical care for people who have no income at all, or very little income, so we put that area aside with the idea that it could continue to be covered the way it has been covered in the past.

No one company could extend coverage to the uninsurable group and the substandard group, because of the antiselection that would be involved. So we felt that this had to be a cooperative effort, and to be a cooperative effort it would require some form of legislation, first because of the Combines Act and second to be sure that all insurance companies, and also private carriers and self-insured plans, came into it—so that nobody sat back and tried to take off the cream and not take their share of the high risks. I emphasize that this must include the union welfare plans, the employer-administered plans, the so-called self-insurance—every kind

of provision for the costs of medical care. Otherwise, if we as insurance companies, for example, are going to accept a share of the high-risk group, we would price ourselves out of the market if others could come along and take only the good risks.

Out of this evolved the idea of a pool. You will hear more from the next speaker on the Connecticut pool. The one in Canada is somewhat similar, although with major differences. In the first place, it covers all ages; in the second place, each company is expected to sell its own policies with its own provisions and its own premium rates, and we maintain the principle of choice of benefits and competition on rates, services and costs. But the basic idea is that there would be some kind of legislation passed, we would hope in the nature of a licensing requirement in the Insurance Law to avoid the necessity of setting up a whole new body of legislation. This would provide that nobody could be in this field, either on a self-insurance or a prepayment plan or on an insurance basis, who would not agree to offer a certain agreed-upon minimum level of medical care benefits at a premium determined by each carrier, but not in excess of some magic figure yet to be determined which, for illustrative purposes, it is convenient to refer to as $5 a month. Any risk that an insurance company feels it could not insure for less than $5 a month it would accept, give its standard policy, and charge $5 a month. The financial experience of all those risks would be put into a common pool, the losses of which would be shared by all insurance companies, prepayment plans, self-insured plans, and so forth. Since all would get their share of the cost of these high-cost groups whether they are covered in one company or some other company, each company might as well go out to get them. By this means we hope that instead of carriers avoiding these high-risk groups because they can't afford them, every carrier would be out trying to get them because it is not going to cause them any loss. That, we hope, would finally get enough in so that the Government could not say that these people could not get insurance.

This is rather a large undertaking, as you can see, and it involves quite a commitment on the part of the insurance companies that they will extend insurance to everybody regardless of their risk. Because of that we feel it would be necessary in any such proposed legislation to have two key elements. One is that this is an experiment for a period such as three years to see if it works. If it does work, fine; everybody is happy; we have voluntary insurance and the Government has been kept out of this basic field. If it doesn't work—if we can't at the end of that three years work out any modification that may be needed—then we just admit that it won't work and the Government can move in. We are no worse off than

if we hadn't at least tried to keep it on a voluntary basis. At the same time we have not committed the companies to an indefinite program for the future. We have terminal facilities, which are important.

The second factor which would be necessary—and the Government itself would certainly want this—is that unless a certain percentage of the Canadian people had elected to come into this program by a certain date, the program would not become effective. That would assure the companies of having a reasonable base of healthy lives to carry the burden of the high-risk group.

With those two safety factors in it, we hope that the plan would work and not subject the insurance companies and the prepayment medical plans to too high a long-term risk.

I haven't said anything yet about what the benefits are to be. That has been deliberate, because it seemed to us that the plan of benefits at this stage of the discussion, while obviously essential, is a secondary step. The first thing is to see if we can sell this idea of the pooling arrangement to make the coverage available to the entire population. If we can sell that idea, then the question is, what should the benefits be? That will require a great deal of discussion. It is a balancing off the cost of what the people think they can pay and what the benefits should be. That, we again concluded, is not for us to decide but for the people of Canada through their elected representatives. We think this plan could work within almost any schedule of benefits.

Obviously, what we have in mind is starting on a relatively modest basis and expanding it if the experience warrants it. The relatively modest basis would be something like surgical benefits on the Ontario fee schedule basis, home and office visits with some kind of coinsurance and deductible, or skipping the first visit, or some other kind of financial controls to protect the plan against overuse.

This leaves one remaining large gap, which is an integral part of any voluntary system. Even if we make a plan available to the high-risk and the aged and everybody else at a reasonable cost, some of them are not going to buy it. We know that. We have been trying to sell life insurance for a long time! Some people are not going to buy this coverage even though they could afford it, and later on certain ones, or members of their family, are going to have a serious medical expense and are going to have difficulty paying the bill. They are then going to cry to their political leaders that they do not have the coverage they would have had on a universal compulsory basis. If this is considered a weakness, we must face it and say, "This is a weakness, but it is overbalanced by the many weak-

nesses of a universal compulsory Government plan"—which I don't need to recite to this audience.

On the other hand, I personally believe that we can turn that into not a weakness but a strength, that we in both Canada and the United States are still firm believers in the free enterprise system, that every citizen has the right to make his own way. In the absence of personal difficulties he is supposed to take care of his own family. Our proposed voluntary approach gives every Canadian the right to obtain medical care coverage at a reasonable price. If he doesn't buy it when he has the opportunity to buy it, then he no longer becomes a responsibility of the Government.

That takes an awful lot of selling, and whether we are going to be successful or not only time will tell.

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