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NATIONAL HEALTH INSURANCE IN GREAT BRITAIN AND CANADA

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A discussion of the experience in the two countries:

1. What are the main features of the plans and their cost? How effective are they?
2. How are doctors, dentists, nurses and hospitals affected by health care provided outside of the national plans?
3. How can private health insurance and prepayment systems function effectively alongside the national plans?

UNITED KINGDOM (U.K.) NATIONAL HEALTH SERVICE

MR. ALAN BACKLEY: The U.K. National Health Service (NHS) was established on the premise set out in the 1943 Beveridge Report that there was a finite amount of morbidity in society and that a state run health care system would reduce that morbidity. The reduction was to be brought about by ensuring equal access to all health services without any relationship to personal income.

There were exceptions to these generalities. First, occupational, environmental and nursing home services were not included. Second, as a quid pro quo to the medical profession, private hospitals could exist independent of the system and the NHS hospitals would have some private, or paying beds, and physicians could engage in private practice if they wished. The private system was reinforced by allowing insurance coverage for the private system.

Organization

First, some historical background to the present organization.

Following the publication of the Beveridge Report legislation was enacted in 1946, and in 1948 the NHS came into operation. The organization structure for England and Wales differed slightly from that for Scotland and Northern Ireland. For this presentation, however, I will concentrate on the English form. From 1948 to 1974, the tripartite form was:

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- 15 Regional Hospital Boards, appointed by the Minister of Health, responsible for planning, construction, allocation of hospital funds, appointment hospital specialist medical staff, and appointment of hospital management committees.

Hospital Management Committees ran groups of hospitals on a day-to-day basis, appointed all staff including junior medical staff - 400 of those throughout the U.K.

36 Boards of Governors, appointed by the Minister, were affiliated with medical schools. They administered teaching hospitals, appointed all staff including senior medical staff even though located in geographic regions administered by Regional Hospital Boards, and planned their own services.

- 140 Local Health Authorities, appointed by municipal government - provided community and environmental health services including ambulance services.
- 140 Executive Councils, appointed by the Minister - arranged contracts for services with general practitioners, dentists, ophthalmic professionals and pharmacists.

From 1946 there were continuing concerns about the divisions between the three parts of the tripartite structure. After a series of studies and consultative documents were produced, in 1974 the structure was revised to produce some integration of the organization structure. This new structure was considerably more complex.

The key authorities are the Area Health Authorities (AHA) (90 in total) which are responsible for health care in geographic areas. The AHA's are grouped under 14 Regional Health Authorities (RHA). Within the AHA's there is a further division into districts which serve as the basic organizational unit for the planning and provision of health services, serving approximately 200,000 people. RHA's and AHA's have membership similar to that found previously in the hospital sector, representing most segments of society. Districts are administered on a consensus basis by multidisciplinary teams, who have their counterparts at the area and regional levels. However, to maintain local "consumer" involvement there are community health councils for each district (1/2 representing local authorities, 1/3 voluntary agencies, remainder RHA appointed).

Family Practitioner Committees exist to provide contracts for service for the individual community practitioners - a role previously undertaken by Executive Councils; thus the attempted integration of the three parts of the system has not been accomplished fully.

I have dealt at some length with the structure of the system to make quite clear that government not only took on the responsibility for paying for health services used by patients but also, by means of elaborate mechanisms, for the planning and administration of those services.

How did the system work?

In general, all services are provided free at the time of consumption of the services, although there are nominal co-payments for dental, ophthalmic and pharmaceutical items.

The system is financed 88% from general taxation, 9.5% from national insurance payments made by employed individuals, 2% from charges and the balance from miscellaneous sources. In 1978-79, costs were over £8,100 million or \$280 per capita. 70% of the expenditure is in hospitals, including salaries to hospital physicians. Administrative costs for the total system amounted to approximately 5%.

Depending on one's perspective, it is in the area of expenditure control that the system has been most successful. Although cost growth has exceeded Gross National Product (GNP) growth in each of the last 25 years, cost had reached only 6.5% of GNP by 1977. In addition, the growth in health costs was slower than any other common market country. The 1960-1972 increase was 22%, compared with the U.S. at 44% and Canada at 34%. Thus, the initial expectation by external critics that the system would be a financial catastrophe has not been borne out, simply because it ignored the fact that the total resource control remained with government. This control included medical and other health professional manpower planning, hospital construction and operating costs. In addition, hospital physicians on salaries and general practitioners on per capita payments had no incentives to over-serve.

Through resource control the government has attempted to redress regional disparities that existed prior to 1948. However, although hospital and specialist medical services are universally available, the extent and quality vary considerably.

Although the system may be relatively low in cost - what about quality? This is a very subjective area but let me try to pick a few indicators.

In 1974, West Germany had over three times as many deaths in childbirth, despite spending 60% more per capita and having some 50% more physicians. Delays in the system are publicised but 83% saw a specialist within six weeks of referral. In general terms, hospitals provide excellent care for urgent cases and primary care is good outside the core of urban centres.

Physician manpower is an area of some interest. They form 6.7% of the total National Health Service workforce but are the driving force behind the system. In 1974, the ratio was approximately 1 to 725 (U.S. and Canada about 1 to 585) population.

The make-up of the physician population is interesting. Every hospital has interns and residents but they perform only service functions except in the 36 designated teaching hospitals. Sixty percent of these junior medical staff were born outside the U.K. The "consultant" is the specialist that we know in North America. Of these 8% of surgeons and internists, 24% of psychiatrists and 40% of gerontologists were born outside the U.K. By using these physicians from outside the U.K., it has been

possible to make substantial increases in the total numbers of physicians and to address regional maldistribution.

What does the future hold?

A Royal Commission has reported recently on the National Health Service organization and operation; a Commission brought about by the medical profession's resentment of underfinancing of the system.

The Commission's recommendations include:

- removing two tiers of the organizational structure - district and ministry;
- eliminating Family Practitioner Committees to improve integration with Area Health Authorities;
- better use of resources - more money would not mean better health;
- more attention to prevention and health education, including environmental measures such as mandatory seat belts in autos;
- further emphasis on:
 - community care
 - elderly
 - children
 - handicapped - physical and mental;
- less emphasis on high technology;
- improvements in dental and primary care services; and
- more peer review by health professions.

Almost without exception they have been proposed before and resisted by one pressure group or another.

In my view, the system will continue, with minor organizational changes, and will change only in peripheral areas until the consumer gets an opportunity to sample services provided in another way. The relatively rapid growth in private insurance in the U.K. is at present a safety valve, treating a small proportion of patients. As it expands, expectations will change and pressure will increase on the National Health Service to make better use of its resources. Hopefully, this may spill over into major health education programs to reduce illness.

Let me end by quoting the Royal Commission Report:

"Whatever the expenditure on health care, demand is likely to rise to meet and exceed it. To believe that one can satisfy the demand for health care is illusory...."

That is 30 years after the Beveridge Report. It is quite clear that the initial premise that providing National Health Insurance would limit total morbidity is a premise that is totally incorrect.

U.K. NATIONAL HEALTH SERVICE - A CRITICAL REVIEW

MR. JAMES M. GILL: This presentation will:

1. outline some of the more significant criticisms levelled against the N H S ,
2. review the development of the private practice of health care in the United Kingdom, and
3. review the development of private health insurance schemes.

A. Criticisms of National Health Service (NHS)

The National Health Service was developed following World War II and has undoubtedly done much for the general health of the nation. Recently, serious criticisms have been levelled against the National Health Service; some real and some not so real. That the government has taken these criticisms seriously is indicated by the appointment of a Royal Commission which reported to Parliament in July of 1979. For those who are interested in it in more detail, the Report of the Royal Commission on National Health Service can be obtained from Her Majesty's Stationary Office in London. The reference number is CMND 7615.

The general conclusion was that the National Health Service was neither the envy of the world nor was it on the point of collapse. The following summarizes the more important conclusions reached by the Commission.

Services to Patients

1. The NHS has been criticized as being a "National Sickness Service" in that it concentrates on healing the sick, rather than promoting good health. The Royal Commission saw fit to recommend improved health screening, the introduction of seat belt legislation and more emphasis on health education for the public.
2. Primary Care Services (including services of local general practitioners) are perhaps the most visible services provided by the NHS. The Commission recognized a number of shortcomings of the system in the area of Primary Care Service, particularly the fact that general practitioners yielding to the pressures of both patients and pharmaceutical companies have had little incentive to control their prescribing practices and in particular have often prescribed "expensively and often ineffectively". The Commission also recognized a number of other valid criticisms of the system including:
 - (a) The quality of medical care is not uniformly good.
 - (b) A decline in services provided in declining urban areas.
 - (c) An uneven distribution of general practitioners geographically within the country.

- (d) General practitioners criticize its size and their consequent overwork.
- (e) Waiting times in order to see a doctor and the general condition of the doctor's office.

The Commission noted that it would be necessary to improve the development of the primary health care team through training and co-operative effort between various health care practitioners.

3. Pharmaceutical Services were declining through the reduction in the number of drug stores.
4. General Ophthalmic Services were generally misunderstood by the public.
5. The Commission particularly criticized dental services which have so far failed to improve the general dental health of the nation. The Commission says "the prevalence of dental disease remains unacceptably high". Specific criticisms of dental services include the following:
 - (a) The difficulty in finding a dentist who will accept NHS patients or is willing to perform certain services (e.g., crowns) under the NHS.
 - (b) The lack of information about services covered by the NHS.
 - (c) The decline in the quality of dental treatment.
6. In examining Hospital Services the Commission identified the following criticisms:
 - (a) Waiting times for entry into hospital are unreasonably long. The Commission noted that in a survey in 1975, 37% of those awaiting surgery had been waiting for one year or more to get into a hospital and 20% two years or more.
 - (b) A lack of communication between doctor and patient, regarding the patient's treatment and progress.
 - (c) The lack of privacy in NHS hospitals.
 - (d) The Commission noted a lack of co-operation with community health services, especially in the area of rehabilitation.

The National Health Service and its Workers

In an article in the July 21st issue of the Economist, it was noted that "The 1974 reorganization of Britain's greatest post-war social institution has in practice been a disaster. Doctors, nurses, patients and even the administrators themselves have come to spend an exhausting, expensive and demoralizing amount of their time wrestling with a bureaucratic octopus." In general, the Commission noted that the morale of the

workers in the NHS is low, but noted that this was a symptom rather than the disease itself. Industrial relations with workers are poor. Following are some specific comments with respect to certain groups of workers.

1. Nurses, Midwives and Health Visitors - This is the most numerous and costly group of workers in the NHS, where the standards of care have been criticized. In particular, it has been noted that untrained staff have been left in charge of hospital wards, that there is poor supervision of learners and basic nursing routines have been neglected.
2. Doctors - This group constitutes 7% of NHS workers but authorizes most of the expenses involved. The Commission noted that a very high percentage of doctors associated with hospitals were born outside the United Kingdom, in particular in India and Pakistan. It also lamented the Service's inability to attract British physicians to certain specialities (e.g., geriatrics).

The British Medical Association has complained that the Service is seriously underfinanced. The Commission, on the other hand, while recognizing that Britain does not spend as high a percentage of its GNP on health care as some more advanced countries, is not convinced that the expenditure of added sums of money would result in any general improvement in the health of the nation although the Commission did admit that higher expenditures would improve the conditions for patients and staff.

B. The National Health Service and Private Practice

The National Health Service in Great Britain operates on a "utility principle" where the government has provided a health service which is available for all, whether they wish to use it or not. The individual may make alternative arrangements if he wishes. In this respect, it is instructive to compare the NHS and the development of private practice with the development of the public versus private school systems in North America. The public school system is available for use but you can avail yourself of private educational systems for your children. This can also be contrasted with the Canadian scheme which is to some extent monopolistic and operated by government.

In the U.K., NHS hospitals and private hospitals co-exist. Also, NHS hospitals contain wards for the treatment of private patients. Many specialists work in part for the NHS and in part in private practice.

Why has the country seen the development of the private practice of medical care? Generally speaking, it is the outgrowth of the criticisms of the NHS which have been outlined above. The proponents of private practice list the following four reasons as the major ones which would attract an individual to consider private practice medicine for himself and/or his family:

1. Convenience of the time of treatment and/or hospital admission.
2. Choice of physician and/or hospital.
3. Flexibility of visiting hours.

4. Amenities available, including private room, private bath, television and telephone services.

As one might expect, these are the specific areas exploited by the insurers of private health insurance schemes in the U.K.

C. Private Insurance Schemes

The best estimate, at the present time, is that private health insurance schemes now cover about 2 3/4 million people in the U.K. The largest insurer, B.U.P.A. (British United Provident Association), covers about 2 million and the next largest, P.P.P. (Private Patients Plan) covers about 500 thousand. In total, the annual premiums collected for private health insurance amount to about £105 million per annum and the benefit payout is about £85 million per annum, with surplus funds going to provide additional reserves and private hospital financing.

Benefits provided under these plans include:

- (a) Hospital room and board
- (b) Specialist fees, including inpatient, surgical and medical fees and outpatient consultation fees
- (c) Costs for x-rays, pathology, physiotherapy, drugs and operating room charges
- (d) Nursing
- (e) Coverage outside the United Kingdom, while on vacation or business trips.

It is also interesting to note that for an individual who is insured under one of these private schemes, who nevertheless makes use of an NHS hospital, a daily cash payment is made in lieu of hospital room and board charges.

MR. J. C. MAYNARD: Mr. Gill, why are the staff who work for the U.K. plan dissatisfied?

MR. GILL: The report of the Commission to study the NHS shows that there have been too many levels of bureaucracy between the patient and the government. Also working conditions have been poor. Britain has a lot of very old hospital buildings.

MR. BACKLEY: Certainly buildings are old. The first hospital that I worked in celebrated its 100th anniversary and it was a poorly designed building. One of the reasons I left the U.K. system was that I was engaged in hospital planning as part of a ten-year plan for replacement of major hospitals. Every time that we planned starting dates of construction, they were postponed, so that all that we were planning were more and more obsolete hospitals. From my point of view, this was very dissatisfying. The system is a highly centralized bureaucracy. Each day there would be two or three administrative circulars from the government saying how things were to be done.

All salary and wage negotiations were done centrally so that local management had no control over their payroll. If you promoted somebody, the

formula to three decimal places was laid out in detail. It was all very tightly controlled and I think this is probably reflected in the way they have been able to control the costs. Part of the dissatisfaction is related to the general climate in the country. The economy has been in a terrible state and the unions are unhappy. It is difficult to get the health professionals working together as I found in Canada as well. The nurses try to be doctors and the doctors do not want that. Physiotherapists and other allied health professionals gain more and more skills, have more and more complicated educational programs and want to have more influence. The medical profession generally does not want to see this happen so tensions build up.

MR. MAYNARD: Mr. Gill, you pointed out that some privately operated health plans are growing in the United Kingdom. This seems to contravene one of the objectives of the U.K. plan, to have equality of access to health care. Has there been any reaction in this way to this?

MR. GILL: The largest private insurer of health benefits in the United Kingdom is B.U.P.A.. The growth in it is recent. The organization itself has been in existence for a long time. Until recently, most of the interest in private health care has come from the executive and managerial classes of people, who have wanted the ability to choose a doctor and arrange the time of hospital entry and frequency of doctor's visits. However, one of the major unions, the electrical and plumbing workers with 40,000 members, has just recently concluded a contract with a group of employers (it is an industry-wide plan) under which their members will be insured by one of the private insurers - I think it is by B.U.P.A. This strikes at the issue of accessibility and has touched off quite a controversy in the union movement in Great Britain.

MR. MAYNARD: This would mean that one type of worker had access to only the National Health Service Plan while another type of worker could have access to that plan or a private plan.

MR. GILL: Yes, and I understand that the trade union council is concerned about the weakening of the national plan which comes from this.

MR. BACKLEY: For a long time between 1 and 2% of the beds in the National Health Service hospitals have been paying beds available for people who either wanted to pay their own way or had insurance coverage. At the present time, there are about 2 3/4 million people covered by private health insurance in the U.K. out of the 54 million population. A couple of years ago, about 4% of acute patients were actually treated in private hospitals which provide some 2% of the acute beds. Subscribers to B.U.P.A. have gone up 10% in the two years since 1977. The company president used to have that kind of insurance package. Now the credit unions are wanting to have the same package and I think instead of being a safety valve, this may well develop into a parallel system and it could be a healthy development.

THE CANADIAN SYSTEM

MR. BACKLEY: The British North America Act, which is Canada's constitution, allocated the responsibility for health services, with certain minor exceptions such as the services for Indians, to the ten provincial governments. Over 85% of the costs of health services are now covered by government programs. This was brought about primarily by two federal acts even though health is a provincial responsibility.

In 1958, the Hospital Insurance and Diagnostic Services Act came into effect. This Act offered the provinces 50% of the funds required to operate their own hospital plans, provided certain basic program principles were met. For example, to participate in the plan, a province was required to make insured services uniformly available to all its residents. Ten years later, in 1968, the Medical Care Act did for physician services what the Hospital Insurance Act did for hospital care. The federal government again paid one-half of the cost of insured services in the participating provinces, and all the provinces participate.

Unlike the British system, however, few organizational changes took place. Each province already had a Ministry of Health and those ministries, sometimes with the addition of special purpose commissions which had varying degrees of autonomy, flowed funds to hospitals and were expanded later to flow funds to physicians.

Existing hospital boards continued to run their hospitals; Boards of Health continued to provide public health services as before; and health professionals submitted their claims more or less as before. One difference between the two countries is that additional private insurance for physicians fees was prohibited.

Although we have a so-called premium system in Ontario, the health insurance premium itself only generates 27% of the cost. The individuals across the province think that the premium pays full cost when, in actual fact, 73% of the costs are being met from straight tax revenues.

Both pieces of federal health legislation had substantial skewing impact on the pattern of health services that have evolved subsequently. Both placed emphasis on high cost services, hospitals and physicians, and the provision of these so-called free services brought about an inevitable increase in the demand for them.

Experience

Though there are differences between provinces, I will concentrate on the Ontario experience.

Both of the programs, the Hospital Program and the Medical Care Act, had by their very nature a high degree of open-endedness for the federal government's contribution to each province, and subsequently the responsibility of the provinces themselves. The federal government was in essence a paymaster, who did not have the constitutional jurisdiction to control the amount or the degree of health care provided in each province but for which it was obligated to provide a portion of the funding.

Similarly, because of the nature of the particular legislation, the demand and subsequent delivery of services provincially was beyond the ability of the provincial governments to control.

Following the introduction of hospital insurance in 1959, we saw the creation of new and enlarged hospitals. Particular emphasis was placed on bed care, stimulated by an endeavour to meet the demands created for diagnosis and treatment at all levels of health care.

During the first half of the 1960's the total impact of this was not truly apparent. This is primarily because the skilled workers who are so vital to overall institutional operation were in short supply. A natural demand for major increases in the output of these skilled people resulted, and was subsequently met by government building new nursing schools, institutions for the training of technologists, and so on. By the early 1970's, reverse pressures began to generate. We are now in a position where skilled persons, particularly nurses, are finding it very difficult to obtain employment, especially in the preferred urban areas.

All provincial governments realized that health care costs were consuming more and more of the public sector dollar. The stage was set for a series of moves aimed at realigning the health delivery system away from these expensive creations. In Ontario, with 100% provincial financing this time and not a cost-shared federal program, ambulance services were added as a benefit in 1968. Subsequently, in 1972, approved nursing home and home care services were made universally available. In 1974, we added a drug benefit plan for those over 65. For the cost-shared nursing home program, the patient pays about a third of the per diem cost and the provincial government pays the rest. If the patient cannot pay his third, it is picked up by welfare. At the time that the program was introduced in 1972, the provincial active treatment bed standard of five per thousand was reduced to four per thousand for planning purposes. In other words, at that point in time beds were not closed. Other provinces have taken similar steps and some have added further programs including children's and senior citizens' dental plans.

Let's look briefly at cost experience in Ontario over the last few years. In the four years, 1973 to 1977, gross expenditures of our insured health services increased by approximately 104%. During the same time, the Gross Provincial Product (GPP) grew by 82% and provincial revenues by 79%. Thus, we had a situation where health care expenditures were consuming a rapidly growing share of government tax revenues, revenues for which a multitude of other services compete.

In analyzing health care costs over the recent past, certain significant factors surface. The major factor is the hospital system. This accounts for approximately 53% of our total expenditures on health services in 1977 to 1978. Roughly 75% of total hospital costs arise from salaries and wages. Wage negotiations have had a direct relationship to the significant overall hospital cost increases over the past few years. Hospital costs in 1974 to 1975 increased by some 29% over the previous year and the next two years by 17 and 13% respectively.

In 1974, major hospital group contracts for nurses, cleaners, and other categories of health workers, increased some 45 to 52% on a one- to

two-year contract. These dramatic wage increases created an obvious ripple effect in other parts of the health care system, for other government workers and also for non-government workers.

Another factor in our increase in health care costs is the increased reimbursement to physicians. While it is less in percentage terms and dollar terms, nonetheless it does contribute to the increased cost. Physicians, through billings to the health insurance plan, represent some 25% of total costs. During the four years when hospital costs went up about 104%, increases in physician billings were about 70%. Most of that increase was not in the fee schedule, but an increase in utilization. We found a large number of physicians immigrating from other countries to Canada, and the number of services per patient increased by some 50% over the period of time from 1969 to 1976, at which point physician immigration was terminated.

General inflation, as well as the open-ended nature of many of our health care programs, has contributed to the cost escalation spiral. The introduction of new programs as well as the expansion of existing programs during the past four or five years has also had an obvious economic impact. For instance, the nursing home program now runs over \$100 million a year.

What was done about measures to introduce hospital cost control?

Apart from limiting expenditure increases to inflation, a major program commenced to reduce hospital costs. In hospitals a number of steps were taken: global versus line-by-line budgets were introduced, new programs were limited, bed closures were requested, mergers of services in adjacent hospitals were encouraged, use of consultants to constrain costs were urged, ambulatory care programs were promoted, development of a new reimbursement system was begun.

With these actions we succeeded in reducing the growth in health costs below the C P P growth, so that currently it is just under 7%.

This program of constraint was extremely unpopular with hospitals, physicians and public. During this year there has been an easing of the policy where hospitals have been able to demonstrate that they are running as efficiently as possible but still incurring a deficit.

Future

The movement of government into the field of health care financing through the assumption of responsibility for the first dollar payment of various kinds of health services has not been merely a transfer of funding for such services from the private sector to the public sector. People no longer demand only that their bills be paid, but also that prompt and efficient services be available to them in their own locations and, to a large degree, under circumstances which they feel are suitable to them. This important fact in itself is bound to bring about significant changes in any system of health care delivery. The people, quite understandably, bring relentless pressures upon their elected representatives for the government to provide additional services. They usually suggest that, as the government requires them by law to pay a premium for their health services, these services should always be conveniently available to them,

no matter where they live, in the north in the rural areas, or in the south in the urban areas. These forces are even more accentuated under a government umbrella because the political parties in opposition usually find it to their political advantage to rebuke the party in power for not acceding to stated demands of the citizen groups, and are of course in a position to ignore the greater question of the overall cost involved in attempting to meet such requests.

Most governments have difficulty with detailed planning and management of health care delivery systems at the local level. In my view, our role at the provincial government level is to lay down broad guidelines for the system. Without them, there could be bare spots and overlapping, which are difficult for any one segment of the system to overcome. We are also convinced that a great deal of the necessary co-ordination should be done, not at the provincial level but at the local level. With this approach in mind, we have been busy over the past three years establishing district health councils all over the province. There are now over 20 of these councils, and they cover some 85% of the population outside of the major metropolitan urban areas. Within the largest urban area, which has a population of some two million, a council is likely to be established in the next 12 months.

Each district health council represents a cross-section of its own community. Its members typically include doctors and other health care professionals, businessmen, housewives, clergy, municipal officers, and so on. All of them are familiar with their community, and are well-versed on local problems and priorities in the field of health care. The councils mainly serve in an advisory capacity to the Minister. Advisory though it may be, a district health council bears the major responsibility for the planning of the delivery of the established health program.

It is possible that in the next decade we might move to global health budgets on a geographic basis. Unfortunately, we still do not have the sophistication in the areas of management information systems that is vital and necessary for the tough decisions to be made by the health councils and by the individual agencies. This, in Ontario, and in other provinces, is being given serious attention.

The questions of which health services, how much of these health services, the method by which they should be provided, and for whom they should be provided, still have to be addressed on an on-going basis. Resources are limited and human wants are relatively insatiable. Only an accurate and current information base will enable the government to judge further benefits and costs of programs accurately, and that includes the agencies and the health councils as well. Health care policies and the methods incorporated in implementing these policies have in the past seldom been based on the results of specific scientific research. In view of the rapidly changing social and economic situation, the need to encourage more research on policy issues is essential, and the government is certainly intent on directing its own research funds in that area. In my view, these policy reviews could include a close look at the HMO and Kaiser-Permanente models. The Canadian pattern has removed competition and consumer choice to a large extent.

Over the last 18 years, the Canadian Federal and Provincial governments have learned the truth of this quotation from Victor Fuchs, regarding the contribution of health services to the American economy:

"The greatest potential for improving the health of the people is not to be found in increasing the number of physicians, or in forcing them into groups, or even in increasing hospital productivity, but it is to be found in what people do for themselves. With so much attention given to medical care, and so little to health education as an individual responsibility, we are in danger of pandering to the urge to buy a quick solution to a difficult problem."

No matter what our expenditures on health care, we have not really improved dramatically the health of the population. We have to start looking at individual responsibility as one of our major concerns for the future.

THE CANADIAN SYSTEM - A CRITICAL REVIEW

MR. RAYMOND L. WEALEY: Because of Canada's proximity to the United States and because of the many similarities in our economies, our democratic traditions, and our social values, there has been considerable interest in the U.S. over the last 30 years in the Canadian health insurance system, especially with greatly heightened interest in national health insurance in the United States in the last five years. Proponents of a national government-operated health insurance plan for the United States point to the Canadian system as their model. Opponents look for fatal flaws or serious defects in the Canadian system.

The Canadian system is, by and large, a well accepted part of Canadian life. I cannot contemplate any political party pushing to restore the financing of our health care system to private enterprise.

There have been problems from the outset and there are problems now. They are mostly problems which are not inherently the result of the financing mechanism.

You must realize, of course, that there are differences between the way Canada was in the 1940's and 1950's when our system was first being planned, and the way the United States is now, 30 year later. The overwhelming problem facing Canada during the Great Depression and the war years was that significant segments of our population, particularly the aged and the poor, simply could not afford adequate health care, and the private sector had not yet found ways to extend insurance or stigma-free assistance to them. Rather than attacking the financing problem segmentally, as has evolved in the U.S., Canada chose the broadbrush treatment. But the top priority problems Canada faced then are not necessarily the top priority problems the United States faces today. And correspondingly, the solutions for Canada then are not necessarily the most appropriate solutions for the United States today.

The most pressing problem in the Canadian health care system today is the rapidly rising levels of expenditure and unit costs. As in the United States, we have been faced with health care expenditures which have been rising somewhat more rapidly than personal income, GNP or GPP, causing a growing concern that an increasing proportion of the national effort is being devoted to health care.

Curiously, the current public concern over the "cost crisis" in Canada is out of phase with increases in the GNP ratio. When the ratio was rising rapidly, from about 4% of Canadian GNP spent on health care in the early 1950's, to over 5% in the early 1960's, to a peak of nearly 7 1/2% in 1971, little public concern was expressed. But in the 1970's, when the ratio appears to have plateaued between 7% and 7 1/2%, or even dropped a little, the "cost crisis" has been a continuing public issue. Perhaps this simply reflects the lag in communication between the time something is actually going on and the time of public awareness of it.

Proponents of the Canadian system, both in Canada and the United States, point out that the rate of increase in health care spending in Canada has been no more, and perhaps less, than in the United States, and that the "percentage of GNP" figures for Canada are less than the comparable U.S. figures. However, when one examines the way Canada went about installing its present health care system, it appears that little thought was given to cost-effectiveness.

In Canada, we really began our system in 1948 by instituting a set of federal conditional grants to the provinces, designed to pave the way for the later national hospital insurance and medical care insurance plans. The most important of these was for hospital construction. Federally assisted hospital insurance plans and medical care insurance plans followed. During the 1960's, hospital services were "free" but physicians care was not, and until 1970, the federal government offered to pay half the costs of hospital construction. Undoubtedly, these two factors contributed to over-building and over-utilization of active treatment hospital beds. This led to heavier utilization at 50% higher than in the United States. Even recognizing demographic differences between the two countries hospital utilization in Canada is significantly higher than in the United States.

Accurate utilization data for physicians' services are unfortunately not available. However, Professor Robert Evans of the University of British Columbia has developed some indirect estimates which suggest that utilization increased during the decade 1958 to 1968 at something less than 5% annually, 10% per annum during the four years which the medical care plans were implemented (1968 to 1971), and then after 1972 apparently tapered off at quite a low level of increase once a plateau of utilization was reached. Unfortunately, there are no comparable U.S. statistics. One can infer from these estimates that utilization probably increased under the "free access" system in Canada to a significantly higher level than in the U.S.

One of Parkinson's Laws says: "Work expands to fill the time available.". In the health care field, "treatment expands to utilize the facilities available". Thus, Canada's higher hospital utilization may result primarily from the fact that we have 40% more beds available per 1,000

population! In both countries, the occupancy rate is in the 75% to 80% range.

Words such as "over-bedding", "over-utilization", "under-utilization" are subjective words. How much of the difference in utilization between two systems represents over-utilization, if any, in the one and under-utilization, if any, in the other is a question of values which the citizens of each nation must decide for themselves.

A second problem perceived in the Canadian system is the question of geographic imbalance in facilities and in the availability of services. In a free enterprise economy, imbalances can be tolerated and are accepted as simply an inevitable fact of life. Under a socialized system, however, there is an expectation of equality, and an expectation that governments will rectify any deficiencies.

The adoption of universal health insurance eliminates financial barriers to necessary health care, but will not guarantee an adequate system of health services. Indeed, it may well tend to highlight other defects in the system such as the organization and distribution of health services which may earlier have been of lesser significance. Such has been the case in Canada. Our system has generally not included mechanisms to ensure a balanced pattern of health care facilities, to reduce the duplication of facilities, or to rationalize the distribution of highly specialized services. And the process of rationalization is very painful. A community may well be content with or even applaud a reduction in costs by closing an inefficient hospital or withdrawing infrequently used facilities - provided it is some other community that is being affected.

Other shortcomings of the initial cost-sharing arrangements between the federal and provincial governments were their rigidity and complexity, the limitations on the types of health care that were eligible for federal financial support, and the consequent lack of incentive for the provinces to encourage cost-saving innovations. For example, initially there was federal cost-sharing for acute general hospital beds but not for nursing homes; for the most costly of health practitioners (i.e., physicians) but not for paramedicals.

Another aspect of our system which might be criticized in retrospect is that the national medical care insurance plan has tended to reinforce the existing fee-for-service system of medical practice. The Hall Commission on which the National Plan was based realized that a national plan must have as much co-operation from and acceptance by the medical profession as possible. It deliberately avoided recommending the British capitation system which was largely unknown in North America. While the federal legislation did not preclude alternative modes of compensation, the provinces generally adopted fee-for-service as the standard method. The result is that there is little incentive in Canada for either physicians or patients to evolve more effective and economical approaches to the delivery of primary care, such as we are seeing in Health Maintenance Organizations (HMO) in the U.S.

Contrary to the recommendations of the Hall Commission, most of the provinces permitted physicians to "over-bill" or charge fees in excess of those reimbursed by the provincial plan. During the early years of

Medicare, this was not a major problem, because Medicare brought with it an almost automatic increase in the earnings of physicians resulting from increased utilization and elimination of the problem of uncollectable accounts. Consequently, in the early 1970's, most doctors were content to accept the government plan benefits as payment in full, and to settle for relatively modest annual increases in their fee schedules. Between 1970 and 1975, for example, doctors' fee schedules rose less than 20%, compared with a 45% rise in the Consumer Price Index and a 60% increase in the average income of all Canadians. This situation could not long continue. For example, in 1978 the Ontario Medical Association approved a new fee schedule calling for a 36% overall increase in fees. However, the Ontario Health Insurance Plan subsequently approved an average benefit increase of only 6 1/4%. The previous relationship between the Medical Association fee schedule and the insurance plan benefit was thereby abandoned. Following this break, more and more doctors have been "opting out" of the Plan in that they no longer accept the government benefit as payment in full but are "overbilling". The same thing is happening in other provinces.

Since most provinces prohibit private insurance from covering such excess charges, any significant spreading of the practice of overbilling strikes directly at one of the cornerstones of Canada's whole socialized health insurance system, namely removal of financial barriers to universal access to health care.

The first problem in the Canadian health system has been rising costs. The final problem is to raise the revenue to meet the costs. During World War II, the federal government acquired a very dominant position in taxation and assumed a great deal of authority in running the country and in planning for the post-war years. This extended even into areas such as health, over which the provinces have exclusive constitutional jurisdiction. But by using its pre-eminent revenue-raising capacity and disbursing enormous grants to the provinces, provided they established health programs meeting federal criteria, the federal government was able to engineer a nearly uniform "national" system of health care insurance, administered by the provinces. The federal government soon discovered that it had no effective control over its payouts, being obliged to pay essentially 50% of whatever the provinces chose to spend on the recognized services. There were no real incentives to use less costly services that were not eligible for federal cost-sharing. The increases in utilization of services, coupled with inflation in the early 1970's, resulted in dramatic annual increases in the federal outlays. The federal government soon resolved to turn over the full revenue responsibilities to the provinces. After prolonged negotiations, this was largely accomplished in 1976. The original cost-sharing formulas were abandoned and the federal government simply transferred to the provinces additional personal income taxing capacity plus some cash payments, with no restrictions on how the provinces should use the money.

Thus, we have come full circle in Canada, with the federal government having stretched, if not exceeded, its constitutional powers in order to coerce the provinces into implementing socialized health care plans which it perceived to be in the national interest, then turning back to the provinces the problem of financing the plans which, once implemented, can never realistically be abandoned!

Health has now become the major item of provincial expenditures, and represents nearly one-third of all provincial government spending. There is naturally concern that this one item is distorting the allocation of provincial resources in the public sector and that competing programs with equal or higher priorities may be suffering. Much thought is therefore being directed by the provinces both toward coming to grips with the various problems of inefficiency and the problem of raising the required revenues.

In 1976, the Ontario Economic Council published six papers entitled "Issues and Alternatives" covering six fields of concern, one of them being Health. Fourteen main policy issues and conclusions were identified as follows:

1. The most notable economic implication inherent in the objectives of the Canadian health care insurance plans was that the public purse was underwriting virtually all of the demand for hospital and medical services.
2. Practically nothing was done about the organization of the health care delivery system when the insurance plans were introduced. A major error was the failure to even attempt to rationalize the delivery system before public health insurance was introduced; at a minimum, they should have been concurrent.
3. One of the most attractive reform proposals appears to be the introduction of group practice.
4. Manpower substitutions through other means, in addition to group practice, should be encouraged.
5. Too many strongly vested interests typically have developed around the hospital to permit major adjustments at the hospital or community level. Such decisions should be made by the province or at the District Health Council level. The development of less costly alternatives to in-patient hospital care are not only desirable but much needed, and must be predicated on a simultaneous reduction in the resources devoted to active treatment hospital care.
6. There are complex problems of physician supply and distribution both in terms of speciality and geography, that will not be solved by the forces of the "free market".
7. Decentralization of the system via District Health Councils is favoured.
8. The current financial incentives affecting patients, physicians, hospitals and the government are all essentially "open-ended", with little constraint on the use of health care resources. But the incentives system must be consonant with the delivery system, and attempting to solve financing problems without solving delivery system problems can be disastrous.

9. Some of the existing financial arrangements could be improved without serious prejudice to the fundamental objectives of the established system:
 - (a) The original rigid, open-ended, cost-sharing agreement between the federal and provincial governments was clearly unsatisfactory and was subsequently changed.
 - (b) The traditional fee-for-service system, in the context of a largely publicly financed health care system, is undesirable in many respects for remunerating physicians.
 - (c) Cost-sharing by patients is a highly contentious issue but a majority of the Council recommended that there should be some form of cost-sharing on a progressive basis which should encourage an awareness of the use and the costs of care, but some members of the Council dissented with this view.
10. There is a much weaker case for comprehensive "free" dental and pharmaceutical programs than there was for hospital and medical care.
11. In the dental field there are severe manpower shortages, geographic maldistribution, and under-utilization of auxiliaries, hygienists and assistants; there are considerable payoffs to prevention programs; group practice should be examined; alternatives to fee-for-service should be examined.
12. In the pharmaceutical industry there should be more competition, more consumer information about true costs and use, and wider use of pharmacists.
13. Prevention should be given increased emphasis relative to the curative orientation of the present health care system, particularly in the areas of accident prevention, environmental management, occupational health, nutrition, recreation, and oral health.
14. Measures to control health care expenditure need not result in a lowering of the quality of health care. Resources can be freed through reallocation of resources in the hospital sector, manpower substitution in the medical sector, prevention activities, and reduction in unnecessary use of medical and hospital services through the incentives operating on physicians and patients.

Since publishing "Issues and Alternatives - 1976", the Ontario Economic Council has sponsored two interesting economic studies. The first, published in 1978, studies the areas of Pharmicare and Denticare, which the Royal Commission on Health Services in 1964 had recommended eventually be brought into the public sector. The Ontario study concludes that the benefits of universal public programs in these areas would not be great and would probably be outweighed by the costs. Far more desirable would be specific and limited public programs designed to alter the patterns and raise the efficiency with which these services are delivered.

The second study, just recently published, is a critical and detailed examination of the 1976 proposal of the Council, that there should continue to be patient cost-sharing in Ontario but on a more progressive basis than at present. The conclusion of the new study is that, in a universal system, direct charges to patients provide no significant tangible social benefits and can, on the contrary, produce positive social harm.

Finally, the Council has released a brief "Update 1979" which noted that in recent years Ontario had instituted several cost-control measures affecting hospitals and physicians. Hospitals have been closed; the number of beds in use has been reduced; entire wings and departments have been emptied; budgets have been constrained; mergers of facilities have been forced; there have been staff layoffs; hospital capital spending has been curtailed; etc. In addition, the government took a tough stand on physicians' fee schedule increases. The Council noted that as a result of these measures, health care costs have become relatively stable. It also noted that some of the more severe measures, such as the decision to close down certain hospitals, encountered strong opposition and were later rescinded or modified. There continues to be increasing dissatisfaction among physicians with what they see as government interference and the inequities that have followed.

The Council concludes that the cost-containment measures that have been taken to date are of the "cut, freeze and squeeze" variety and are effective in the short run only. For the long run, they reiterate that the broader measures they recommended in 1976 should be followed.

The issue of health financing continues to receive a good deal of attention in Ontario, probably more so than in most other provinces, with various alternatives being studied by the Economic Council, by the government, and by the Legislative Assembly.

Reverting to the federal scene, although the federal government has achieved its primary objective of engineering universal health care and has effectively turned over all operating and financing responsibilities to the provinces, it continues to feel that it has a national responsibility in this area. In September, 1979 the Minister of Health in the new federal government stated that he intended to try to define more precisely what the basic national standards for medicare should be. At the same time, he also announced that Mr. Justice Hall, who headed the Royal Commission on Health Services 15 years ago, was being appointed to review Canada's medicare system to determine if it is fulfilling the goals for which it was created. The Minister referred particularly to the number of Canadian doctors opting out of their provincial plans or moving away from Canada, and to doctors and hospitals charging more than medicare pays, and said that "I do not think we can ignore these indicators that renewal is necessary". Mr. Justice Hall has been asked to complete his report within six months.

MR. MAYNARD: When the Canadian Health Plan was introduced there were cries of doom and gloom from the insurance companies that they would have no part to play in the future. Has this happened?

MR. GILL: In 1958 the government introduced hospital coverage and it then took the insurance industry a couple of years to recover its premium

income. It did so by extending coverages to drugs, nursing home care and related services. About ten years later, when government medical service came in, the companies again lost. Again it took the companies a couple of years to rebound and get their premium income back - mainly through long term disability income. More recently, companies have increased their premium income through the expansion of dental care benefits. Whether this is a true growth or whether we are seeing simply the effects of inflation on medical care costs, I am not quite sure. Circumstances in the United States today may be different in that most ancillary medical care services are already covered to a large extent. When the national health plan began in Canada employers were not permitted to reduce the amounts they had been paying for employee benefits. The result was that many employers had to look around to find ways to channel what they had been paying into alternative programs.

MR. WHALEY: Another result was that most companies found it simply was not economically feasible to continue to sell individual health policies. Individual policies have reverted to income protection only.

MR. KIRK L. DORN : Has it been possible to persuade professional staff to move to places where they are needed, in particular to remote areas? Have incentives been used?

MR. BACKLEY: There is an incentive scheme of a guaranteed minimum income, for physicians who work in northern areas of Ontario. Currently, there are about 140 physicians in that area. To a very large extent, they are immigrant physicians who came from the United Kingdom. Since 1976, there has been no immigration and we are now finding that we are not getting enough people to go north. Although we are continuing to produce medical graduates, those medical graduates still want to practise in the urban areas. Even though they themselves have been born in the north, they do not want to practise there and so we must rely on imports. Other provinces have tried to get over this problem by saying to physicians from outside the country, "You may come in, but you may only practise in this area." They then found that they ran foul of their own human rights legislation. Once an individual is in the province, then there can be no restriction on where he may go to practise. Experience shows that physicians who begin in the north begin to move south. It remains a problem. It was recommended, by one study, that there should be some manpower control. Specifically, after a certain number of internists are operating in an area the plan would not pay for any more internists moving into that area. That was considered politically inappropriate. We have a plan for people to go north and we have some vacancies which we are trying to fill. If you live in the north you are not going to get the same level of medical services as you would in major metropolitan areas. We provide air-ambulance services but this does not make up for the difference.

MR. MAYNARD: In the past year the doctors in Canada have been dissatisfied with their compensation from the national plan. Are there any solutions?

MR. BACKLEY: A lot of physicians have come from the U.K. to Canada with high expectations. They believe the system is perhaps moving towards the constraint that there was in the U.K. on expenditures on health services.

Ex-U.K. physicians tend to be quite vocal members of the medical association and indeed some have emigrated to the United States. I do not know how one satisfies an individual physician who in the past may have accepted that there was a limit on the amount of money that could be paid for services to an individual patient, but does not see the limit being imposed today.

Now the physicians feel the payment for those services is coming from taxation and that there are billions of dollars there. There should be no limit, therefore, on the amount that they should be paid. They have expectations of personal expenditures that many of us do have. We are seeing in other parts of the private and public sectors a compression in higher salaries and high incomes. The percentage increases are not so high. Physicians, as a whole, appear to be dissatisfied with having to experience that compression themselves. Some of them are opting out of the plan and wanting to extra-bill. There is no easy solution, except perhaps a gradual change in expectations.

MR. GREGORY S. BENESH: All the emphasis of these National Health Plans seems to be on cost-containment - reducing the cost and providing similar medical care to all people. There have been some huge technological advances in the 30 years since the United Kingdom plan came into effect. Have the United Kingdom and Canada kept up with other countries, like the United States and West Germany, in those technological advances and are the people of those countries benefiting from those advances?

MR. BACKLEY: In the U.K., I would say the answer is probably no. There are cities in the United States where every hospital might have a scanner while there are very few scanners in the whole United Kingdom even though that is where scanners were developed. In Canada, we try to limit the amount of expenditure on high technology by a screening process at the local level. We also use the medical association to advise on the need for these new devices. One of the problems is that one can never be sure just how good the piece of equipment is. There are vogues. Currently, arterial bypass surgery has been criticized. Is it really worth the expenditure? It may make the individual feel better but is it really worth it?

I think it is fair to say that in Canada people in the urban areas have equal access to any technology that will be found anywhere. The introduction of new technology is slower in those areas where there is government financing, particularly for high cost items. There will be a controlled development.

MR. BENESH: The geographical problem exists in the United States, too. However it seems that the United Kingdom is making a lot slower progress. They are not making use of all the advances that other countries are developing and maybe that keeps the cost down, but is it in the good of society?

MR. BACKLEY: This is a philosophical point. Is it better to spend 3/4 of a million dollars on a piece of equipment which will only benefit a small proportion of the population or spend it on home care services for the elderly, which would bring a marginal improvement to a larger number of people?

MR. MAYNARD: The Canadian Plan began as a national federal plan, but the financing of it has now been given back to the provinces. Will there be less uniformity in the future?

MR. WHALEY: I would assume that this is one of the concerns of the new federal health minister who is now trying to define what should be the minimum standard plan. Without control of financing, he does not have much power or persuasion to set standards. He will be setting guidelines specifying requirements for the provinces.

Coverage is now universal for ward-level care for all physician services. There are minor variations between provinces in the degree of nursing, geriatric and paramedical services. These minor variations may continue and there may be more variations from province to province. I do not think there will be a major variation from basic hospital/medical criteria.

MR. MAYNARD: If the Ontario plan were being initiated today with hindsight, could some improvements be made?

MR. BACKLEY: Difficulties arise when government is not just paying the shot but also is expected to provide services. Peoples' expectations (physicians included) from government are much higher than if any other agency provided those services. For example, the government has tried to use some of the ground-rules established by Physician Services Incorporated, the physicians' own insurance plan, prior to the introduction of Medicare, in controlling the amount of psychotherapy. It was a reasonable amount of no more than 20 hours a month or so. But when government comes along and says that this seems a reasonable rule because it was used in the P.S.I. insurance plan, immediately there is a violent outcry from the medical profession complaining of government harassment and of dictating to physicians how to practise. The insurance industry tells how they were able to control claims from the physicians, often by just cutting them back quite arbitrarily. Government cannot do that. Government might have been better off involving a third party in the payment of both hospital and physician claims and avoiding the front line itself. It is inevitable with government involvement that peoples' expectations are going to be higher. But in the administration of the plan, it appears that government finds it difficult to be as restrictive as a third party would be. Some have said they wished that they could take all the money and give it to an insurance commission and let them get on with it.

MR. MAYNARD: What problems will the Canadian health plan have in the next twenty years?

MR. BACKLEY: A major area is the aging population. Currently, Canada has about 8% of its population over 65 and soon after the turn of the century will be up to 12%. This 8% are very heavy users of the system. Currently we have 9% of that group in institutions. That rate is twice the rate of the U.K. and I believe higher than the rate in the United States. If present trends continue we will need to provide 26,000 additional nursinghome beds in the next fifteen years, i.e., almost as many again as we have now. The aging population alone is going to cause rapid escalation costs and increased pressure for services. As the costs of those services are going to increase in real terms, we must look for other methods of providing those services. Currently in Canada active

treatment bed utilization is 50-100% higher than in the United States. We must redirect some of our resources from that area to other areas, particularly to services for the elderly.

I do not foresee any radical changes. The system is likely to stay pretty much the way it is because that is the way the electorate like to have it. Over a period of time, we need an agreement between the health providers and the politicians, that there must be some shifts, otherwise we won't be able to afford the health system.

MR. MAYNARD: There is a considerable difference between U.K. and Canada in the participation and compensation of doctors. Is one method better than the other?

MR. BACKLEY: In the U.K. a physician may operate on one patient in an operating room at 10:00 under the National Health Plan at no charge to the patient. The next patient at 10:30 may be a private patient and there will be a full charge to him. Both patients will be resident in the same hospital in different wings, one getting full hospital accomodation while the other pays a full-day cost for that accomodation. In Ontario, 83% of the physicians take the plan payment as payment in full, another 17% will take the plan payment as part with the patient paying the balance. In Quebec, there are a small number of physicians who will have nothing to do with the provincial plan.

In Quebec there are ceilings on the physicians' payments. The province agrees with the medical profession as to the total increase in payments to physicians and reviews it quarterly. If it looks as though the payments are going too high, unit fees are reduced in the next quarter. If they are going too low, unit fees are raised. That system looks attractive to other provincial governments. However, the other medical associations oppose this strenuously. They do not want any income ceilings, either on the total or the individual.

MR. JOHN H. MILLER: Ever since the British plan was unveiled, we have been inundated in this country with commentary ranging from mild criticism to horror stories. Yet, we know that in practically all of continental Europe they have national medicine of one form or another. We hear very little about it, but what I have seen it works pretty well. Is there some survey that would give one a picture of the scene throughout all of Europe, for example?

MR. BACKLEY: There was one which is about seven years old now. It was done by Titmus for the World Health Organization. It was a comparative analysis of experience in about seven or eight different countries.