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LESSONS TO BE LEARNED FROM THE CANADIAN SYSTEMS OF GOVERNMENT HOSPITAL AND DOCTORS' CARE INSURANCE

Moderator: CECIL G. WHITE. Panelists: DOUGLAS R. PEART, B. E. FREAMO**, WILLIAM A. ALLISON, DAVID A. STOUFFER*

The panelists present the views of doctors practicing in Canada, of executives responsible for hospital administration, of government officials responsible for advice on budgets, and of actuaries responsible for group health insurance operations in Canada.

MR. CECIL G. WHITE: I would like to begin by introducing the members of the panel this morning. First, we will hear from Mr. Douglas R. Peart, who has many years of experience in hospital administration and is the author of many articles and papers. In addition he is a Fellow of the American College of Hospital Administrators and of the Royal Society of Health and is a charter member of the Canadian College of Health Service Executives and a member of the International Hospital Federation. Our second speaker is Mr. B. E. "Woody" Freamo, who will present the viewpoint of physicians. Mr. Freamo was the first Economics Secretary of the Ontario Medical Association. He is now with the Department of Economics at the Canadian Medical Association and is Executive Vice President of MD Management Limited, a wholly-owned subsidiary of the Canadian Medical Association.

Our third speaker is Mr. David A. Stouffer, an actuary in the public service of the Province of Ontario. As a Senior Budget Advisor, Mr. Stouffer has responsibility for provincial policy on budgeting and other matters connected with social security systems. Our final speaker is Mr. William A. Allison, a Fellow of the Faculty of Actuaries as well as a member of the Society of Actuaries; Mr. Allison has responsibility for the group life and health insurance operations at Confederation Life.

MR. DOUGLAS R. PEART: The lessons to be learned from "The Canadian System of Government Hospital and Doctors' Care Insurance" are very complex and, in the time available at this occasion, I can give only a general overview and hope that the questions to follow may help to fill in the gaps. My remarks are going to be primarily related to the hospital aspects of our Canadian programs, and particularly with respect to the Province of Ontario, where my career in hospital administration has been centered.

The Canadian Hospital Program came into operation in 1959 and the Medical Program came into being ten years later. After an experience of twenty years, the health of Canadians and the quality of our health care compare favourably with international standards and the system is relatively well managed.

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This opinion has been expressed by James Bennett and Jacques Krasny of McKinsey & Co., management consultants, in a series of articles which appeared in the Financial Post, a national Canadian business weekly. In a recent gallup poll survey of Canadians, it is noted that health care services or the insurance plans through which health care is delivered are rated as a top government "buy" in comparison with other public services, such as police, fire, education, and so on.

More than 99 per cent of Canadians have truly comprehensive prepaid protection against the costs of medical services by physicians and surgeons, all hospital in-patient treatment and a wide range of out-patient and extended care services.

Many of you are knowledgeable about the Canadian system, but I believe we should describe certain aspects of our program as well as point out some differences in social context which make the Canadian plan uniquely Canadian.

First, there is a difference in government and population size between Canada and the United States -- we have ten Provinces versus 50 states -- 24 million people versus approximately 220 million. The ability to communicate with 10 administrative centres versus 50, to analyse data for 24 million versus 220 million, is vastly different.

Second, senior government officials do not usually change with elections. Some of the senior provincial and federal officers who were present at the inception of the plans are there today.

In Canada, there are fewer hospitals to deal with than in the United States. About 200 of the larger hospitals in Canada represent 80 per cent of hospital costs, while some 25 hospitals may represent 20 per cent of costs. These are mainly teaching hospitals.

In purely quantitative terms, according to Bennett & Krasny, the Canadian system supports more than 38,000 physicians, 350,000 other health care workers and 1,400 hospitals, adding up to a total expenditure for health services in 1978 of 16.2 billion dollars. In relation to the overall fiscal situation for health in Ontario, hospitals spent 60 per cent of Ontario's health bill of 6.1 billion in the 1978 fiscal year. It is expected that that figure will rise to 7.25 billion in 1980-81. In Ontario, it may be of interest to note, 19 per cent of the cost is recovered through subscriber premiums, which are currently $480.00 per annum for family coverage and $240.00 per annum for single coverage. Only three Provinces in Canada, namely Alberta, British Columbia and Ontario, charge premiums. Other Provinces finance their plans through a special sales tax or simply through general provincial revenues.

Health Insurance Plans

Under the British North America Act, which in effect is the Canadian constitution, the responsibility for health services is basically a provincial responsibility. Therefore, instead of having a national plan, we have a national program that achieves objectives through interlocking provincial plans all of which share certain common features, common basic standards, and common coverage.

The federal government is not involved in the day to day administration of our Hospital Plan nor our Medical Plan, but rather individual Provinces administer their individual programs for their residents and the federal government pays roughly half the cost. To receive federal financial support of approved operating costs, each provincial program must meet certain basic national standards.

These standards are based on four common points, that is, the provincial plan must be:

1. Comprehensive - All the hospital and physicians' services will be covered with no dollar limit.

2. Universal - The Health Care Plans will be available to all eligible residents.

3. Portable - Coverage must have portability among the Provinces.

4. Publicly Administered - These are non-profit plans run by a public agency accountable to the provincial government.

Costs

The experience of the Canadian Health Program has reflected an increase in cost since the inception of hospital insurance in 1959. At that time the cost of health care in Canada represented approximately 5.2 per cent of our gross national product and in the 1970's climbed to a total of 7.3 per cent of the G.N.P. Some degree of stabilization has come about in recent years as the percentage of gross national product now appears to be about 7 per cent. These increasing cost factors have happened for several reasons which are generally well known, such as rising costs of salaries and wages, cost of equipment, and more complex diagnostic and treatment procedures.

The per diem standard ward rate for the year 1980-81 for complete hospital coverage at the Ottawa Civic Hospital, which is a large teaching institution, is $260.00. This includes the usual hotel services, such as a bed, meals, and housekeeping, as well as all diagnostic tests, drugs and medications, case rooms, operating rooms, blood and any other clinical services the patient needs except doctors fees. The patient may be an arthritic receiving aspirin as a medication or a patient receiving open heart surgery and the per diem rate is the same. The rate is set and funded by the provincial government. Our budget for the year is $71,000,000.

With the start of the Hospital Care Program, governments soon found a good deal of catching up to do in the way of new and expanded facilities and new and expanded services with a view to ensuring that all regions in the Province were somewhat comparable. Hospital administrators therefore had a heyday in the 1960's when monies available to the health care system seemed to be without limit. However, the end came in the 70's when the provincial government put hospitals on a global budget in 1972 and granted annual increments to the budget which were less than the average increase in cost of living. While global budgets have probably given hospital

administrators more flexibility to manage, it can also be said that hospitals across the Province have been forced to scrape "the bottom of the barrel" in maintaining existing programs, and the development of new programs is almost non-existent through government funding.

With continually rising costs, government's philosophy seems to have been that the situation can be dealt with in a number of ways, such as by containing the benefits, by higher taxes, or by increased spending for health care at the expense of other public-supported programs. Many of our provincial governments have taken the route of containing benefits by limiting the amount of money flow, but another form of constraint has been a reduction in the number of beds available, from 5 active treatment beds per thousand population to 3.5 active treatment beds per thousand population. While belts have been tightened, our provincial governments have been looking for alternative ways to provide health care at less expense, such as home care, ambulatory care including day surgery, and shared services, which have been pioneered by many hospitals across the Province.

There is also the point of diminishing health returns insofar as life style and environment account for two-thirds of years of life lost before the age of 70. In the three decades from 1931 to 1961, Canada increased its spending on health care by 1¼ percentage points of the gross national product and life expectancy increased by nearly eight years. In the following decade, when the proportion of gross national product devoted to health care also grew by 1¼ points, life expectancy rose by only one year.

After a certain point in the economic development of a society and the evolution of its health care system it appears there is no correlation between resource supply and health status. The major causes of death are life-style related such as accidents, drinking, eating, smoking, and other causes. Spending more on health care will therefore not bring the life expectancy up, but more exercise, less smoking and a better diet will whittle down the substantial heart disease rate of Canadian men. Although increased expenditures have not and will not pay off in freedom from illness and gains in Canadians' life expectancy, there is little doubt that they will buy more comfort, less pain and more peace of mind. These intangibles do not appear in mortality or sickness statistics and some people may argue that they are worth every penny.

Lessons Learned

In dealing with lessons learned from the Canadian Health System, we should probably talk about good lessons as well as bad lessons and what has actually happened after twenty years of experience in Canada. Some of the interesting and positive lessons which have been learned are as follows:

1. The once existing bad debt problem of hospitals prior to 1959 has been eliminated.

2. Doctors who devoted varying amounts of time in free work for the sick poor prior to 1969 are now receiving a fee for service, albeit the fee may not always be as high as desired.

3. The Health Care Program has in effect made hospital administrators more innovative and perhaps more community-minded rather than competitive. When we think of today's total body scanners or linear accelerators each costing a minimum of $750,000 and higher, it makes sense that every hospital should not have this kind of expensive resource. Likewise, every hospital need not have an obstetrical unit or an emergency department, and benefits in costs can be achieved through shared services such as central purchasing, central laundries, central food production factories, and laboratory services. The Ontario government has set up a system of district health councils to coordinate the health system at the local level and these councils must approve service programs, building programs and the purchase of expensive equipment before a recommendation is forwarded to the provincial government for consideration. In other words, hospital insurance has been helpful by either good luck or good management, in eliminating the duplication of facilities and resources.

4. Another interesting aspect in the introduction of hospital insurance and later medicare was that some of the previous carriers of prepaid insurance moved from the private to the public sector. In many cases, Provincial Blue Cross and physicians' services plans were absorbed and enlarged and in effect became the administrative arm of government. The expertise was not lost and, as an analyst of the Canadian system explained, "They did not create something new -- they made Blue Cross compulsory". As you are aware, Blue Cross still exists insuring extra benefits, sometimes competitively with many insurance companies across our continent.

While some favourable lessons or benefits have been achieved, we also have some less favourable.

1. There is a problem in resource allocation insofar as the consumer looks on health care as a right and probably may not even know what the costs are. As a result, his inclination may be to consume more of the services than is absolutely necessary.

2. When the Health Care Program came into being in 1959, the program was hospital-oriented and costs of services were underwritten only if the patient received care in hospital. This, of course, created a huge demand for hospital service, and at the Ottawa Civic Hospital our number of emergency visits increased by three hundred per cent in the first two years of the program.

3. Planning for the future has been mostly limited to short term rather than long term, probably because provincial government budgets are prepared on an annual basis. Long term projections could conflict with future courses of public action, a point that is important to the elected representative. This, of course, can be frustrating to the progressive hospital executive who has a responsibility to plan for a period of years.

4. The old saying of "he who pays the piper calls the tune" is quite true, and each provincial government holds its own purse strings and flows money based on government decisions. While the Province of

Ontario had district health councils, these councils are advisory and have no fiscal responsibility. Hospital trustees, who as volunteers donate their time and talents to their local community hospitals, have found that their responsibilities have deteriorated in the determination of policy for the institution and in the setting of rates.

5. Changes in government have had effects on the plans in some provinces. Likewise reorganization by government in the administration of plans has created problems.

6. Insofar as our provincial governments are under the control of politicians, it is found that decisions made by politicians are sometimes made on a basis of emotion or reaction to strong lobbying. In this regard, pressures by politicians have stimulated decisions to build new hospitals or to expand hospitals or to acquire expensive pieces of equipment.

7. Teaching hospitals in Ontario are having financial difficulties in government funding insofar as annual percentage budget increases apply in the same way to all acute care hospitals across the Province with few exceptions. Teaching hospitals are different from non-teaching institutions because they provide what is frequently called tertiary care on a regional basis, and these procedures are very expensive and require complexities of facilities, expertise in staff and expensive equipment. These include various types of intensive care units, renal dialysis, hyperalimentation, open heart surgery, expensive drugs for medical oncology and others. Teaching hospitals are the only true centres for these programs and, as the demand increases and new specialization comes about, the cost naturally increases to the embarrassment of the budget.

   Teaching hospitals have other problems because of the teaching function, which requires space for faculty and students. The style of practice is perhaps also different in a teaching hospital as students invariably write more drug prescriptions and requests for diagnostic tests as part of their learning. Further, teaching hospitals are also expected to develop inquisitive minds, which means research, and the Hospital Insurance Program does not underwrite the cost of research. Hospital Insurance Programs should therefore accept the premise that teaching hospitals should be funded differently from non-teaching institutions because of the difference in case mix and other responsibilities accepted by teaching institutions.

8. My final comment on lessons learned relates to our aging population. According to the Economic Council of Canada, Discussion Paper No. 123 by Jac-Andre Boulet and Gilles Grenier, one out of every twelve people in Canada was sixty-five years of age or over in 1976, and the projection is that one of every eight Canadians will be sixty-five years or over by the year 2001. As older people require more hospital care and medical care than do younger people, the phenomenon of aging has not been given adequate attention under our health care programs. On a relative population ratio, we now have more people over the age of sixty-five in institutions in the Province of Ontario than in any

other province in Canada, or for that matter in the western world. This future demand of health care for the aged will again escalate costs unless changes are made in our Health Care Programs.

Trends

It is interesting that the Canadian Health Care Programs, in spite of costs and complexities, are expanding benefits. For example, premiums for Hospital and Medical Insurance have been dropped in recent years within the Province of Ontario for individuals sixty-five years of age and over. Likewise, people in this age group are entitled to receive free drugs and medications, and in other provinces dental care has been added to provincial health programs.

Summary

The Canadian Health Care System would appear to be in good hands and is well received by most Canadians. Many lessons have been learned over the past twenty years, both favourable and not too favourable. Greater public education would be helpful to warn Canadians about hazards in life style. Adjustments will be required in the decade of the eighties in providing alternative methods of care and particularly in the best interests of our aging population.

MR. B. E. FREAMO: When Medicare was introduced in Canada in the late 1960's, it was a symbol of our then euphoric economy. The federal government used surplus revenues to bribe the provinces to introduce the first dollar coverage system which the government designed. The program was called a Medical Insurance Program although over time the insurance aspect of the title has gradually diminished.

The medical profession opposed the basic concepts of this Federal Government Program - primarily because there was no element of patient participation and we were deeply concerned about the effects of a completely government-dominated administration. Subsequent events indicate that we were right in our concern. During the decade of the seventies, provincial programs roughly similar in nature were developed to conform to the criteria established by the federal government. Some changes were made in the interval. Benefits were extended to include, in many provinces, optometric and chiropractic services. As well, three years ago, the basic funding agreement between the federal government and the provinces was altered to provide more federal monies to most provinces. During the past three years, this increase in the flow of federal funds has resulted in some decrease in the proportion of provincial revenues allocated to medical care costs. However, the existing level of federal funding should remain relatively constant and this will mean that our provincial governments will have to finance an ever-increasing proportion of Medicare expenses over the next few years.

What is the medical profession's view of Medicare? Let me say at the outset that most Canadian doctors want the system to continue in much the same way as it currently operates. A minority would prefer that we scrap the system and return to true insurance principles. However, such an event is unlikely unless dictated by inadequate government funding.

Last year, the federal government appointed Mr. Justice Emmett Hall as a one-man commission to examine our Medicare system. The politicians were concerned that some physicians were billing patients amounts in addition to the Medicare Benefit and there were suggestions that some federal monies earmarked for Medicare were being used to build roads, hire teachers, et cetera. Mr. Hall had been the chairman of a Federal Royal Commission which in 1964 made recommendations for the establishment of the Medicare system. Not all his 1964 recommendations were accepted by the government, and it is not surprising that his most recent report indicates his view that the problems would be largely solved if we had adhered to his original Royal Commission report.

The Canadian Medical Association submitted a presentation to Mr. Hall outlining Medicare problems as we perceive them. Our primary concern was the underfunding of the Medicare Programs by the provincial governments and the reflection of this underfunding in physicians' income levels. 1971 was the first year that the program was in operation in all ten provinces. Between 1971 and 1978, the level of payment for physicians' services increased by 36.8%, whereas the Consumer Price Index rose by 75.2% and the average hourly earnings of all Canadians rose by 107.9%. If Medical Care Insurance payment levels are adjusted for inflation, they dropped 28% between 1971 and 1978.

Statistics Canada reports also indicate that physicians' earnings have fared poorly with those of comparable self-employed professionals in Canada. In the 1971-77 period, physicians taxable income increased 30.7% compared to 58.3% for lawyers, 70% for dentists and 102.6% for accountants.

When Medicare was first introduced, we disagreed with the predictions that health care costs would run out of control and escalate like a skyrocket. We were all too well aware that the potential for government control would ensure budgetary restrictions which would keep costs in line. In fact, our main concern in the late 1960's was that the proposed system would not provide Canadians with the best possible system of health care, but rather that it would provide that level of excellence which governments felt they could afford, and that budgetary controls would be utilized to determine the level of health care to be available to Canadians.

On a broader basis, Canada spent about 7.1% of our GNP on health services during the 1960's. In 1971, the first year that Medical Insurance was in operation in all provinces, the gross national product share rose to 7.3%. In 1976, the last year for which figures are available, our expenditures on health care dropped to 7.04% of the GNP, and in the same period the percentage of the GNP spent on physicians' services dropped from 1.31% to 1.11% -- a reduction of 16% in 7 years.

In effect, the medical profession has been subsidizing Canada's health care system. It is not surprising therefore that more doctors are billing patients amounts in excess of the Medicare Benefit. Other doctors voted with their feet and left the country. The number of physicians moving to the USA increased from 242 in 1975 to a high of 663 in 1978. In 1979 and 1980 these numbers have reduced. A major factor in these decisions is that the Canadian physician is being paid at about 50% the rate of his US counterpart. These lower paid rates become even more striking when compared

with average wages and incomes for Canadian industrial workers and other professional groups that are 20 to 30 per cent higher in Canada than in the United States.

The profession maintains that underfunding caused by extraordinary government cost control has affected all aspects of health care, including hospitals. Physicians, as advocates of individual patient needs, perceive the negative effects of fiscal restraint on hospital care in terms of staffing, bed cutbacks, withdrawal of services, and restraints on the purchase of necessary equipment. There is a direct correlation between funding and access. Less money means fewer services. We can only conclude that continued underfunding will inevitably lead to restrictions on the accessibility of hospital services.

In his recent report Mr. Hall documented the underfunding of Medicare. He recommended that more government monies be available for services and payments to doctors, but he was unable to indicate where the money would come from. He singled out the direct billing of patients by doctors as the major area of concern of politicians and patients. He recommended that this right be eliminated and that adequate payment levels to doctors be ensured by providing doctors with more clout at the bargaining table through the availability of a system of binding arbitration.

The medical profession has opposed the elimination of private billing. We see it as the only safety valve in the system. If governments refuse to allocate sufficient monies to provide adequate compensation, the only way in which the public will become aware of the budgetary inadequacies of the system is through experiencing an increased level of private billing. With the experience of government controls during the 1970's, the profession has no confidence that government will mend its ways and suddenly find sufficient monies to adequately finance health care in this country.

The negotiating process between the profession and the provincial governments can more aptly be called "collective begging" rather than "collective bargaining".

In most Provinces, governments discuss the level of Medicare Benefits with the profession, but in all provinces governments retain the right to legislate their own point of view. This is the negotiating process which has led to budgetary controls and consistent underfunding. Surely, in any system in which government controls the benefit level, physicians should be allowed some measure of direct billing to patients. Such patient participation provides a key safety valve for unsatisfactory negotiations. It prevents the creation of an adversary position between physicians and government, retains a professional physician/patient relationship and in large measure eliminates the possibility of disruption or withdrawal of services. In his report, Mr. Hall suggested a twinning of the two main problems in Medicare. In his opinion, the profession should not be allowed to bill patients directly and provincial governments should be required to accept binding arbitration.

The attitude of our provincial governments was virtually predictable. They would not object if the federal government took away the right of physicians to bill patients but they are unwilling to accept the fiscal

consequences of binding arbitration. In other words, they want state medicine but are not prepared to pay for it.

Mr. Hall made a number of other recommendations on problems that have not been solved within the first decade of Medicare. One of these is portability of benefits. Even though provincial government committees have been studying this problem for many years, there is no guarantee that a citizen of one province can obtain medical services in another province within the Medicare System.

There are other problems which concern the profession a great deal which Mr. Hall did not mention in his report. One of these is the diminishing role of the physician in health care decisions. While this in part evolves from our system of strict budgetary controls, there is a growing belief in government that medicine is too important to be left in the hands of doctors. One provincial government in the concluding pages of its report to Mr. Hall stated, "The physician's perspective is single-mindedly medical and his duty is to the ill individual; it is not appropriate to make his profession responsible for the multi-faceted general health of the population, particularly when it is not accountable, in the ministerial sense, to the public. Far from being accorded more power - such as would result from a private direct patient payment scheme - physicians should be more controlled, in the sense of inter-related with the many parts of the entire health system. That implies the need, beyond the procedure for remuneration, for regulation or at least orchestration of manpower, quality and patterns of practice."

The medical profession has in this decade seen its economic position deteriorate. It has seen its professional position eroded and it is extremely concerned that the final step in this process will be to make the medical profession de facto civil servants. It is in this light that the medical profession considered that it must forcefully express its views on the Hall report. Our recent annual meeting in Vancouver approved the following statement of our position:

"The CMA will support several of Mr. Emmett Hall's recommendations in his review of health services, but categorically rejects his package of proposals to resolve what he calls the dominant issue. Mr. Hall's proposals that all direct personal responsibility for the payment of health care costs be eliminated, that all health care costs be paid by government from taxation revenues, that payment for physicians' services come from that one source and if necessary be determined by compulsory arbitration - are not in the best interests of the public or the profession.

"Mr. Hall's proposals would infringe on the patient's right to select a physician of his choice. Under the proposals, patients choosing an opted-out doctor would be denied their share of the financial benefits of the Medical Care Insurance Program. In effect, Mr. Hall would severely restrict the patient's right to retain the advice and services of the physician of his choice on a mutually agreed basis. At the same time, the doctor would no longer be his patient's advocate, and an independent provider of health care - a professional legally and otherwise responsible to the patient. Instead he would become, in labour relations terminology, a government-retained dependent contractor -- a de facto civil servant. In a very real

sense Mr. Hall is recommending that health care insurance, which the medical profession of Canada has pioneered and strongly supports, be abandoned in favour of state medicine.

"The CMA has strongly supported medical care insurance for many years. It has been a fundamental CMA principle that "the patient should be aware of, and wherever possible pay part of, the cost of medical services he receives". That principle applies not only to the cost of services provided by physicians but includes hospital and other institutional services. It has always been subject to the financial ability of the patient to pay. We believe that the patient should be protected from catastrophic health care costs, regardless of their cause, but that he should retain some direct responsibility for the cost of personal health care. It also provides a most important safety valve for unsatisfactory medicare benefit negotiations, a means whereby the physician can oppose naked fiscal power exercised by provincial governments without harm to his patients.

"The Association believes that a health care insurance program that pays all costs for some of the population and most of the costs for the rest is a pragmatic solution infinitely preferable to a state health care system, one that provides "free medical services" for all. It protects the independence and freedom of the physician to service as the patient's personal advocate, free to criticize on his patient's behalf the deficiencies of governmental or institutional policies detrimental to health care. Finally, it allows the patient more freedom to decide how much of his personal resources he will spend on health care.

"In its submission to Mr. Hall the CMA has supported the insurance principles which form the basis of our present legislation, and has argued against Mr. Hall 's determination to end all forms of extra billing. We will continue to defend our position by forceful presentation of our views to the public and to our legislators.

"If the people and governments of Canada reject our advice, if they accept Mr. Hall's proposal, deny physicians the right to serve as self-employed professionals, direct that state medicine be introduced, convert physicians to dependent contractors or civil servants, it will be a sad day for patients and doctors alike. Regrettably, it will make it inevitable that physicians seek the protection of some form of union organization rather than our current voluntary association of self-employed professionals. In case that unfortunate decision is made by governments, our general council directed the board to explore the potential benefits of unionization of the profession with attention to such issues as defined hours of work, premiums for hours on call, overtime, weekend and holiday service, standardized working conditions and grievance procedures, indexed pensions and other fringe benefits that are available to state employees."

This, unfortunately, is the medical profession's view of Medicare in Canada today. It is difficult to know how these issues will be resolved. However, the medical profession has served notice that it no longer will be the whipping boy; it will no longer subsidize governments' promises to the public. If government wants state medicine - they will have to pay for it.

And, of course, in the long term we will all have to pay for it through a reduction in professional freedom for doctors, and an eventual reduction in the quality of health care for the people in Canada.

MR. DAVID A STOUFFER: I have been asked to speak to you today on current problems of a National Health Insurance Plan from the point of view of a government actuary concerned about the budget as well as on the problem of keeping both the providers of service and users satisfied. Although my remarks will be limited to a discussion of Ontario's plan, I believe that they will be general enough to apply to a national system. I should point out that in Canada, each of the provinces runs its own health insurance scheme and that there are differences between the plans, particularly in the area of financing. Although I will be discussing only the problems with the system, it is important to remember that from the point of view of the user, the Ontario Health Insurance Plan (O.H.I.P.) has been a remarkable success.

My comments examine the problems of a National Plan under three broad areas prefaced by a brief summary of the O.H.I.P. system.

1. Financing.

2. Problems on the demand for services side.

3. Problems on the supply side.

I would point out that, although I am an actuary by background, my approach to the subject is not a traditional actuarial one which is concerned with matters of insurance principles and equity in a broad sense. Rather my comments reflect my orientation toward problems of government finance and the framework of political realities within which I must work. Finally, these remarks are my own and should not be construed as setting out policy positions of the Ontario government.

A. The O.H.I.P. System - brief summary

Medical Services

Basically, all physicans services in office, home and hospital are covered. In addition, with certain limitations, the services of optometrists, chiropractors, osteopaths, and podiatrists are covered as well.

Drug Program

Prescription drugs for persons over the age of 65 who receive the Old Age Security are free.

Hospital Services

O.H.I.P. provides standard ward coverage, necessary nursing services and drugs during a period of hospitalization. In addition, services in hospitals related to occupational therapy, physiotherapy and speech therapy are covered.

Extended health care is provided for persons requiring continuous nursing services and regular medical supervision. In these cases, the patient pays only a portion of the regular ward rate.

There is also a home care program covering health care services at home on a visiting basis when prescribed by a doctor.

Out of Province Coverage

Coverage is extended with certain limitations to persons requiring services outside of the Province.

Financing

In Ontario, the program is financed through premiums, general tax revenues and transfers from the federal government. Presently, premiums are $20 per month for single person and $40 for families. There is also a premiums assistance program for low income persons.

B. Problem Areas

1. Financing

In order to give you some idea of the magnitudes of the costs of Insured Health Service and how they have developed, consider the following facts.

In 1972-73, insured service costs amounted to $1.606 billion. This cost was financed by $520 million (32%) in premiums, $746 million from federal cost sharing (47%) and transfers from general taxation of $340 million (21%).

By 1978-79, the cost of the program had increased to $3.340 billion with premiums of $975 million (29%), and federal transfers and general revenues accounting for $2,365 million or 71% of the balance. I should point out that new federal cost sharing arrangements were introduced in 1977-78. Under this new system, funds were transferred to the provincial governments through an increased percentage of the personal income tax allocated to the province, as well as an increased share of corporation tax. Under the system of federal transfers in effect prior to 1977-78, the provinces received roughly 50% of their health care costs from the federal government. This system was relatively open-ended and did not provide enough incentive for the provinces to limit the costs of their health care programs. The new system, under which an increased proportion of the personal income tax and corporation tax is transferred to the provinces to cover costs of both the health care system and education, has created a substantially greater incentive for the provinces to control health care costs.

You will note from the previous figures given that the premiums charged account for a declining proportion of the health care cost.

Just to provide another perspective on the cost of the program in relation to the premium income, in 1972-73 the per capita premium income was $66 and the per capita insured health expenditure was $205. By 1978-79, the per capita premium income had increased by 74% to $115 and the per capita expenditure by 93% to $395.

Of particular interest is the rapid growth in the per capita cost of health insurance, 93% in 6 years from 1972-73 to 1978-79. The C.P.I. increased in that same period by approximately 67%. Clearly, costs of health care increased dramatically faster than the C.P.I. However, as a proportion of Gross Provincial Product, the costs have moderated slightly.

In order to assess the reasons for the increase in health costs, I looked at the changes in costs for hospital costs and medical services separately. Unfortunately, the analysis had to be confined to the years 1970-71 to 1975-76. On a per capita basis, the cost increased from $105 in 1970-71 to $198 in 1975-76, an increase of virtually twice the rate of inflation. In that period, the volume of hospital services had not increased substantially. Consequently, the entire cost pressure had arisen from rising unit costs. The primary cause of the increase can be traced to the wage and salary bill. The number of paid hours increased only 4% by the period 1970-71 to 1975-76, but the average increase in pay per hour rose 96%.

In the case of the medical services, the cost trends are somewhat different. The per capita cost for medical care rose from $58 in 1970-71 to $90 in 1975-76, an increase of 55%. However, total expenditures rose by 70% from $436 million to $742 million in the same period. Unlike the hospital sector, where unit costs pushed up the total expenditure, in the medical sector it is the volume of service which drove up spending. The volume of claims increased 60% over the period.

To analyze this further, we found that the number of practitioners had increased over the period by 28% and the claims per practitioner by 26%. Utilization of medical services as well as the population of doctors appears to be the prime problem area here. In 1975, Ontario had 1 doctor per 565 population, the U.S.A. 1 per 620. The World Health Organization suggests that a rate of 1 physician per 650 population is more than adequate.

One is tempted to speculate that the presence of a national insurance plan may have the effect of creating an oversupply of physicians. This is inspite of the fact that doctors are vehemently opposed to "socialized medicine".

The figures above would suggest that in creating the national insurance program, we have created a monster. The problem then becomes, how do you control the monster? Especially such a politically popular one.

Perhaps the easiest sector to control is the hospital services sector. As was mentioned earlier, the problem of the increasing cost in this sector was not utilization, but unit costs. Individuals have a greater reluctance to enter a hospital than they have to pay a visit to their friendly doctor. In Ontario, the Ministry of Health which supervises the budgets of hospitals, embarked on a long-term program to reduce the spiraling cost of hospital services. These actions included the elimination of surplus hospital beds, controlling the volume of lab tests, restricting capital financing, and placing hospitals under tight constraints in budget financing. The actions are now being felt and have been highly effective, at least from a financing point of view. However, I would point out that the closing down of hospitals met with opposition so strong in some areas that those plans had to be abandoned.

Controlling the costs on the medical services side has not been so easy. First, the individual visiting the doctor does not seem to understand that an expenditure has been made on his behalf. Because the service appears free, he is inclined to see a doctor for relatively minor ailments - a practice that doctors tend not to discourage.

Second, the supply of doctors is increasing. The increasing availability of physicians per patient may increase patient utilization. This problem is exacerbated by the fact that the price mechanisms which enter the usual supply and demand equation have been eliminated. These factors are probably the most direct and indirect contributors to increasing utilization. The supply of Ontario graduates is presently sufficient to maintain the population of physicians. However, there is a substantial immigration of doctors and it is impractical to limit immigration entirely.

Attempts have been made to limit the growth in physicians' fees. For example, as a first attempt, the Ontario Medical Association (O.M.A.), whose fee schedule was used until 1978 to establish the amount of reimbursement, was asked to limit its fee schedule increase in 1976 to 8.1%. Later in 1978, the Province abandoned the O.M.A. schedule and developed a reimbursement schedule of its own, independent of the O.M.A. Physicians who accept the level of O.H.I.P. and do not bill their patients are called opted-in doctors. The others (opted-outs) bill their patients directly and the patient receives a cheque from O.H.I.P. based on the O.H.I.P. fee schedule.

Initially, the move was successful as far as limited costs under the plan. However, an increasing number of doctors decided to opt out until presently about 17% of physicians in Ontario are in this category. The result has been that, as the difference between the fees of opted-out and opted-in doctors increased, the opted-out doctors could earn a higher level of income even on a reduced patient load. If the trend to opting-out should escalate, the O.H.I.P. system will either be forced to adopt higher fee schedules to lure physicians back into the plan, or become progressively ineffective in its attempt to provide comprehensive medical service coverage. The patients who have been using a physician who has decided to opt out are faced with out of pocket costs of perhaps 25% of the fee charged. Further, these persons do not have access to private insurance coverage. One can say tough luck, see an opted-in physician. However, the selection of a doctor is a highly personal matter.

There are other cost control mechanisms that might be considered to limit utilization.

For example, patient participation or utilization fees could be instituted (e.g. patient pays $2.00 cash for an office visit). Other jurisdictions have experimented with the approach and found that it is not a satisfactory curb to consumer demand. The problem is that, to be effective, the utilization fees must be fairly high. However, if they are too high, they may defer the patient from seeking necessary help and be prohibitive for the poorer patient.

A second approach is to attempt to control physician generated utilization with regard to particular items. This is not feasible due to the multiplicity of items in the schedule and the variety of ways physicans can circumvent the government mandated actions.

2. Problems on the Demand Side

With so many services covered, it would be difficult to see how there could be problems from the user point of view. However, there are.

Prior to the introduction of the Ontario Medical Services Plan, many persons were covered under private medical insurance plans. These plans in many cases provided a higher level of coverage than the 90% offered by the Ontario plan. With the introduction of the national plan, private insurance to cover the difference between the bill rendered and the portion paid by O.H.I.P. was made illegal. Presently, since many doctors have opted-out of the O.H.I.P. system, and since the fee paid by O.H.I.P. is now substantially below the Ontario Medical Association fee, persons who see an opted-out physician can be faced with substantial medical bills for which no insurance coverage exists.

Several solutions are possible. First, the levels of fees paid doctors could be increased so that fewer physicians would opt out. This could be costly and would likely attract even more doctors to Ontario.

A second approach could be to allow private insurance to cover the difference between the fee paid by Ontario and the fee charged by the doctor. This would undoubtedly result in even more doctors opting-out of the system and consequently prove a hardship for persons without the second level of coverage.

3. Problems on the Supply Side

I have already discussed the high cost of the program and the difficulties with controlling those costs in the first section. Perhaps one of the more difficult non-financial problems is the doctors' aversion to socialized medicine. Each practitioner wants to be the master in his own house, and somehow the presence of a large national system creates an uneasiness among practitioners.I think that Ontario has coped reasonably well with this problem even though opted-out physicians form 17% of the population. It should be noted however, that many in this group do not charge above the O.H.I.P. fee schedule.

A second problem centres around the covered services. There is pressure from some sources for a drug program.

Finally, although the system is coping well at the present time, there are pressures created outside of the system which may have an impact on the program's ability to cope in the future. Of primary concern is the spectre of Canada's aging population. As the population ages, there is an increasing demand for medical services and hospital care. Because of the strain this effect may create in terms of capital requirements for increased facilties in future years, the system may be taxed beyond its capabilitites.

To conclude, I would draw your attention to a comparison of health expenditures in Canada and the United States. Health expenditures in Canada in 1973 as a percent of G.N.P. were 6.7%. The comparable figure for the United States was 7.7%, one percentage point or 14.9% greater. By 1976, the Canadian experience showed only a nominal increase to 6.9% whereas in the U.S. health expenditures as a percentage of G.N.P. rose to 8.6%, 1.6 percentage points or 24.6% greater. I would point out that these expenditures do not include administrative costs of insurance programs which would be relatively much larger in the U.S.

Most critics of a national health insurance scheme argue that the presence of such a program can only lead to soaring health expenditures. The statistics alone would suggest the converse more likely to be true.

MR. W. A. ALLISON: The introduction of government hospital insurance in Canada in the late 1950's and the subsequent introduction some ten years later of government doctors' care or medical insurance were two experiences from which there was ample opportunity for those life insurance companies with health insurance operations in Canada to learn several important lessons.

Whether these lessons have been learned is an interesting question, but not really the most important point to emerge from the Canadian experience.

The most important point which has come out of the Canadian experience is that even if the health insurance industry had learned all of its lessons in advance; even if it had been able to mount a powerful lobby against the introduction of government health programs; even if the health insurance industry had been able to demonstrate that it was doing an effective and efficient job in the areas of health insurance which were of interest to government, none of these are factors which would appear to have had anything other than a temporary influence on the political mind whose decisions were eventually made based on other political factors such as public opinion, social conscience, the availability of money, and the need to be re-elected.

I mention this at the beginning because, when I describe for you some of the lessons which the health insurance industry has learned in the past twenty years, I do not want you to lose sight of the real points at issue from the politician's point of view.

In 1958, the federal government, by means of the Hospital Insurance Act, offered to pay 50% of the costs to those provinces who would provide hospital and diagnostic services to all residents on uniform terms and conditions laid down by the federal government. If a province wanted the federal money, they had to set up a hospital insurance plan on the terms set by the federal government. Within a year of the federal government's offer of financial assistance, all provinces except Quebec had set up hospital insurance plans that qualified. Quebec set up its plan at the beginning of 1961.

The health insurance industry in Canada was not organized to defend its position nor was it able to respond effectively to the criticisms being voiced about the industry.

When these plans were introduced, there was a great concern among the life insurance companies who were writing health insurance that a significant part of that business would be lost and would not be replaced. In fact, although it is true that the amount of health insurance premiums written did drop in 1959 and again in 1961, when Quebec joined the government plan, within a year health premium income was higher than it was before the government program was introduced and each year after that made substantial further gains.

This happened because the insurance industry was able to offer additional coverages such as prescription drugs, nursing home care, and related services. In addition, when the government hospital plans began, employers were not permitted to reduce the amounts they had been paying for employee benefits. As a result, many employers were seeking ways to spend what they had been paying on alternative programs.

There were perhaps three lessons to be learned from this experience. The first was that although a significant portion of the health insurance market had been removed through introduction of the government hospital plans, in fact the remaining market was, although smaller, still so large that the life insurance companies writing health insurance could still achieve rates of growth which compared very favourably with the rates of growth in their other lines of business.

The second lesson was that the health insurance industry would need to be organized in order to present a common front if it hoped to defend the industry position against further government encroachment. Only in this way could the industry hope to answer criticisms of industry practices and develop industry alternatives which might persuade government to use existing vehicles rather than replace them. In fact, in 1959, the Canadian Health Insurance Association was born, subsequently the Canadian Association of Accident and Sickness Insurers, whose main purpose was to present an industry voice to government.

The third lesson was perhaps the most ominous: hospital insurance was only the first step in the government's efforts to take over the health insurance business. What happened in the 1960's has been discussed many times during and since at Society meetings. Sufficient to say that in 1968 the federal government's Medical Care Act took effect. This legislation did for physician services what the earlier Hospital Insurance Act had done for hospital care. The federal government again offered to pay 50% of the costs to those provinces providing medical services to all their residents on uniform terms and conditions laid down by the federal government. Any province without such a program would get no such federal assistance.

No provincial government could afford to have its citizens without a medical care program since in that event they would be subsidizing through federal taxes those provinces which did. There was, therefore, a rush to introduce a program and by the beginning of 1971, all provinces had one in place.

When this second major bite was taken out of the health insurance market, the life insurance companies were convinced that the days of significant growth in their health business were over. Once again, they were proved

wrong. Within a couple of years, all the premium lost to the government medical care programs had been recovered and even higher growth rates than those experienced in the 1960's were experienced in the 1970's. This was partly attributable to inflation but also to the introduction of group dental plans and to a significant growth in both the number of plans and the amount of coverage under long term disability plans. One casualty of the government programs was that health insurance on an individual basis was now restricted to income protection only. However, the growth in group health insurance coverages, which continues to this day, is nothing short of remarkable.

In addition to the fact that the remaining health insurance market was still large enough to permit the life insurance companies to grow in that business at a quite remarkable pace, there were other lessons to be learned as a result of the government activities which culminated in the government medical care programs.

Being organized had allowed the health insurers to present a common united front in opposition to further government involvement. Being organized had also allowed the industry to respond to criticisms and to develop alternatives which could be just as effective as government programs, without destroying private insurance. What the industry learned was that being organized to defend your position is effective only to a point - really the private insurers were at the mercy of the governments they dealt with. Whenever it became politically more expedient to take over the private insurance, that is what was done.

Another lesson was that money can be an irresistable lever to force government action. None of the provincial governments could afford to ignore the offer of federal aid, since their citizens would then end up subsidizing through federal taxes those provinces which did. The cost factor of a medical care program had been reduced in such a way that provincial politicians could not afford to stay out and expect to keep their constituents' votes.

The industry also learned that any partnership between private health insurers and a government is at best a temporary arrangement. Two examples come to mind. During the 1960's, in Alberta, the insurance companies, in co-operation with the provincial government, the medical profession, and the doctor-sponsored plan in Alberta, operated a plan of basic medical insurance which was a working alternative to a monopolistic government plan. When the federal government made its offer of money to the provinces in 1968, Alberta was forced to abandon its government-private insurer plan partnership.

The second example is Ontario, which started its medical care plans by contracting out administration of the plan to a group consisting of life insurance companies and other agencies. Within a few years, however, Ontario had established its own administrative facilities and the private carriers were out of that business. The Province of Ontario had simply used them while they themselves got organized.

During the 1970's we have seen the health insurance market grow quite dramatically as income replacement and dental plans have become popular group coverages. Governments have again been casting their covetous eyes

in our direction, but to date they have restricted their activities to programs which either help the elderly or provide some basic dental care for children.

The big problem for governments in Canada today is cost - that is, the costs of existing programs and the costs of programs that they would like to introduce, such as universal dental coverage - but which they cannot afford. Their partner in the small earlier ventures of hospital and medical care insurance, the federal government, is no longer interested in putting up any of the costs of new programs. Money talks. It talked governments into action when it was available and now it is talking them into postponing action because it is unavailable in the amounts required.

But the lesson to be learned is clear. Governments are not likely to stop looking at the remaining aspects of the health insurance industry in Canada, and, wherever possible, they will continue to make inroads. For example, the government of British Columbia has announced a cut-down dental plan for many of its residents to be effective January 1, 1981. The plan, which will pay up to $700 each year, will cover the elderly, children up to age 14, and all those who require financial assistance in the payment of their Medical Services Plan premiums.

A second situation exists in Saskatchewan, where the government seems determined to take over the income replacement business of private insurers because, they claim, the private insurers have done an inadequate job. The industry is fighting back with a plan of its own. This is a standard plan of disability insurance which would be available to permit more extensive coverage of all kinds of risks at a uniform rate to all employed individuals who apply for it, regardless of occupation or health. Operation of the plan will involve the creation of a pooling mechanism that will allow participating insurance companies to share equitably the risk of insuring high risk individuals and groups. Even if the private insurers prevail - what concessions will they have had to make to governments and for how long will they be allowed to offer their plan. The industry proposals envisage private plans for employed citizens who can afford it, and a government plan for the unemployed and the low wage earner who cannot. This is a kind of partnership with governments with all the political risk that entails. There is a broader point at issue here too. This is not just income replacement coverage in a small province of Canada that is being threatened. The threat is to our whole concept of income security and private industry's role in providing it. Past experience indicates that no program having this social importance is introduced in one province and remains only there. Sooner or later it will spread to the rest of the country unless it is effectively delayed or stopped right at the beginning, which now looks to be Saskatchewan.

The basic problem with all governments is that they tend to confuse what the role of the private insurer was designed to be with the social and political objectives of a government sponsored program designed to alleviate particular problems in our society and which private insurance was never intended to solve.

This automatically places the insurance industry on the defensive. However, the defensive role is one which is becoming quite familiar to the private health insurers in Canada. Last year, the Canadian Association of Accident

and Sickness Insurers published a booklet entitled "Forewarned and Forearmed," which some of you may have seen. In it, amongst other things, the industry suggests possible initiatives that could be taken by private insurers to blunt industry criticisms and preserve a meaningful role for the private health insurance industry in Canada.

The title is very appropriate and allows me to close my remarks on an optimistic, if defensive note. Whatever other lessons have been learned by the private health insurance industry in Canada, it does know that as far as any future government activity in the business is concerned, it has been forewarned and will be, as a result, forearmed.