HEALTH CARE IN CANADA:
THE FINANCIAL POST CONFERENCE, 1989

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On 1 and 2 June 1989, in Toronto, the Financial Post, in cooperation with the Ontario Medical Association, held a conference called Health Care In Canada: Cost Control And The Rationing Of Care. As this name suggests, a primary concern of participants was whether controlling health care costs implies the rationing of care. New, cost-efficient approaches to health care delivery were scrutinized in light of the requirement to make good quality care available to everyone, regardless of financial ability.

Approximately 350 delegates attended the conference, including representatives from universities, governments, hospitals and business in Canada, the United States and Britain.

SESSION TOPICS

1. Centralization vs Decentralization: Management of Health Care Resources

Decentralization implies the delegation of authority for decision-making from central governments to those who implement the decisions. Its advocates argue that decentralization provides for more cost-effective health care that is more responsive to local needs. Fiscal constraints, however, with their tendencies to centralize, have militated against the decentralization of health budgets and decision making.
Current efforts to decentralize the health care system in Canada, Britain and Sweden were discussed in this session. In Canada, Manitoba and Quebec have created regional organizations to effect decentralization, while sub-regional organizations allow for input from local health care providers and consumers. In Britain, decentralization has taken the form of local autonomy in policy-making with central control of funding. In Sweden, where decentralization is most advanced, general goals are set centrally but implemented by 23 elected county councils with the ability to finance health care through local income taxes.

2. The Ethics of Rationing Care: If We Must, How Can It Be Done Ethically?

Speakers agreed that some recent developments in health care delivery, such as global budgets for hospitals and alternative payment arrangements for physicians, are implicit forms of rationing. It was suggested that, though some form of rationing is inevitable, at present it is being imposed quite blindly in the form of unplanned restrictions on hospital beds, human resources and services and by "throwing money at" particular services, where identifiable victims do not get heart surgery, CT scans or dialysis. Speakers warned Canadians to be cautious about cost-control measures which have not worked in the United States (US). Examples were Diagnosis Related Groups (which restrict payment to hospitals for patients under Medicare according to average costs) and Health Service Organizations (group-practice arrangements in which payment of physicians is by capitation or salary).

It was generally concluded that ethical issues arising from the rationing of health care must be made explicit. Accordingly, governments should facilitate a public dialogue in which the community decides in the community's interest how much to spend on health care and how to allocate health care resources. Governments, according to this perspective, would continue to make the big decisions and be held accountable for them but the implementors (the health providers) would make the smaller micro-choices.
3. Technology and Access: The Myth of Fair Access to the Newest and the Best Health Care Technology

Speakers in this session indicated that better use of existing technology and procedures could reduce health care costs. Better assessment of technology is required at the medical, ethical and economic levels. Mechanisms are already in place for medical and scientific assessment. Economic assessment should compare the costs of technology with the resulting benefits as expressed in such measures as "quality-adjusted life-years." Technology also raises serious ethical questions, including altered definitions of "life" and "death."

The speakers observed that competition among various health providers, for the prestige and power associated with introducing new technology, can result in the acquisition of costly health care technology which may duplicate what is already present in the community, and seriously challenges the rational allocation of health care resources.

Concern was also expressed about the costs resulting from unnecessary use of lab tests and other technical procedures.

4. Entrepreneurship RedisCOVERS Health Care: Beyond the Public Purse

Participants in this session explored how the private and public sectors might cooperate to provide a more cost-efficient health care system. Until recently, the role of the private sector in health care has been confined to providing services under contract and to pharmacies, laboratories, nursing homes and ambulance services. More recently, private companies are becoming involved in administrative/management services in hospitals and Health Service Organizations (HSOs), including organizing staff, implementing new billing systems, pre-admission testing services, scheduling of patients and joint ventures in medical research.

Speakers claimed that a high quality health care system at a cost-efficient price is best achieved through cooperation between the
public and private sectors. Other participants were concerned about conflicts between public accountability and the pursuit of profit. Some feared that the private sector might concentrate on the easier, more lucrative services, leaving the more expensive and potentially less profitable services to the public side; thus the private sector would profit from the public purse at the expense of universality of care.

5. Managed Care: How Applicable For Canada?

6. Alternate Health Care Delivery Systems: In Search of a Fair but Affordable System

Sessions 5 and 6 considered alternatives to the existing system of health care delivery and its financing. Many of these new approaches tend to fall into the category of "managed care," which takes into account both medical and economic responsibility for patient care, in contrast, for example, to fee-for-service medical care funded by governments through universal Medicare.

Under managed care, based on the principle of "market forces," a series of prepaid organizations compete for consumers on the basis of cost, quality, preventive services, access, etc. Money left over because of "good resource management" can be used to enhance programs. This gives such organizations an incentive to reduce costs. These organizations can be non-profit or for-profit and take many forms: HMOs, Preferred Provider Organizations (PPO), and other group practice arrangements. Managed care was introduced in the US in the early 1970s in an attempt to make the delivery of health care more cost-effective and co-exists there with private fee-for-service medicine and government-funded services for the elderly and the poor.

Dr. Paul Ellwood, the designer of the original HMO, was one of the speakers in this session. He reported that HMOs have not worked economically in the U.S. Utilization of and length of stay in hospital beds have been reduced but intensity and volume of physicians' services have increased. Dr. Ellwood and others are at present involved in
developing tools to measure, manage and account for the impact of health care on the clinical status of patients and the quality of patient lives produced.

Dr. Ellwood observed that HMOs have not caught on in countries where there is universal health care coverage and predicted there would be problems with organizations such as HMOs in Canada.

7. Care for Target Groups: Can the System Accommodate Special Cases?

The elderly and patients with AIDS, cardiovascular disease and organ transplants were given as examples of target groups putting particular pressures on health care services. Approaches ranging from special care facilities to community-based prevention, health care and support services were examined. Discussed were the needs to:

- avoid duplication in special care facilities, technologies and services;
- avoid putting groups in competition with each other for health-care resources; and
- better educate physicians, nurses and other personnel in the special problems faced by members of particular target groups.

FEATURED SPEAKERS

MAUREEN DIXON, Director of the Institute of Health Services Management, London, Britain, entitled her talk "The Cult of the Individual."

Ms. Dixon spoke about a recent government White Paper proposing changes in health care policy in Britain. She said these changes reflect a disturbing shift in emphasis from collective interests to individual interests.

I think the prevailing ethic is that great value is attached to personal value, personal endeavour, entrepreneurship and a thrusting, driving attitude to life. --- the converse to that is that for those who are sick or frail or out of work or who are in any way disadvantaged, it's their fault. ---- I think there
has to be a switch back or a readjustment towards some sense of community, some sense of responsibility of citizens to look after those who cannot look after themselves.

The British White Paper would provide for competition between providers and greater private sector involvement in health care delivery. Hospitals there may now elect to become self-governing, with their own financial resources and capital-raising powers and freedom to make contracts for services with districts, general practitioners and the private sector. The Paper also provides for GP (General Practitioner) practices to have special budgets, allocated by regions, for the purchasing of services from hospitals (diagnostic services, out-patient care and in-patient care for elective surgery). GP practices can purchase these services from self-governing, district or private sector hospitals. Anthony Culyer, a health economist, spoke favourably of these British trends as a way of producing a more cost-effective health care system. Ms. Dixon on the other hand, takes the view that a two-tiered system, one for those who can afford it and one for those who can't, would be the inevitable outcome where a public and private system co-exist.

Ms. Dixon agreed with many other conference participants that how much to spend on health care, and allocation and/or rationing of health care resources must be a local collective decision, reflecting local needs.

She also proposed that there is a need for more appropriately educated managers in the health care field to mediate between politicians, health care professionals and other decision-making forces.

UWE REINHARDT, James Madison Professor of Political Economy, Princeton University, gave the closing luncheon address entitled "Rationing the Nation's Health Care Surplus: An American Paradox." He refers to the American system as paradox because,

If you believe in the market, there will always be surpluses and deprivations side by side. It is so in food, it is so in shoes, it is so in housing, it is in anything that you treat as a private consumption good. If you have a market driven system like the US, you will have many people who have a terrible health care experience, even if they get it. They are broke,
they have to beg for it or they have to go a hundred miles with a comatose three-year old. ---- But at the top, and I believe American physicians when they say this, we probably do things that other nations don't even dream of doing.

Mr. Reinhardt compared the American system to the one-tiered system in countries with a system of national health insurance, such as Canada, Germany and France, where 90% of the people get the same quality of care and the remainder - "health care globe trotters" - have private health insurance that pays for everything. Mr. Reinhardt said if he were an uninsured gas station attendant he would prefer the "socialized system" but if he were a corporate executive with comprehensive private insurance he might prefer the American system.

Mr. Reinhardt reported that the effect of the market strategy on the quality of American health care has been to reduce its social quality and he would not advocate privatization of health care services as a solution to controlling costs.