Government Involvement in Health Services Delivery: The Canadian Experience

Proceedings of the Sixteenth Annual Symposium on Hospital Affairs
May 1974

Conducted by the Graduate Program in Hospital Administration and Center for Health Administration Studies, Graduate School of Business, University of Chicago.

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PROLOGUE

Government Involvement in Health Services Delivery: The Canadian Experience

Over these last few years, we in the United States have been grappling with the problem of how to guarantee adequate health care coverage for the entire population at a minimum cost to the consumer. Countless pieces of legislation have been introduced into Congress only to have each proposal found inadequate in some measure.

Canada, on the other hand, has in operation a comprehensive medical care system based on a fee-for-service method of payment, which is government financed. The physician, if he elects to participate in the Plan, is not an employee of the state, and no dollar limit is placed on the amount of care the Canadian citizen may obtain in or out of the hospital setting. As mandated by the British North American Act, Canada's constitution provides that health care is a provincial responsibility and, accordingly, a medical plan is administered separately by each of the 10 provinces.

The participating physician is typically prohibited from charging the patient anything. The government pays up to 50% of the medical cost, and insurance carriers are allowed only to offer coverage which supplements the government coverage. This insurance provided by the provinces is available to all without reference to age, previously existing health conditions, or employment status, and is available to each citizen in all the provinces. Thus, moving from one province to another does not negate previous coverage. Finally, each province may individualize their coverage by extending benefits if it sees fit.

Of course there are inherent problems in any government administered medical plan—some solvable, others, not.

Could the Canadian health care experience serve as a model for a national health insurance plan in the United States? If so, what can we extrapolate from their experience? There are enough similarities—the medical structure with voluntary hospitals not state owned, and the fee-for-service method of payment. Politically, the tension due to the decentralization of authority perhaps bears resemblance to the tension of State and Federal authority.

Alumni, faculty and students of the Graduate Program in Hospital Administration of the University of Chicago, executives of hospital associations, and insurance organizations, facul-

The Sixteenth Annual Symposium on Hospital Affairs conducted by the Center for Health Administration Studies, Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on May 3 and 4, 1974. Chairman for this Symposium was Odin W. Anderson, Professor in the Departments of Sociology and the Graduate School of Business, who is the Director of the Center for Health Administration Studies.

These symposia explore current problems in the health field looking at present trends and anticipating the future needs. Because the subject of his Symposium, "Government Involvement in Health Services Delivery: The Canadian Experience," was one of such concern and importance, and, because of the interest demonstrated by those attending, the transcripts and papers presented have been published for distribution.

ties of other programs in hospital administration and other invited guests met this year at our Sixteenth Annual Symposium which explored the issue of "Government involvement in the health services delivery: The Canadian Experience," an approprate topic in light of the heated debate in Congress. The Canadian experience was explored by long-range planners, professors, and administrators from that country with first-hand knowledge of the system. Their charge was to describe and analyze the Canadian experience and attempt to identify the implications it might have here.

There are many alternatives to the present organization of health care coverage: one need only look at the massive number of legislative proposals before Congress. Possibilities for changes are limitless. The papers presented and the related discussion reported in these proceedings will hopefully have continued importance in the development, examination, evaluation, and ultimate choice from among these alternatives.

ELAINE SCHEYE
Editor

Introductory Remarks

STEPHEN M. SHORTELL, Ph.D. and ODIN W. ANDERSON, Ph.D.

DR. STEPHEN SHORTELL: Good morning, Welcome to the Sixteenth Annual Symposium on Hospital Affairs. This year's meeting will be chaired by Odin W. Anderson.

Odin, of course, is known to all of you. I am not going to give him a long introduction, or we would be here until the noon hour. He is Professor of Sociology in the Graduate School of Business and the Department of Sociology, Director of the Center for Health Administration Studies. His recent book, "Health Care. Can there be Equity?" is a comparative study of the health systems of Sweden, Great Britain and the United States, and I think represents sort of an intermediate, at least, culmination of Odin's thought and work in thinking about comparative health systems and the components of health service delivery systems. He is currently engaged in research himself on the Canadian Health Services System with one of our speakers this morning. I am sure that we will be learning more of some of Odin's work in this area.

CHAIRMAN ODIN ANDERSON: Thank you very much for that generous introduction, Steve. I am pleased to have had something to do with this particular meeting because of my interest and the gathering interest in the experiences in Canada and in other countries.

This meeting today is, I must say, a spinoff of the work that Robin Badgley and I are doing in Canada with particular reference to Ontario. He will be the first speaker this morning.

I am also very flattered by the ready acceptances that the speakers gave me when I wrote to them a month ago if they would take time off from their busy schedules and share their experiences with me. But last week I got a little worried whether they would be coming at all because I was going over my private papers and sort of preparing for life hereafter, you might say. I was looking at my pension schemes, and then I came across a little document from the "Canadian Pension Council." I contributed a little money into that in the three years during which I was at the University of Western Ontario. I noticed that I would have a pension of $225.00 a year at the age of 65 from the contributions that had been made. So I thought I would write to the Canadian Pension Council and ask if I can't negotiate a flat sum now because I can't take it with me.

I wrote a letter, and then the next day a letter came back postmarked Chicago and said, "Temporarily out of service."

I thought: Is Canada temporarily out of service, and then I thought of this wonderful conference we were planning, and I thought maybe you wouldn't come here at all.

In introducing the speakers today, I will not go into elaborate backgrounds which they all have; we will simply take it for granted that they are illustrious. I will introduce them in terms of their current positions.

The first one will be my friend and colleague, Robin Badgley, who is Professor and Chairman, Department of Behavioral Science, University of Toronto Faculty of Medicine. He will set the framework for the Canadian scene. Although I haven't cleared this with him I hope he will tell us why Canadians behave the way they do.

An Overview of the Canadian Social and Political Scene and Universal Health Insurance

ROBIN BADGLEY, Ph.D. and CATHERINE A. CHARLES

DR. BADGLEY: Odin hadn't previously told me of the second part of his expectation—that I was to discuss the whys of being a Canadian. Perhaps that will become obvious as my colleagues and I from North of the Border speak.

As I was coming on this trip through the Toronto International Airport, I had my bag cleared and ticket checked. I then met the American immigration officer, a man in his mid-fifties. He asked me the typical questions: Where do you live? Where were you born? How long are you going to be in the United States? Where are you going to? Why?

When I came to the "Why," I said: "I have been invited to speak at the University of Chicago."

He then asked a question which was of personal interest. "What are you going to say at the University of Chicago?"

I said, "I am going to talk about how health services are organized in Canada."

He said, "Do you think the doctors will like what you are going to say?"

He had immediately assumed that my talk was going to be somewhat negative and made before a medical audience.

Without waiting for a reply. He said, "I have been here three weeks. My family and I are staying at the airport Howard Johnson's. I have heard of your health plan (Ontario Health Insurance Plan). God, you are lucky. I am just waiting to get my family on this plan to get complete coverage."

This was an intriguing start. I then picked up the evening Toronto Star. Let me pick out some of the items in that edition.

> Non-professional hospital workers' pending strike settled with 61 percent vote of the hospital workers representing a 50 percent salary increase over a two year period.
>
> Three-quarters of the nurses in Saskatchewan, are threatening to go on strike (in 84 of 130 hospitals) protesting the level of their wages and wanting to widen the wage differential between themselves, nursing assistants and other hospital workers.
>
> May Day isn't celebrated in Canada, but it was in Quebec this year. There were rotating strikes including hospital workers in Montreal.
>
> In Hamilton, a city about 40 miles from Toronto, the Professional Association of Interns and Residents voted 148 to 52 seeking to have the provincial government negotiate their wages, hours and working conditions. They are seeking a 43 percent increase from a base sum of $7,000.00 to $10,000.00.

These issues in just one issue of a paper suggest that our immigration friend who said: "God, you are lucky," should read that paper. He would then find that there are some rough burrs in the Canadian health system.

I will draw here from a study on which I have been working with Odin Anderson and a research colleague, Catherine A. Charles. We have been looking at the overall impact of hospital and health insurance on the health system in Ontario with the aim of trying to put these events in a comparative perspective.

Speaking to the Committee on Health of the House of Commons in 1944, Henry E. Sigerist called state health insurance a corrective mechanism, not a revolutionary idea. Tracing the history of social security legislation for members of parliament and the senate, this distinguished medical historian observed that among available options in providing state medicine "health insurance . . . seems preferable to many people because the change is less radical and permits the preservation of some of the traditional forms of medical service." He continued: "It may . . . be considered as an intermediate step . . . no bill is perfect from the very beginning." But "a beginning must be made and be made soon because in war as in peace the people's health is one of the nation's most valuable assets."

In weighing the assets and liabilities of state health insurance, Sigerist advocated that this form of social security should be universal, comprehensive and compulsory. Such a plan would protect the individual from unforeseen health risks. As a population's health needs

were predictable, such a program could be established on a firm actuarial basis. Most state programs, he noted, included only medical benefits, not services provided by other health workers such as chiropractors or osteopaths. The needs of the disadvantaged, special groups such as Indians and people living in isolated rural areas required a greater allocation of health resources if they were to achieve equity with other citizens. Group medical centers were an effective and more economical alternative either to solely hospital-based or solo medical practice. In the past Sigerist warned the established health professions had opposed the changes he called for, but such a state program was a "stop-gap" to more radical legislation which guaranteed work and a sufficient standard of living for the individual.

The difficulties of state health insurance forecast by Sigerist in 1944 was that it was a cumbersome and costly program to operate. Such plans were often unsatisfactory to doctors because they required incessant itemization and surveillance of bills rendered for services. The unit fee-for-service basis of payment, in contrast with salary or capitation methods was variable; it rewarded men unequally on a basis of their experience, type of practice setting or specialty training. The type of state medical care he envisaged, Sigerist predicted, would become a public service just as education already is.

Sigerist's parliamentary audience was knowledgeable but wary of the federal government's prerogative in the sphere of national social security. Parliament's efforts, it is recalled, to enact a national Employment and Social Insurance Act had been declared ultra vires in 1937 by the Privy Council. To achieve its intent of introducing national social security legislation, parliament subsequently embarked on specific, conditional health grants to the provinces. These programs whose constitutionality is still untested by judicial review established minimal terms under which federal monies might be used to initiate various provincial health programs. Some thirty years after Sigerist's landmark address, Canada now has a complex mosaic of a national health program which includes the training of health professionals, support of public health activities and state and medical care insurance plans.

The beginning Sigerist called for has evolved slowly, deliberately resting at each stage on the thrust of public opinion and the uncertainty of constitutional validity. While the structure of the national health system is still changing rapidly, it is relevant drawing on his blueprint to examine the nature of changes which have occurred in how the health professions are organized, in the shape of current health institutions and in the concerns of the public for whom the services are provided.

Health insurance has had some significant effects on how the professions are organized, what they do, how they are paid and on the very nature of professionalism as a social phenomenon. In many respects the health system is now the cynosure for all professions. What is happening here may eventually affect all of them. There is a growing public scepticism about the concept of professionalism held by the public and government about the health field. The general trend in new legislation is to curb the traditional powers of the established professions and to restrict the degree of power and autonomy of the would-be professions. If professionalism means a grant by the state of self-regulation in exchange for the guarantee of ethical behavior in the public interest then these basic terms of reference are being questioned, in some instances, redefined and on occasion, challenged.

Many of the changes that are taking place are intangible while others have had a direct and visible consequence.

From a financial point of view, most of the health-related occupations have benefited from universal health insurance. Before the advent of hospital insurance most hospital employees were poorly paid in comparison with similar occupations in other industries. The hospital's position was then a "resource-starved" institution which had to get by with whatever resources were available. During the Sixties the Department of National Health and Welfare found that although hospital workers started from a low income base, they enjoyed relatively higher wage gains than most workers in other industries.

The health workers who have done the best out of health insurance are those who were already on top, the physicians. Their income climb started in the early '60s before the introduction of medical care insurance. During the past decade, physicians' average net incomes increased faster than other professions and fast-

er than the average gain in wages of the total employed labor force. According to a federal report "while the average net income of physicians from all sources in 1960 was 4.1 times that of all employees, the equivalent ratio in 1970 was 5.4 to 1."

Health insurance has widened, not narrowed, the fiscal and status gap among health workers. While all have gained, some received substantially more benefits than others. As national guidelines emerge some of the workers who are now receiving proportionately less than others will use a relative job income yardstick as a basis for contract negotiations.

The role of the individual practitioner may not have changed substantially but more radical changes may be in the wind. To this point the possibilities of increased surveillance of practice and compulsory continuing education or relicensing remain more dim specters than imminent realities. The practitioner lives in an atmosphere of a stream of radical new proposals for how he should work and the way he is to be paid. As the swirl of debate continues, he can hardly avoid a sense of concern about all these foreboding currents which may change his traditional role. The reward system is changing. He may be less motivated by the mystique of service which was prominent in the days of private payment and forgiven debts and more determined to charge fully for everything he does since his relationship to the state is an impersonal businesslike one.

In its corporate manifestation the profession of medicine has emerged from the coming of Medicare with a still strong but changing basis of power to shape its own affairs. Its financial status has materially improved. Its position at the top of the healing division of labor has not been significantly challenged. Its representative associations and educational institutions, although subject to more outside scrutiny than in the past, are larger and more influential than ever before. The profession still faces an uncertain future, but events so far have done little to justify the objections of some segments to the original implementation of Medicare.

The provincial licensing bodies and voluntary associations in medicine have found themselves undertaking significant additional responsibilities. They have been in part co-opted by government and have been given a status as quasi-official arms of government in the policing of Medicare and as the bargaining agents for the revision of fee schedules. Although these are functions which they performed before, these activities now come under much closer and more critical government and public scrutiny. In line with these increased powers, membership in provincial voluntary professional associations has risen substantially. Although much has been made of lay and government representation on professional boards, with some significant exceptions in Canada, such changes are still of a token nature.

Health insurance has ushered in a complex new relationship between the professions and the state. Malcolm Taylor's review of the changing medical profession suggested that in earlier decades most health policies were developed by an informal entente involving the medical associations and public administrators. In most jurisdictions health insurance has institutionalized this quasi-official mechanism. Licensing bodies have been co-opted to act as policing agencies for the state. Voluntary associations, representing only part of the profession, have become officially recognized agents for bargaining over professional fees. However reluctantly, these groups have been "co-opted", and some of their traditional powers constrained.

The power of the medical profession has declined relative to government as a consequence of civic bureaucratization. Men trained as physicians no longer hold the same positions of power within public departments of health. Because of non-competitive incomes and changing job functions in both the federal government and Ontario, the role of doctors has been recently downgraded in filling senior administrative posts. Many of these posts in the past were filled by physicians. But today new skills are needed, especially administrative expertise. As Oswald Hall has argued, there are fundamental role-problems for doctor-administrators. This dilemma has hit hard the specialty of public health. Provincial departments as well as local units were traditionally the preserve of public health doctors. Now new medical men have come in, but most senior appointments are made to non-medical specialists such as accountants, administrators, or computer systems men.

What these numerous changes represent is a profession in a period of transition. The mandate of medicine as one of the traditional "free professions" has been curbed but doctors have not yet become public servants like school teachers or institute research scientists.

The doctor in Canada, we would conclude now, neither enjoys unbridled power nor is he yet fully attuned to a role as a career public servant. In the context of Canadian experience it is unlikely that he will adopt either role but rather emerge as a professional entrepreneur with certain privileges sharply defined by the state. In this new evolving role private and public interests will co-exist which will challenge a rigid specification of work functions, and in turn, contribute adaptability by the profession in the face of social change.

When the 1958 federal hospital insurance program was ushered in, many hospitals which were in financial difficulty were not adverse to more extensive governmental support. Four provinces already had a variable form of government sponsored hospital insurance. Political support for the program was widespread; the medical profession had for several years anticipated, indeed called for the fulfillment of this program. The newly established provincial hospital programs designed to be cost-sharing mechanisms also sought to raise the quality of care and to develop an integrated hospital system. The programs, it was anticipated, would have rationalizing and standardizing effects on hospital financing, operations and planning. Implicitly, but not stated these changes would require a substantial transfer of power and responsibility to the public sector.

Hospital insurance led to an inter-provincial rationalization and standardization in accounting and operating procedures. Prior to the program hospital budgets were developed in terms of special institutional needs, priorities and formats. To obtain financial reimbursement prospective budgets must now be submitted to the scrutiny of a provincial agency. Accounts must be uniformly formulated to permit valid comparison with other hospitals of the same size in terms of their requirements for personnel, salaries, days of service equipment of general operating costs. Unlike the immediate post World War II period, hospitals now, although they complain vigorously, no longer live in a world of economic uncertainty. Through long-range planning, major deficits can be avoided or minimized and major expenses predicted in advance.

Current budgetary review mechanisms illustrate the growing bureaucratization of the hospital system and the flow of power from local to central units. The development of complex social and administrative machinery at the provincial government levels has evolved to implement these massive programs. Provincial budgetary review procedures provide the opportunity for a centralized evaluation of local costs and operating efficiency on a comparative provincewide basis. Individual budgets can and are pared down or expanded in keeping with government guidelines and standards.

Overall expansion has become limited to specific growth lines. The Saskatchewan Minister of Health last year for instance cited with some disbelief one hospital's 1973–74 estimates which sought a 56 per cent increase. Hospitals must now meet provincial criteria before receiving their defined 'necessary' costs of operation.

Because hospitals are dependent on the public purse, fiscal control is a significant lever for effecting related organizational changes. This dependency is exemplified by the various provincial government inquiries into medical staffing procedures and by the concern with modifying prevailing hospital acts. Provincial and federal agencies offer consultant services to local hospitals concerning their operation and administration. The effect of these several changes has been to promote a far greater degree of state involvement than before, not only in the financing of hospitals but in their surveillance and possibly in the raising of institutional standards.

There is now a limited margin for private enterprise in the development of the hospital system. Capital costs can and still are financed independently. Since the start of health insurance, major building projects have been undertaken by parochial hospitals, certain centers with a national service reputation, by some municipalities or by private business as One Medical Place and Medical Inns, Ltd. in Ontario. The construction of such new hospital facilities does not guarantee their financial solvency for operating costs. Unless provincial governments back up these extended facilities with subsequent legal and financial support, these private enterprise undertakings may fail or continue to rely on private philanthropy.

Centralized planning and fiscal control have become the evolving hallmarks of the hospital insurance program. How effective they have been in establishing an integrated hospital system and in improving the level of patient care is unknown. Recent government fiscal ceilings

and cutbacks in hospital beds, some observers contend, may have an adverse effect on an institution's ability to maintain high quality patient care. In other respects, provincial plans have done little to change the distribution either of doctors or hospital facilities.

In essence, the insurance mechanism itself was neutral with regard to existing patterns of distribution. The fact that the rural and outlying areas in a province like Ontario were perhaps able to hold their own in the supply of doctors may reflect the impact of special programs for underserviced areas rather than the impact of medicare.

In the short run health insurance has crystallized the status quo ante; it may be, however, generating pressures which will lead to some radical change.

Stringent controls on hospital operating costs are emerging at a time when the hospital labor force is becoming unionized and the hospital workers are becoming increasingly restive. Although many of these workers have traditionally espoused professional ideals, centralized planning and its structured by-products are fostering the growth of union membership in hospitals, a trend which is occurring within overall fiscal ceilings. Union negotiation and contracts will begin to replace bargaining by individuals. Strikes and walkouts, until recently, rather rare in the Canadian health system, are now becoming more common levers to extract more favorable wages and working conditions, and the momentum of these can be expected to increase sharply.

The service intensive hospital industry can be expected to rely more heavily than in the past on labor-saving procedures and facilities.

These cumulative pressures, if hospital budgets are to be contained, will redefine in the future the nature of hospital care and determine the volume of patients admitted to hospitals. This transformation, now slowly gaining momentum, may be a contributing force in shifting the fulcrum of the health system from the hospital to the community where institutional alternatives will begin to assume some of its traditional functions. During the current transitional period, few such viable alternatives have yet emerged to meet the persistent demand for hospital care or to compensate hospitals with institutional incentives to realign more efficiently existing programs.

The long held justification for implementing national health insurance has been to secure and improve the public well-being. Two anomalies remain as these programs have evolved in Canada and as more recent proposals have been considered by provincial legislatures. Little is known about either their impact on ameliorating the health of Canadians or the nature of their performance rating in public opinion.

The introduction of Canada's health insurance plans has not, based on available evidence, seemed to have insured a sense of broad satisfaction by the public or represent on its part a lasting endorsement. Health legislation erased the traditional idea of privilege ingrained in health care replacing it in the public's mind as an individual right paid for by taxes. Such a program in the Canadian experience has served like Oliver Twist to raise the public's hopes to expect more services to which they feel they are entitled, even though these aspirations on occasion may be unrealistic or not readily feasible. A state program which deals only with health costs does little by itself to alter the structure of hospital care, the distribution of facilities or personnel or the conditions under which medical care is provided. These issues, vaguely perhaps incoherently voiced in opinion polls or letters to newspaper editors, are at the root of much of the public's present disenchantment.

The current organization of the health market place still favors some individuals on a basis of residence and social class while discriminating against others in the types of services which are available. The existing system, as it distributes health services, cuts across lines of language, income and health needs. Tradition and personal convenience still rule where health workers and facilities are located. Up to the present time politicians and the health professions for the most part have ignored or tolerated these inequities. Their efforts to effect a balance between regions have been symbolic, ineffective. The move toward a rational allocation of scarce health resources within regions of provinces is now being considered in several provinces. The success of these as yet mostly untested blueprints will depend on whether government is prepared, for whatever reasons, to exercise sufficient and adequate controls in a hitherto free market sector which it is within its power to rectify through legislation. If the health of all Canadians is to be considered of equal import, then political philosophy and pride of profession must confront these issues.

Power to shape health affairs in Canada is delicately balanced between federal and provincial jurisdictions. While a highly centralized

and rationale plan is precluded, this division of responsibility ensures structural flexibility and a measure of regional autonomy. Programs of special concern to a province can and are started by local tax monies. These experiments in social security innovation function as a social testing ground for possible subsequent adoption by the nation. This degree of structural flexibility carries with it the liability of certain inequities as residents of an affluent or socially reformed-minded province may enjoy greater benefits from the state in these respects than other Canadians.

During the past three decades the Canadian health system has shifted from a mix of free enterprise values, limited civic support and philanthropic service to an emergent federal-provincial public service. The priorities of the state now largely prevail. Although inequities and glaring disparities persist, the reins of government control the training of health workers, how their services are paid for and provided. The beginning which Henry E. Sigerist called for in 1944 before the House of Commons Committee on Health has been completed and for the most part is well endorsed by Canadians.

Sigerist then envisaged a universal, compulsory and comprehensive state health system which was publicly administered incorporating central planning with a regional allocation of facilities and personnel. Such a plan has come about but only in part and with some unanticipated consequences. Certain disadvantaged groups identified by Sigerist, such as Indian bands or isolated rural residents, who he felt needed special programs, have not benefited as fully from health insurance as other Canadians. Although this issue to the present has been of marginal concern to health policymakers, some current measures as, for instance, the Ontario rural doctor program or expanded federal Medical Services for Indians are extending care effecting a more equitable regional distribution of services.

Sigerist assumed that once national health insurance was established, its total costs would be known based on accurate predictions of the expected volume of a population's illness. In the open-ended payment system which now prevails, the scope of treated illness and the number of medical visits have risen sharply, almost as though the state had opened a Pandora's medicine chest. Health costs have usually not exceeded estimates but these have risen by an average of nine per cent for several years. What constitutes sufficient or adequate therapy as defined by physicians complemented by an expanded public concept of the sick role have resulted in an unprecedented demand for health care.

As fiscal controls emerge, and this process is now starting, the new constraints will clash with public expectations for service and challenge the level of expensive technical care to which they and their highly trained healers have become accustomed. This dilemma, unforeseen by Sigerist, may well result, if fiscal constraints are enforced, in a greater restructuring of the health system than that witnessed in the past three decades. Current proposals being considered by federal and provincial ministers of health, if approved, would tie health cost increases from federal contributions to the growth rate of the gross national product.

Sigerist's second concern about health costs, that retaining the fee system would be expensive and inefficient has proven to be valid. The inherent attributes of this established payment system have not rewarded doctors equally on a basis of their training or experience, has widened the income differential between them and allied and paramedical workers, created a magnetic marketplace for emigrant entrepreneurial physicians and stimulated the construction of costly technical facilities. Sigerist's forecast that the fee system would be cumbersome to administer has been experienced by several of the provincial plans. An expected byproduct of the fee system would be a detailed scrutiny of services rendered by physicians, again an accurate prediction which combined with the capability of the computer gives an instant profile of patient and healer activity attributes.

On the positive side of the ledger the fee system has preserved certain intangible values but at a stiff price. Core values of Canadian society seek to ensure an individual's right to choose what type of work he does, where and how he works. While preserving the spirit of these values and the right of professional associations to challenge and counterbalance state policies, the traditional framework of the health system will increasingly emerge as a state directed public service. The introduction of state health insurance by itself Sigerist contended was not a social revolution. Rather, it was a barter to preserve the *status quo*. A genuinely significant

change would be the acceptance of a complete integrated social security system in which an individual's health care was protected with his right to work and to rely if need be on a guaranteed income. Only when such measures were combined would the health of the individual and of the state reach optimal levels.

In calling for his utopian health system within a broader social security context, Sigerist transposed to an essentially colonially reminiscent free enterprise society ideas developed and partly implemented in some of the European socialist and communist nations. Wise in many of his observations, he ignored or chose to underestimate the political changes which his proposals represented and that values appropriate and accepted in one state may not enjoy universal appeal. As a distinguished medical historian his writings deal little with the primacy of law and constitutional precedence. These forces combined with Canadian values of how men should be governed molded its health system with attributes common to other nations but with its own consensus and distinctive shape. Like many other aspects of Canadian life the health system is a complex matrix of overlapping and balancing civic powers.

At a time when government was held to be the dispensable voice of the public, Sigerist assumed that its health programs would be sensitively attuned to changing social needs. Left unspecified in his proposals were the types of institutional mechanisms which might be required to check or challenge the powers of a total institution or how old policies were to be discarded, new plans adopted. Some health systems, or so it would seem, have the relative inflexibility of a 1984 Orwellian fantasy. For better or worse and despite its deficiencies the "check-countercheck" Canadian health system is relatively amenable to constant accommodation to variable public and political interests. In addition to counter-balancing political constraints the health system blends at virtually every level public and private concern. In a nation which has had five minority federal governments in seventeen years, yet during this period enacted sweeping health legislation, the timeworn adage must be transposed to: "United we stand, divided we rule."

The goals which Sigerist set for his parliamentary audience in 1944 have yet to be attained, their social feasibility still far on the horizon. They remain optional targets, a baseline to measure change and a constant spur in the search for social equity.

CHAIRMAN ANDERSON: Thank you for that presentation, Robin. Instead of giving a paper on "Why Canadians Behave the Way They Do," he gave a paper on "Why Human Beings Behave the Way They Do in Certain Political Systems." Are there any questions?

MEMBER: I would like to ask Dr. Badgley if he would talk to the point of self-sufficiency of physician manpower or whether Canada is still utilizing imported manpower from countries that were former members of the British Empire.

DR. BADGLEY: Migration is a national affair; Licensing a provincial one. Some of the provinces have actively sought out physicians from abroad over the years. Some provinces have depended extensively on foreign health manpower, as in the case of British Columbia, where recent estimates suggest that a sizable number of their doctors came from other parts of Canada or from other countries.

Since the introduction of medical care insurance, there has been a phenomenal upsurge, almost a deluge of physicans coming to Canada and to Ontario in particular. Certainly, the Ontario Medical Association and the medical faculties are actively concerned and are seeking ways in which changes can be made. Migration of professionals goes beyond the question of national restrictions as it raises the international ethic of people migrating.

MEMBER: You spoke of consumerism. Are there structured ways in which this is brought into the system?

DR. BADGLEY: There is an active sense of momentum now moving across many of the provinces to introduce regional programs, to decentralize the power of provincial health departments of their hospital and medical insurance programs and to seek coordination between health and social development services as for example in the Province of Manitoba.

There is a great deal of variablity in these efforts across the country. For example, various options in organization suggest that within a given region there should be a coordinator; or a board; that this board should pull together representatives from traditional hospital boards, from voluntary organizations and members of the public. In Ontario a recent green paper has recommended that boards be appointed. A proposal for British Columbia suggests initial

appointments with a subsequent election of members. In Manitoba, an active program is beginning of introducing district health and social development regions which are seeking a fusion of health and essentially Social Security programs. These boards are now established by appointment. There is then, now, no uniform structured mechanism across Canada for direct consumer participation, although such involvement is likely within a decade.

MEMBER: At the last APHA meeting there was a paper that indicated that the policies in Ontario and other provinces rather than stimulating the development of group practice and improving organization are eroding the position of those group practices that have been developing.

Has the government given any thought to that? Are there any policies under consideration that would provide incentives for physicians or patients to enter that kind of organization?

DR. BADGLEY: It would be appropriate to ask this question of other speakers, but there are two issues. One is the upward trend in Canada toward group practice which over a period of two decades has changed substantially. For many years it was at a relative plateau, perhaps between 8–11 percent of all physicians in private practice. From a recent trend report it might now be as high as a quarter of the physicians working in some form of group practice.

What makes an answer difficult is what constitutes a definition of group practice. If you mean corporate group practice in the sense of pooled earnings along the model of the American Kaiser-Permanente Programs or in Ontario, centers such as St. Catherine's, or Sault Ste. Marie, then it must be concluded that the conservative government has not encouraged these programs. It hasn't forced them out of business, but it has not enthusiastically facilitated their growth. Global budgeting for these programs based on a previous year's experience has recently been established.

As well there has been relatively little active encouragement in other provinces. The medical profession is now merging into groups for professional convenience. When I asked first-year medical students at Toronto this spring about their ideas of future practice, between 50–60 percent envisioned that they will be working in some form of group practice. They disliked the idea of solo work or small partnerships. The development of group practice will probably come about in Canada more because of these forces reshaping medical practice than by adhering to a stated intent of what might be optimal for patients or the doctors who serve them.

There have been a number of proposals at the provincial and federal levels about how health services should be organized. These reports receive little professional or critical review of their total import. Usually they are criticized for specific, convenient reasons relating to one occupation's stance or as they relate to the mandate of the hospital.

None of these proposals has been anchored to meeting the actual health needs of the Canadian population. Typically, the data in the reports have been derived from existing hospitalization figures or on an emerging basis from medical insurance data which are superb. But these findings don't tell us about the actual health of the Canadian people.

The health programs are operating on the basis of current demand. There is now a proposal by the federal government to launch a national health survey modeled along the lines of the U.S. National Health Survey which would seek to monitor health needs. Whether such information, if obtained, would then serve as an effective and significant basis for building health programs remains to be seen. Certainly the experience of other nations does not foster much optimism that this will be so.

The Impact of Health Insurance on Health Service Organization and Delivery—The Ontario Experience

STANLEY W. MARTIN

CHAIRMAN ANDERSON: You see before you a rather rare species in that he had combined over his long administrative career both the private and the public sectors in hospital administration in the Ontario Blue Cross. He became director of the Hospital Service Corporation when the province went into hospital insurance and then when physician care came in they had two separate organizations. They combined them, and Stanley Martin is now heading the whole ball of wax.

So I present to you Stanley Martin who is on the firing line in Ontario, and will tell you, at least so the title says, about "The Impact of Health Insurance on Health Service Organization and Delivery—the Ontario Experience." Stan.

MR. STANLEY W. MARTIN: My Good Friend, Odin, Ladies and Gentlemen: I am assuming that most of this group are familiar with the relatively short history of government-sponsored health insurance in Canada and its ten provinces. I had just commented upstairs that Robin Badgley had done a superb job in trying to wrap up a very complex social development in a period of about 35 minutes. My role in this symposium in the general overview of the Canadian system is, I think, to reflect for you from my experience some of the more important effects and forces for change that I personally believe occur in a health delivery system that is backed up by universal health insurance coverage under the direct administration of, and funded by, governments.

Private-public sponsorship of health insurance

Many times over the past two decades, I have heard people suggest that the movement of government into the field of health care financing through the assumption of responsibility for the payment of various kinds of health services is merely a transfer of funding for such services from the private sector to the public sector. Therefore, the overall economic effect should not be significant except for the extension of protection from the cost of such services to those in our populations who previously could not, or would not, seek such protection from private insuring agencies—either for-profit or not-for-profit in their operations.

I submit that a fundamental weakness in such a position is that when the cost of health services is financed for individuals through other than governmental channels, the people thus protected anticipate that when they require such services their insuring agency will take care of, directly with the supplier, or by rebate to them, all or part of the cost of services received as identified on a statement of charges. I have seen little evidence to suggest that the people expect the insuring agencies to insure that, through their prepayment mechanism, these commercial enterprises should not only pay their bills but also assure the adequate availability of hospitals and other institutions or the services of doctors and other health care workers. Immediately, however, the responsibility for payment of required health services is moved from these commercial carriers to government, the 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 high 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 government to provide additional services, usually suggesting that as government requires them, by law, to pay some form of premium or ear-marked tax for health services, these should be always conveniently and qualitatively available to them. These forces are even more accentuated under a government umbrella because the political parties in opposition usually find it more to their advantage to

rebuke the party in power for not acceding to stated demands of citizen groups and ignore the greater question of overall cost involved in attempting to meet all such requests.

Priority setting in government programs

A second, and equally important, factor involved in government sponsored health insurance programs is the choice of priorities, by governments, of those health services they decide to move into their area of responsibility, and to what extent selected benefits are made universally available.

At the time the federal government of Canada was attracting the provinces to introduce universal hospital insurance coverage by offering to pay approximately half the cost of such a program, our province (Ontario) made strong representations to the law makers in Ottawa that unless similar financial incentives were simultaneously introduced to afford equal sharing of costs for other parts of institutional care, and possible substitutes therefore, a most expensive and self-perpetuating skewing of the health care system would occur.

This hypothesis seemed valid because their emphasis was being directed to the maintenance of the most expensive type of health care institution and, furthermore, unduly priorized the secondary level of health care. If hospital services exist to effectively serve the most important levels of primary care, the cost effectiveness of such a move should have been clearly self evident. Such a thrust also required these highly sophisticated and expensive forms of health delivery to take over increasing amounts of primary care delivery services.

These arguments were forcibly set out in a series of papers developed in Ontario in support of including the services and costs of ambulant (out-patient) services, nursing homes, home care, ambulance services and total psychiatric care at the outset of universally available hospital insurance to permit of a more orderly development of health care delivery.

Again, in the late 1960s, when the federal government decided to attract the provinces to introducing government-sponsored universally available personal health care services, strong arguments were advanced for equal cost sharing for the services provided in a variety of health disciplines other than physicians. It appeared clearly evident that, again, undue emphasis was being placed on the highest cost services within the personal health care field, those provided by physicians. The federal government justified their actions by indicating they were anxious to assist the people by providing immediate assistance with high cost items of health care and in making access to these services available to everyone regardless of their economic condition. Their failure to recognize that allocation of fiscal resources would skew delivery to the highest common denominator has proven to be a misfortune for our country which will take a number of years, involving large amounts of money, to effect any reasonable measure of correction.

These, you might say, are brash and generalized statements, but before condemning them as some form of political propaganda, let me review a few facts as they relate to my own province of Ontario and, to varying degrees, to the rest of our country.

Effects on health delivery by government sponsored health insurance

Immediately prior to, and following introduction of, universally available government sponsored hospital insurance in 1959, the creation of new and enlarged hospitals with particular emphasis on bed-care facilities raced ahead in an endeavor to meet incessant demands for the diagnosis and treatment of all levels of health care. One could hardly expect the people to be sympathetic to the fact that many health conditions could be adequately cared for through the use of the hospital on an ambulant basis, or that many degrees of illness could be suitably treated in nursing homes or by home care services when under the economic circumstances then prevailing, treatment within the hospital required little or no immediate outlay of funds. The options demanded outright and, in many cases, continuing cash outlays for which no form of first-dollar prepayment coverage was available. Additional treatment services on an out-patient basis in hospitals were added in Ontario five and one-half years (July 1, 1964) after the introduction of the Plan, but even this move continued to center health delivery on the hospital.

During the first half of the '60s, the total economic impact of this course of action was not truly apparent because the supply of skilled

workers, so vital to overall institutional operation (such as nurses, technicians and technologists of various kinds), was in very short supply. This fact brought about quite a natural demand for major increases in the output of these skilled people. A massive attack was made on this problem in Ontario through an objective of doubling the annual number of graduates and by creating new regional schools of nursing and various technologies. The attack was quite successful and by the early '70s reverse pressures began to generate. Certain skilled persons, particularly nurses, began to find it difficult to obtain employment, especially in the preferred geographic areas of the Province.

With a reasonably adequate supply of labor of all kinds becoming available, the cost of operating the extensive institutional network, built up across the Province, began to be felt in rapidly escalating terms. Suddenly governments realized that health costs were consuming more of the public-sector dollar than they felt was warranted, and the stage was set for a series of moves aimed at skewing the health care delivery system away from these expensive creations.

Hospitals had successfully met the challenge of the demands made upon them by the people, but their very success resulted in such a cost that the people (as represented by their governments) concluded they could not afford it.

Over the years, the various provincial governments have repeatedly requested the federal government to extend its shared-cost agreement relating to hospitals and diagnostic services to embrace alternative forms of care such as nursing homes, home care, ambulance services (to permit of better district developments) and all psychiatric services; but the federal government, realizing the "blank check" aspects of existing agreements, not only refused to consider such requests for the same type of cost sharing, but began to present proposals of their own which would have had the effect of limiting or "close ending" their portion of the costs under modified agreements.

Despite the refusal of the federal government to cost share in alternative forms of institutional services, certain provinces, including Ontario, realized that positive moves had to be made to better balance the health delivery system.

Costs of ambulance services were added to the government sponsored program in 1968; and approved nursing homes and home care services were made universally available in 1972.

The costs of all of these services were financed almost entirely by the provincial government.

Concurrently or shortly following these moves, annual spending ceilings were placed on the operations of all active treatment hospitals in the province, in recognition of the fact that, as economic barriers to the use of alternative facilities become a reality, there should be a reduced need for a certain amount of the bed-care facilities in almost all active treatment hospitals. Besides certain designated bed reductions identified by government in very obvious surplus bed locations, the approved spending ceilings were set extremely tight, but the hospitals were permitted to live within them by either closing certain numbers of beds or improving the overall quality of their administration, thus achieving a greater degree of cost effectiveness.

These forms of reparative treatment to the health delivery system were indeed drastic and received not without considerable pain and criticism. Additional costs are also incurred, as resources required to start up alternative forms of care to that provided by active treatment hospitals are necessary before such bed care services can be rationally cranked down. Various devices have been utilized to develop an appreciation for the need to reduce the numbers of active treatment beds in the individual hospital but I will not take time to elaborate on them this morning other than to say they include both statistical and on-sight evaluation methods.

I mentioned a few moments ago the assumption by government in Canada of the responsibility for the cost of personal health care services in the late 1960s and the determination by our federal government that basically the services of medical doctors of various kinds would form the cost-sharing model. Certain of the provinces, realizing that if the services of these individuals were the only ones to be available under a government-imposed plan, took a decision that their programs would have to be much more broadly based. In Ontario consideration was also given in the program to those services provided by osteopaths, chiropractors, optometrists, podiatrists and dental surgeons, although annual dollar limits were placed on the amount of services which would be paid for by the Plan for the services of these practitioners. No proper arrangements were made to include services provided by other important health disciplines such as nurse-practitioners (physi-

cians' assistants), public health nurses, physiotherapists, occupational therapists, dietitians, etc.

Again, the thrust of government-sponsored insurance payments was directed to the most highly skilled and most expensive parts of the health delivery system. The suggestion that if government provided relief from the high cost services the people could afford to purchase needed auxiliary health services ignores a basic fact: people compelled to participate in a form of health insurance resist and rebel against on-the-spot payments, and will seek out the services of individuals for whose services the costs are covered under their health insurance plan.

Simple anomalies within the insurance mechanism in Ontario (such as the constraint suggesting that eye examinations by optometrists would be paid for only once a year while no similar constraint was applied to services provided by ophthalmologists) further amplified the streaming of people towards the most highly skilled and relatively most expensive practitioners. Relatively small considerations, such as this example, together with the much larger consideration that it is comparatively easy to define the scope of practice for medical practitioners while accepted scope of practice for other health disciplines is clumsy or nonexistent, undoubtedly contributed heavily to pursuing the expedient course of action we in Canada have taken.

Private health insurance can provide a measure of control over the extent of services to be available by the tool of indemnity and/or fixed co-payment mechanisms. Governments find such fiscal devices almost completely untenable as already demonstrated in several Canadian provinces. Imposition of fixed co-payments for either basic institutional or personal health care services by the governments of the day have been frequently followed by defeat of that government and either complete or substantial withdrawal of such mechanisms by the succeeding legislatures.

This observation then brings me back to the powerful and explosive tool represented by government-sponsored health insurance in the development of a health delivery system. Recognizing that there is a wide variety of skilled practitioners who are a vital part of any health care delivery system, and that the efforts of these practitioners should be properly orchestrated to provide efficient and timely care for the people, it is becoming increasingly apparent that fairly clear practice lines need to be determined. The major controls that are really effective in any form of government supported health insurance are not basically fiscal but, rather, the volume of facilities of every type and the number of practitioners with varying skills making up a health care delivery system.

Ideally, decisions on this type of objective should be made before governments embark on universally available health insurance programs. The alternatives adopted for expediency lead to delivery systems more closely oriented towards the benefit of the providers of service than to the real health needs of the people they must eventually serve.

I have already indicated that in Ontario we are at present suffering considerable agony in our endeavors to redirect the health care institutions sector, but we realize codifying and rationalizing the personal health care services will be an even more difficult and challenging task. We have, however, taken the first steps by introducing legislation to create a health disciplines board; to provide for public representation on the boards of all the self-governing professional colleges, and to enable our ministry to require of the professional colleges compliance with desirable changes in their operations and practices, if they themselves will not take such action of their own volition. Each of the recognized health disciplines will eventually have a section within this legislation related to their particular place in the health care delivery system, including definition of a specific scope of practice. Within this context the health insurance tool becomes very important in influencing the health delivery system as it will be the major economic resource for those disciplines whose services are included in the government-sponsored plan.

Organization

Up to this point I have been largely directing your attention to the question of the impact of health insurance on the delivery of health services. I would now like to consider with you the separate but related issue of some of the effects I feel take place within several organizational patterns in the overall management of health services.

For some years now, in both Canada and the United States, various individuals, committees and task forces have been consistently observ-

ing that the existence of health insurance, while making available to many people medical services they could not afford in the past, have not automatically improved the level of health for the population. ("Health Care in Canada: A Commentary"—H. Rocke Robertson, March, 1972) While we repeatedly speak of "health insurance," careful analysis clearly indicates that a more proper designation might be "sickness insurance", as most of the benefits made available are directed towards treatment of existing illnesses or disabilities with little, if any, thrusts toward prevention. The promotion of positive health has not been seen as an important role of the health insuring agencies.

All of these studies and reports relate to the same basic issues—availability of services, quality of care and costs. These are the same concerns expressed by consumers in their demands for better service.

Because of the relative level of prosperity in our two countries since World War II, governments themselves have been in a position to respond with fiscal resources to an unlimited number of special interests in the health field. While various individuals and agencies have not always received all the financial support they feel they deserve, they have obtained enough to enable them to pursue their self-appointed goals with little need to constructively evaluate how such goals might best integrate with others serving almost identical client groups.

Organization of both government and health-oriented associations, corporations and colleges trended toward emphasis on various aspects of health delivery with overt, if not outright, competition for allocation of resource dollars to their own specific area in the health field. Programs directed to treatment of physical illnesses received much greater support than those applicable to mental or psychiatric illness. Public health programs, largely conducted by government agencies, had difficulties in competing with private practitioners and proprietary or public health care institutions. A multiplicity of special purpose bodies came into being dealing directly from a central source with their clients in their particular area of interest. Health services became fragmented, on distinct *program* bases, with limited integrative interaction possible between the disparate groups.

Alarming annual increases in the cost of treatment services, and a realization on the part of government and the public that such conditions begged speedy change, have contributed to major shifts in organizational patterns, at least in our province.

Several studies in our Province suggested that only by decentralizing the functions of health planning and evaluation to a level compatible with local community identification could more effective integration of the delivery of health services be achieved. To accomplish such an objective it became readily apparent that resource-allocation mechanisms and competing program-oriented structures, long a traditional form of organization at the provincial level, would have to be radically restructured.

During the long period of expansion in our Province following World War II, there was believed to be sufficient resources to make it possible to settle most of the claims on government through an allocative process. This process did not give everyone everything they wanted, but at least everyone got something and the purposes of the competing institutions were left largely unchanged.

Now, however, with a growing demand on available resources, a disenchantment with categorical programs, and with a growing recognition of the interdependence of things, particularly in the health field, the solutions which policy makers need to come up with are integrative. This is to say that, in order for governments to be authoritative, it is necessary that political decision-making should bring the aspirations of competing institutions into direct relationship with one another and, through a process during which these aspirations are modified, produce solutions which have a wide degree of acceptance. This acceptance will have been achieved through a series of stages in which the point of view of all the participants gradually changes.

With the advent of government-sponsored health insurance, our Province, like many others, recognizing that the delivery of such services would be accomplished through a series of autonomous institutions and practitioners, had set in place commissions with broad and important delegated powers to not only operate the health insurance plans but also to plan for and manage the facilities and practitioners involved. In the meanwhile, our Provincial health department was left with the responsibilities for public health and mental health and other aspects of the total health picture as these were seen as more direct service operations of government itself. These were ob-

viously competing systems with the health insurance aspects having a high public profile backed up by cost-sharing agreements with the federal government, leading, for some time, to the rather erroneous philosophy that thrusts under this umbrella were only fifty-cent dollars insofar as the Province was concerned.

As it became clearly apparent that the traditional allocative process could no longer be sustained and it would have to be replaced by some form of "integrative" functioning, it became evident also that a new administrative structure would have to be created having as its objective all aspects of total health. To this end, the special purpose commissions were dissolved and, as part of a general reorganization of government in our province, a Ministry of Health was created with complete responsibility for all aspects of health.

Within this massive reorganization the former emphasis on "programs" (here I refer to programs as public health, mental health, treatment rehabilitation, the traditional forms that we have seen the health picture broken up in) gave way to a "standards" model, with a focus on health-care delivery in all its forms, as the central core for Ministry functions. The intention is that the Province will be divided into approximately thirty districts each having a District Health Council which will be responsible for health-care services, planning and policy in its own geographic area, that there will be a link here with the social services because it is recognized that the line between health and the so-called social services is very gray and obviously the overlays here are many and important.

While at this stage it will not have direct power to authorize expenditures, since the tax base is largely at the provincial level, its advisory function will be acutely recognized and, with broad provincial guidelines or standards, it will be able to plan, priorize and evaluate all health services within its geographic area. It is a process which, we hope, will give us significant rationalization of our health programs at a local level, particularly, as for the foreseeable future. All health programs will have to be contained within some fixed dollar limits.

This is the art, then, of trade-offs, priorizing, to see which becomes more important.

The Ministry itself will be organized to support such a district and area concept largely through a strong Standards Division which will

not only be charged with the development of flexible standards for all aspects of health care of our Province, but also will have a capability of providing expert consultative advice to Councils and agencies throughout the Province. A series of six or seven regional offices and Directors will also be established within the second major group of the Ministry, i.e., Health Services Delivery, to insure close liaison with District Health Councils and to assist institutions and agencies in carrying out their responsibilities.

Hopefully, the Ministry will eventually be able to divest itself from the direct operation of health delivery services by folding them back to their community interest. This should strengthen the Ministry's major roles of planning, research, major goal setting, development of standards and evaluation.

The Health Insurance function is now recognized as a basic administrative machine responsible for the usual business aspects of premium collection and claims payment. But policies for its administration will be developed within other groups of the Ministry whose overall objective is total health. It is anticipated that, in this way, the workings of health insurance can be utilized as a major fiscal resource for support and development of total health care, rather than the more limited perspective of specialized treatment procedures or facilities.

Basic to the health delivery system will be a strong emphasis on primary care. A recently concluded report of a special Health Planning Task Force[1] describes the essence of this approach:— "The Health Services System is an aggregate of inter-related health services arranged so as to function as a complex whole. Within the system, there are two distinct sectors: Primary care and secondary care. Primary care services are provided by groups of medical and allied health personnel. Each group, in the provision of such services, contributes to an overall program of primary care in the community. In the secondary-care sector, the services of specialists are grouped around programs or areas of specialty.

"The concepts of primary and secondary care are basic to our proposals for health care in

[1]Report of the Health Planning Task Force—January 28, 1974.

Ontario. It is through the development of integrated and co-ordinated primary and secondary care services that the quality and efficiency of future health services will be maintained and improved."

The Minister of Health, on the occasion of his introduction of the Report of the Health Planning Task Force (January 28, 1974) stated:— "It makes proposals and recommendations that could bring about wide and fundamental changes affecting the entire health care system, changes in roles, structures and practice, at all levels."

Within this model are contained inherent changes in the Health Delivery System affecting the traditional functioning of almost all agencies and practitioners. The Report was tabled with our Ministry early this year and has now been made public. Interested groups, associations and individuals are being asked to review and comment upon the Report. These observations and suggestions will be carefully reviewed by our Ministry and in due course the final results will form a working objective for the health delivery system of our Province. There are several suggestions within the Report as to how Health Insurance funding can be used to reorganize and revamp our health delivery system.

In the sense of a Monday morning quarterback, it would seem that great advantages might have accrued to our health delivery system if the feasibility work related to both the health disciplines and the delivery system had preceded the introduction of the universally available government sponsored programs of health insurance. However, without the practical experience of the past fifteen years it is highly probable that many of the innovations now taking place would have met with serious resistance by almost all parts of the health field.

I would just like to say a few words, then, about the payment mechanisms before I close, Mr. Chairman.

Institutions. As you are no doubt aware, even prior to the introduction of hospital insurance our provincial government enacted legislation whereby no hospital could be created, enlarged or modified in any way without its explicit approval. Generous capital support programs have been in existence, although approximately one-third of approved capital requirements have remained the responsibility of the hospitals themselves. The costs of operating hospitals have largely been met from the insurance plan through a system of prospective budgeting permitting of bulk sum payments twice monthly in accordance with prior approvals by our Ministry.

When care in nursing homes became part of the health insurance package, legislative action was taken to provide the full licensing of any nursing home in the Province. Standards for licensing were carefully set out and provision made for license revocation or levying of fines for failure to comply. No nursing home can now be erected, modified or sold without the permission of our Ministry.

Payments for nursing home care and home care are slightly different but all controlled by government legislation. The insurance mechanism is thus used extensively as a control tool for institutional care.

Personal Health Care Services

Payments for personal care services are also controlled through the health insurance plan. The traditional fee-for-service patterns are still used based, in the case of doctors, on a fee schedule developed initially by the Provincial Medical Association. While in the early days of the Plan the doctors demanded the right to alter the fee schedule unilaterally, this past year has seen the creation of a Joint Committee on Physicians' Compensation for Professional Services, comprising representatives of government and the medical association for negotiation of changes in unit amounts for services as well as relative values in the schedule itself. The results of the first round of negotiations have been fairly successful. Payments from the government sponsored program can, however, be made on an alternative basis to fee-for-service and there has been a steady increase in alternative modes of professional remuneration. This ability to vary payment methods is particularly useful as practitioners increase group operations and extend their basic services within the group to include other health professionals and social workers. Again, the health insurance payments are being used to effect significant changes in our health delivery system.

Universal insurance permits the development of most accurate practice profiles for each doctor in the Province. These profiles are reviewed on a monthly basis. With the co-operation of a special Medical Review Committee of our provincial College of Physicians and Surgeons, there has been developed acceptable practice

profiles for all medical generalists and specialists. These are used by the Administrators of the Health Insurance Plan to monitor the actual billing experience of the doctors. Deviations in excess of these standards are immediately forwarded for review to the Medical Review Committee. After careful consideration by the Committee, with the assistance of their inspectors, recommendations are made to the Administrator of the Health Insurance Plan as to whether accounts submitted by the doctor should be paid in full, at a reduced rate or not paid at all. Through this process certain doctors are then referred to the Discipline Committee of the College or the Ministry itself may instigate legal court action if fraud is suspected.

Such controls covering all aspects of a doctor's practice have only been possible since the government took over complete administration of the insurance plan and eliminated the services of some forty-plus payment agencies comprising commercial insurance carriers, not-for-profit voluntary plans and other designated agents.

The Health Insurance Plan has also been used to provide special payment arrangements for doctors locating in designated "underserviced areas" of our Province. Over eighty communities in our Province have already been provided with medical services by this special arrangement.

Payments under our health insurance plan are also being utilized to assist in the organization of community health services and community health centers.

We now have a special group within the Ministry that is quietly, hopefully effectively, obviously very slowly, picking up areas in the Province that are interested in this type of approach because our philosophy is not one of imposition but rather one of evolution, hopefully by education and working with local people.

Summary

Mr. Chairman, I have attempted briefly to bring to your attention certain basic considerations relating to how a government-sponsored universally available program of health insurance effects a health delivery system by:

1) Making certain basic health care services available to almost all people of a designated jurisdiction.

2) Indicating how priority-setting by government as to which health services are included in a health insurance plan can have significant impact on a health delivery system.

3) Suggesting that, while private health insurance can be operated without creating inordinate demands for service, a government-sponsored program carries with it a heavy responsibility to develop a balanced program of institutions and personal-care providers to meet demands of the public.

4) Outlining the need, within a government-sponsored health insurance plan, for the development of some form of control over quantity and quality of health care services forming part of the health insurance package.

5) Requiring basic changes in traditional patterns of organization for the development, evaluation and delivery of health care services.

6) Permitting the health insurance payment mechanisms to be used as a vehicle for the development of a balanced and integrated health delivery system.

I would like to conclude, Mr. Chairman, because obviously these sort of introspective naval engagements may suggest that we have problems, and we do. Ted Doerr who is head of the Orthopedics at Toronto General and Professor of Orthopedics at the University of Toronto Medical School called me a few weeks ago and he said, "Stan, how do I get in touch with the editor of the *Daily Star*?" (which is our large daily newspaper). "How do I get hold of *MacLean's?*" (a large popular magazine).

He said, "I have just spent three and a half months traveling around the world looking at various health care systems, and I have got to get to the people to tell them how fortunate they are, and what they have, and for God's sakes hang on to it!" So that you can get this kind of introspective focus that sometimes, obviously, we are very much aware of the weaknesses that we have. But this committee that functioned, that I referred to in the report on the Health Planning Task Force, said, "We are fortunate in Ontario in that the present institutions, personnel and arrangements within the health-care sector represent, for the most part, a sound base on which to build a comprehensive system. It is neither necessary nor desirable to sweep away the solid foundation of programs, services and traditions on which health services now rest. Our proposed plan, therefore, projects a system that can evolve from existing ar-

rangements. We are aware that many changes are currently taking place in the health care sector that conform to the general direction of our recommendations. We are confident that with the cooperation of all persons involved in health care, an efficient system of high quality health services can evolve that meets existing needs and, also, will be capable of meeting the needs of the future." Thank you.

MEMBER: How many people live in the Province? What is the population of the Province?

MR. MARTIN: It is just over eight million. It has the same population as Sweden.

MEMBER: I don't know if this satisfies your criteria, but I am curious, Mr. Martin, as to the predominant mode of hospital reimbursement for their costs within your Province of Ontario.

MR. MARTIN: Yes, it has been a prospective type of global arrangement for about the last six years.

MEMBER: So rather than prospective rates, it's prospective global?

MR. MARTIN: Yes.

MEMBER: You mentioned that some consumer groups had formulated objectives for revamping the system, hearings had been held, and they were going to be considered now by the provincial authorities. Are those administrative objectives for running the system better, or are they service objectives for meeting the needs of the people better?

MR. MARTIN: I think in my hurry to get through I misled you a little. I said that this report was developed by a group of people selected as a task force, that this had now been floated, in our terms, as a green paper. It provides a model for the delivery of health services involving the aspects of consumer participation and all the rest of it. It is now out in the field, and it is being examined by the ministry within the next four or five months. It has only been out about two weeks. So we are waiting for this to be examined by all groups all over the Province for the feedback from it. We haven't had it yet.

The Function of a Data Base for Health Services Planning—The Canadian Experience

WERNER F. O. DAECHSEL

CHAIRMAN ANDERSON: Werner Daechsel, a consultant with National Health and Welfare in Ottawa, will be giving the next presentation on "The Function of a Data Base for Health Services Planning."

I would wish to make a passing observation. It is interesting that you can formulate and develop and enact large scale health services plans without reference to data, and then after you have been in operation for a while, they will say, "Let's find out what is going on," I gather, and so now we are going to go into planning. I am curious to see if Werner can tell us what data are necessary and meaningful. I don't want to steal your thunder. So here we are moving into a data base for planning, and what this country has, we have more data about health services than any other country in the world, but we don't have a policy. Werner, will you please elaborate on the function of a data base.

WERNER DAECHSEL: It is the intent of this paper to discuss the use, misuse and neglect of the data base for Health Services Planning as related to the Canadian experience. This discussion should provide you with knowledge related to the environment in which you will administer your hospital in the United States in the years to come. The semantics of the title and Canadian data base practices will be discussed as background. Comparisons with practices in the United States will be included.

By way of definition data will be defined as "factual material used as a basis especially for discussion or decision," base, "supporting or carrying ingredient," function, "the action for which a person or thing is specially fitted or used or for which a thing exists," planning, "to arrange the parts, to devise realization or achievement."[1]

In terms of the above definitions one could restate the title as "The Canadian Experience in using the factual material available as the supporting or carrying ingredient for discussion or decision making related to arranging the parts of the health system to devise realization or achievement in the provision of health services."

I am committed to a broad definition for health services such as all activities which contribute to the maintenance and improvement of well-being of people of all ages with particular references to the fields of preventative, curative and restorative health services; ecological arrangements for human habitation; employment and food production; and approaches to leisure time activities. For the purpose of this discussion it seems desirable to limit the health services under consideration to those provided in hospital and to those provided by physicians in or out of hospital. This limitation is not denying the importance of the other services but merely a practical device to concentrate on those services which have developed with some divergence between our two countries during the last decade.[2]

One difference which has become more pronounced during the last two decades is the quality and quantity of factual material available to use for discussion or decision. Dr. Perrin's recent article in the January–February issue of Health Service Reports in announcing "The Cooperative Health Statistics Systems"[3] for the United States enumerates a number of objections which have been either in part or in total attained in Canada. Hospital care statistics and ambulatory care statistics in Canada seem to meet the enunciated objectives of Dr. Perrin's proposal. At some future date the writer hopes to have an opportunity to learn more about this proposal to make a more

[1]Webster's Third New International Dictionary, 1961.

[2]The papers which preceded on the program provide an insight into some of the differences in the development of Health Services.

[3]The Cooperative Health Statistics System, Edward B. Perrin, Ph.D., Health Services Reports Jan–Feb. 1974, Vol. 89, No. 1.

thorough comparison to the Canadian experience.

The Canadian Data Base Pattern

For the purpose of this discussion, it is important to remember that the basic responsibility for providing health services rests with the Provinces. In Canada, the Federal role by consent is primarily coordinative and supportive. It has accepted responsibility for providing leadership and support for efforts to establish standards for data.

The national standard in Canada for the Admission and Discharge form provides an example ~~of~~ the type of arrangement that has been achieved. These forms are designed by the Provinces on the basis of decisions made at Federal-Provincial meetings with respect to the common information which is to be included by all Provinces. The province sends the Admission and Discharge Data on computer tapes to Ottawa for the purpose of processing by Statistics Canada. The forms used in Canada are, in content, similar to those used by the Michigan Blue Cross.[4] Differences occur because of the case billing system which is used in Michigan but not used in Canada.

Canadian Hospitals submit these forms even though they do not serve a billing function. Under the Canadian system hospitals are paid on the basis of what the Province considers reasonable operating costs. Unlike most hospital charges in the United States, charges and remuneration are not directly based on individual cases.

Each year the hospitals in Canada prepare an annual return in two parts, the first part being "Facilities and Services" and the second "Financial." The Regional Planning Council for New York City[5] uses a similar set of forms for hospitals of its regions although the Canadian form is more detailed.

Unit values for departments in Canada have been designed for the purpose of comparing departments in different hospitals. They do not serve for comparing non similar departments. For departments such as Clinical Laboratory and Occupational Therapy, a unit value is placed on each procedure. Each hospital reports the unit value for the work done by the departments concerned. The Clinical Laboratory unit has led to some inquiries from other countries, including the United States.

It is important to recall that under the Canadian system there is no departmental revenue such as you have in the States. The unit values for departments concerned serve as a possible alternative means for measuring the output of these departments. The above forms and returns are universal in Canada for all general hospitals which includes Chronic and Psychiatric Care but excludes Mental Hospitals and Nursing Homes.

In addition, a number of our hospitals are voluntarily participating in the "Quarterly Hospital Information System" which is designed to provide hospital management with current indicators for level of services, efficiency and cost of operations. Statistics include activities such as average daily number of operating room visits, percentage of inpatients visits, utilization in terms of occupancy, average length of stay and bed turnover, etc. Costs are reported in terms of total paid hours, average wage, and salary rates. Profiles are provided by individual hospital departments by hospital groupings based on size and type and by provincial grouping. Thus the hospital administrator has access to information on operations on his own and comparable hospitals enabling him to make performance comparisons.

The Quarterly reports were organized by the Canadian Hospital Association with some co-operation from the Provinces and Statistics Canada. This is a service not unlike that which is offered by the American Hospital Association to Hospitals in the United States.

In addition, some hospitals in Canada subscribe to the Professional Activity Study Service from Michigan or the Hospital Medical Record Institute service which is Toronto based. One province, Alberta, requires hospitals of that province to subscribe to the Professional Activity Study Service. Recently, Ontario has encouraged its hospitals to subscribe to at least a portion of the Hospital Medical Record Institute Service.

The basic method of payment for physician services is on a fee for services basis.[6] This arrangement requires that a document be created for each service. The physician or his

[4]Michigan Hospital Service, Inpatient Admission Notice and Bill, 0256 March 1972.

[5]Health & Hospital Planning Council of Southern New York, Inc., Uniform Statistical Report for Hospitals, 1972.

[6]With exception of salaried physicians which include physicians in mental hospitals, public health physicians and some physicians who are on staff of other hospitals or clinics.

office is asked to record the type of service rendered and the illness involved. Based on this simple document, a Province like Saskatchewan has developed an extensive physicians' profile system with regard to the type and quantity of service rendered by the individual physician. Thus the Canadian data base includes a record of services by physicians as well as hospital cases.

The data base for Health Services Planning with respect to manpower has been broadened by a co-operative arrangement between Health and Welfare Canada and Revenue Canada by including information about physicians income without identifying the link between the specific physician and his income. It is possible, however, to be specific with respect to size of the community, type of practice by specialty, fee for service or salary, full-time or semi-retired. Information about overhead costs for private practitioners is also included.

Some examples of the nature and scope of the data base available for Health Services Planning in Canada are provided as an appendix to this paper.

Applying the Data Base

The Canadian experience has been similar to other nations in that use, misuse and neglect have occurred with respect to the data base available for health services planning.

Most of the major changes planned for Canadian Health Services particularly with respect to arrangements for financing have been preceded by careful examination of the data base. This examination has taken place both at the Provincial and Federal level. Three major studies conducted by the Federal Government and the Governments of Ontario and of Quebec serve as examples. These are:

1. Report of the Royal Commission of Health Services (Ottawa Queen's Printer, 1964, 1965)
2. The Report of the Commission of Inquiry on Health and Social Welfare (Quebec: Queen's Printer, 1967),
3. Health Care in Canada; a Commentary Health issued between 1969 and 1973.

In addition extensive studies which could be included are:

1. Task Force Reports on the Cost of Health Services in Canada (Ottawa, Queen's Printer, 1970),
2. The Community Health Centre in Canada (Ottawa, Information Canada, 1973),
3. Health Care in Canada; a Commentary Background study for the Science Council of Canada, Information Canada, Ottawa, 1973.

The Report of the Royal Commission on Health Services provides a reasonable example of how the data base is used for health services planning in Canada. A major portion of the report is devoted to identifying the data base which was considered relevant. When one examines the recommendations, however, they appear to represent objectives which, although within the context of the data base, do not stem directly from the data base. This judgement is not made in a critical fashion. In planning health services on a broad basis, it is desirable that the available data base be examined to establish measurements for requirements and the limits of resources which may be available for the provision of Health Services. Judgements can be made within these limits. The commission paid attention to the data base in this fashion. Particular attention was given to financial and manpower resources which might be available for the provision of Health Services. Certain international comparisons were included particularly with the United States and in some cases other countries.

When one examines the report of the Health Planning Task Force of Ontario[7] which was released in 1974, the relation between the data base and the recommendations made is very similar to that already described with respect to the Royal commission.

Ontario has a distinguished record in referring to the data base when engaging in health services planning. Mr. Martin,[8] the Deputy Minister of Health for Ontario, has been associated with and on many occasions responsible for the creating and the maintenance of the record. He has been part of this achievement both in and out of government.

In considering Health Services planning, however, it is important to keep in mind the environment which influences planning as well as the written recommendations and subsequent decisions. Misuse of the data base can

[7]Ontario, Report of the Health Planning Task Force, 1974.
[8]The previous speaker on this program.

occur when isolated or casual examination of the data base leads to misconceptions which interfere with both rational and humanist objectives. In 1970 the Economic Council of Canada issued a report that contained the following statement.

"Looking ahead to 1975, about $1 out of every $6 or $7 of the increase in the total income in the economy could be taken up by health care and higher education. But such a rate of expansion in expenditures in these fields is simply not sustainable for the long run if the rate of increase of the past five years were to continue unabated, these two areas of activity alone would absorb the entire potential national product before the year 2,000."[9,10]

As an individual I recognize that any component of a mix which increases its share of a mix, no matter how small the increment each year, will if the increments continue indefinitely take over the total mix. The year 2,000 is of course a rhetorical alarm bell.

In 1973, the President of the Manitoba Medical Association in his comment on the Manitoba White Paper on Health Policy included the following observations: "In 1969 and 1970 the Canadian public spent more on its amusements than on all health care services combined; hospitals, doctors, drugs, dentists, etc. (Statistics Canada).

"In 1971, the Manitoba public spent $113 million on alcoholic beverages. Per capita average of $113 compared to a per capita average for medical services of $52.50.

"In Manitoba less than $5 per capita is spent monthly for comprehensive medical care. That is considerably less than the average smoker (one package per day) spends monthly on cigarettes, cigars or tobacco."[11]

More recently in this regard United States M.P. Congressman William R. Roy predicted that the United States slice of the gross national product may finally top out as high as 15 percent (present rate 7.7 percent).[12]

It is interesting to speculate if an informed public might not vote for allocating to health and education two or three dollars of every six dollars of any increase in the total economy. An informed public might be puzzled by a claim that the devotion of one dollar out of every six dollars of an expansion in the economy for health and education is not sustainable.

Some neglect of the functions of the data base for Health Service Planning in the Canadian experience might be admitted here. The most important in the judgement of the writer has been the lack of adequate development of subjective measurements as an important component of the data base for Health Service Planning. Dr. Badgley and his associate are making a contribution towards filling this gap with respect to the subjective views and roles of the consumer, the provider and others involved in health services.

Mr. G. B. Rosenfeld[13] considers the Health Services Planning process as a four element paradigm. He identifies the consumer, the producer, the conceptualizers and the decision maker. He looks upon the planning process as four-staged, beginning with fact flowing to decision flowing to implementation and then to results. Latent and recognition periods precede this four-staged process.

He stresses that the passage of time is very important. Problems don't remain static. Changes require considerable time, often a whole decade. For example, if one considers physicians manpower based on current population to physician ratios, it is important to remember that current trends will continue before any measures to change the trends can become effective. Time lag for change becomes part of the important data base for Health Service Planning.

With the lapse of time, during the stages of this process, the nature of the problem may change. The decision maker may be faced with a different problem than the one which he recognized originally. The decision maker must be alert, otherwise he might apply to outdated solution to the problem as it exists when the solution is being applied even though the solution was appropriate for the original recognition of the problem.

This paradigm also requires that the subjective approach of each actor in the paradigm be considered. Without a good subjective data base, it is difficult to take into account the influence of the subjective views which the con-

[9]Economic Council of Canada, Patterns of Growth, Seventh Annual Review, September 1970.

[10]The type of data given or implied by Dr. Badgley's presentation this morning provides examples of data fields which need development.

[11]Connelly, P. "President challenges government" (President of Manitoba Medical Association) Canada Medical Association Journal, Volume 108, Feb. 17, 1973. p. 512.

[12]"How much for Health?" Medical Economics, March 4, 1974. p. 47.

[13]Rosenfeld, G. B., Acting Director General, Program Development and Evaluation, Health Programs Branch, Health and Welfare Canada, Ottawa.

sumers and producers will have with respect to any given proposal for health services.

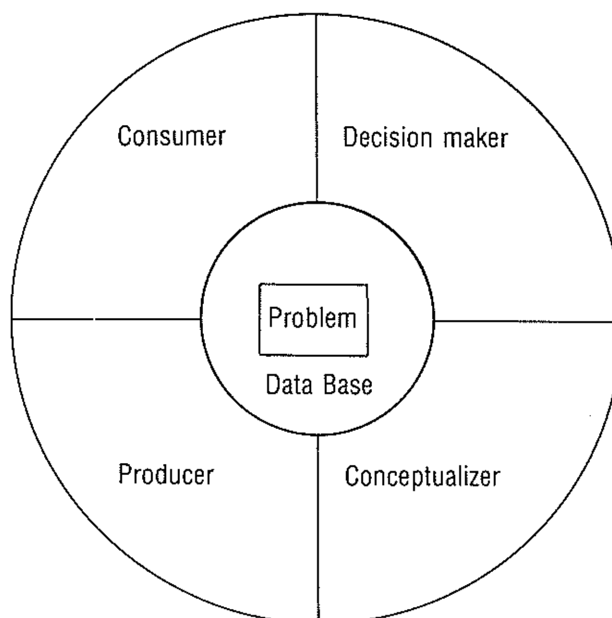
A general high level of commitment to health has prevented disaster resulting from the lack of subjective measures. In the judgement of the writer more effective results would be possible if more efforts were placed on identifying and measuring subjective attitudes of the principal parties concerned. One only need to consider the amount of attention the advertising industry for commercial organizations pays to learning consumers attitudes when considering plans for the future.

Evaluation is required for an effective on-going planning process. Past evaluation data has been limited to negative measures such as the ratio of normal to diseased appendix tissues removed which function as surrogates for positive measures. Once a more adequate subjective data base is available, the potential for positive measures for evaluation will be enhanced. Health service evaluation requires subjective judgements of well informed individuals as well as objective data. Methodology for subjective measurements requires development.

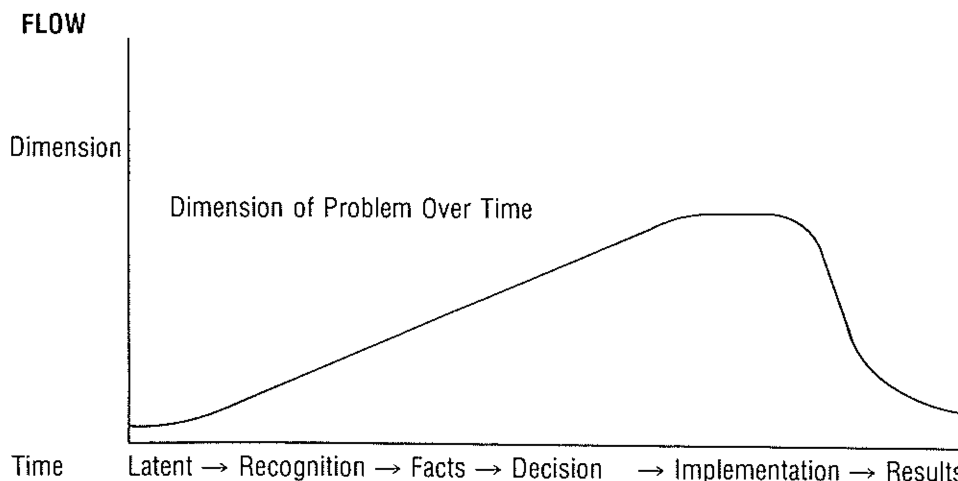
Acceptance of Mr. Laframboise's message will create new data base requirements for

Health Service Planning Paradigm

ELEMENTS



FLOW



Health Services planning.[14] He places new emphasis on environment and lifestyle of the individual as an important aspect of Health Services Planning. This emphasis has grown out of his development of the Health Field Concept.[15] Episodical data which have been available up to the present may not adequately serve future Health Services Planning. This inadequacy will make more urgent the need for a lifetime health profile of each citizen. Such a system must clearly identify the specific groups of special risk to which an individual belongs for giving advice to the individual as well as recording experience by risk group. Such a service will assist in planning for improved health treatment and prevention as well as providing a sound information basis for assisting the individual in choosing the lifestyle that will fit his requirement. "It may be, for instance, that if he is in a high cardiac risk group that he will be advised to eat only unsaturated fats, or if he is in a high cancer risk group, he will be advised to abstain from certain vegetable fats. A lifetime health profile record would assist in planning for the reduction of the number of occasions when drugs and other treatments which are known to be contraindicated for the individual through previous medical examinations are prescribed."[16]

In Canada we have come frustratingly close to gaining this capability. We have not, however, managed to take the final crucial steps. A demonstration project has been conducted in the smallest province, Prince Edward Island. A lifetime number is used (Social Insurance Number) to identify the individual with respect to all contacts for Health Service. A hand record is kept for each individual listing the services given to him.

This modest beginning has still not been expanded to a major proportion of the population or to a more detailed profile. It would seem reasonable to expect that eventually the public will demand that a health record be kept on the individual which will provide adequate benefits to the individual.

Interaction

An examination of the function of the Data Base for Health Services Planning requires some focus on the interaction between the planner, the keeper of the data base and the data base. The keepers of the data base become frustrated from the impressions they receive that the data base is being ignored or inadequately utilized for health service planning. A review of the papers of a recent international conference on health statistics[17] indicates that considerable attention was paid to the need for and use of data. Health services planners on the other hand yearn for simplistic and definitive answers to questions. They tend to demand a high level of reliability and don't wish to be bothered by caution about reliability.

There are of course techniques to reduce these problems of interaction. Maps and displays assist the planner in visualizing the message of the data base. The synectic approach which allows the individual to contribute and interact with a minimum emphasis on predetermined roles also can help understanding.

The problems I have referred to exist not only in health services planning but in urban and other planning as well. It is useful or at least reassuring on occasion to have a model of a situation to assist in understanding it. Dr. Eugene Roberts, a neurochemist in Los Angeles, may have developed a useful model for understanding the problems of interaction between discipline or role actors.

Dr. Roberts' theory of human action and interaction is based on a model which includes a command neuron for a circuit which has a specific programmed function. The circuit is pre-programmed to fire when triggered by an appropriate stimuli. Pre-programming is determined either by hereditary or early experience or both. Nothing happens until the command neuron lets it happen.

The command neurons are restrained by GABA[18] neurons which hold the command neuron in check unless or until they are disinhibited by an appropriate incoming stimuli thereby allowing the circuit to fire. In contrast to the previous reliance on excitation, Dr. Roberts' theory is dependent on a co-ordinated interplay between excitations and inhibitions.

The interplay between the Health Service Planner and the Keeper of the Data Base seems to provide some relevance to this model. Train-

[14]Mr. Laframboise will be addressing you this afternoon.

[15]Laframboise, Hubert J., Health Policy, Breaking It Down Into More Manageable Segments, Journal of the Canadian Medical Association, February 3, 1973.

[16]Daechsel, Werner. "Will Canada Adopt the Universal Health Number?" Canadian Hospital, March, 1972, p. 21, 22.

[17]The Second International Conference of National Committees on Vital Health Statistics held under the Auspices of the World Health Organization in Copenhagen in October 1973.

[18]Gama amino butyric acid or GABA.

ing and experience associated with the two roles may cause the individuals concerned to react in very different fashions to the same stimuli. Yet once the command neuron which is pre-programmed to respond fires "the fat is on the fire." Sometimes the same stimuli can have opposite effects on two individuals that are dealing with a situation. A given stimuli may inhibit one actor and disinhibit the other, or it may have the same effect on both actors. The planning process as related to the data base is very dependent on the reaction and interaction between the principal participants.

In the foreword of the paper entitled "The Consequences of Health Care Through Government"[19] Mr. Detwiller[20] states "Canada's experience has shown an over-utilization and over-servicing, thereby inhibiting optimum usage of health care facilities and finance." Even though approximately the same data base is available to both of us, I would question the inevitability of this conclusion from examination of the data base. I hasten to add that others share his reaction.

The underlying assumption which Mr. Detwiller makes seems to be represented by the statement, "a population that is promised 'universal and comprehensive health services' will demand that everything possible be done for every patient. This is impossible today and no system can continue to stand up to this type of demand."[21]

This assumption could be wrong. It seems to ignore the number of cases where available services are not utilized even without the requirement for direct payment of service. The demand for health services may be finite not infinite. The finite limitation may be within the range of a given society's available resources to meet the demand. Further development of subjective and other measurements will assist in examining this Health Services Planning problem.

[19]Detwiller, 27, "The Consequences of Health Care Through Government."

[20]Mr. Detwiller may be addressing you tomorrow on a similar basis.

[21]ibidem, p. 25.

The United States and Canada

It is unlikely that your health service will become a duplicate of Canada's. It is likely, however, that as your government plays an increasing role you will be faced with some similarities with the Canadian experience.

As hospital administrators in the United States in 1974 who face a future that appears to offer increased government involvement, how relevant is Canada's experience in applying the data base to Health Services Planning?

My advice would be to be as aware as possible of the functions of the data base so that you might be articulate to the planners in terms that are relevant to the data base. Also almost of equal importance, be aware of the potential misapplication of the data base so that you can assist in preventing inappropriate planning. The use, misuse and neglect of the data base for Health Services Planning under government involvement in health services are dependent for effective and efficient goal achievement on feedback and reaction from health service administrators and other participants.

Planning judgement is the important element of health services planning. The data base provides data not foregone conclusions. The function of the data base is to provide guidelines with respect to limits and to stimulate action. The data base function is to assist the decision maker, not to supplant him. Your participation is required.

Appendix

INPATIENT CARE BY DIAGNOSIS (CANADIAN LIST**) 1972

International Statistical Classification	Canadian List Number and Diagnosis	Separations	Separations Per 1,000 Covered	Patient Days	Patient Days Per 1,000 Covered	Average Days of Stay
	V. MENTAL DISORDERS	7,641	8.2	93,750	100	12.3
291	52. Alcoholic psychosis	218	.3	2,070	2	9.5
295	53. Schizophrenia	856	.9	16,878	18	19.7
296	54. Affective psychoses	1,042	1.1	14,802	16	14.2
290, 292-294, 297-299	55. Other psychoses	455	.5	9,373	10	20.6
300	56. Neuroses	2,470	2.7	20,237	22	8.2
303	57. Alcoholism	1,402	1.5	14,108	15	10.1
304	58. Drug dependence	124	.1	1,525	2	12.3
301, 302, 305-309	59. Other nonpsychotic mental disorders	948	1.0	9,773	10	10.3
310-315	60. Mental retardation	126	.1	4,984	5	39.6
	VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	8,608	9.2	78,839	84	9.2
320-324	61. Inflammatory disease of the central nervous system	157	.2	3,367	4	21.4
330-333	62. Hereditary and familial diseases of nervous system	59	.1	1,016	1	17.2
340	63. Multiple sclerosis	263	.3	5,745	6	21.8
342	64. Paralysis agitans	309	.3	5,187	5	16.8
345	65. Epilepsy	680	.7	4,707	5	6.9
341, 343, 344, 346-349	66. Other diseases of central nervous system	784	.8	13,712	15	17.5
350-358	67. Diseases of nervous and peripheral ganglia	882	1.0	8,080	9	9.2
360-369	68. Inflammatory diseases of the eye	503	.5	3,498	4	7.0
373	69. Strabismus	587	.6	1,928	2	3.3
374	70. Cataract	1,031	1.1	9,335	10	9.1
375	71. Glaucoma	198	.2	1,425	1	7.2
370-372, 376-379	72. Other diseases of the eye	433	.5	3,012	3	7.0
381	73. Otitis media without mention of mastoiditis	1,942	2.1	13,223	14	6.8
382, 383	74. Mastoiditis with or without otitis media	132	.1	1,073	1	8.1
380, 384-389	75. Other diseases of ear and mastoid process	648	.7	3,531	4	5.4
	VII. DISEASES OF THE CIRCULATORY SYSTEM	20,635	22.1	304,529	326	14.8
390-392	76. Active rheumatic fever	192	.2	3,038	3	15.8
393-398	77. Chronic rheumatic heart diseases	470	.5	6,478	7	13.8
400-404	78. Hypertensive disease	2,187	2.3	21,930	23	10.0
410	79. Acute myocardial infraction	2,145	2.3	41,055	44	19.1
411-414	80. Other ischemic heart disease	3,840	4.1	50,618	54	13.2
420-429	81. Other forms of heart disease	4,701	5.0	65,919	71	14.0
431	82. Cerebral hemorrhage	138	.2	1,999	2	14.5
432-434	83. Cerebral embolism and thrombosis	396	.4	8,751	9	22.1
430, 435-438	84. Other cerebrovascular disease	2,192	2.4	49,105	53	22.4
440	85. Arteriosclerosis	391	.4	6,653	7	17.0
441-448	86. Other diseases of arteries, arterioles and capillaries	710	.8	13,454	14	18.9
450	87. Pulmonary embolism and infraction	189	.2	3,238	4	17.1
451-453	88. Phlebitis and thrombophlebitis and venous embolism and thrombosis	859	.9	10,744	12	12.5
454	89. Varicose veins of lower extremities	1,033	1.1	11,621	12	11.2
455	90. Hemorrhoids	1,014	1.1	7,999	9	7.9
456-458	91. Other diseases of circulatory system	178	.2	1,927	2	10.8
	VIII. DISEASES OF THE RESPIRATORY SYSTEM	40,477	43.3	298,228	319	7.4
460-466	92. Acute upper respiratory infection, except influenza	9,812	10.5	60,842	65	6.2
470-474	93. Influenza	3,080	3.3	19,284	21	6.3
480-486	94. Pneumonia	9,488	10.2	103,837	111	10.9
490-492	95. Bronchitis and emphysema	5,738	6.1	52,316	56	9.1
493	96. Asthma	2,850	3.1	22,750	24	8.0
500	97. Hypertrophy of tonsils and adenoids	6,208	6.6	15,000	16	2.4
503	98. Chronic sinusitis	384	.4	1,940	2	5.1
504	99. Deflected nasal septum	807	.9	2,942	3	3.6
501, 502, 505-508	100. Other diseases of upper respiratory tract	696	.7	2,923	3	4.2
510, 513	101. Empyema and abscess of lung	16	*	464	1	29.0
515, 516	102. Pneumoconiosis and related diseases	9	*	21	*	2.3
511, 512, 514, 517-519	103. Other diseases of respiratory system	1,389	1.5	15,909	17	11.5

INPATIENT CARE BY DIAGNOSIS (CANADIAN LIST**) 1972

International Statistical Classification	Canadian List Number and Diagnosis	Separations	Separations Per 1,000 Covered	Patient Days	Patient Days Per 1,000 Covered	Average Days of Stay
	IX. DISEASES OF THE DIGESTIVE SYSTEM	24,770	26.5	219,169	235	8.8
520-525	104. Diseases of teeth and supporting structures	2,019	2.1	4,549	5	2.3
526-529	105. Other diseases of oral cavity, salivary glands and jaws	398	.4	2,824	3	7.1
532	106. Ulcer of duodenum	1,672	1.8	20,036	21	12.0
531, 533	107. Ulcer of stomach, and peptic ulcer site unspecified	1,089	1.2	11,883	13	10.9
535	108. Gastritis and duodenitis	1,785	1.9	9,391	10	5.3
530, 534, 536, 537	109. Other diseases of esophagus, stomach and duodenum	627	.7	5,438	6	8.7
540-543	110. Appendicitis	3,024	3.2	19,782	21	6.5
550, 551	111. Hernia without mention of obstruction	2,874	3.1	24,279	26	8.4
552, 553	112. Hernia with obstruction	280	.3	3,299	4	11.8
560	113. Intestinal obstruction without mention of hernia	782	.8	7,904	9	10.1
563	114. Chronic enteritis and ulcerative colitis	274	.3	3,749	4	13.7
561, 562, 564-569	115. Other diseases of intestines and peritoneum	2,543	2.7	23,602	25	9.3
571	116. Cirrhosis of liver	354	.4	5,813	6	16.4
570, 572, 573	117. Other diseases of liver	154	.2	1,684	2	10.9
574	118. Cholelithiasis	4,370	4.7	52,119	56	11.9
575	119. Cholecystitis and cholangitis, without mention of calculus	1,828	2.0	15,115	16	8.3
576	120. Other diseases of gall bladder and biliary ducts	290	.3	3,099	3	10.7
577	121. Diseases of pancreas	407	.4	4,603	5	11.3
	X. DISEASES OF THE GENITOURINARY SYSTEM	18,108	19.4	143,585	154	7.9
580-584	122. Nephritis and nephrosis	351	.4	6,697	7	19.1
590	123. Infections of kidney	1,625	1.7	12,008	13	7.4
592, 594	124. Calculus of urinary system	801	.9	7,303	8	9.1
595	125. Cystitis	1,103	1.2	7,172	8	6.5
591, 593, 596-599	126. Other diseases of urinary system	2,049	2.2	16,338	17	8.0
600	127. Hyperplasia of prostate	1,728	1.9	32,218	35	18.6
605	128. Redundant prepuce and phimosis	506	.5	1,806	2	3.6
601-604, 606, 607	129. Other diseases of male genital organs	942	1.0	6,823	7	7.2
610, 611	130. Diseases of breast	875	1.0	4,334	5	5.0
612-616	131. Diseases of ovary, fallopian tube, and parametrium	965	1.0	6,865	7	7.1
620, 622	132. Infective diseases of uterus, vagina and vulva	718	.8	3,910	4	5.4
623, 624	133. Uterovaginal prolapse and malposition of uterus	1,532	1.6	16,930	18	11.1
626	134. Disorders of menstruation	3,398	3.6	11,806	13	3.5
621, 625, 627-629	135. Other diseases of female genital organs	1,515	1.6	9,375	10	6.2
	XI. COMPLICATIONS OF PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	22,809	24.4	120,402	129	5.3
630, 635	136. Infections of genital tract during pregnancy and urinary infections during pregnancy and puerperium	298	.3	1,405	2	4.7
632	137. Hemorrhage of pregnancy	959	1.0	4,590	5	4.8
636-639	138. Toxemias of pregnancy and the puerperium	686	.7	3,402	4	5.0
631, 633, 634	139. Other complications of pregnancy	2,429	2.6	6,936	7	2.9
640-645	140. Abortion	2,567	2.8	8,777	9	3.4
650	141. Delivery without mention of complications	12,231	13.1	68,660	74	5.6
651-653	142. Delivery complicated by: placenta previa or antepartum hemorrhage, retained placenta, or other postpartum hemorrhage	448	.5	4,041	4	9.0
654-657	143. Delivery complicated by: abnormality of pelvis, feto-pelvic disproportion, malpresentation or other prolonged labor	1,268	1.4	10,930	12	8.6
658-662	144. Delivery with other complications including anesthetic death in uncomplicated delivery	1,535	1.6	10,363	11	6.8
670-678	145. Complications of the puerperium	388	.4	1,298	1	3.3
	XII. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE	4,349	4.6	37,088	39	8.5
680-686	146. Infections of skin and subcutaneous tissue	1,942	2.1	14,047	15	7.2
690-698	147. Other inflammatory conditions of skin and subcutaneous tissue	1,347	1.4	13,279	14	9.9
700-709	148. Other diseases of skin and subcutaneous tissue	1,060	1.1	9,762	10	9.2

INPATIENT CARE BY DIAGNOSIS (CANADIAN LIST**) 1972

International Statistical Classification	Canadian List Number and Diagnosis	Separations	Separations Per 1,000 Covered	Patient Days	Patient Days Per 1,000 Covered	Average Days of Stay
	XIII. DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	7,929	8.5	90,368	97	11.4
712	149. Rheumatoid arthritis and allied conditions	681	.7	13,096	14	19.2
713	150. Osteoarthritis and allied conditions	1,326	1.4	20,075	22	15.1
710, 711, 714-718	151. Other arthritis and rheumatism	1,688	1.8	15,317	16	9.1
720-723	152. Osteomyelitis and other diseases of bone	503	.5	7,716	8	15.3
725	153. Displacement of intervertebral disc	1,353	1.5	15,657	17	11.6
724, 726-729	154. Other diseases of joint	1,061	1.1	8,496	9	8.0
731	155. Synovitis, bursitis and tenosynovitis	526	.6	2,801	3	5.3
732-738	156. Other diseases of musculoskeletal system	791	.9	7,210	8	9.1
	XIV. CONGENITAL ANOMALIES	1,881	2.0	21,161	23	11.2
741, 742	157. Spina bifida and congenital hydrocephalus	67	.1	2,026	2	30.2
746, 747.0-747.2	158. Congenital anomalies of heart	272	.3	3,576	4	13.1
749	159. Cleft palate and cleft lip	101	.1	1,287	1	12.7
750,751	160. Other congenital anomalies of digestive system	233	.2	2,233	2	9.6
752, 753	161. Congenital anomalies of genito-urinary system	371	.4	3,305	4	8.9
754-756	162. Congenital anomalies of musculoskeletal system	389	.4	5,146	6	13.2
740, 743-745, 747.3-747.9, 748, 757-759	163. Other and unspecified congenital anomalies	448	.5	3,588	4	8.0
	XV. CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY	1,603	1.7	13,614	14	8.5
764-768-4th digit .0-.3, 772	164. Birth injury	67	.1	583	1	8.7
764-768-4th digit .4, 776	165. Asphyxia, anoxia or hypoxia	256	.3	3,008	3	11.8
774, 775	166. Hemolytic disease of newborn	123	.1	895	1	7.3
777	167. Immaturity unqualified	14	*	469	*	33.5
760-763, 764-768-4th digit .9, 769-771, 773, 778, 779	168. Other causes of perinatal morbidity and mortality	1,143	1.2	8,659	9	7.6
	XVI. SYMPTOMS AND ILL-DEFINED CONDITIONS	8,873	9.5	54,670	58	6.2
793	169. Observation, without need for further medical care	189	.2	527	*	2.8
780-792, 794-796	170. Symptoms, senility and ill-defined conditions	8,684	9.3	54,143	58	6.2
	XVII. ACCIDENTS, POISONINGS, AND VIOLENCE (NATURE OF INJURY)	21,414	22.9	174,348	187	8.1
N800-N804, N850-N854	171. Fractures of the skull and other intracranial injury	2,652	2.8	14,186	15	5.3
N805-N809	172. Fractures of spine and trunk	948	1.0	15,198	16	16.0
N810-N819	173. Fracture of upper limb	2,420	2.6	12,283	13	5.1
N820-N821	174. Fracture of femur	1,101	1.2	32,533	35	29.5
N822-N829	175. Other fractures of lower limbs	1,651	1.8	16,709	18	10.1
N830-N848	176. Dislocation without fracture, sprains and strains of joints and adjacent muscles	1,662	1.8	9,143	10	5.5
N860-N869	177. Internal injury of chest, abdomen and pelvis	355	.4	3,920	4	11.0
N870-N929	178. Laceration, open wound, superficial injury, contusion and crushing with intact skin surface	4,930	5.3	26,415	28	5.4
N930-N939	179. Foreign body entering through orifice	382	.4	1,492	2	3.9
N940-N949	180. Burns	816	.9	10,373	11	12.7
N950-N959	181. Injury to nerves and spinal cord	59	.1	1,061	1	18.0
N960-N979	182. Adverse effects of medical agents	1,721	1.8	8,410	9	4.9
N980-N989	183. Toxic effects of substances chiefly non-medicinal	498	.5	1,436	2	2.9
N997-N999	184. Complications peculiar to certain surgical procedures, other complications of surgical procedures and other complications of medical care	1,535	1.6	15,489	17	10.1
N990-N996	185. Other effects of external causes	684	.7	5,700	6	8.3
SUBTOTAL		215,080	230.1	1,957,424	2,094	9.1
SUPPLEMENTARY CLASSIFICATIONS		16,192	17.3	94,606	101	5.8
Y00-13	186. Special conditions and examinations without sickness	2,816	3.0	14,949	16	5.3
Y20, 22, 23, 26, 27	187. Mature infant	12,700	13.6	67,041	72	5.3
Y21, 24, 25, 28, 29	188. Immature infant	621	.7	11,871	12	19.1
999	—— No Diagnosis†	55	*	745	1	13.5
TOTAL		231,272	247.4	2,052,030	2,195	8.9

NOTE: "Patient Days Per Thousand Covered" are indicated as the nearest full day.
* Less than 1 per 1,000.
** A Canadian List of 188 diagnoses selected as a basis for study by provincial hospital insurance programs.
† Diagnosis without a code for outside-of-Canada.

PROCEDURES, DAYS, AND AVERAGE DAYS OF STAY FOR SIXTY-FOUR SELECTED OPERATIONS FOR PROVINCIAL PLAN INPATIENTS*

(Including out-of-province hospitalization)
January 1 - December 31, 1972

ICDA Code	Operation	Number of Procedures	Number of Days	Average Days of Stay
A2.3	Biopsy of breast	120	533	4.4
A4.6	Cystoscopy and urethroscopy without effect upon tissue or lesion	1,339	11,009	8.2
03.0	Laminectomy	105	2,909	27.7
14.5	Extraction of lens, intracapsular	1,037	9,775	9.4
17.0	Myringotomy	284	852	3.0
17.6	Tympanoplasty, Type I (myringoplasty)	181	1,266	7.0
17.7	Other types of tympanoplasty (Types II, III, IV, and V)	36	269	7.5
19.1	Section of nasal septum	776	2,855	3.7
21.1	Tonsillectomy without adenoidectomy	1,402	3,938	2.8
21.2	Tonsillectomy with adenoidectomy	4,564	10,811	2.4
21.3	Adenoidectomy without tonsillectomy	284	734	2.6
22.1	Thyroidectomy, partial or subtotal	247	2,569	10.4
22.2	Thyroidectomy, complete or total	36	424	11.8
24.4	Excision and ligation of varicose veins	718	5,887	8.2
25.0	Incision of lymphatic structure	15	131	8.7
25.1	Simple excision of lymph nodes and lymph cysts	107	1,249	11.7
25.2	Radical excision of lymphatic structure	27	452	16.7
38.0	Repair of diaphragm and diaphragmatic hernia, abdominal approach	92	1,624	17.7
38.1	Repair of diaphragm and diaphragmatic hernia, thoracic approach	10	275	27.5
38.2	Repair of inguinal hernia except recurrent	1,820	14,138	7.8
38.4	Repair of femoral hernia except recurrent	76	751	9.9
38.6	Repair of ventral or incisional hernia	353	4,746	13.4
38.8	Repair of umbilical hernia	271	2,307	8.5
41.1	Appendectomy	2,606	19,403	7.4
43.5	Cholecystectomy	3,682	50,464	13.7
46.1	Pyloroplasty and other drainage procedures	468	7,893	16.9
46.2	Gastric resection, partial or subtotal	361	8,052	22.3
46.8	Vagotomy	5	88	17.6
47.5	Resection of colon, partial or subtotal	310	8,840	28.5
47.8	Colostomy	103	3,089	30.0
50.3	Proctectomy	93	3,260	35.1
51.3	Hemorrhoidectomy	863	7,719	8.9
56.1	Local excision and destruction of lesion of bladder, transurethral approach	303	5,066	16.7
57.5	Dilation of urethra	842	5,499	6.5
58.1	Prostatectomy, suprapubic	87	2,403	27.6
58.2	Prostatectomy, transurethral	1,233	28,113	22.8

Appendix C-10—(Continued)

PROCEDURES, DAYS, AND AVERAGE DAYS OF STAY
FOR SIXTY-FOUR SELECTED OPERATIONS FOR PROVINCIAL PLAN INPATIENTS*
(Including out-of-province hospitalization)
January 1 - December 31, 1972

ICDA Code	Operation	Number of Procedures	Number of Days	Average Days of Stay
58.3	Prostatectomy, other	171	4,879	28.5
60.1	Vasectomy	128	211	1.6
60.2	Ligation of vas deferens	....	....	....
61.2	Circumcision	456	1,752	3.8
65.0	Mastotomy	29	201	6.9
65.2	Mastectomy, partial	984	4,442	4.5
65.3	Mastectomy, complete	63	1,038	16.5
68.5	Ligation and division of fallopian tubes, bilateral	2,324	14,675	6.3
69.1	Abdominal hysterectomy, partial or subtotal	11	142	12.9
69.2	Abdominal hysterectomy, complete or total	2,146	25,991	12.1
69.4	Vaginal hysterectomy, total and subtotal	703	8,999	12.8
70.3	Dilation and curettage of uterus	4,173	11,274	2.7
70.7	Uterine suspension	88	700	8.0
71.3	Colporrhaphy	59	524	8.9
71.4	Plastic repair of cystocele and/or rectocele	751	8,727	11.6
71.6	Dilation of vagina	148	818	5.5
74.7	Dilation and curettage to terminate pregnancy	458	1,353	3.0
74.8	Intra-amniotic injection to terminate pregnancy	134	453	3.4
74.9	Other antepartum procedures to terminate pregnancy	79	216	2.7
77.1	Cesarean section, low cervical	832	9,212	11.1
78.1	Dilation and curettage after delivery or abortion	1,649	4,984	3.0
81.5	Internal fixation device without fracture reduction	186	6,185	33.3
81.6	Traction and external fixation device without manipulation for reduction	745	7,392	9.9
83.3	Closed reduction of wrist fracture	533	1,905	3.6
84.4	Closed reduction of other bone site fracture	730	4,642	6.4
86.4	Excision of intervertebral cartilage (prolapsed disk)	382	6,107	16.0
86.5	Excision of semilunar cartilage of knee joint	404	3,992	9.9
99.3	Extraction of tooth, forceps extraction	1,833	5,985	3.3
	SUB-TOTAL	45,055	366,192	8.1
	ALL OTHERS	28,072	316,157	11.3
	TOTAL SURGICAL PROCEDURES	73,127**	682,349**	9.3

* Excluding newborn.

** Excludes codes R1.0 - R1.9 radiotherapy and related therapies, R4.0 - R4.9 physical medicine and rehabilitation and R9.0 - R9.9 other non surgical procedures for 1,797 separations and 16,089 days.

TABLE A8

Number of Admissions (Adults and Children) to Listed Hospitals Reporting, and Rates per 1,000 Population(1) Canada and Provinces, 1961, 1966-1970

TABLEAU A8

Nombre d'admissions (adultes et enfants) dans les hôpitaux énumérés aux Accords et faisant rapport, et taux par 1,000 habitants(1) Canada et les provinces, 1961, 1966-1970

Province	Admissions						Rate of Admissions par 1,000 Population – Admissions par 1,000 habitants						Province
	1961	1966	1967	1968	1969	1970	1961	1966	1967	1968	1969	1970	
Newfoundland	50,915	65,427	69,900	74,954	78,009	78,971	111.2	132.6	140.1	148.1	151.8	152.7	Terre-Neuve
Prince Edward Island	16,225	18,136	18,526	18,992	19,561	21,445	155.1	167.1	170.0	172.7	176.2	195.0	Île du Prince-Édouard
Nova Scotia	109,270	117,939	117,575	119,880	125,260	131,490	148.3	156.0	154.7	156.3	161.6	168.1	Nouvelle-Écosse
New Brunswick	104,333	107,297	107,038	112,141	112,513	115,652	174.5	174.0	172.6	179.4	179.2	184.5	Nouveau-Brunswick
Quebec	725,535	792,920	785,754	807,054	777,775	769,663	138.0	137.2	134.0	136.1	130.0	128.0	Québec
Ontario	949,771	1,064,236	1,086,705	1,131,476	1,185,850	1,269,985	152.3	152.9	152.5	155.8	160.6	168.2	Ontario
Manitoba	165,555	174,979	173,565	179,227	181,425	184,636	179.6	181.7	180.2	184.6	185.5	187.8	Manitoba
Saskatchewan	199,448	211,495	206,243	204,712	206,611	214,712	215.6	221.4	215.5	213.2	215.7	228.2	Saskatchewan
Alberta	261,617	292,758	307,550	321,732	329,970	353,132	196.4	200.1	206.4	211.1	211.7	221.4	Alberta
British Columbia	285,835	329,311	338,609	352,172	364,455	381,762	175.5	175.8	174.1	175.8	176.9	179.4	Colombie-Britannique
Yukon	3,491	2,963	2,900	2,956	3,429	3,886	238.7	206.0	193.3	197.1	214.3	228.6	Yukon
Northwest Territories	4,554	7,072	7,457	7,490	7,593	8,184	198.0	246.1	257.1	249.7	244.9	248.0	Territoires du Nord-Ouest
CANADA	2,876,549	3,184,533	3,221,822	3,332,786	3,392,451	3,533,518	157.7	159.1	158.1	161.0	161.5	165.9	CANADA

(1) Based on the Census of Canada in 1961 and 1966 and revised population estimates of Statistics Canada as of June 1st in other years.

(1) À partir des recensements du Canada, 1961 et 1966, et des estimations démographiques revisées, Statistique Canada, au 1er juin, pour les années intermédiaires.

TABLE 9

Approximate Sources of Increase in Budget Review Hospital Expenditure For The Period 1961 to 1970

Source	Annual Average Percentage Increase of Expenditure by Source	Percentage of Total Increase
1. Population growth	1.79	12.85
2. Increased number of patient days per capita	1.48	10.66
3. Increase in hospital salaries and wages per paid hour of work	6.25	44.88
4. Increase in paid hours of work per patient day	1.67	11.97
5. Increased cost and/or volume per patient day of:		
(a) Medical and surgical supplies	0.30	2.17
(b) Drugs	0.22	1.60
(c) Food	0.13	0.90
(d) Other non-labour items	2.09	14.97
TOTAL	13.93	100.00

TABLE A19

Operating Expenditures Per Patient Day (Adults and Children) of Budget Review Hospitals Reporting(1), Canada and Provinces, 1961, 1966-1970

TABLEAU A19

Dépenses d'exploitation des hôpitaux à examen du budget faisant rapport(1), par jour d'hospitalisation (adultes et enfants) Canada et les provinces, 1961, 1966-1970

Province	Operating Expenditures per Patient Day — Dépenses d'exploitation par jour d'hospitalisation						Province
	1961	1966	1967	1968	1969	1970	
	$	$	$	$	$	$	
Newfoundland	20.00	32.10	38.75	44.90	48.64	52.15	Terre-Neuve
Prince Edward Island	19.04	26.61	29.43	31.62	35.31	39.12	Île du Prince-Édouard
Nova Scotia	23.66	34.01	41.15	45.20	50.57	55.37	Nouvelle-Écosse
New Brunswick	23.72	32.31	36.02	39.64	43.37	44.82	Nouveau-Brunswick
Quebec	22.63	44.00	47.46	50.05	57.99	(1)65.94	Québec
Ontario	24.26	35.63	40.69	47.15	52.36	58.29	Ontario
Manitoba	21.94	31.34	35.55	39.89	43.80	49.58	Manitoba
Saskatchewan	21.18	30.60	33.99	38.07	42.23	(2)44.26	Saskatchewan
Alberta	20.42	30.04	33.93	37.47	41.36	(3)44.54	Alberta
British Columbia	23.85	31.80	35.88	40.95	45.69	50.38	Colombie-Britannique
Yukon	29.43	52.87	70.74	89.87	87.96	97.30	Yukon
Northwest Territories	34.45	33.84	38.08	41.15	54.93	62.90	Territoires du Nord-Ouest
Canada	23.01	36.18	40.54	45.18	50.67	56.27	Canada

(1) One hospital deleted during year, provided information for part of year coverage.
(2) Six hospitals did not provide financial data.
(3) One hospital deleted during year, provided information for part of year coverage.

(1) Un hôpital, rayé des Accords durant l'année, a quand même fourni les renseignements pour la période couverte par l'assurance-hospitalisation.
(2) Six hôpitaux n'ont pas fourni les données financières.
(3) Un hôpital, rayé des Accords durant l'année, a quand même fourni les renseignements pour la période couverte par l'assurance-hospitalisation.

TABLE "A". PROVINCIAL MEDICAL CARE INSURANCE PLANS (As of March 31, 1973)

NOTE: (1) All plans provide insured services of federal program (i.e. medically required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospital).

(2) The premiums given in the table are those for persons who do not qualify for premium assistance on account of limited income. The provisions for assistance vary from province to province.

Province	Date of Entry	Extra Benefits (b)	Public Authority Responsible for Plan	Regular premiums payable by those who do not qualify for a subsidy, per month, and other charges ($)		
				Category	Regular Premium	Other Charges
British Columbia	July 1, 1968	Optometry, chiropractic, naturopathy, physiotherapy, podiatry, orthoptic treatment and services of Red Cross nurses, special nurses and V.O.N.	Medical Services Commission, Parliament Buildings, Victoria, B.C. (Insurance contract may be obtained from British Columbia Medical Plan, 1410 Government Street, Victoria, B.C. or approved carriers.) (c).	Single Couple Family	$ 5.00 $10.00 $12.50	– – –
Alberta	July 1, 1969	Dental services rendered by dental surgeons as specified in regulations, optometric, chiropractic, podiatric and osteopathic services, and appliances provided by podiatrists. (An optional health services contract is available through the Commission at subsidized rates to residents who are not members of a group.)	Alberta Health Care Insurance Commission, P.O. Box 1360, Edmonton, Alberta. T5J 2N3	Single Couple Family	$ 5.75(d) $11.50(d) $11.50(d)	– – –
Saskatchewan	July 1, 1968	Optometry, referred orthodontic service provided by a dentist for care of cleft palate, chiropractic.	Saskatchewan Medical Care Insurance Commission, Provincial Health Building, 3211 Albert Street, Regina, Saskatchewan, S4S 0A8	Single Couple Family	$ 1.00(e) $ 2.00(e) $ 2.00(e)	– – –
Manitoba(a)	April 1, 1969	Optometry, chiropractic. Prosthetic devices and services and certain limb and spinal orthotic devices when prescribed by an M.D.	Manitoba Health Services Commission, 599 Empress Street, Winnipeg 10, Manitoba	Single Couple Family	$ .55 $ 1.10 $ 1.10	–
Ontario	Oct. 1, 1969	Optometry, chiropractic, podiatry, osteopathy.	Ontario Health Insurance Plan, 2195 Yonge Street, Toronto 295 Ontario. (Insurance contract may be obtained from the Plan at that address or from district offices.)	Single Couple Family	$11.00(f) $22.00(f) $22.00(f)	– – –
Quebec	Nov. 1, 1970	Optometry; oral surgery in a university institution. Drug benefit (social assistance recipients.)	Quebec Health Insurance Board, P.O. Box 6600, Quebec 2, P.Q.	All Eligible Residents	–	0.8% of earnings with ceiling of $200.00 /year(g).
New Brunswick	Jan. 1, 1971		Department of Health, Box 5100, Fredericton, N.B.	All Eligible Residents	– –	–
Nova Scotia	April 1, 1969		Medical Care Insurance Commission Lord Nelson Building, P.O. Box 500, Halifax, Nova Scotia	All Eligible Residents	–	–
Prince Edward Island	Dec. 1, 1970		Health Services Commission, P.O. Box 4500, Charlottetown, P.E.I.	All Eligible Residents	–	–
Newfoundland	April 1, 1969		Newfoundland Medical Care Insurance Commission, Elizabeth Towers, Elizabeth Avenue, St. John's, Newfoundland	All Eligible Residents	–	–
Yukon Territory (a)	April 1, 1972		Yukon Health Care Insurance Plan, P.O. Box 2703 Whitehorse, Yukon.	Single Couple Family	$ 6.50 $12.50 $14.50	– – –
Northwest Territories	April 1, 1971		N.W.T. Health Care Plan, Yellowknife, N.W.T., X0E 1H0	All Eligible Residents	–	–

(a) Coverage depends on residency status rather than on payment of premiums.

(b) These benefits are provided generally on a limited basis. For specific details, information may be obtained from provincial authority; the federal government is not contributing towards the costs of these extra benefits.

(c) Approved carriers limited to group coverage.

(d) Premium exemption for basic (and for optional) coverage if member of a premium unit is 65 years or more.

(e) Premium exemption for resident 65 years or more.

(f) Rates are for combined medical care and hospital insurance coverage. Premium exemption if member of premium unit is 65 years or more and resided for at least the previous 12 months in province.

(g) Single persons with net incomes under $2,500 and families under $5,000 are exempted.

TABLE "B"
TABLEAU "B"

ACTUAL VERSUS ESTIMATED ENROLLMENT AND PER CAPITA COST
CHIFFRES RÉELS ET ESTIMATIFS DU NOMBRE D'ASSURES ET COÛT PAR HABITANT
1972-73

Province	Actual No. of Insured Persons (b) Nombre réel d'assurés (b)	Actual per Capita Cost Coût réel par habitant
Newfoundland – Terre-Neuve	534,000	31.99
Prince Edward Island – Île-du-Prince-Édouard	113,000	40.67
Nova Scotia – Nouvelle-Écosse	783,000	46.21
New Brunswick – Nouveau-Brunswick	640,000	37.60
Quebec	6,043,000	55.98
Ontario	7,827,165	67.90
Manitoba	1,014,846	46.48 (c)
Saskatchewan	917,500	47.32
Alberta	1,685,000	55.19
British Columbia – Colombie-Britannique	2,256,000	63.28
Yukon	19,000	38.55
Northwest Territories Territoires du Nord-Ouest	37,000	43.76
Canada	21,869,511	58.55 (c)

b) Used for calculating actual cost to provinces.

c) Costs of laboratory services in the province of Manitoba were transferred from this program to the Hospital Insurance Program retroactively to 1971-72. The total amount transferred, $9,103,251, reduced Manitoba's per capita cost from $55.45 and the national per capita cost from $58.97.

b) Utilisé pour le calcul du coût réel supporté par les provinces.

c) Les coûts des services de laboratoire rendus dans la province du Manitoba ont été transférés de ce programme au programme d'assurance-hospitalisation, à compter rétroactivement de 1971-72. La somme totale transférée, $9,103,251, a réduit le coût per capita du Manitoba de $55.45 et le coût national per capita de $58.97.

TABLE C6: INDICES OF MEDIAN NET PROFESSIONAL EARNINGS OF ACTIVE FEE PRACTICE PHYSICIANS, CANADA, BY SPECIALTY, 1966 TO 1971

(ALL PHYSICIANS = 100.00)

Specialty	1966	1967	1968	1969	1970	1971
General Practice	88.60	88.21	87.59	86.61	90.20	89.37
All Specialties	114.70	115.75	116.97	117.06	110.77	112.82
Paediatrics	93.36	91.24	92.60	93.61	92.94	98.54
Internal Medicine	94.88	95.37	98.04	94.75	92.61	94.67
Psychiatry	92.46	92.41	97.02	95.02	87.76	87.14
Dermatology	109.27	117.31	107.90	108.10	115.33	111.75
Anaesthesia	112.91	112.60	112.11	117.92	104.45	105.87
Cardiovascular & Thoracic Surgery	117.97	112.71	140.93	148.97	110.92	122.25
General Surgery	121.08	121.75	120.45	120.79	112.38	115.37
Orthopaedic Surgery	164.39	159.33	152.81	149.88	142.90	139.95
Plastic Surgery	129.36	139.27	141.30	146.10	145.10	134.04
Neurosurgery	144.06	154.97	141.91	146.68	131.15	138.50
Obstetrics/Gynaecology	116.99	118.14	120.06	120.69	124.13	133.72
Urology	135.72	144.91	149.56	141.33	132.54	125.58
Ophthalmology	141.64	141.56	148.38	143.43	130.10	129.24
Otolaryngology	143.16	143.30	146.19	146.79	130.22	137.78
Ophthalmology/Otolaryngology	109.45	101.78	98.18	100.08	94.31	107.41
Radiology	147.73	139.23	153.64	151.24	132.01	129.11
Pathology	112.89	102.80	112.72	111.73	97.89	110.04
Neurology(1)	n.a.	n.a.	n.a.	n.a.	97.66	100.85
Allergy(1)	n.a.	n.a.	n.a.	n.a.	121.38	122.51
Physical Medicine(1)	n.a.	n.a.	n.a.	n.a.	86.50	96.05
All Physicians	100.00	100.00	100.00	100.00	100.00	100.00

(1) Included in Internal Medicine until 1970.

SOURCE: Unpublished data compiled by the Health Insurance Directorate of Health and Welfare, Canada, from Department of National Revenue Statistics.

ESTIMATED NATIONAL HEALTH EXPENDITURES BY BROAD CATEGORY
1970
CANADA AND THE UNITED STATES

	Total Expenditures (in millions of dollars)		Expenditures As A Percentage of G.N.P.		Expenditures As A Percentage of Personal Income		Estimated Per Capita National Health Expenditures (in dollars)	
	CANADA	U.S.A.	CANADA	U.S.A.	CANADA	U.S.A.	CANADA	U.S.A.
Institutional Care (includes hospital & nursing home care)	2,989	30,667	3.5	3.1	4.5	3.8	140.19	150.47
Professional Services (includes physicians, dental & other professional services)	1,398	20,179	1.6	2.1	2.1	2.5	65.57	99.01
Drugs & Appliances (includes prescribed and non-prescribed drugs, eyeglasses, hearing aids, etc.)	753	9,163	0.9	0.9	1.1	1.1	35.31	44.96
TOTAL PERSONAL HEALTH SERVICES	5,140	60,009	6.0	6.2	7.7	7.5	241.07	294.44
Other Health Services (includes prepayment & administration public health, Voluntary organizations, research, & medical facility construction)	632	11,564	0.7	1.2	1.0	1.4	29.67	56.74
TOTAL	5,773	71,573	6.8	7.3	8.7	8.9	270.74	351.18

TABLE 3. EXPENDITURE ON PERSONAL HEALTH CARE, CANADA, 1960 - 1971

EXPENDITURE PER PERSON

YEAR	HOSPITAL SERVICES GENERAL AND ALLIED SPECIAL	MENTAL	TUBERCULOSIS	GOVERNMENT OF CANADA	ALL HOSPITALS	PHYSICIANS' SERVICES	DENTISTS' SERVICES	PRESCRIBED DRUGS	TOTAL
1960	35.77	6.80	1.60	3.01	47.18	19.82	6.12	7.40	80.53
1961	39.52	7.38	1.54	3.50	51.94	21.25	6.39	7.43	87.02
1962	43.61	7.76	1.48	3.78	56.63	21.82	6.53	7.76	92.74
1963	47.97	8.60	1.49	3.89	61.95	23.91	7.22	8.53	101.61
1964	52.53	9.42	1.36	3.97	67.28	25.65	7.65	9.24	109.82
1965	58.16	10.75	1.32	4.05	74.29	27.70	8.13	10.75	120.87
1966	65.79	12.06	1.29	4.09	83.24	30.19	8.80	11.57	133.80
1967	74.61	13.91	1.28	4.08	93.88	33.62	9.17	13.01	149.67
1968	86.35	15.16	1.31	4.20	107.02	38.02	10.31	14.34	169.69
1969	96.29	17.23	1.24	4.19	118.95	42.87	11.40	15.15	188.36
1970	107.96	19.11	1.11	4.32	132.51	48.24	12.29	16.90	209.94
1971	120.15	20.25	0.81	4.76	145.96	57.24	13.84	19.56	236.61

The Medical, Social, and Political Problems of Long Range Planning in Health—The Canadian Projections

H. L. LAFRAMBOISE

CHAIRMAN ANDERSON: As you can see in trying to design this program, I tried to have something for everybody. I also have the past, the present and the future. Those of you who have found the past intolerable and the current scene hardly bearable, we have a futurologist with us.

I am glad to present H. L. Laframboise, Assistant Deputy Minister, Long-Range Health Planning, Department of National Health and Welfare.

MR. H. L. LAFRAMBOISE: I want to thank Odin first of all for asking me to come down to speak and secondly, I would like to say that the subject of Canada's experience with health insurance and health care delivery services is one which is being well covered both by the speakers we have already heard and those that we will be hearing tomorrow morning.

What I am going to try to do today, instead of giving you one more angle in respect to universal health insurance and Canada's experience, is to stretch the subject out to the whole field of health, not simply health care. In talking to you about the long-range health planning we are doing, and I am talking about the whole health field, not simply the health care delivery system, I will speak of the things which might be of interest to you as hospital administrators and people involved in health care delivery.

When I accepted Odin's invitation to come, I didn't know whether today would be a "pre-working paper day" or a "post-working paper" day because I didn't know the day in which our Government would issue its comprehensive Working Paper on Health, that is its long-range view of health problems in Canada. If it hadn't been issued, I would have had to have been a little careful in what I said, but on Wednesday afternoon, this week, my Minister tabled in the House of Commons of Canada a document called "A New Perspective on the Health of Canadians". It is the document that the Long Range Health Planning Branch has been working on for the past seven or eight months. Since it is public, everything that is in it, all the ideas and all the angles that led up to its preparation can be exposed.

So I will give you a general outline of long-range health planning from the federal point of view, and will try to relate it to the particular interests that you have.

You will find at the same time, that many of the things I talk about are outside the health care field because health—the level of health, the status of health, the factors influencing the health of Canadians and Americans—is far vaster than anything that can be corrected or pursued solely through the provision of personal health care.

Before my branch was established, and it is only three years old, the federal approach to health planning started from a jurisdictional point of view. That is, the federal government would say: "What are our constitutional powers and our constitutional responsibilities?"

And having determined these, "What kind of programs can we develop?"

This jurisdictional approach seems very logical on first glance, but it had a very limiting effect on the horizons of what the federal government could do. By approaching health problems from a jurisdictional point of view, we have seen developed food and drug laws, which are federal, narcotics control laws, laws respecting hazardous substances, health services to the Indians, Northern Health Services for the Northwest Territories, quarantine medicine, emergency health, particularly in respect to the atomic threat of several years ago, veterans treatment services, immigration medicine and so on, and this has tended to be the range within which federal health planning took place.

The second approach, in addition to the jurisdictional one, is the one we all know called the "reactive approach", so that when some pressing public need arises, the elected representatives react to it.

This can be said to be true in respect somewhat of universal medical and hospital insurance, but it is particularly true in the problems that have arisen for drug abuse which had all our teeth on edge three or four years ago and which has not managed to work itself into the limbo of our immediate consciousness.

The reaction to the thalidomide crisis in Canada and the number of controls that we have put on new drug submissions is again a reactive approach. We are always reacting as well to things which get a lot of press but which are sometimes of very little significance in the over-all picture of health.

If there is an outbreak of Salmonella in black pepper as there was last week, we get all worked up working weekends on recalling all the black pepper manufactured by a particular company, but the net importance of such incidents is usually blown up by the press out of all proportion.

Single incidents such as these create a great press, but in fact, the policies and the activities and the protection regulations that we set sometimes are reacting to these crises and really are not as important as a lot of other things that are going on unresolved but do not get much publicity.

As a result of limiting itself to jurisdictional and reactive approaches to long-range planning, the federal government has played a relatively minor role in many areas of health. This can be understood, in retrospect, because direct health care to the general public is a provincial responsibility which is jealously guarded by the provinces. As a consequence no major federal thrusts have been launched in such areas as mental health, or on such specific diseases as cancer and coronary artery disease. Divided federal-provincial authority over the environment has severely limited federal initiatives, and the same situation obtains in respect of accident prevention programs and the care of the aged.

Finally, when it comes to data management, we all know that if we could meld on a national basis, with a standard methodology, those data that are lying there in our data banks, our Medicare data banks, that we could learn a great deal about the health status of Canadians, at least those who come in contact with the health care system; we could also learn a great deal about the utilization. We would learn about ages and sexes in relation to specific procedures used and diseases and so on. Much as we would like it, we still federally have not brought together this kind of a thing or subsidized, as you have in the United States, the data collection facilities at the state level such that we have a standard system of integrating these data.

So what I have said in effect is that the jurisdictional and reactive approach has led the federal government in the past to disregard large areas on the simple and understandable basis that they didn't fall within its responsibilities.

Now what has been done in the last three years, and it has been done gradually, is to change this approach to long-range planning to an entirely different view.

We have started by determining what Canada's health problems are. We don't care about jurisdiction. We say, "What are the problems?"—the problems having to do with the health status, whether it be morbidity or mortality, problems having to do with cost, accessibility, quality and so on. What are the problems in this country that are really significant and worth looking at?

It has not been done in as orderly a fashion as I am perhaps giving you the impression. It is a little more disjointed, but basically, this is what we have done. We have attempted to rank these problems as to their gravity, and I am speaking particularly of problems of mortality or morbidity.

We have also identified problem areas to which a great deal of attention is now being given. For example, there is no point in long-range planning heading into the problems of delivery health care in Canada because of the amount of attention that this problem is already getting from so many other people.

We have had in Canada in the last few years, the Royal Commission Report by Justice Hall, and the Castonguay Report in Quebec. We have had a report of the Council of the Healing Arts in Ontario. We have had a White Paper from Manitoba. We have had the Task Force Report on Health Costs, nationally. We have had the Foulkes Report in British Columbia and the one that Stan Martin mentioned today prepared under Dean Mustard from McMaster University. So the whole business of how you organize and deliver health care is getting so much attention by so many people because of the costs that are involved, that although we recognize this problem, we do not put our long-

range planning resources on it because we would simply be falling over one another's feet in a field which is crowded with a herd of buffaloes right now, figuratively speaking.

When we look at the problems, however, we are interested in knowing what their underlying causes are. It is by looking at the underlying causes of problems that you can develop some plans so that these causes can be moderated. You can identify the ones that are "attackable", if you want to use that word. You can identify the ones where the benefits and costs are favourable, and you can identify the ones in which there is a sufficient sharing of interest by other people in the decision making process, and by this I mean provincial or municipal governments, professions and so on, that you can reasonably expect to get a consensus on a program being put under way.

Having again identified the underlying causes of these problems, we are interested in knowing what can be done to abate the problems. What are the tools that we have available? What are the avenues and the corridors that are open to us? And only after all this analysis has been done, "What can the federal government do?"

This particular approach of leaving the federal role to the end of the analytical process instead of defining it at the beginning has resulted in us finding all kinds of things which the federal government can do to help abate these problems and their underlying causes which were nowhere evident had we started with the narrow jurisdictional approach.

We learned, for instance, that in federal planning we have to set out to influence the whole system.

In other words, it is not simply a new regulation under the Food and Drug Law or some new activity in respect to the problems of alcohol abuse among the Indians or something. There are out in the health field not only those people in health care delivery. There are physical educators. There are teachers. There are voluntary associations. There are citizen's groups. There are media people, people who are interested in programming for television and so on, in areas of public concern in health.

There is a whole system that is involved in health that affects health directly such as the food processing industry, and we have to get at the whole system and not simply try to function on a simple federal regulatory basis.

Finally, we came to the conclusion that the information we develop and the ideas that we bring forward have to be presented in a fashion that is sufficiently dramatic that the information will influence some one, whether it be one of the partisan groups in health or the Minister, the Deputy Minister or the provincial government or the public or something, because planning information or the identification of underlying causes and courses of action never materialize into programs unless the information itself and the gravity of the problem are well understood by the people concerned.

The people must identify themselves with a need to do something for the problem and, in fact, must be taken to the point where they decide that activity is necessary. This requires the presentation of information in simple language, and, if at all possible, the use of simple graphics in order to communicate.

One of the things I didn't know but which I found out in the course of looking at what the federal government can do is to find that under the Canadian Constitution, there is a federal power called the "spending power."

This sounds sarcastic, about the amount of money that the federal government spends, but it is not. The federal government under the Constitution is allowed to give money to any person, organization or otherwise in an area of provincial jurisdiction as long as it does not constitute a regulatory activity.

This permits us to provide the 50 percent that we provide under medical and hospital insurance. It permits us to do the research funding through the Medical Research Council directly to universities for medical research. It permits us to grant money to associations, recreation and sports associations, to finance the cost of our Olympic Team and our International Teams, and in fact, this spending power is a corridor so wide that given the availability of funds and subject to the condition that we are not making regulations in a field of provincial jurisdiction we could launch programs in our country in areas of health promotion, research, experimental and clinical trials, almost without end as long as we didn't pass laws or require regulations in areas which were not our own authority. So the corridor is very, very large, and it is a corridor that not very many people in the federal government were aware of at the time that we started doing studies.

I am going to get on now to some of our findings. When we looked at health, we were very much influenced by Professor Thomas McKeown who is Professor of Social Medicine

at the University of Birmingham in England, and who, as an historian in the status of the health of people, studied England and Wales. The factors affecting health in England and Wales were analysed as far back as data were reasonably reliable, back to about 1800, and his conclusion is quite simple that the changes in the level of health of the British and Welsh people were, first of all, due to a limitation of family size, a reduction in the average number of children born to a woman during her child-bearing years.

The second most important factor he found to be the increase in food supplies. There has been a general increase in the amount of food available per head of population so that the problems of deficient or insufficient nutrition had largely been overcome.

The third most important factor he found to be a healthier physicial environment, the changes in the conditions of work and the hours of work, the ages at which people went down into the mines and worked in the cotton mills, the factors of sewage disposal and potable water and so on.

The fourth most important factor affecting health was specific preventive and therapeutic medicine.

This was a revelation certainly to me as a layman coming in the health field who has always put medicine and health care first, as the most important factors affecting health.

McKeown's review of history tells us that this is not so, and furthermore, he makes the statement that these environmental and lifestyle factors are still the ones to which we have to look if we want to make significant improvements in the level of health of Canadians.

By "level of health," I am going to use a simple definition, just as increase in the number of disability-free days in the lives of an average person.

McKeown puts the case so strongly that maybe he is overstating it to make his point. He says that if a heavy smoker who has no congenital abnormalities and has sufficient income to meet the ordinary needs of food and shelter and so on were to give up smoking and give up physician services, he would probably do more for his health than if he kept both.

When we look at these figures, we looked first of all at the mortality. Mortality is a suspect figure as far as health status is concerned. People say "Well, you can't dwell too much on mortality. You have got to think of hospital morbidity, untreated morbidity and so on," but the mortality figures, limitations as they may have, gave us some very important information.

As you are well aware, Canada and the United States are very similar. There is a 7-year gap in the life expectancy of the average male at birth as compared to the average female. Females in Canada on the average have seven years longer life. This is growing. In 1931 it was only two years. It was 60 for men and 62 for women. Now it is 69 for men and 76 for women, and they are racing right out of sight.

That reminds me of—who is that crazy American poet? Ogden Nash. He wrote a poem called "Sexual Politics Farewell", and in it he says:

> We grew careless,
> We grew lazy and slumberous.
> Little did we reck
> That you were preparing to outnumber us.

Canadian figures that you could probably find paralleled in American statistics are: Two men die for every woman between the ages of 15 and 69. In 1971 there were 43,500 male deaths and 22,100 female deaths between the ages of 15 and 69, and it really does make you wonder.

The girls are preparing to outnumber us!

We found that just looking at gross mortality statistics gave so much weight to the deaths over age 70, if you take all the causes of death at all ages together, that the over-all statistics obscured those causes of death which were important in premature or early death, and we consider this to be death before 70. So we eliminated all causes of death over age 70 as an analytical assumption and focused on all the deaths between age one, eliminating congenital and neonatal deaths, and age 70, that is, between one and 70. We then calculated years of potential life lost according to the average age at death by cause, from people who died between the ages of one and 70.

So that if the average age at death in an automobile accident is 26, there are 44 years of potential life lost from each such death, and if the average age at death from coronary artery disease is 43, then there are 27 years of potential life lost. By using this as a measure for ranking the gravity of causes of death and making the assumption that people over the age of 70 have, in fact, made it in a way, that they have

lived a long life—and hopefully they will live to be 90—and worrying more about the people who die before their time, we found the causes of death in Canada ranked as follows:

Number One, automobile accidents caused more loss of potential years of life than any other single cause of death between one and 70.

Number Two is coronary artery disease.

Number Three is other accidents, including industrial, recreational and so on.

Number Four is respiratory disease including lung cancer.

Number Five is suicide.

Those are the major causes of premature death and the major causes of potential years of life lost in Canada for people between age one and 70.

When we looked at hospital morbidity, we could have done it in more than one way, but we looked at it by measuring days of hospitalization. We excluded days of hospitalization for normal deliveries, child birth, as not being a sickness, but being a normal, natural health service, and, having done this, we found the major cause of hospital days was coronary artery disease.

The second was all accidents and trauma, burns, violence, automobile accidents, home accidents and so on.

The third was respiratory disease including lung cancer.

So the pattern has changed a little from the mortality to the morbidity aspect, but the same package of accidents, respiratory disease, coronary artery disease comes out in the hospital days as comes out in mortality.

When we looked at the underlying causes of these, we found that the aggregation of individual decisions made by people as to their lifestyle, as to the things that, at least, in theory they can choose to do or not do, was very, very important. We found as well that unless we could do something to bring those risk factors down, then all the health care services in the world which were serving as a catchment net for these victims, whether they be coronary artery victims or automobile accident victims or long cancer victims—obviously the suicides succeeded in evading the health care system —that if we don't do anything to reduce these factors or at least interest ourselves in them, then we will be pouring, and we will be continuing to pour, an awful lot of money into sophisticated life-saving facilities and skills for diseases which, at least in theory, are very, very largely preventable.

Turning to traffic deaths, for example, we had 6221 in Canada last year which is a 15 percent increase in two years. Alcohol is involved in 50 percent of the accidents. It is not necessarily the governing factor in every case, because accidents are a combination of things, but we know that alcohol is important.

We also know that if 50 percent of the population properly wore seat belts, we would probably effect a 15 percent reduction in the number of deaths of automobile occupants and a similar number of hospital injuries. So when you look at these figures and you say to yourself these possibilities or these potentials are there for us if we can get mandatory seat belt legislation accepted and delivered in a way that the Canadian people will understand, there is a lot more that can be done by that than perhaps by adding to the sophistication of the life-saving facilities in a particular location and at very little cost to the taxpayer.

As a result of this, we came up with a Health Field Concept which I have written up in the "Canadian Medical Association Journal", and which is the basis for this working paper. I haven't got copies of it, but I have copies of a summary which are on the corner of the desk here should any one want it. The Health Field Concept as a result of analysing these factors breaks the health field down into four elements.

One is human biology having to do with all those health problems that come as a result of us being human beings, our genetic inheritance, aging, maturation, our body systems and so on.

Secondly, the health problems that result from the physical and social environment about which the individual can do little or nothing as an individual.

The third areas are the health problems that arise from lifestyle or self-imposed risk which are the health problems that arise from the things that individuals can, in fact, do something about; and the fourth element consisting of the health care organization which is the traditional health care delivery system of all the people and the facilities involved in delivering personal health care, both preventative and curative.

If you take these four elements of the health field and you start to analyse your health problems across the elements to determine what various contributing causes are coming from each area or looking at what can be done in each of these areas in order to modify in a positive way the health status of the people, you will

get quite a different view of the health field than if you simply deal with the health care organization, which is the area that you are interested in. You come to the conclusion that we are not exploiting the possibilities for improving the health of Canadians in the areas of human biology and lifestyle to the extent that we could by comparison with the amounts of money that we are pouring into the system that most of us have been discussing today.

This doesn't mean that the system needs to be neglected because the Canadian people wouldn't stand for it. They want better health care. They want more health care. They want more insured services, and the demand by the public for these services assures that the funds will be made available within the limits of not completely bankrupting the governmental treasuries. But for the other areas of prevention and research of health promotion, of recreation and fitness trails and all of the areas of physical education in schools, the public demand is not there with the same kind of urgency as the demand for health care, particularly for the sick.

Therefore, it is a responsibility of the government, if they analyse out these problems and ascertain their underlying causes, to themselves give attention to the opportunities in these other areas because the direct public pressure is simply not strong enough. So government has to accept its responsibility to act as a surrogate for the Canadian people in promoting programs in areas which may or may not have an extremely popular political appeal and for which there is no great sense of urgency.

The problem with preventive health measures is that you are asking people to sacrifice some self-indulgence as Odin said in one of his articles which helped get me on to this particular theme. People prefer the short-range hedonistic model, and they don't like to sacrifice an immediate pleasure for a long-term reward or to avoid a long-term punishment. It is a marketing problem.

How do you get people to buy life insurance? How do you get people to make out wills?

This is spending money for something which they can't see for a long time.

The same kind of challenge exists in getting people to modify their behavior (and you won't do it by preaching sermons) so that they will, in fact, be prepared to give up a small bit of immediate pleasure as a means of obtaining a long-term reward, or the possibility of a long-term reward, or the possibility of avoiding a long-term punishment.

Our thinking led us to the concept which you are all very familiar with which is a population at risk concept. Rather than dwelling on the individual episode of illness, we needed to identify high risk populations and to direct programs at reducing the risk in those high risk populations so that tens and hundreds of thousands of people would be affected by the programs rather than the individual episode of illness itself, and the population at risk approach means taking a population, and you can take a population in Canada, in respect of a certain health indicator, infant mortality or whatever it may be, the accident rate, coronary disease, by age, by sex, and determine what part of that population is the greatest adverse contributor to the statistic.

You might find in Canada that our infant mortality rate, the favourite toy of health status indicators, is 17.5 child deaths per thousand births, but in a wealthy Canadian suburb, it may be 11, and in the Indian northlands, in Manitoba and so on, it may be 40. So you don't come out with a national infant mortality reduction program. You select the high risk element or that element which is contributing the most adversely to that factor, and you aim a program at that high risk element.

Similarly, the drinking driver, the cigarette smoker, the person who lives a sedentary life, is 25 or 30 pounds overweight and 45 years old, has a high-pressure job, drinks a lot of coffee, and gets no exercise is a candidate for a coronary. He is a high risk person, and he is the person to whom you should direct your risk reduction programs and not just simply conduct a program across the whole Canadian population that is directed to everybody regardless of their risk state.

The population at risk concept is a treacherous one because you can get into some very subtle analysis. For instance, if you look at sickness and death among children five to fourteen, you will find that the rates are very low. In other words, they are theoretically one of the healthiest groups in our population, and you wouldn't consider them to be a population at risk, but if you peel one layer off the onion, you will recognize that the way those youngsters are being formed in the ages five to fourteen and even before five will be very important in whether they start smoking, whether they abuse alcohol, whether they will feel comfort-

able and have fun doing physical recreation and playing games, whether they will be or will not be promiscuous, whether they will be careful drivers, whether they will be rebellious against society and so on.

So this threshold age group of five to fourteen (or you can make it four to sixteen), in spite of the fact that sickness and death factors don't indicate them to be at high risk, becomes a very important population for directing programs that are going to shape their ideas and their attitudes and their lifestyle health habits, perhaps for the rest of their life.

So if you are going to use populations at risk analysis, you don't only deal with statistics, but you also deal with threshold populations which are exceedingly important.

This has led us into an area which is very contentious, and we always speak of it with great care and qualification, and it is an area called social marketing. Social marketing quite simply is to take the marketing practices of business that are used to modify people's buying behaviour in respect of goods and services and to see whether or not the same skills —analysing the market motivations of people, identifying needs and then providing services at a certain cost, either financial or in convenience—can get people to modify their behavior or their attitude.

Now we know it is not easy. Behaviour modification is not easy, but there are some successes that we can point to.

We take it for granted in North America, in both Canada and the United States, that as the deadline rolls around, we must complete our income tax form. We do this at great inconvenience because the forms are not easy to fill out. Quite often we will pay money to go to a tax consultant or a tax firm to have it done, and then we send it in with a check for the amount, if we happen to owe some money, and we take this for granted.

People in Italy who come over are amazed that the Canadians should be so submissive in respect to paying over money to governments, but we have been social marketed in this country in respect of the need to respect the income tax law.

I know that there is fiddling that goes on but in getting that form done and in on time, it is a marvel. It is an absolute marvel to an Italian tax collector who has to pursue people and seize their books and take them to court for ten years in order to get them to pay their income tax.

So we are socially marketed.

We had a campaign some years ago in Canada which you also had in the United States, a "Mail Early" campaign in order to get people to mail their post cards or Christmas cards to beat the log jam at Christmas, which was very successful. By December the 15th, there was no mail left.

Now, obviously, things have deteriorated, particularly with our sporadic strikes in Canada, to the point where it doesn't really matter whether you mail it or not, it is going to take a long time to get there. But it was good social marketing.

Campaigns for War Savings Bonds in the last war were excellent social marketing. Kate Smith was appealing directly over the radio to people to pick up a telephone, call a certain number and pledge themselves for bonds.

So there are areas where social marketing has taken place, but it is relatively rare in Canada.

We are financing federally a private corporation called Sports Participation, Canada, and we finance it to the extent of half a million dollars annually. It generates five million dollars a year in publicity, through the media of radio and television and others, aimed at getting people to be more active physically.

Your own President's Fitness Council (I was talking recently to one of its members) operates on an annual budget of $500,000.00 which is really very little money and generates 35 million dollars of activities in the course of a year. It gets a big piece of the public service time that the National Advertising Council provides.

You might say, "What effect has this got? You spend a lot of money", and so on. It is, of course, just one, and you don't want to generalize from a single case, but this year, when the program is finished, we will have 67 miles of bicycle paths within the City of Ottawa. We have 50 miles now, all within the city limits, on which there is no other traffic but bicycles. So in Ottawa there are literally hundreds of families on every nice day from the 15th of April through to October who are out bicycling especially on Saturdays and Sundays. There is an urge by people to get out and do something. If we can provide facilities easily available to them, they will, in fact, do it.

One of the marvels of Ottawa is that the Rideau Canal is converted into a 5-mile skating rink in the wintertime, and there are as many as 35,000 people out on a given day skating on this 5-mile rink, of all ages. So it is with the interest

of Canadians in weight control, and an interest in knowing the nutrients that they should be eating; all are elements which are positive in our society and which indicate that social marketing can build on trends and needs and motivations, many of which the Canadian people now have.

Many of the solutions to our problems do not lie with the Health Department. We find this more and more. It may lie elsewhere with the federal government, but not with us. It may lie in Indian Affairs. It may lie in the Department of Labour, the Department of Transport, the Department of Justice, the Department of Finance.

There are a multitude of agencies who have the power to act in matters affecting health, much greater in certain areas than the Health Department has.

As far as automobile accidents are concerned, the Departments of Highways and Transports and the laws that they are prepared to administer, and the law enforcement agencies are prepared to enforce, are much more important in reducing the deaths and injuries than anything that the health people can do in the provision of emergency services and ambulances.

What does all this mean for health administrators? It certainly doesn't mean that the federal government in its paper is just leaving or abandoning its interest in health care administration, in order to pursue all these routes. There is no way that can happen.

The federal government's contribution to the various health care plans you heard of this morning is of the order of 2.3 billion dollars a year, whereas its expenditures on the health side in all other activities only amount to about 150 million dollars. Thus we have a very large interest in that sum of money that we are spending in health care administration.

When we looked at the basic problems in health care administration, we have looked at these in a less comprehensive way than we have at some of the other problems, and we read all the reports and still continue to read the reports that are prepared by provinces in health care administration.

We came to the conclusion that mostly the problem was not in learning what we should do. We certainly have reached the point where we have sufficient knowledge to warrant action being taken in certain directions.

The problem is that we don't know how to go

about doing it, and one of the reasons is that we have an open system, and there is either a reluctance or an inability to put the system on a command and obedience basis. This is quite understandable because if we had health planners in, say, Stan Martin's department that would say "From here on in we will tell the doctors where to practice, and we will tell these people and those people", and so on, we could have corporate-type plans the same as General Motors or Ford have in bringing out cars like the Edsel. But we haven't got that.

So we have a system wherein an analogy is a team managing a chess board where the different types of pieces belong to different players. They all want to win, but no one wants to win at the expense of sacrificing those pieces that are his. So the guy who should move the bishop up to sacrifice says "I am not going to move my bishop up. I want to win, but you put your knight over there and sacrifice your knight."

Everybody wants to win this game and I think pretty well has an idea of how to go, but each person who holds a piece of the action wants the game won without him having made a sacrifice in the interest of winning the game.

We think, too, and not always with the agreement of our colleagues, that the physician is the key person in health care delivery not only in the provision of services, which is all well admitted, but also in the manner in which those services are being provided.

We feel that until we consciously recognize that the physicians should be organized in a way by which they have spokemen who can commit them and negotiate with them and commit their people to experimental arrangements, to participation in district health councils and so on, we are going to have—I won't say nothing but trouble—but more trouble than we would otherwise have.

As long as physicians are independent of direction by their own profession in the organizational and service arrangements that councils and regional boards are going to require, we are going to have difficulties, and we should do everything we can to pursue a system of building physicians into the organization in a formal way.

We have looked in Canada at the measures that are being taken with respect to establishing regional health authorities, and my branch has

prepared a report showing at least at the point in time we did it, which is about six or eight months ago, what each province in Canada was doing in the way of evolving a system for establishing either regional or district councils, and of the kinds of authorities they were giving or had given or intended to give to these councils, of the extent to which they were bringing together health and social services within the same organizational and geographical framework. So we have looked at the problem of regionalization in Canada, and I must tell you, if I can quote Mao-Tse-Tung, "It's a many flowers approach", and it proves to you that there is no one way that is so clearly superior to all others that this can be done; and secondly, that the attitudes and circumstances (and I don't mean political; I mean social values) vary a great deal in Canada from one province to another. What might be ideal in one place may be anathema in another place. But the purpose of a report like this is simply to provide a "state of the art" review for everybody as to what is going on so that each province can learn what the other is doing, and perhaps get some idea on what is and what isn't working.

We have in Canada, as Werner mentioned, a data resource which is perhaps unavailable in any other country. These are the data banks for all the medical care treatment that is provided.

The United States hasn't got it. You haven't got it as comprehensively as we have in Canada. Great Britain hasn't got it because they don't operate on a fee-for-service basis. But in Canada, every contact between a physician and a patient is going into a bank with a physician's name and the patient's name. The physician's specialty can be obtained, the age of the patient and the sex. Very often the diagnosis is given (even though the diagnosis is often very dicey as a means of measuring the illness) but the data are all going into our data banks.

If we could design a methodology for unlocking these data (we are already doing it, as Werner says, in some directions) but if we could do it in some other directions such as in measuring days of disability that can be extracted from the kinds of illnesses that patients are being treated for, we might be well on our way to measuring changes in health status and also well on our way to assessing the consumption of services according to age, sex, economic class and so on and so forth.

The area of community health services is very contentious in Canada. It is the most motherhood area you have ever heard of—we had a report by Dr. John Hastings a year ago, in which very few people could find things to disagree with, but certainly couldn't find in there what action needed to be taken in order to arrive at the promised land.

Community health centres are no panacea. There is no model. Everybody want a model. They want it simplified for them. They want to be able to say "Five physicians of this kind, two of these, one of those and so many square feet" and so on and so forth for such-and-such a population.

These things aren't there, and I must say that I commend Stan's government in Ontario for responding to the initiatives that are being taken at the local level so that they can help in the development of things which suit the people, with the professional advice of his branch, rather than sitting in Toronto and laying down a particular building and multiplying it fifty times over in different communities.

We are interested in the problem of chronic care and particularly the care of the aged because we know, as you do, that the proportion of the total population over age 65, or if you want to go down to 60, is going to increase by about 35 percent, from 8 to 11 percent of the total population in Canada based on present growth rates between now and year 2000, and if, as we know, that a person over age 65 requires something like three times as much in the way of health care services, as the average population, and if, as we hope, our program succeeds in reducing premature death it will increase the number of people who will survive to 65 and therefore generate greater costs. Taking all that together and taking together the importance of chronic diseases today as opposed to acute illnesses and parasitic infectious diseases, we are very concerned about attention being paid to the problems of the aged and the problems of long-term care; and we are also concerned with the insufficient value which the health care system and the physicians place on long-term care by comparison with the importance that they place on acute care and the great thrill they have when they cure somebody who is sick.

We don't attract nearly enough people to rehabilitation medicine, geriatrics, psychiatry and a whole flock of areas where we have to somehow get the system to appreciate that that kind of care is as important and rewarding as the cure which is the thing to which a physician is usually trained.

Now the Concept and all of these solutions in

the Working Paper result in five federal strategies. One is a health promotion strategy with a whole number of propositions aimed at influencing people, associations and so on, to be more active in matters concerning health.

There is a research strategy for what the federal government hopes to encourage in eight or nine different areas in order to improve our research facilitity, among which is learning more about the relationship between self-imposed risks and diseases, and also identifying high risk populations.

In addition to the health promotion and the research strategy, there is a regulatory strategy consisting of propositions by which we expect to use our power and encourage provinces to use their power to pass regulations which may have an important effect on the people of Canada.

There is a health care efficiency strategy which has 13 or 14 items to improve or to bring into the best possible balance the cost, the accessibility and the quality of medical care and personal health care; and finally, the fifth strategy is a goal-setting strategy whereby we hope to set goals either quantifiable or by date or both in respect to all of these four areas, so that where we can get agreement with provinces or other participants in the decision-making process, we will try to set goals as to what we expect to achieve in relation to particular areas.

These five strategies encompass 74 propositions, most of which are not in the federal domain. They are simply exhortations to all of the people in the health field to please let's get together with the federal government and see what you can do with our leadership and assistance in moving in certain directions.

They can be as simple as subsidizing people to be trained as counsellors in alcohol abuse for industry.

They can be encouragement for trade unions to establish physical fitness programs as part of the contracts they negotiate with their employers, but these 74 propositions in these five strategies are aimed at two simple goals.

One is to reduce the hazards in the population to mental and physical health, and the other is to improve the costs, the accessibility and the quality of personal health care.

Now the subject of my talk was "The Medical, Social and Political Problems of Long Range Planning in Health in Canada." I have answered to that, I think, in an indirect way. I think it is very plain that if you are going to move in this area, you have to have a sound framework from which to work. You have to have people who agree that this conceptual framework is a reasonable one, and you have to be able to work the invisible system.

This is an open system of influence, contact, pressure in which you have to do your homework, as far as using and analysing the information that is available. You have to apply your efforts to this total system rather than simply rely on one-shot, individual programs that are all wrapped up in a nice legislative way.

Thank you very much.

MEMBER: You stated that the demand for services assures that funds will be available. Yet Stanley Martin has explained that in the Ninteen Sixties health costs were more than warranted, and he described provincial actions to close dead capacity to discourage abusive demand.

Could you explain the formal mechanisms available for consumer influence in long-range health care planning in Canada?

MR. LAFRAMBOISE: You are talking about two things. When I say that the public demand for health care is an imperative, it is not something that you can play around with, I am simply saying that if political or government people ever withdrew or made less available in a substantial way the things that Canadians are now receiving, there would be hell to pay from a political point of view, and one of the reasons that we have permitted the cost, or we have had to accept the cost escalation of 12 to 14 to 16 percent over an extended period of five years is that we have shown the people a promised land, and there is simply no way that we can abate it.

Now not only do I hear few complaints from the Canadian citizens as individuals about the cost of health—I never hear them, I have never heard one in my life. I have never heard it from the people involved in the field.

Generally speaking, the hospital administrators and physicians don't complain about the cost. They are the complainees, not the complainers.

But where the complaints come from are from public servants and politicians who see the alternative ways of spending that money going up the chute because of the increases in health costs, and if they weren't going too fast, we would have five million dollars more for this and

ten million dollars more for this, and my experience has been that our political masters and our public servants are the prime ones who are concerned about the cost of health services.

I have tried to impress audiences with what it costs, $275.00 per head for a year in Canada for personal health care. It is $1100.00 for a family of four.

I have spoken to Kiwanis groups and so on and tried to shock them. I have never once had any one come up and say "Isn't this shocking?" They say "It is quite normal."

MEMBER: I think your long-range plans are admirable.

Have you any evidence to indicate that campaigns at the political or social level to get people to change their lifestyles to reduce hazardous behaviour will be successful?

MR. LAFRAMBOISE: On the whole scale of behaviour modifications, it is obvious that marketing campaigns aren't going to do much for heroin addiction, nor are they going to do much for cigarette smoking, not all that much, but a little bit of success. They are certainly not going to stop an alcoholic from abusing alcohol, but as you move down into the areas of ignorance and indifference, that is where the people are not doing things because they don't have enough information.

I hate to come back to the safety belt usage because we have had so many public education campaigns that have failed. The wearing is at 15 percent and we can get it up to 25 percent by intensive advertising and so on. Within six months it is right back down to 15 percent again, but I do perceive people interested in their weight, more people interested in their weight today that I did ten years ago. This may not be such in your particular circle, but I am talking about my own perception in Canada.

I do see more people interested in physical exercise. You have got the cycling craze. We know that it might be a fad. We have bicycle paths. We have people skating. We have swimmers. We have all kinds of things. People are building horse shoe pits. I don't say every second house, but they want to get out from behind the television set more often.

Do you have cross-country skiing? Do you have the cross-country skiing craze in the United States? There are golf clubs in Canada that are staying open in the winter now, when they used to be closed, because they have so many of their members out cross-country skiing. As if they don't suffer enough misery on that course in the summer, they want to do it all year!

PANEL DISCUSSION

Planning for Health

ODIN W. ANDERSON, *Moderator*

Panel Members:

SPEAKERS FROM PREVIOUS SESSIONS

EVELYN LAZARE, *National Administrator of the Canadian Red Cross, Blood Transfusion Service*

MURRAY BROWN, PH.D., *Associate Professor, Department of Preventive Medicine, Dalhousie University, Halifax, Nova Scotia*

CHAIRMAN ANDERSON: You have before you a cross section of the six healthiest Canadians that I could find. They are a product of the Canadian's Insurance System.

Since most of the people in the audience are in hospital administration, I want to start out with a question directed to the hospital. I probably should have had a person who administers a hospital in Canada, but I think maybe a person like Stanley Martin, and several others, who have had a great deal of experience and can speak to the issue might answer this question.

What is it like to be an administrator of a hospital in Canada?

MR. MARTIN: Two things, I think, have contributed to some change insofar as the role of the chief administrator officer of the hospital under the structure.

First of all, it is very important that when government enters the picture, there is the political route. The politicians are probably more prone to listen to the voice of the voluntary people, i.e. Board of Trustee members for example in the picture than the paid official. Consider now some of the actions that can take place between the individual hospital and the central agency. Obviously, in these cases pressures can center around the power base, center around the chairman of the hospital board agency.

The administrator, or the chief executive officer's position in most of our hospitals, I think, has been considerably strengthened when it comes to the kind of traditional no man's land that may exist between board, medical staff and the administrator.

The program of accreditation involves the fact that inspectors from the College can drop in at the hospitals at any time. They may want to review the charts to see whether or not the medical people are utilizing the facilities of the hospital in a proper manner. The force of these recommendations and so on are then left. They do eventually strengthen up the role of the administrator. The medical staff are much more responsive to the direction that may come from this spot. This has been our experience prior to the last five or six years. I had a simple axiom that there were three fixed places in the hospital—the board, the medical staff and the administrator. The one that was expendable was always the administrator. I think that the accreditation program has improved the role of the administrator considerably in areas of quality control and certainly standard of service for example.

CHAIRMAN ANDERSON: I want to introduce more formally the two new panel members. Evelyn Lazare is an MBA graduate from the University of Chicago. She is now The National Administrator of the Canadian Red Cross, Blood Transfusion Service. Murray Brown recently got a Ph.D. in Economics from the University of Chicago, was a research assistant for the Center for Health Administration Studies and did a dissertation with us on physicians' incomes in the United States.

He is now at the medical school of Dalhousie University in Halifax.

MEMBER: Stan, did I understand you correctly that the chairman of the board plays a role in this voluntary hospital in Canada? If

there is priority of funds and there is only a limited number of funds, let's say, in the province, the chairman of the board might be instrumental, or that board of that hospital, in having a say in the priority or getting their share of the priority?

MR. MARTIN: Certainly, the concept is that the prospective budget of that hospital that arrives at the ministry is not the administrator's budget, but it is the board's budget. Therefore, this puts the fair onus in regard to the further discussions, if differences develop, as between what the stated needs of the hospital are and the decisions of our ministry as to what they are going to get.

The fact remains that our people on a routine basis will be dealing with the chief executive officer. When the crunch comes, it is going to have to be the chairman of the board because it is their budget, not necessarily the administrator's budget.

MEMBER: If the administrator's hospital is located in the district of a very influential parliamentary leader or what not, is it conceivable that might have an effect?

DR. BADGLEY: Let me respond to that as a sociologist. This is obviously one of the questions that would be very nice to study.

CHAIRMAN ANDERSON: As another sociologist, do you think it is researchable?

DR. BADGLEY: Yes.

CHAIRMAN ANDERSON: Are there further questions from the floor regarding the hospital?

MEMBER: I just wanted to point out that it seems one of the things to consider in any setup like this is whether your political arena is manageable. I think that Ontario, populationwise, is about the same size as New Jersey. One wonders in our own setup with a national system whether anybody is worried about how the political situation is going to be managed.

I would gather in a province of 8 million people with politics everywhere, you can visualize that it begins to fall into some kind of pattern and becomes manageable.

I don't see how that is going to work on any kind of a national basis in this country.

CHAIRMAN ANDERSON: Do we know yet?

MR. MARTIN: I think that is a very good point. Some people who listen to my remarks today and who had heard me speak eight years ago might think it was all purely coincidental if anything was the same.

In those days I think I said we saw some strength in the fact that the administration of these programs was at the provincial level because of at least some flexibility. If it were a completely national program, we would have problems that were even worse.

Now I recognize that in saying that, that I don't really see how your program can be done any other way. But, that doesn't excuse the fact that, as an individual, I would still make the observation that I think our programs are more manageable broken down into ten distinct parts than if it were a total national.

MEMBER: Why do you say that our program can't be done any other way?

I presume what you meant by that is that in this country if we were to have national health insurance, the administration would have to be on a national level.

MR. MARTIN: No, I just said I couldn't figure out how you would do it in a country this big on a national level.

MEMBER: I understand.

MEMBER: I have spent a lot of time in and out of Canada now for the last 20 years and have been in all of the provinces. When you talk about federal policy, two things stand out in my mind: you didn't talk about the Indian problem, and you didn't talk about the Eskimo problem. They are not really provinces in the Northwest Territory.

I don't even quite understand how that is organized from a managerial point of view, but are there not also problems in the care of both the Eskimo and the Indian?

MR. LAFRAMBOISE: There are problems at many levels, not only at the level of health care. The principal problem is that the Indians have no right under the law to free health care. But, we have been giving it to them for so long that we continue to give it to them while denying our constitutional responsibility for doing so.

We are, therefore, involved. There are many kinds of Indians. There are only 250,000 or 300,000 Indians to start with, but there is variance among their levels of economic activ-

ity, language, location and so on, as you could possibly imagine.

There is no single type into which all Indians fall. We would like to gradually transfer the responsibility for health care to Indians over the provinces such that they would get their care in the same way as any other resident of the province that they get in.

We are prepared to pay their premiums if there are premiums for health care in that province. However, the quality of care that the Federal Government is giving the Indians in isolated areas in very small groups is far superior to that which the provinces would be prepared to give them. The coverage we give them not only with respect to medical and hospital care, but dentistry and drugs and so on, is far greater than most provinces would be prepared to give and that which they now give their own other non-Indian citizens.

As a consequence, we are trapped with not being able to transfer. The Indians themselves don't want to get their services from the province because they know that they have far more leverage from the Federal Government.

There is far more popular emotion behind the cause than if they were simply residents of Saskatchewan, Manitoba, or wherever. So we are caught with delivering health care services or financing the health care services of a population for which we have no constitutional responsibility with respect to this particular thing.

Now what are the health problems of Indians? We know them all. We know from research that the conditions under which many Indian populations live are a far greater threat to their health than the availability of health care services.

We are talking about sewage disposal, the availability of potable water, electricity, refrigeration for food, housing, clothing, and all of the other things. We can treat Indians and save the life of a child with intestinal flu and send that child right back to a community where that bug is going to be picked up within a week.

These other elements of health, the environmental elements, are not in our Department of National Health and Welfare. They belong to the Department of Indian Affairs. So whether a sewage disposal plant or a garbage disposal plant or a plant for purifying water is installed is something which Indian Affairs decides, and not us.

MEMBER: How about the Northwest Territories?

MR. LAFRAMBOISE: The Northwest Territories have a territorial government now. There are only 56,000 or 60,000 people in that whole vast land. There are another 35,000 or 40,000 in the Yukon so the total population of the North doesn't amount to 100,000 people.

They have a territorial government to provide services to the North, both for the native and non-native population. We were, in fact, provided with and administered a health plan on their behalf.

We do the same thing with the Yukon simply because they haven't got the money in such a small population to be able to finance the kind of care that requires long distance plane flights and nursing stations serving communities of only 75 or 150 people. Theoretically, we are facing the responsibility for health care in the Northwest Territory, to the territorial government, and theoretically we are doing the same with the Yukon, but only as they are willing to take it on, and as their income base permits them to finance it.

CHAIRMAN ANDERSON: Murray, do you have any observations? Are there emerging trends in controls or patterns of paying physicians in Canada in this system?

MR. MURRAY BROWN: I think one of the interesting developments is the pattern of bilateral negotiations which occur in each of the ten provinces when it comes time to adjust the fee schedule which is used to pay 75% or so of all clinicians in Canada.

The pattern which is emerging is that the provincial medical societies, more specifically their economic subcommittees, undertake either officially or unofficially to negotiate with the insurance commission at the first step, and ultimately through the insurance commission, with cabinets to decide firstly, what sort of global increase in total payments to physicians for services rendered under the plans is acceptable in the following year or two; and then a second phase of negotiation is concerned with how the global increase shall be translated.

CHAIRMAN ANDERSON: By global increase, you mean the whole pot?

MR. BROWN: That is right. The total expense of each program.

CHAIRMAN ANDERSON: In each province? Are the physicians at risk in that pot? I mean, are they limited to that pot for the year?

MR. BROWN: No, it is not quite as strict as that. In terms of projecting increases and expenditures, there is some negotiation about what is a target level of change. At a more detailed level, there is the question of how the change is to be translated into increases or decreases in specific fee items. As I see it, the negotiations at this stage are largely within the medical society itself. So, you have a situation where different specialties are competing against one another for the pot.

MR. DAECHSEL: As to this question of the specialties, there is quite a wide disparity. I think there is some common ground between various provinces and the medical profession that they would like to even some of this out.

They don't feel necessarily that that range should continue. This is a range which is based on a fee schedule which members started in the days when collections were a problem and some specialties had a harder job collecting money. Also, the other question was the years at which they would earn the most—earn at their maximum capacity.

We do have, of course, additional charts on that to show the difference between various specialties, and some of these things are trying to be evened out, I believe, through the negotiations. There is often unwillingness on the part of both parties.

CHAIRMAN ANDERSON: Are there any questions that the panel wants to ask each other?

DR. BAGDLEY: There is a question, Odin, which I would like to ask both Bert Laframboise and Werner Daechsel, and it concerns the information base.

It seems to me that there is a neat circular logical argument that goes in the following lines:

The data which we have are not adequate. We recognize that they are collected for accounting purposes. However, on the basis of this, we have a superb data system, and we aren't going to make too much of an effort to go out and collect subjective data as Werner was mentioning this morning.

It seems to me that that is, on that part, limiting very sharply what we know about the health status of Canadians.

At no point in Canadian health history has, to the best of my knowledge, a government, provincial and/or federal, ever gone directly to the people themselves in one of two ways, either undertaken a clinical health survey (and I don't include the sickness survey of '51 in that category) or have they gone out directly and approached the population to find out what their health interests are?

Now the usual argument runs that we are doing it through the legislative procedure. When it comes to the deluge of task force reports, I am often at a loss to know how they get them. So it seems to me one of these dilemmas, Werner, in your statement of data is that I don't think there has been a very strong effort to collect adequate data. I would like perhaps comment from both of these members of the panel.

MR. LAFRAMBOISE: I would answer Robin's question first by saying that no, it is unlikely that large sums of money are going to be made available for medical sociologists.

As Robin is aware, and in one of the propositions made in the working document, the Federal Government is now deeply interested, but not committed to a continuing national health survey broken in two parts: one is a household survey, which I consider the most important part because it is the kind of subjective data as Robin says that we just don't have, the untreated illness, the prevalence of chronic cases of arthritis and so on, the living habits of people, the number of days' work that have been missed, or school and so on, we can only get from going to the people; the second part is the clinical survey which is a very expensive one involving medical examinations at a price of $150 a head which is intended, according to the people who are promoting it, to find the health needs of people through clinical tests and so on that are not being met.

I don't consider the clinical side of the thing, considering the cost and the limitations on the size of the sample that you can give it to because of the cost, to be nearly as valuable as the information that we can gather from household surveys. What is being done by Statistics, Canada, and the Department of Health and Welfare—and it is Werner Daechsel's branch of health programs—is to have together a group of people who, although they are not working full time on it, are certainly moving very quickly

into a proposal which is going to be put jointly by Statistics, Canada, and National Health to the Cabinet to seek a sum of money which will be one and a half to two million dollars a year. So there will be a continuous month after month gradual coverage of a representative sample which will give us the kind of information we need to identify what is happening in our population other than those things that appear in hospital statistics, mortality tables and Medicare data banks.

I am very optimistic about this. I am prepared—I can't promise because I haven't got the decision-making power—but I am prepared to guess that by 1975, in 18 months' time, approval and most of the design will have been done.

We have beautiful experiences to draw on. We have your own American National Health Survey and all the things that have been learned as a result of it, and we don't need to repeat your mistakes.

That is not what the people in Washington tell us. You have programs. I don't say that we can take your survey holus-bolus, but we can build on the experience that you have with very, very little design cost.

We also have a Federal Provincial Committee, not all the provinces, but for provincial representatives, who are particularly interested. We are in the age old argument. They would like to increase the size of the sample, such that within provinces they would be able to distinguish differences, urban, rural and by area.

We want something which will perhaps tell us differences between provinces, but not the local areas. So the provinces are asking if they can participate financially in that part of the sample, so that their sample can be a much larger one and provide them with the information they need as well as the national one.

There are no brakes being put on in the administration. My deputy minister, my minister, have put the proposition to the conference of Health Ministers of Canada. So I see nothing but green lights in getting the kinds of information, household information, subjective data, of the kind that Robin is asking for.

We should have done it long ago. I can't understand what has taken so long.

CHAIRMAN ANDERSON: At the risk of asking an obvious question, how do you see these household results being used for health delivery and planning purposes?

MR. LAFRAMBOISE: I am not a specialist in the information gathering business. There are two areas. One has to do with health status. The other has to do with consumption. We don't know what people are consuming. We have gross figures, let's say, on over-the-counter medication and so on, but we really don't know where it is going, what classes and so on.

We don't know whether the people are significantly deprived of access because of geographical reasons and social and other reasons! We haven't any idea as to whether the frequency of different kinds of disability such as missing school, missing work, being laid up in bed and so on varies at all from one group or another.

I would say two things. If you want to identify high risk populations, and this is one of the things we want, we need the information from the national survey in order to identify what those high risk populations are. If we want to know something about the distribution of the consumption of health services and health goods, then we need this information from household surveys as well.

If we find, for instance, that certain classes of Canadians get medical care for conditions which other classes of Canadians for some reason or other don't consider worthwhile, we are very interested, as well, in identifying abuses that might come up as a result of this.

These are just some of the questions. I think we are all aware that we are not using the data we have got. We have got data coming out of our ears telling us all kinds of interesting stories that should affect policy. Somehow or other between the data collections, as Werner said today, and the policy maker, there is some kind of a communications gap that we just don't seem to be able to move that information up in a form that is going to excite the interest of a political party, and this is what we have to do.

So we not only have to collect more data from national health surveys. We also have to improve our capacity to transform that data.

An example of a little thing that we did in our branch is a mortality graphic which has been published in the *Canadian Medical Association Journal*, in *Weekend Magazine*, which is a weekend insert with a circulation of 2,144,000 and 5 million readership, in *Management Journal*, "Optimum," and in the *Journal of Canadian Public Health in Canada*.

In addition, a pharmaceutical company bought our negatives and ran 10,000 copies to be distributed by their detail men to physicians.

That little graphic, although it is very hard for us to repeat that kind of success, still is an illustration of how you can get a bunch of statistics together and present them in a form where more or less anyone with a Grade 10 education can look at it and be interested in what the stories are about the major causes of death by age and sex in Canada.

Now that kind of transformation has to be done more often so that decision makers will look at things and see what they need to do.

MEMBER: Putting on my Canadian hat, let me ask two questions, one of which can be answered fairly briefly. The other one might be a little more complex.

I think it would be useful for this audience if someone would explain the function of the ministerial conference as a negotiating device between the federal and provincial levels.

The second question has to do with the interface between welfare and health. We have it at the federal level in the departmental organization.

Stan mentioned that the regional councils, at least in Ontario, are defined as being health and welfare. We have in our own field a training program at the University of Alberta which is moving its training people in social welfare administration as part of a health administration program. Much more significantly for the practicing health administrator, increasingly, I seem to see welfare people at the provincial level in the deputy minister role or in similar decision-making positions which have significant leverage over, for example, those budgets that come up in the hospital board. The whole interface is something that I think has some implications for what is happening here.

MS. LAZARE: I would like to take the second part of that question about the interface between health and welfare.

A lot of the work I did was as a health consultant first for a private company and then a free lance consultant in Ontario for three years. Most of the work I was involved in was in districts in northern Ontario doing studies not necessarily for individual hospitals but for groups or districts which were supposed to have banded together in forming district health councils to provide coordinated or cooperative services.

One of the problems that we found was that in Ontario, in our province, certain things, for example, homes for the aged, may come under the Ministry of Social and Family Services. Other things, such as nursing homes, do come under the Ministry of Health. Active hospitals come under the Ministry of Health, et cetera.

In theory, these district health councils at the moment are supposed to have representation from not only health providers, but from people whose ministerial relationships, I guess, is the best way to put it, would be with the Ministry of Social and Family Services.

It is very, very difficult to define sometimes which ministry is responsible for what.

However, I guess what I am really doing is rephrasing the question a little bit to Stan Martin and asking him how in a population spread over several thousand square miles you can say to the people, "Don't talk to me about this. Go to the other Ministry."

The other Ministry turns around and sends them back, and people end up with no service after all this negotiation.

MR. MARTIN: I think first of all I would like to make a distinction between the groups that you were probably dealing with because these were originally the basic hospital planning groups where some 30-odd of them had been structured across the province over the past decade. At that time this was done under the umbrella of the Hospital Services Commission with a definable role and a definable mission which obviously was limited to the question of hospital care, be it active treatment, convalescent or long-term.

Obviously once you start to think of health as a total objective, this, of course, brought about the demise of the special purpose body, the Commission, it will also bring about the demise of the special purpose local body known as the Hospital Planning Councils because their place will be taken by the District Health Councils, and the entities that you have been dealing with aren't health councils.

Some of the hospital councils have changed their name to a health council. In actual fact, they are still a single purpose body devoted mostly to institutional care. So, you did run into the problem that the model, at least, the new model that has been visualized, is quite different than the one that you have been used to dealing with.

Now secondly, I would go back to the first part of the question, if I may, Odin, and say this—with the restriction of government in our province, the whole function of government in our province, the whole function of government has been broken up into several policy fields, and within the social policy field, it is involved with the Ministries of Education. In our case, there is a separate one for colleges and universities, so that is two. There is the community and social services and health, and now policy issues that come from any of these ministries have to be interfaced because these ministers are compelled to sit down now as a Cabinet Committee once every week. Nothing can go forward to Cabinet or on up to policy priority board that hasn't been through the innovative process that is involved in the total Cabinet Committee and Social Development.

Any issue raised by any ministry that has an overlap into any of the others has to be worked up. All of the factors involving any of the ministries then have to be correlated so that when the policy does come out, at least, it has made allowance for the fact that there are gray areas between various administrative ministries within the social policy field.

The second thing that is within the breakdown of the new district health council structure in our ministry, it just so happens that this happens to parallel absolutely and completely the same planning districts as are now being structured for the community on social services mechanism.

These can't be short-term goals. I was amazed to find that for the first time within a really definable and not too disparate district many of the social service people and many of the health people had never really met each other before. There is no doubt about it that there is a tremendous amount of work to be done. There will be and the further development and why it will likely occur is that our province is being divided into a series of regional governments. Unquestionably the problem, the use of our district health council as an advisory body, both to local government and to the ministry will change. I think, in fairly short order as these regional governments become more sophisticated in their workings, that the natural result will be that the health and social planning will be done under one body, so that we are playing quite a long-range game here.

It will be imperfect at certain stages, but the other, the further development, is that between our ministries at the provincial level, that is between mine, health, and my sister ministry, the community and social services, we now have a joint planning group. No capital projects, either be they hospitals, homes for the aged or any other type of institutions, are approved unless they go through a joint group to make sure that the planning is at least harmonious and hopefully particularly for some of the districts that you are thinking about. I think in the North that we can use it probably rather than planning separate entities, that it would be a constant development that would come out of it.

In other words, it would probably be a complex involving not only a hospital but also, likely, nursing home, home for the aged type of thing, all wrapped up in one.

CHAIRMAN ANDERSON: In the debate in this country in national health insurance, a political administrative issue is one of the public sector using intermediaries like Blue Shield, private insurance companies, to pay the providers.

Now in Canada you had by all standards a rather flourishing voluntary health insurance sector, 70% of the population, something like that for both hospital and physician services.

Was the possibility of using these existing insurance agencies ever debated or discussed seriously, and if not, why not?

MR. MARTIN: I certainly will want to comment.

As you are aware, back in the Fifties, some 500 employees involved in the original Blue Cross organization in Ontario were turned over to the government for the nucleus for the administrative arm of the then Hospital Services Commission.

At the time the possible utilization of multiple agencies was looked at. At that time the insurance companies, particularly the private ones, however, were not particularly interested in merely being an administrative arm.

At that time they really took the attitude that government should take on the poor risks, and they wanted to continue to use the usual insurance practices in the preferred risks, and these were mostly employed groups.

So negotiations broke down because the Premier at that time said, "I am not having any part of that, so I will take the whole bag on."

When it came to medical, the personal care services or the medical care services, the gov-

ernment did go the route because by this time the attitude had changed somewhat. Among the private insurance companies and the voluntary nonprofit plus certain other designated agencies that were handling union groups and so on, there was an effort made for about three years. These people were used as the agencies, but it broke down really because basically it was most difficult to get uniform administration across the total of the 40-odd agencies that were involved.

Secondly, there was no central depository of information in relation to the total claims experience here in a uniform manner; and thirdly, it was extremely difficult with 47 agencies to begin to get any kind of practice patterns, be they either on the part of the producer or the consumer.

So government, after taking a look at this in three years' experience, said: This is not going to work out, and having already got the basic machinery that was there anyhow involved in the hospital end, I had three years ago the task of phasing out 47 agencies, phasing out two commissions and putting them into one.

There is a little bit of economics in it, too, because in the process we were able in the consolidation to obviously get the objectives we wanted. That was patient profiles or we will get particularly doctor profiles.

The thing came down in uniform administration, and in the process we reduced our resources application by some 875 people.

CHAIRMAN ANDERSON: You are giving the impression, contrary to what I had up to this moment, at any rate, that it was a matter of expediency or decision on its merits.

My impression has been that it was more or less a political philosophy, that government money, tax money, should be administered by directly accountable agencies. Wasn't that so then?

MR. MARTIN: Well, if that had been an absolute, our province would not have been able to embark on the program for three years and use the intermediaries. Unquestionably, the process of government funding, and particularly when it comes under scrutiny of the government's public accounts and public auditor, when they go in and want to account for spending of public funds through the insurance companies, other private agencies, the questions that arise are very, very difficult to rationalize because obviously one has to accept the practices that go on in some of these agencies if you are going to go that route.

You can do it by a certain form of contract, but it doesn't alway work out because you don't get uniform claims administration for one thing.

I know that you people have had fair success in your administering of your program through the Blues and the commercials, but within a structure then that became totally really funded by government. I must admit from the beginning that I supported this principle. But I saw by bitter experience, at least in our situation, that it wouldn't work.

CHAIRMAN ANDERSON: May I ask one more question along that line? You began to allude to it.

What degree of interest was there in Blue Cross when administering an intermediary? Wat it felt to be something worth doing? Did they fight for it?

MR. MARTIN: This goes back to the Fifties as far as Blue Cross is concerned, and I recall because I was the chief executive officer for the group at that time.

There were some real heart searching moments, but the eventual decision was that they felt that this agency in administering would have to be carrying forward. It is a different ball park because right from the beginning the funding of the hospital was done on prospective budgeting, so that the manner of straight bills being rendered on the basis of charges that are set by the producer on his own hook is not there any longer.

They were legislated out because the total control over the amount of money that was going to be allowed to any one of the providers was legislated by government. Our group, of course, the Blue Cross was a division of the entire hospital association, concluded that it wasn't the feasible way to go, and then elected to work with government to try and work out a reasonably satisfactory piece of mechanism to administer, and on reflection, I think their decision was probably the wisest one.

MEMBER: We have heard a lot about the process of coming decision, but I wonder if one of you or more would respond to a question about levels of citizen satisfaction with your health insurance scheme?

I heard two contradicting views. One view is that there are significant areas of discontent from different speakers. Badgley referred to areas of substantial discontent; and the speaker this afternoon described a population, at least on the cost side, that was not discontented.

This may not be a direct contradiction, but one area of planning and investigation that you are not referring to is discussions of the response of the Canadian citizenry to the implementation and operation of these plans.

MR. DAECHSEL: I don't think the two speakers were contradictory. I think Robin was referring mostly to the producers and the government and Burt said that the people, the consumers, that is, the ordinary consumer, is generally satisfied. I think this is true.

MEMBER: Is there any evidence that you can refer to on that?

MR. DAECHSEL: Yes, but most of it is of a personal nature. This leads back to the problem of our inadequate data base, and I would like to take this chance to say a few words on what Robin said.

I quite agree with Burt that this health survey is going to be a step forward, but I think it is far short. I suspect it will be far short of really providing us with an adequate data base either in the subjective area, on what I consider may be just as important, or almost as important, and that is this question of providing a working health profile on the individual person which will be used for him, plus for identifying special risk groups.

I think that when you are asking us, "Do we have any data base to judge the public?" the answer is no; we don't, other than with the political one of the fact that we suspect, and we have had some indication about when the system has been monkeyed with in terms of the consumer, there has been a change.

Now you never can tell with the political action how much of that you can charge to the health part of it, but on an individual basis, and I draw my information primarily from personal acquaintance with Canadians who now live in the United States, there seems to be a high level of satisfaction.

They are always making comments similar to what Robin said of your United States officer who is looking forward to being able to be part of the Canadian system.

DR. BADGLEY: I would like to try to answer your question and expand on what I was trying to suggest.

I think there has been a very long-standing, indicated interest in health insurance in Canada. If you go back and look at the biasing sources of the Gallup Polls which have been conducted over the last 30 years—I say biasing because of the way the questions often have been phrased: Would you be in favor of health insurance if it meant an increase in your taxes? these kinds of nice, limiting phrases. Consistently, from the Forties when these questions were starting to be asked, there has been almost invariably between 65 to 85 percent of the population that has indicated a favorable response.

The current evaluation of health insurance as introduced since the last four or five years can be gauged from three or four sources. Number One, a joint study between Enterline at the University of Pittsburgh and the Department of Epidemiology at McGill which did a before and after study at Montreal which is being reported now in the *New England Journal* and several other journals.

There was part of the Johns Hopkins International Comparability Study which surveyed some 6000 households in Saskatchewan, Alberta and British Columbia, which went into great depth into life style information and attitudes toward care.

There is even a small study that I started in 1960 in Saskatchewan. It went back to 1965 in a rural community, with a professor of internal medicine Vince Mathews at Saskatchewan. We are planning to perhaps go back again over an 11- or 12-year period to look. So there are quite a few sources of information.

There is one in Ontario which I didn't mention, the Pickering Report which was undertaken for the Ontario Medical Association and surveyed some 800 or 900 families quite selectively. They excluded the families who might have the sharpest criticisms, those in rural areas or isolated areas.

These sources, when taken together, would seem to suggest that there is a growing concern about fragmentation of care, about the buffeting, the question of accessibility.

In general, there is a satisfaction with what is being provided, but a sense of frustration in wanting more. One would almost have to look at the individual items to pick this out.

MR. LAFRAMBOISE: The extension of insurance to medical and hospital care has made the people more irritated by the things they still have to pay for such as dental bills and drugs and other things.

Some of the dissatisfaction has to do with the fact of health insurance not covering enough services. So rather than be dissatisfied with the insurance they have, they want the plan extended such that they can insure themselves through whatever premiums or taxation against the cost of prescription drugs, dental care and so on. The dissatisfaction is not with the health insurance, but with the limitations which it has.

The second is the problem of accessibility.

People are voting with their feet to go to the emergency services of hospitals. The emergency departments of hospitals are becoming ambulatory care centers. Hospitals don't want them to become ambulatory care centers. They are grousing and complaining all the time about people dropping in with things that are not really emergency. But the people are doing this because they can't get house calls. They sometimes don't have any way of knowing.

They are dissatisfied very often with the accessibility of medical care at times when they feel they need it.

Finally, there is one little irritant which continues in Ontario for those physicians who choose to bill outside the plan, to bill the patient directly. They extra-bill the patient, and the patient gets a bill for $20 of which he recovers $16 from health care and has to pay $4 from out of his own pocket. This is another irritant.

There are problems of dissatisfaction. One of the dissatisfactions is the survey mentioned by Robin Badgley in Montreal where before Medicare and after Medicare, for quite a good sample of physicians, the physicians have reduced their work week before Medicare of 56 hours on the average to 48 hours after Medicare.

So they have withdrawn something like eight hours a week of time from the public. They have reduced the amount of time they spend per patient from something like 19 minutes, which was the average before Medicare, to 14 minutes. In French, we say this is to make volume, and they make money by making volume. So it is the problem of accessibility. Another thing is that physicians are not paid for anything given over the telephone because it is uncontrollable, and where in the past they might have given a lot of temporary advice by phone, they are now asking the patients to come in to the office because this constitutes an office call worth $6.00. So they clog their offices up to some extent by calling in more patients than they otherwise would.

The delay factor measured by the same study reported in the "New England Journal" indicates the amount of time it takes to get a physician appointment has not increased significantly.

Contrary to opinions of long queues, the founder of Kaiser-Permanente says that if you introduce a national health plan, your offices are going to be clogged with the non-sick, if you will. It just hasn't happened in Montreal.

You might have had to average, let's say, seven days delay for a physician appointment. It may now be eight and a half days, but there hasn't been this clogging up that has taken place, but accessibility is something that people do complain about.

MEMBER: At the same time you went from private money to public money, you went, in effect, from multiple sources of payment to a single source of payment. One impression I got was that there was a lot of pressure politically to keep on spending more, increasing the volume of facilities, improving them. Another impression I get is that it is now possible, given the single source of payment, to take a look at the alternatives, to compare and say, "What are we getting for this?"

I am wondering on balance where you think you are coming out now, whether there may be a change in the near future, and is there any diversity among the various provinces? Is there some attempt in some provinces to keep the lid on while elsewhere they are spending more? Because it seems to me that in England I always had the impression that going to a single source of payment made it possible for them to keep down the amount of money spent.

DR. BADGLEY: I think this is both one of the great strengths and one of the weaknesses of the Canadian system.

It is my understanding that your first point is quite correct. There has been this flowing from many into a single source.

However, as you look across Canada, you see almost a bewildering array of new programs beginning to emerge. So you have various forms of pharmacare, various forms of denticare, home nursing programs, et cetera.

MEMBER: Inside or outside your system?

DR. BADGLEY: Being pulled inside the system, and almost every province, in fact, is getting some variant of a new program.

This is the traditional hoisting of a balloon, and if it succeeds, then it becomes something which becomes very well known across the country and serves to raise expectations that other people want it as well.

CHAIRMAN ANDERSON: I wish to answer a rejoinder. It is really not a single source of payment. It is government, yes, but it is both a federal and a provincial.

DR. BADGLEY: These initiatives typically are taken on, though, under the provincial initiative.

MEMBER: I thought the Federal Government just pumps the money in.

CHAIRMAN ANDERSON: On a 50 percent basis, yes.

MEMBER: In regard to some of the administrative processes going on, they are very much similar to the certificate of need kind of legislation that we have here. In using the Galbraithian notion of technical structure, directing the movement of this corporate structure called the health industries, you have key people who are in the strictest role sense responsible for directing the kind of rules that are made.

I was wondering about the other kind of experimentation that is going on here in terms of generating consensus of public via this certificate of need process.

For example, in Minnesota we have two large institutions, one is my own and another one is the Hennepin County General Hospital with the Metropolitan Medical Center which had mandates given to them through this certificate of need process to open up an ambulatory care type of program.

This was a grass roots kind of input into decisions which would affect the delivery of care outcomes.

It seems to me the reverse decision-making

process that is going on, as opposed to the public being involved in consensus generating, is that there is a technocracy in making these kinds of decisions.

I wonder if there is any alternative available?

The other thing I question is how is the new technology evaluated in terms of the prospective reimbursement?

You have a major kind of treatment that requires a major capital investment. How is that money monitored on an ongoing basis? Here, we are trying to separate our educational costs from routine, mostly recognized kinds of treatment. Since you do have a unified source of funding, I am wondering how do you separate out the decisions which are made to continue a routine kind of care versus those which would bring in a new kind of technology.

I am very interested in how you, among your provinces, deal with the question of reciprocity in terms of sharing of personnel or the movement of personnel who are trained in one area from one province to another province such as doctors.

How do you deal with that particular question? There is a great deal of investment going into man power development, and it is so provincially controlled, I am wondering how you balance out interests in it.

MR. LAFRAMBOISE: What is being done in Canada so that the system can become more responsive to consumer needs, and you gave examples of institutions in your state where ambulatory care was being delivered on an experimental and pilot project basis in response to consumer needs?

We have a very unorganized consumer citizenry in Canada in respect to health care. We haven't got activist groups. We haven't got Nader type community organizations in the health care field. We have them in many other fields, tenants associations and neighborhood associations and so on, but in health, we haven't got them.

What we have instead is a scattered rumbling of various proportions about the mess that most people think they face when they go to an emergency department of a hospital: The waiting time, the filling out of forms, the feeling that their problem is more serious than some of the others that are being looked after before them and so on and so forth is being heard.

The message is being heard by political people as well as by officials. There is no question that even though the consumers are not organized to demand a responsive ambulatory center or ambulatory care, our governments are well aware that we are going to have to do something to provide for the people, in an organized way, the kinds of things they are trying to get out of emergency departments of hospitals which the emergency departments consider to be not emergency. That is the consumer thing.

As far as new technology is concerned, it would have to be some one in medicine to answer that because we haven't yet in Canada, I think, ever decided to deprive some one of, say, dialysis.

CHAIRMAN ANDERSON: Do you think medicine would be complaining about the lack of technology again?

MR. LAFRAMBOISE: No, if it was a question of cost and we say, "We will have to let that person die because he is not on the priority list for this particular technology," I don't think this is anything that anybody does in Canada in any sort of an open way.

In other words, we haven't started to limit the availability of services because of the cost or the population thing.

DR. BADGLEY: I disagree with Burt, at least, in degree.

I think there is fairly active interest. I think across the country one can find a whole burgeoning of small groups of people who do have an active interest. Their voices typically aren't well heard. They aren't well organized, but I think it is there. There is the concern, and it hasn't been well understood or well tapped.

This would make me somewhat skeptical about perhaps proposed national health surveys because I think it is going to ask safe questions since it will be a national survey. There will have to be a lot of bartering as to the types of items that will go in or not go in, I suspect even bartering as to the types of analyses that will come out precluding certain types of data runs potentially.

I would like to see it obviously not just ask people how many days they spent at home or out of school or off their job because they have been sick, but really some evaluated questions about the range of services that they are currently getting, about the local hospital, about their doctors, and so forth.

MR. MARTIN: I would like to comment just on the question of the new programs really that came in because basically this is one place, of course, where central authority does have some restraining influence in that obviously the resources of new programs cannot be allocated unless they are approved.

So in our situation obviously we are working toward the type of regional organization particularly for the more esoteric services in the health field.

Just any hospital can't set up a dialysis service nor can just any hospital start an open heart surgery unit.

Until the squeeze was on, this was fairly loose, but now these fairly esoteric services are being planned out on a regional basis. Then, only certain hospitals are allocated as a base hospital for it with others satellited to it in the development of a grid, mostly in relation to these kinds of services.

Now up to this time, the governments have not yet faced up to the very interesting question which I think may be faced up some time as to whether or not they will continually allocate resources to take up whatever may develop in the field of medical science.

I can see there is one coming up now where there is a suggestion for a whole grid of specialized perinatal services to cover the province, and these, as most of you in the hospital field know, are selective cases where from the time a fetus is about a month and a half old, there is some suspicion that there will be physical or mental illness developed. Concentrated care is needed with the mother over that whole period, and they hope to be able to reduce the possibility of a physically or mentally disabled child being born.

The interesting thing is that as far as we can figure out, the resources needed for this unborn child will amount to about $40,000 by the time it comes on the scene. The issue I see about it is whether government is going to be prepared to continue to put that kind of resource allocation in as opposed to a much broader kind. There is obviously the hopefully preventive aspect of not having to look after that child then as a mental retardate or a complete moron for the rest of that life, against the other pressing needs of, say, the rather incessant demand that is coming on the scene to provide drugs for the older people particularly in a bracket that can't afford to pay for the drugs.

These, I think, are going to be the interesting decisions that are going to be facing the politi-

cians. At this point in time, I obviously see that they don't like this kind of decision making, and one can well understand why. But these are avoided, up to now, as long as there is enough resource to cover everything in all demands. My guess is that very nearly certainly in our jurisdiction the proliferation of the advances in medical science are not going to be made in the context of the market. They will first appear in the highly specialized centers. Then as they become refined, they do spread. Right now we, in Ontario, recognize that they are training far too many heart specialists, particularly in the surgical field.

These people go up to a small area, and it looks like a great thing. They think that it is wonderful to have this very outstanding, well trained individual. But what he needs right away is a whole heart-lung pump machine and all the trained technicians that go with it.

We have already bumpered this one, and we have said no. So the battle lines have been drawn already. That is the answer now on the extension of specialist services into the system.

As far as the manpower issue is concerned, obviously we have a fair degree of reciprocity right across Canada insofar as the certificated or the licensed people are concerned. Although there are some variations on the West Coast, I think they still have a little bit of reluctance to take anybody out there because a lot of people want to retire there.

It was asked what happened to medical manpower in our province. You can see that the program was introduced in between 1968 and 1969 here. At that time, we were producing from our own medical schools about 278 graduates that were being registered, about 116 from other parts of Canada and about 218 foreign.

We refer here to "foreign" as those people who are from anywhere else other than Canada.

CHAIRMAN ANDERSON: Trained elsewhere?

MR. MARTIN: Yes but you can see what happened. I left 1971 out just to get it down more quickly, but what seems to be of concern is that while now we are at a point of about 359 graduates from our own school, the other parts of Canada shifted in here a bit. Obviously, we are now registering more people from other jurisdictions than we are of our own people, in this particular year 1024.

Our projections here that concern me now are that we have one physician to about 580 population. The one big element of cost in any public program is the number of people practicing or the number of institutions available.

Our population is growing at a rate of about 1.7 million, so this is growing at about 6% a year, and this is what we are looking at now as being obviously a problem with regard to how we will cope.

DR. BADGLEY: Would you agree, Stan, that perhaps we will be moving toward the idea of a concept of a medical establishment, this will probably not only result in changes of the Federal Government with migration into Canada, (in a sense, Canada has become a magnetic medical marketplace attracting a very large number of physicians from other countries in the last four or five years) but also, the regional imbalances as indicated in the question, because there is quite a sharp difference between the provinces.

It is my understanding that Ontario gets just about as many doctors as it loses. There is perhaps a stand-off. A province like Manitoba, on the other hand, loses a very substantial number of its own graduates to other provinces and doesn't get a repatriation, as it were, from people trained elsewhere. As was indicated, the net gainer, British Columbia, up until recently had only trained 15 percent of its own doctors.

MEMBERS: I would like to ask this question from the point of view of a person who works for a proprietary hospital chain. What kind of incentives are built in to your system to prod the manager to provide high quality care that the customer, whether that is a physician or the patient himself, is satisfied with on an out-of-the-pocket cost basis? Is there anything you know that tells this manager: If you do a better job, you will come out better in X.

MR. MARTIN: Again, there are no parallel patterns in every province. This is a distinctive thing. I did say at least Ontario, for the last five years, has prospective budgeting on a global base.

Now within that kind of situation, we have been working under a system whereby if the individual hospital manages its resources in a manner that is obviously satisfactory, and I mean by that, that they haven't cut out the es-

sential services, that they have provided the services. But, it would appear that they have been able to do this at something less than what the prospective budget came out. There are two or three forms of sort of incentive payments whereby they can retain portions of the money that is there.

I won't get into the details only to indicate that there is some incentive for that hospital and that board because they then retain certain portions of the funds on a free basis.

MEMBER: What percentage of those physicians would be called primary care physicians, internists and GPs; and also you alluded to an oversupply of heart specialists.

I am curious in terms of your current trends in medical education and especially composition mix overall to what extent you have any control over this, in terms of trying to match it up with the population health needs or medical demand, and of course, in the context of our country with the medical supply of surgeons and indeed some evidence to support that contention.

Murray might want to comment on that also.

MR. BROWN: This question of how to match demand and supply in terms of medical manpower is somewhat a tricky one.

The pressures which are on provincial governments who are experiencing fairly rapid increases in the numbers of physicians which come in to the province are substantial. The claims generated by additional physicians on the medical care insurance plans must average out to $60,000 or $70,000 per physician who comes in. Yet, it is rather difficult to take a public stance that we are better off with fewer physicians than more physicians in terms of meeting consumers' demands for more and better quality of care.

I have not yet heard any public discussions which indicate that they have reconciled this particular problem in terms of controlling costs which are escalating as a function of the fact that more of this desirable man power is becoming available and also meeting the apparently real demands of the people for more services.

MR. LAFRAMBOISE: There are many problems to which we have answers. But, we don't know how to put them to work. I think the problem of geographical or specialty distribution of physicians could be answered if we had reasonable estimates as to how many physicians, taking into account distance, population, specialty, and so on are needed to service a specific area.

If we had this, and if a physician could locate only in an area where there was an opening in the same way that there is a job available in most of our professions, then the specialization would be chosen by the medical graduate according to the market demand that he could foresee for that particular specialty.

You would see a very quick reduction in the number of people training in specialties which are in over supply for which very few openings exist in those areas in which they would like to live such as the metropolitan areas.

So much of this sounds distasteful. The answer is to establish medical estimates for particular areas based on population needs, on the distance that people have to travel, on a regional organization of services, on the usual hierarchy of establishments of university hospitals and acute care hospitals and primary care and so on institutions would, over the long run, solve the problem of what specialties were chosen and bring about a balance.

It is an answer, as I said, which we do not know how to implement, but the answer is there.

MR. SHORTELL: Is it more difficult for a physician from Canada to create their own demand for medical care. It seems to me, in part, that is what you are implying. In this country even though we have some evidence that there is an over supply of surgeons, they are still flocking into the surgical specialties. We have some indirect evidence that they treat an awful lot of primary medical care and deal with a lot of primary medical care patients. Why wouldn't that also occur in your country?

MR. MARTIN: It obviously does. Within those set of figures on the board, particularly the foreign trained people, we are getting a much higher proportion of specialists than you would prefer to when the need is really for primary care or family care, or general practitioner, whatever term you care to use.

I would say, of course, again that we do control some of the keys to this. We, at the moment, have a group, a task force, combining the medical schools and certain people of our own in the medical fraternity.

We intend to come up hopefully by this fall

with a pattern for solving the problem.

In other words, we are going to set goals for all of the number of specialist trained people that we are going to support through the insurance mechanisms, through all the teaching hospitals, and through the number of residencies and internships that will be funded.

Because we have a parallel program of capital inducement going on in what we call our health resources development program, we have set as a target for this and participation in it a production of 50 percent of the output of the medical schools at the family practitioner level. This will have to be supported in various ways. Basically the support will be by the development of more general family practice clinics and so on, but the ingredients are here. It is a matter of starting to put the mosaic together.

Now having said that, we then have to face up to the problem that we can't penalize our own people as opposed to immigrant physicians. If you can put the controls on the number of specialists that are going to be permissible from your own people, you have to find some way to put the cap on. You can't just have people coming in from other countries with a great advantage of being able to step into practice without the same restrictions that your own people are on.

I think we have had some indication from the Federal Government that as long as we will define by some kind of a complement basis and indicate to people the precise kind of person and the precise location, where they are going to practice, that will be an ingredient in the immigration situation.

A Critical Review of the Problem of Universal Health Insurance in Canada: Solvable and Inherent Problems

L. F. DETWILLER

CHAIRMAN ANDERSON: I would like to get started with the windup session. I think we are very fortunate to have what we say in baseball "clean up man with all bases loaded," and to have another Canadian who has been looking over the field in the Canadian scene for a long time and can take a critical view. So I am very pleased to introduce Lloyd Detwiller from British Columbia who is Administrator, Health Science Center, Faculty of Medicine, University of British Columbia in Vancouver.

MR. L. F. DETWILLER: My assignment today is to review from a somewhat different point of view, some of the areas that our former speakers covered, in addition to new ones. This is being done in order to highlight some of the problems that are presently emerging in our health systems and have laid dormant for 25 years, simply because Canada was prepared to pay its health bill. This is no longer the case and, as a result, these problem areas are coming to the surface and represent the kinds of issues which America and other countries are interested in studying. The time has arrived in Canada when we are able to look at ourselves and ask: "Were we able to do it again, what would we do differently?"

As my role is to be analytical and critical of our programs, I would like to point out that I am very proud of the Canadian plans; that they are as good as any I have ever seen but, at the same time, can be improved since they are giving rise to problems, especially financial ones.

Canada would not want to go back and start all over again, nor return to its old systems. However, there are lessons to be learned from the Canadian experience. It must be remembered that each society is different and every country has its own particular characteristics.

This is basic when one discusses national health systems and their applicability to other countries. Canada is saying to America: "Examine health programs elsewhere but don't copy them without question." While Canadians and Americans are very similar in the majority of ways, there are still some basic cultural differences. Canadians have an outlook on society that is closer to the European point of view, especially that of Great Britain, than Americans. We are much prone to accept government in our affairs. The American public creates government authorities and then resists its intervention into the activity of everyday life.

Canadians are much more likely to accept regulation, and that is why Canadian health plans have tended to develop along government controlled lines.

When one looks at to-day's society and reads about it, all of us have our favourite authors. At the moment, I find Huxley's "Brave New World" and Toffler's "Future Shock" both stimulating and enlightening. Then there is Odin Anderson and his most recent book "Health Care, Can There Be Equity?" It is excellent, especially since the views coincide with my own.

I am an avid follower of the press, believe in the democratic process, and think that, in this era, we are very fortunate in having a communication system where we, as individuals, and members of nations can sit in our front rooms and really take part in a mass decision process about the affairs of the country.

Because of the previous papers, their contents, and my desire not to be repetitive, I took the liberty last night of reviewing the several clippings which I had used as source documents for my prepared paper, re-arranged them, and should like to review them with you as illustrative of the points I should like to emphasize in analyzing our Canadian health plans.

Like Stan Martin, my main qualification for appearing before you this morning is that both of us have worked for government and hospitals. I started in government by running the B. C. Hospital Insurance Service and have ended up in the hospital field, producing patient service. Stan started on the hospital side and has ended up in the government. We both hope that

this type of experience has given us a pretty objective and realistic point of view about what really goes on in the development and operation of government health plans.

When I say to you that health is politics in Canada, I mean just that. Make no mistake about it, and health is quickly becoming a major political issue in the United States.

I have been very privileged to do a lot of work in the United States, as well as in Canada and, therefore, back in the early 60's when Kennedy began to propose medicare with the Johnson administration passing the Medicare Bill in 1965, it was like walking into a theatre and looking at the same show in which I had been involved in British Columbia some 15 years earlier. The same kinds of things appear to happen when governments become involved in health care systems, especially in the developed countries of the western world.

There are major differences for developing nations which do not enjoy the affluence that we have had in North America, where we have been able to develop local health systems, hospitals, fee-for-service medicine, etc. In developing countries, with few health resources, they have had to thrust the system down from the top, giving central direction and control. Canada, like the United States, has historically developed a system of local autonomous hospitals, free enterprise, fee-for-service medicine for the production of health services. Both countries have indicated they wish to retain this method of producing the service, since neither has taken over the hospitals nor the doctors but both are changing the source of the social capital required to run the system.

In Canada, literally all of the money to buy health costs comes from government, federal and provincial. In this way, the Canadian experience is proving that it is possible to use government funds to finance health care and yet produce the service with local and individualistic units. Governments don't have to take the hospitals over nor do doctors have to become civil servants.

In Canada, one of the reasons for the continued argument about our health systems is that we are merging two different ideologies and, like oil and water, they don't mix very well. However, if you mix them enough, you get an emulsion. This is what we are learning to do in Canada—how to mix social and free enterprise concepts in order to get an emulsified situation. The present systems satisfy the requirements of legislative control of funding as well as the desire for freedom of action of the hospitals and professional groups.

It hasn't been easy, but it has been challenging and interesting. Many of you have asked those of us in Hospital Administration in Canada "What has been left for us to do in an environment of government control? You are just puppets."

That same concern was expressed by hospital authorities in Canada in the early forties and fifties, when the hospital system started.

It was the same concern when we started the medical care system. It hasn't been monotonous at all, for there is as much fun in trying to "beat the system" as there is in trying to develop your own.

I speak from experience. I set the system up in British Columbia and I have been doing my darnedest to get around it for the last ten years. I can't beat it.

The new challenge in Canada is to accept the amount of productivity given to you through a system and do the best job you can with that allocation. Of course, Administrators criticize the authority that gave a piece of the action—it's never enough but we are making it work. Perhaps we are able to do this for, as I said before, Canadians are more prone to accept government and, therefore, accept the democratic process of assigning our productivity through the decision made in our Legislatures.

Yesterday, Stan Martin was asked if there was much political influence over Board or Hospital activity. While these pressures exist, there is really very little political influence from Board chairmen and others over the administration of our hospitals. There is some, but surprisingly little under the circumstances. If it wasn't there, we wouldn't be in a true democracy. Very few administrative recommendations are ignored by the politician because administration has been able to show the politician that the cost potentials in our health systems are so great that, unless the politician will listen to the administration's control mechanisms, he is going to unleash—and I shall quote from a Health Minister—this Frankenstein, this monster of cost, that threatens to engulf us all.

This is what Werner Daechsel was referring to yesterday when he stated that, if Canada

continued to add health and welfare services in the future at the same rate we have in the past, they would take our total productivity by the year 2,000. This not going to happen but it is indicative of present trends. This is the type of development that many of us in Canada have been warning the United States about over the years.

The United States will end up with a different system than we have in Canada. I am completely convinced that, because your basic premises and approach are different, you shouldn't expect to develop a system which is the same as other countries.

The contribution of America will likely be a pluralistic method of financing and service production with an increasing percentage of government funds going into financing.

Let us proceed now to discuss the historical development of Canada's health systems, review some definitions, examine how the systems work, how controls are being imposed in certain Provinces, etc. Canada has been interested in health matters for a long time. The attitude of Canadians is that we have always expected to some day have a national health system.

In 1948, the then Prime Minister, McKenzie King, introduced a series of federal grants-in-aid to assist the Provinces in the expansion of certain public health programs, construction, etc. When he introduced this Bill into the House of Commons, he said: "These are the fundamental prerequisites of a nationwide system of health insurance." While this was a public statement of national intent for a nationwide system of health care for Canada, that phrase went unnoticed for years.

In 1958, when the then Minister of National Health and Welfare, Paul Martin, introduced the Hospital Insurance and Diagnostic Services Act, he said: "This is another step towards the system of health insurance proposed in 1948."

In 1968, when the National Medical Care Bill was made effective, the country felt it was a logical next step in a system but it was not introduced as the result of provincial political pressure, but rather for the purpose of obtaining political kudos for the Federal Government in power seeking political support.

It was resisted by the majority of the Provinces, but when it came to the vote it was unanimous. This was interesting, especially since under Sections 91 and 92 of the British North America Act, the majority of health responsibility is given to the provincial governments and the main role of the Federal Government is to assist the Provinces. However, since the federal authority controls most revenues, they can do much more than just assist the Provinces in their endeavours in the health field. In fact, the Federal Government is able to implement national health programs since it presently controls 50 percent of the money which supports them. For example, if the national government says to the Canadian people that it is prepared to pay one-half the cost of a national hospital or medical care plan, when half of the people of Canada and half of the Provinces put in their own plans, this is a great inducement for the residents of any Province to pressure their own provincial governments to implement such programs.

For example, if 50 percent of the Provinces have health plans and a national plan is in operation with participating provinces getting half of the cost paid by the national government, and the residents of nonparticipating provinces are paying federal taxes to support the provincial plans in operation, it means they are paying national taxes and not getting any health benefits. It doesn't take very long to pressure the local politician to have the provincial government join the national plan so that the residents of that Province will get health benefits for their national taxes. In this way, the national government is able to entice provincial governments into implementing national health policy, even although, under the Constitution of the British North America Act, the responsibility of health affairs mainly rests with the Provinces.

The Canadian system has had three ten-year phases—1948, 1958, and 1968—when important legislation was passed, and these make up the first stage of the national health system.

In addition to its health plans, Canada also has programs in Workmen's Compensation, welfare, unemployment insurance, and several others. We are inching into a social security system comparable to those in some European countries.

Canada is now at the threshold of the second phase of development of its health system. It will be a period of measurement evaluation and adjustment, the imposition of controls, and an attempt at the abatement of consumer demand. As Mr. Laframboise described yesterday, the government is embarking on a program of positive health and is asking the population to be-

have and live a health life. I am not sure that we are going to be totally successful.

Dr. Badgley described the historical and sociological developments; Mr. Martin described the systems in detail and also some of the present and future controls; Dr. Werner Daechsel reviewed the evaluation of data, its evolution and the basis of measurement; and finally, Mr. Laframboise spoke on the physical fitness and the health incentive.

With that as background, let us now examine some of the phrases that are used in the discussion of health affairs and, unfortunately, are used very loosely by our politicians in making promises to the populace in return for the vote.

The first phrase is a question: Is health care an individual responsibility, or is it a service that we should obtain through government as a right?

It is that last word that causes a problem. We could spend all of this session debating that one phrase. Its determination is basic to the design and structure of the health systems in any country.

Odin Anderson describes health care as a "civil right." Whiting in Australia calls it a "legal right."

If I had to pick a phrase, I think I would call it a privilege. It is a service which a country or jurisdiction bestows on itself. It is a political decision, but it is a known decision that is made in order to provide a service in lieu of something else.

To illustrate the way in which the debate on this subject has been carried on in North America, let us examine these pamphlets published by various organizations in the past.

This one, published in 1961, states "Your Right to Health." The back printing shows that it came from Saskatchewan. You all remember the doctors' strike in Saskatchewan in 1962. This was the first real confrontation in North America over the interpretation of the rights or individual responsibilities of health care.

This pamphlet, published in 1960–1961 by the AFL-CIO, is entitled "Your Right to Health." The theme is the same as the Saskatchewan leaflet, suggesting that this point of view exists in the United States as in Canada.

In 1970, the Committee for National Health Insurance—the Committee of 100—published this next document. Its first phrase states "The American people have a right to good health care. The Committee of National Health Insurance believes that fulfillment of that right re-

quires the enactment of a national health insurance." All through this pamphlet is the term "right to health care," indicating their point of view.

The April, 1972 edition of the Association of American Medical Colleges Newsletter states: "Kennedy introduces comprehensive legislation on health care services" . . . "Introduces the far-reaching legislation to provide assistance and encouragement for the establishment and expansion of health maintenance organization."

In that statement, Kennedy moved from the position of advocating a universal and comprehensive plan towards the more commercially insurance-oriented concept that health care is an individual responsibility. When Kennedy supported the health maintenance organization concept, he moved away from the pure socialist concept of health care as a service to be provided to the people through governmental jurisdiction to the compromise position referred to above.

About two months before he made that statement, some of the Washington staff spent several days in Vancouver discussing basic concepts, and it could be that that visit had an effect on the counsel the Senator received from his advisors. We do have a lot of visitors in Canada from our counterparts. During these visits, we do our best to highlight what some of the basic issues are and that once a government provides health care as a right it seems inevitable that governments end up going further down the road than originally intended.

For example, when the B. C. Hospital Insurance Service was introduced in British Columbia it was started for fiscal reasons, not for any great altruistic purpose. After the war, B. C. hospitals were in such poor financial shape and needed such amounts of money to keep going that the government found, on studying the situation, that the amount of grant needed to keep the hospitals going was about equal to the amount estimated to start a provincial hospital insurance plan. The original intent of the then government was simply to pay hospital bills, just like the Blue Cross. There was no intention or expectation that it would have to move in later and take over control of construction of beds, set per diem rates, etc. and, in fact, exercise total fiscal and system control in one way or another.

It was a knowledge of what has happened in Canada and elsewhere that, I am certain, influenced Senator Kennedy to make the move he did in 1972 with regard to his health insurance proposals.

That move culminated several weeks ago with the Kennedy-Mills Bill. I have not seen the total Bill but understand it is very similar to that of the Nixon administration, containing deductibles, co-insurance, etc., the main difference being how the funds are to be raised and how they are to be controlled and flow through the system.

The sequel has been the statement by the Committee of 100 or the AFL representatives, in which they disassociated themselves from the Kennedy proposal—and not two years ago he was the champion of the AFL-CIO Committee of 100 proposals. Here is a very important and interesting development in the United States.

Let us return to the sequence of pamphlets we were examining which should further illustrate the conflict of government and medicine:

On the front page of this pamphlet, it says: "Political Medicine is Bad Medicine." It was printed in Saskatchewan in 1962.

This other pamphlet says: "Political Medicine is Bad Medicine" but was printed by the American Medical Association in the same year.

Inside the cover, the first heading is: "Just What is Political Medicine?"

The same paragraph in the other pamphlet is entitled "Just What is Political Medicine?"

Second paragraph of the first pamphlet: "Political medicine is the type of medicine in this Province."

Second paragraph in the second pamphlet: "Political medicine is the type of medicine in this country."

Amazing, just amazing! It is pretty obvious that these two pamphlets came from the same source but were used in different countries.

It is an international problem and should be debated opening and fairly.

The next pamphlet entitled "Medical Care is Not a Right" was put out in 1969 by the Association of American Physicians and Surgeons. The theme of the treatise here is, "No one has a right to anything he must ask permission for or in any way take from another," etc. Hence health care can't be a basic human right.

The next is dated February, 1974, and from Australia. Written by an Australian general practitioner one would expect the following point of view. "Do you realize that Hayden (he is the Minister of Health) intends to wipe out your practice?"

"To claim then that health care is a right, that a man has a right to be cared for by somebody else raises the question, what of that somebody else's rights, since rights cannot exist."

It is the same problem now in Australia and the U.S. that we had in Canada in the early Fifties. In the 1970's, Canada is into a new stage of measurement, evaluation and control and so look at the Canadian system carefully for why I think an examination of how we got to where we are would be a very worthwhile thing for America to do as you move closer to some system of national health insurance.

We will do our best not to give you a biased impression but rather an objective middle of the road presentation. B.C. visitors meet with the British Columbia Medical Association, the British Columbia Hospital Association, private doctors and hospitals, and then visit the capital, so as to spend time with the government prepayment people and the Minister as well. Only after meeting with all sides should a person then arrive at their own conclusions about what they have seen.

All too often visitors are only given one side of the story, they meet their counterparts, hear what they want to hear, and then they go away with a completely biased, prejudiced opinion. See everybody you can, and then get out of the country and look at your own system.

Let's move on and consider the term, "Universal and Comprehensive Coverage," universal, meaning everybody, and comprehensive, covering everything.

If you noticed yesterday when Stan Martin was talking about the Ontario plan, he kept saying, "universally available." Again, that was a key word, and I will tell you why I was privileged to sit in on some of the meetings with Stan Martin, Malcolm Taylor and Premier Frost when Ontario was thinking about going into the proposed federal hospital plan for Canada.

I can remember being very impressed with the then Premier when he said, "I will not go in if the descriptive term is 'universal.' That means compulsion, but if the Prime Minister will change the criteria for entry from universal to universally available, then Ontario will join.

The federal government accepted "universally available," and thus brought in 8 million

people which changed the number of people under provincial plans from 30 percent of Canada to 60 percent of Canada, and this made the national hospital plan possible. It all hinged on that one term "universally available."

"Everything possible is being done for the patient." Another term common psychosomatic support for patient and kin in the old days, and it probably was true, but how many times can you really use it today unless you restrict the phrase to the facilities and the people around the patient? Not very often.

What does the term universal and comprehensive coverage mean? It really means doing everything possible for everybody, and that is not possible today. If this is a fact and it is, then we begin to move towards the area Stan Martin hinted at in yesterday's meeting, when he asked the questions: "What do you do when the demand exceeds the supply? You start rationing, and who does the rationing?"

In Canada, it is done in a fiscal way at the federal-provincial levels, but this does not apply at the level of the individual patient. For example, how do we decide who is going to get the one kidney available if 20 of us need that operation to survive?

There is no question in my mind as to who should get it. Me! On the other hand, should it be the best looking girl or the finest looking young man or the best citizen or the person with the most money or the person with the greatest political influence? I don't know.

The law of natural survival is passé now. We are at a time in history which, while exciting, is awfully difficult, since mankind is no longer able to salve its conscience by doing everything possible for the patient. He now has to decide how much he is going to do for whom. We aren't sufficiently mature and sophisticated to be able to achieve that goal. We are trying hard and are at least beginning to recognize the problem.

When governments pay the health bill this question of choice can very quickly become a problem. For example, in British Columbia when we first started heart surgery and transplant, the government set up an anonymous committee (nobody knew who the members were) to decide who was going to be operated on should the demand for these procedures exceed the supply.

Let us now discuss need. We talked yesterday about the need for a survey to determine what the health needs are of the people of Canada. Already the question has arisen: who sets the criteria? Am I going to accept the fact that the doctor says I don't need care, when I feel myself that I need it. In other words would the producers or consumers set the criteria?

As Stan Martin said yesterday, the point has now been reached where the federal government is making it very clear that it thinks too much money is going into the health care system.

In Canada we have moved from the individual responsibility for health care to it being the kind of service that we expect through government, and all attempts to find a compromise position. We do not want to make doctors civil servants nor take over the hospitals, but must find a way of determining needs which finally get reflected in costs which now appear to be out of control.

Demand has always been influenced by personal priorities of choice. If I can have that outboard motor and get my knee fixed, too, then I'll take both. Remove any need for choice and demand goes up very sharply, and then it levels off. Demand is affected by new advances in health care. If we legislate that there shall be no more advances, then demand should level off. However, I don't think we are going to legislate that there shall be no more advances in health care.

Assume somebody discovers a cure for cancer in Australia this afternoon. The world will know about it tomorrow. If we had cancer in our family, tomorrow morning, I would be down to the hospital with the family member insisting that the hospital or the doctor provide me with that cancer cure immediately. I would probably find thousands of people ahead of me demanding the cure.

Canada relaxed its abortion laws, and the demand for abortion skyrocketed. It pushed back out of the operating rooms many other kinds of elective surgery since abortion can't wait.

It is significant that in the health care system, single events can convert the latent need in the population into instantaneous demand overnight. When government enters the picture, that demand comes right up to the front as a political necessity.

How you meet the demand is difficult. Utilization is meeting that demand, and to finance utilization means cost. That is where we are

having trouble in Canada,—deciding how much we are prepared to put into our health care systems.

Yesterday Mr. Laframboise talked of changing the attitude of the public towards its demand for health care. We have been encouraged in North America by the TV and every other form of media that if you burp twice, see your doctor. Go into that system for everything.

In Canada we are trying to change this attitude.

In the United States the Johnson Foundation, which was set up a few years ago, selected as one of its first projects the development of an adult Sesame Street, whose purpose was to change the attitude of the American people about the consumption of health care.

I am told that that program is just about ready to go on the air.

Dr. Garfield of the Kaiser Plan has always been concerned about screening out the well from the worried well, patient, et cetera. He is concerned as I am that we have lots of facilities and personal right to treat the acutely ill now. If we can just get out of the systems, the well and the worried well, we could cut back on costs. Yet somebody is going to argue that the worried well are sick people anyway and so we should treat them. Mr. Laframboise talked about public relations and press programs to try and get Canadians to think more positively about health. Here is the insert he was talking about.

The topic "How we are dying these days in Canada," is an article with quite a lot of interest. Here is another in the same vein and is an insert right across Canada being read by five million people. The date is February 16, 1974, and the title is "When not to bother the doctor."

It is like the old "Family Physician" that was in your grandmother's house. Canada is starting to say, "Don't always go into the health system. Please reconsider and perhaps treat yourself at home."

The next week the article was, "Are doctors as necessary as we think?"

Here is another one, "Do it yourself medicine. How much is safe?"

I talked to our Minister the other day, and we discussed the possibility of a quiet, behind-the-scenes program, like these insertions. He felt it might well be a way of abating consumer demand and will be looking into it. What are other attempts at abating consumer demand?

As Stan said yesterday, the patient deterrent has been tried, but it was politically unacceptable. Once you give the candy to the baby, it is awfully hard to get it back. The United States does have deductibles. It is using commercial types of controls. As long as you don't promise a universal and comprehensive health system, I think you can contain demand by this type of mechanism.

I am not going to argue whether patient deterrents should be used or not, but I think they are effective. You help people to help themselves by making them consider their system and if demand is necessary. In Canada we have moved in the other direction, yet we are now seeing suggestions about patient and what participation from two of the three socialist provinces in Canada.

In Manitoba the suggestion has been made that it would be proper to charge patients, not a fee for being sick, but something for room and board, an expense they would be incurring if they were home and well. It is similar to the patient deductible of fee but has a politically acceptable label.

The same suggestion was made by the B.C. Minister of Health a short time ago. He said: "It makes sense since our costs are going up and up to begin to ask patients in hospitals to pay something towards their room and board costs." It would appear that we wouldn't be charging patients for being sick, but it wouldn't do the same thing. Encourage people to get out of the hospital more quickly.

Before discussing how our systems operate and the kinds of controls that are beginning to appear, let me refer to the question of physician control which I have been asked to mention.

About three weeks ago our Minister announced that he would be meeting with the College of Physicians and Surgeons to discuss control of the immigration of doctors into British Columbia at the national level. At the last Manpower Conference and Federal-Provincial Health Minister's Conference, the question of immigration of foreign physicians into Canada was also discussed.

It was recommended that the immigration rules be changed so that if a physician wanted to come from Ireland to Toronto, he would be allowed to come in, but he wouldn't be allowed to practice medicine in Toronto. However, if he wanted to go up to the north of Ontario to practice, this would be allowed. Hence we are beginning to see the imposition of controls on the movement of physicians both at the Provincial and Federal levels.

Let us now examine how the Canadian health systems operate. (Drawing on the Blackboard).

This is a hospital with a nursing, dietary and engineering department, etc.

Here is the hospital administrator, Board of Trustees, and a hospital society. The situation about to be described is before we had any prepayment systems, especially governmental. It is budget time. The nursing director wants two more pediatric nurses. The dietitian wants two electric ovens, and the engineer needs to retube two boilers. It is going to cost $10,000.00 to meet these additional requests for all three departments for a total of $30,000.00.

Our present per diem rate is $30 a day. We provide 10,000 days in the year, so if we can increase the rate to $33, we will be all in balance for the next year. You take the budget to the Board of Trustees, give them a good dinner and make the proposal to increase the rate $3.00.

Assume that we are in a valley, and it has been a good year. The board looks at it and appoints the increase to $33.00. You get the two nurses, the two new electric ovens and retube the boilers.

For the next case, assume it has been a poor year—it has rained continually. Instead of all the running shoes being sold, they are still on the shelves of the stores. The motels were half filled, etc. and the economy isn't very affluent in that little valley. It is probable that, when asked for the $3.00 per diem increase, the Board of Trustees will refuse it but may give you $2.00. You get $20,000.00, hire one nurse, get one oven, and retube two boilers, and live reasonably well for the next year.

Assume we are under the Hospital Insurance Service in British Columbia. We have gone through the same process up to the point where the budget request has gone to the Board of Trustees. It is a reasonable request so the Board of Trustees authorizes the Administrator to send the budget to the British Columbia Hospital Insurance Service asking for the $3.00 rate increase. However, in the same mail 99 other letters come in, all asking for the same increase next year.

Therefore, instead of $30,000.00, what is now needed is $3 million. This is a shock for most people have no idea of the amount it takes to run a hospital system.

The Rate Board checked through the budgets and sent on to the Minister of Health the request for $3 million increase in the budget of the British Columbia Hospital Insurance Service.

However, the Minister will also be receiving requests from his other Departments; for example, Mental Health Services may need $3 million; Public Health, $2 million, and the Minister must find $8 million to keep his portfolio going the next year.

Now what is happening? We are witnessing a change in the institutions and systems that are competing for funds and the levels at which the competition is taking place.

At the first level, Departments are competing for the available funds. In the pre-hospital insurance days, our valley hospital was competing for community funds. When we put the hospital under the government, our hospital then began to compete with 99 other hospitals for funds. Now the hospital system is competing with other health systems for the available funds.

The minister takes his health portfolio requirements to the Cabinet and asks for $8 million more to keep the health system going next year. The Cabinet isn't impressed, for it has all the fiscal demands of the other service departments of the government. For example, Education needs $12 million; Highways want $20 million; and Finance wants $15 million; Municipal Affairs needs $4 million, and so on it goes. At this level, the health systems are competing with all of the other governmental services, and when they are totalled we find that, instead of $8 million, $80 million more income is needed to run the Province next year.

At this point, the Cabinet will ask two authorities about conditions in the Province. One is the Treasury Board and the other the Department of Trade and Industry. To the Department of Trade and Industry, they ask: "How are we economically?" Just the same as the little local community asked itself: "Have we had a good year?" To the Treasury Board, they ask: "How are the revenues? Are people drinking enough and smoking enough to keep our income high?"

Let's assume we have a good healthy economy.

The Department of Trade and Industry replies: "Yes, it looks pretty good economically for next year," and the Treasury Board says: "Yes, we are going all right on the income. We think we can find you the $80 million of additional revenue.

The Minister of Health gets his $8 million and allocates it to his departments. $3 million comes back to the B.C. Hospital Insurance Service. It

goes to the Rate Board and one hundred $30,000.00 cheques are written. At our hospital we get the letter, employ two nurses, buy two ovens, retube two boilers, and live happily for the next year, exactly the same way as before when we had a strong local economy.

Where I come from—British Columbia—this has seldom happened, unless it does this year because we have a different government. For 16 years I worked with a government that put more emphasis on building ferries and roads and bridges than it did on health. Our present government may act in the reverse.

To look at the more usual pattern, let's go back to our former government and assume that, when Treasury Board and Trade and Industry are asked about the economy, their replies are: "The United States are not buying enough wood from British Columbia; the newsprint industry is going down, and so our economy isn't very healthy."

The Treasury Board says: "People are very foolishly looking after their health. They are not drinking and smoking as much and so tax revenue is dropping. All we can find for you is $60 million additional funds next year."

Assume there is an election coming up; that the Government has 30 seats and the Opposition holds 28. Politicians want to stay in power. That is quite understandable and so they make political decisions. There is nothing wrong with that.

If you were sitting in their seats, you would do exactly the same thing.

Assume we are now the caucus or the Cabinet and we are planning the election strategy. What is a good pitch for the electorate?

The Minister of Health suggests as an election point: "Promise them all another half hour of nursing care per day." The response is probably "get lost. Nobody plans to get sick anyway."

Then the Minister of Highways says: "There are four seats in the Peace River District in the north which are held by the Opposition. Give me a few million dollars. I will put in 40 miles of hard top road and I will pick those seats up for us."

Who gets the funding—the Highways Minister usually. It is a political decision because we, in Health, haven't made our case to the politician or the populace. We think we are above politics. We are not. We are politics and it behooves all of us to get busy and make sure the electorate knows what the health field is trying to do for them.

We in the Health field are gradually learning this in Canada. It has taken 25 years but progress is being made.

It is at this point in the decision process that the Premier will exercise the authority of his office. He finally has to make the decision as to whether the Government is going to impose more taxes on the population to meet the increased costs of service or whether to reduce the level of service in accordance with the funds available. This is the prerogative of his office.

Let us assume in this instance that he decides to cut the requested additional service. The Government will have only an additional $60 million and if they are going to give additional money to Highways for the next election, Health will have to suffer. Cabinet assigns our Minister of health $6 million. He meets his Deputy Ministers. The Hospital Insurance Service gets $2 million instead of $3 million. The Rate Board then writes 100 letters to the hospitals of the Province and sends out cheques of $20,000.00 instead of $30,000.00—exactly the same as if it had rained previously and we had had a poor year economically in our valley. Of course, in practice the size of the cheques varies between hospitals because of differences in their original budget submissions.

Now let us examine the provincial medical care payment system. Assume we have a total establishment of fine physicians in the Province. Each physician has four patients and each patient visit is $5.00. The cost then of this doctor's office for one day, with each patient visiting the doctor, is going to be five times four, or $20.00 for each. Because there are five doctors, the cost of running the medical care system of the Province for that day is $100.00.

If the situation would remain static, everything would be simple. However, it doesn't and another doctor comes to the Province, takes on another group of 4 patients, and the cost for the day increases to $120.00.

Further, assume that every doctor then takes on another patient. That adds another $5.00 times five which is equal to $25.00 and, by that event, the cost increases from $120.00 to $150.00. The problem is how to control the cost of the system if we allow the number of doctors to freely increase as well as the number of patients and the number of fee-for-service treatments provided those patients.

Ontario has begun to face up to this problem

and has been very successful. The Government has met with the Medical Profession and asked for their co-operation in working out some type of physician-patient control. As a result, an announcement was made a year ago that a ceiling would be put on payments to General Practitioners, the number of patients other specialists could see, etc.

The mechanism works, provided the physician population remains static, but it doesn't. Another doctor moves into Ontario and upsets the calculations and we have the last situation outlined above—the cost of the system rises from $120.00 to $150.00. This is where the doctrinaire laws of supply and demand and economics fall down when you have an insatiable demand for a product like health care but a limited supply.

We have tried to abate this demand by financial deterrents but, to date, they have been politically unacceptable. That is why we may try other devices like the room and board charge or the physical fitness approach. If these do not work, we will have to impose even tighter administrative controls in the future. Ultimately, the Government has control—at least the financial aspects—of the system. It isn't difficult to do it with hospitals—control the numbers of beds and the per diem rate paid. Ontario took 1,500 beds out of service last year and proposes another 1,000 this year. There were very few complaints and the move can be considered successful, but for how long they can be kept closed is another question.

The next move in system control is to regulate the number of private laboratories and other producers of health services. The third part of the equation is the control of the number of physicians, as well as the activities of each physician and his patients. We are at this latter point in Canada. British Columbia is probably as far along as any Province in controlling the number of physicians that are going to be permitted to practice in the Province but there have been no restrictions imposed up to the present time.

What the future is going to be is debatable. It appears that controls are going to be accepted by the health professions, provided they are imposed jointly by the Government and the professional group concerned.

The pattern to date has been to have the government authority develop the statistics necessary for evaluation of the system and its component parts with the application of the control mechanisms taking place through the professions concerned.

The Canadian health systems are similar to those of the United States insofar as production of service is concerned, but differ in the method of financing. There is a health system laboratory to the north with ten experiments running. Study them carefully and then set up your own system.

Thank you.

PANEL DISCUSSION

Canada and the United States: Future Directions

ODIN W. ANDERSON, *Moderator*

Panel Members:

SPEAKERS FROM PREVIOUS SESSIONS

RONALD ANDERSEN, PH.D., *Associate Professor, Graduate School of Business and Department of Sociology, Research Associate, Center for Health Administration Studies, University of Chicago*

GARY FILERMAN, PH.D., *Executive Director, Association of University Programs in Health Administration, Washington, D.C.*

TED MARMOR, PH.D., *Associate Professor of Political Science, School of Social Service Administration, Research Associate, Center for Health Administration Studies, University of Chicago*

CHAIRMAN ANDERSON: Ronald Andersen will be the Moderator of the panel today.

Ron has been an associate and a colleague of mine for a number of years in the Center and has published extensively in the medical care field. We are very pleased to have him moderate the program.

Gary Filerman is Executive Director of the Association of University Programs in Health Administration.

Ted Marmor is Associate Professor in the Graduate School of Social Service Administration and Political Science. The final member of your panel is the speaker, Lloyd Detwiller.

DR. ANDERSEN: Thanks, Odin. What we would like to do as a panel today is to react to what we have heard and bring up some issues that we find of interest and we hope that you will find of interest.

To start things off, I would like to give each of the panelists five minutes to summarize some of their main concerns and subsequently let's throw it open for discussion from the floor.

We might begin with Ted Marmor.

DR. TED MARMOR: I am going to take a selfish approach and ask what is it that we in the United States ought to learn (A) from the conference, and (B) from the Canadian experience, selfish in the sense that there is much to be asked about the Canadian experience that is obviously crucial to their own planning, but my interest is what should we learn from it.

The first thing that I would like to bring up is a set of lessons that I think I have learned from the discussion of the Canadian experience and how they think about it. One is that if you are interested in predicting what the government is going to be saying over the long-run after national health insurance comes in, it would be fair to predict that they would be interested in civilian health, not medical care. There would be an extraordinary interest in bicycles and various other contributants to health.

Secondly, there is wide-spread citizen interest after the introduction of national health insurance in necrophilia, the various details of why people die, that patients worry about access to a great extent, that administrators are particularly interested in questions of control, that doctors are worried about newspaper reports of their incomes. As a last point, Mr. Detwiller, the discussion of national health insurance 5 or 6 years or a decade after its introduction is, very different from the discussion of national health insurance before enacted. That is the first point of a serious nature that I want to bring which touches on Canadian-United States comparisons.

What can we learn from the sequence of con-

siderations that the Canadians have gone through? On that topic, my first generalization would be that whereas considerations of financial barriers to care, equity of access, and, to some extent, the financial problems of the providers dominate the discussion before national health insurance, it is fairly clear that after national health insurance is introduced the fiscal cost constraints and fiscal problems of the payers become a preeminent issue in the politics of health. The answers given to how you deal with problems of cost inflation at the time you introduce national health insurance will have a great deal to do with how those controversies are played out afterwards.

For instance, take a more specific topic that has been discussed here. Mr. Detwiller suggested that one way governments, after they have introduced national health insurance, think about possibly dealing with the inflation in medical care expenditures is they at least contemplate the possibility of patient cost sharing. One of the early Canadian decisions was that significant patient cost sharing would not be a major form of rationing in the health care sector. Yet, a decade afterwards, patient cost sharing, at least in your presentation, is one of the ways people are thinking about this topic once again.

It seems to me one question we can ask is: Is such a decision not to go into cost sharing by patients irreversible? That is, are there any advantages to being last in the United States?

One possible advantage of being last is asking, from the experience of others, which of the decisions they made early on are irreversible and which ones are not. But, the implication I draw from that (I take it that you think pretty much that cost sharing is irreversible) is that a significant role of patient out-of-pocket expenditures as a means of rationing health care to man in Canada is not likely to take place. The experience of Saskatchewan with the government in introducing and taking back provides support for that.

What I want to address is how to use that kind of finding for the debate over the role of cost sharing in the United States.

I was fascinated by your discussion of the Kennedy-Mills Bill because although the Kennedy-Mills Bill provides for significant patient cost sharing (not only premiums but also deductibles, co-insurance, and maximum liability of substantial amount) the rationing of demand you are talking about through cost sharing is likely to be dissipated by an extensive amount of private insurance supplementation. This reintroduces all the questions of equity in the distribution of financial access to pay once again.

The point of your remarks apparently is that the U.S. should seriously consider patient cost sharing as a desirable way to ration consumers demand for health care services. If that is so then I think one would not say that the Kennedy-Mills Bill's handling of deductibles, co-insurance, and insurance supplementation will produce the desired rationing. Instead I would argue that it is likely to produce a very uneven distribution of financial access to care.

One of the things I was interested in along these lines is how Canada dealt with the tax treatment of supplementary health insurance because it is fairly clear in the United States that the fact that employers can give supplementation as a benefit, which is not taxable to the employee and which is deductible from the business, and moreover, individuals can deduct some share of their health insurance expenses against the income. Both of these features of our tax code will make supplementation an equity issue even if we have significant cost sharing for patients in the form of government program.

I think with those remarks they touch upon the central issues that I wanted to deal with among the variety of ones that you brought up from necrophilia to a variety of other Canadian-United States comparisons.

MODERATOR ANDERSEN: I have a related point. Maybe Det could respond. How great is the redistributional effect of governmental insurance which is something Ted is drawing on? I think there is considerable evidence in the United States that the middle-class people, 65 and over, benefitted more from Medicare than did the poor people, the elderly poor. In addition, our Medicaid program in the United States, while you can't argue that it per se benefitted the non-indigent as individuals, there is some evidence that the richer states benefitted considerably more than the poorer states. I think the financing of Medicaid is not unlike some of the financing in the Canadian system.

It has been argued in this country that with national health insurance, there is a good possi-

bility that it would be the middle classes who would benefit more, and consequently, we might not observe the redistributional effect.

I think it is true in Canada, however, at least from the studies I have seen, that some of the initial information suggests higher relative use by the poor following their insurance program.

When we look at waiting times and general levels of satisfaction, it seems to be the middle classes who are doing less well relative to the poor in the function of the doctor insurance.

MR. DETWILLER: Let's start back with the phrase "health care rider individual responsibility." My plea to a nation that is thinking about going into health care is that if at all possible, try and clarify your national concept of that issue.

Where do you place the individual in the societal structure, and where does the nation place the responsibility for health care?

Are you going to provide it as a service to be delivered through government, or are you going to help people to get that service for themselves?

I think that is basic. Does it fit into a part of a total Society Security system, and look at your societal structure.

Is it marketplace, free enterprise, demand and supply, or is it state controlled, owned and operated, because I think these are the kinds of things that form the backdrop against which you have to place your health system.

In a state country like Russia, where you have state control and direction, there is no problem of saying: Here is a totally state controlled entity. The professions, the institutions, will meld into the way of life in that country.

To do that in Canada, if we had our initial legislation that was going to expropriate all hospitals, put all doctors on salaries to make them civil servants, it wouldn't go.

We have been struggling with this oil-water emulsion for 25 years, and I think we are getting places. I think that is one lesson for the United States that it is possible to retain the production of the service through the local hospital and free enterprise doctor, and yet finance it with government money, but that is where you get the conflict.

So when you start talking about the cost sharings and the things that you should take from the Canadian system, my plea is first get back to that issue, if you can possibly do it, and get your politicians to sit down quietly in the back room and argue it through.

We didn't do that. We had an idea. We had very little experience truly to draw on in the kind of societal structure that we have developed here in North America.

You find that you do have private systems operating along side voluntary ones, and they co-exist, and in some instances, the private begin to grow and the governmental ones decrease, a few years later it will change.

I think this whole health system, as I said before, is a very critical point in development. I know that I am out of step with the majority because I am a pretty pragmatic, hard-nosed depression square.

I am used to the idea of individual responsibility for things. Yet, I must turn right around and say, "Yes, it's lovely to know that if I fall ill, that I will not be faced with crippling hospital and medical care costs because it is being looked at by the state." Yet I do feel a little annoyed that I cannot really get the kind of service that I want if I want the super deluxe service.

I can't present myself to the system for immediate repair because I have to go through the criteria that we have set up for entry. So it is even different than Great Britain, where they have a little private system running along side the governmental one.

We have no such thing in Canada. We have one way of entry, and that is into that system.

Now you were talking about costs, the preliminary discussions. I don't think there is any question that we started in first approaching this system, I say, way back in 1919 leading up through the Nineteen Forties in our hospitals and medical care legislation, that this was the evolutionary process of a kernel of an idea that the Canadian people have always had.

They brought it over, I think, from Europe and the systems over there.

Now we moved into it really wanting to improve health systems, but financially, at least, this is what happened in British Columbia and you are quite right. The cost of these things does have tremendous bearing on how they are formulated. At the moment, we have been totally unsuccessful in Canada for the last two or two and a quarter years in solving the problem referred to previously, and that is of changing our cost sharing program from a 50 percent sharing basis to a per capita grant or some kind of sharing of income tax point.

The federal authority knows very well where this spiral is going, and there are lots of statistics here that we could talk about.

It is leveling off on the one hand, but when you look at the percentage of increases by year, we are actually going ahead of the United States at the moment, the last few years. This will change as you go into the same thing as we have been in. But we have been trying at the federal level now to unhitch this blank check or to withdraw the blank check that we have given to the provinces of 50 per cent sharing of the health costs. But, then the provincial premiers when they meet with the Prime Minister and the Ministers of Health and Finance, they say, "Wait a minute. Let's not jump too fast." Here is an editorial which faces the facts about Medicare.

It ends up saying: "The crisis points to a revolution in health care ideas, doctors, et cetera, all aimed at controlling costs. The present system has been called a Frankenstein creation out of control by Ontario's Health Minister, Dr. Richard Porter. The politicians have been warned in time. Now it is up to them to reform this monster before it bankrupts the economy and destroys itself."

We are concerned about the cost structure. The Federal Government has been trying through conference to get off of the 50 per cent sharing agreement. In that agreement we tied ourselves to acute care bed literally, this has really made it very difficult for provincial government to experiment with different forms of health care delivery.

We have all built acute beds like crazy, and yet if you are a provincial premier and you spend another 50 million dollars, you know you will roughly get 25 million dollars of that back from the federal authority. It is a better health system.

It is also new money into the provincial economy. When you are faced with a Frankenstein monster that we have created, we, the federal and provincial governments between the two of us; you are not going to let that federal authority unload the future escalation of costs on the province by getting them into a per capita grant basis. The whole problem of control of the system then passes from the federal to the provincial authorities.

Unfortunately, I think that it is the fiscal problem now that is overshadowing the standards of care, the development of system, because you do finally get back to the budgetary process. The system was designed originally cost-wise, but then it became a system to improve health systems—to do all of the nice motherhood things that we talk about the system should do. Then as we began to become alarmed in Canada about the bill, then those other things began to slip aside, and we got right back to that nasty old dollar.

I think you are absolutely right. Discussions before and after are different.

Now the distribution effects, the richer states, our national program did achieve and our provincial programs achieved the original goals of what I call the first phase. They protected the people. They provided a sound financial base, and they redistributed income. While I say 50% sharing, that is an average. I think the contribution was more like 70% or 80% for Newfoundland.

The poorer provinces got a much higher percentage of the cost, whereas Ontario would get 42% or something like that. It was a leveling mechanism, and it has brought the standards together. And it has achieved the goal of improving those services in the areas where they should have been improved.

Now, because of this continual escalation, the Federal Government says, "Look, I have had enough." I think we will see in the future that either these agreements will begin to be cancelled (it will take five years to do it) or the agreement is going to be wrapped up in a total fiscal package that will be presented to the provinces that they can't help but buy it, and in that way, the percentage sharing will be dropped, and we will be on to a per capita grant and some sort of income tax assigned to the provinces.

MR. MARTIN: There was a question that was asked, I think, rather interesting from the standpoint of before and after consequences. I will just give you three figures here.

I think it was raised. We knew in 1958 that our admissions per thousand or our incidence was about 128 in the group which you might call the lower income group, the social systems group, the people that were probably not as accessible, and compared to that group, the middle and upper were about 156. These probably are not new figures to you.

The assumption was made, and quite properly, that not much would happen to the higher figure, but rather that the gap would be closed. The interesting thing is that the higher figure

rose, by 1968 to 168 (from its level of 156 in 1958). We didn't anticipate that.

DR. MARMOR: What is the spread between the lower income group and the other group, the point you were making before?

MR. DETWILLER: That statistic is not available.

MR. MARTIN: We know the total population is at that figure now.

MODERATOR ANDERSEN: Everybody is equal?

MR. DETWILLER: Everybody has a buck.

MODERATOR ANDERSEN: How do you know?

MR. MARTIN: We don't because we don't have any related income factors in this any more because the program, even though we have some premiums, the program is totally free to all socially assisted cases.

MODERATOR ANDERSEN: But as an indicator of other characteristics besides purchasing power, it would seem to me to be useful. As a matter of fact, in this country the lower income group has a utilization rate which is maybe 15 percent to 20 percent above the rest of the population with quite a different system.

So when you talk about redistributional effects, it is not totally clear, I think, that governmental insurance per se is a prime factor.

MR. FILERMAN: I thought Mr. Detwiller, whom I've known a long time, would make a very strong point of the role of the political process in determining issues that health care professionals tend to view as resolvable on really strictly only, at least in this country, technical grounds. It is a kind of naivete which has epitomized much of the posture with which the health professional in the United States, at least, has viewed these kinds of developments, at least, until fairly recently.

I guess Det is mellowing somewhat. He seemed to come down less hard on that issue in his discussion. But it seems to me that a very fundamental lesson for the hospital and health administrator in the United states is just the extent to which these issues and determinants of the future course of life of himself as a professional and his institution are, in fact, determined in a political process. The political process involves a whole series of issues which are quite removed from the ideological and philosophic issues that we tend to feel underlie our concerns as health workers.

That would seem to indicate the need for another assessment of the political role of the hospital administrator. I don't think that exists today in this country. I can't think of a health professional, with the possible exception of the occupational therapists, who are less influential in national health policy. That is a very unfortunate situation reflecting a number of things.

The sense of professionalism of the hospital administrator, the way hospital administrators are organized, the difference between hospital administrators and health care administrators and some other things I hope will be increasingly talked about in professional circles in the future, hopefully not too late.

A couple of comments specifically are to the question of the lessons to be learned and how they are learned. Obviously, from the American's general knowledge of Canada, it is clear that the institutional structures that we are dealing with in society generally are very similar, and are derived from a lot of the same traditions. Both countries are indeed the beneficiaries of a lot of cross fertilization.

That does, in fact, make it possible to measure, to learn some lessons about the impacts of national health insurance on these institutions. But, I think Americans tend to assume considerably more familiarity with the Canadian environment than is, in fact, appropriate.

There is a tendency to begin with a superficial knowledge of the Canadian environment, society, and its political process. Based on those assumptions, they tend to the conclusions about impact upon the specific institutions and programs with which we are most concerned.

What I am really raising here is a flag of caution that all we have done is touch the very top, skim the surface very lightly, at this symposium. The admonition is: before you draw any conclusions or go any further, take some time to learn much more about the nature of Canada as a society.

The other thing is, I think, we unfortunately tend to view Canada as one country. In fact, perhaps there is not enough emphasis put on the fact that we are dealing with ten major differences in systems.

This has been a very Ontario-oriented con-

ference with a little sprinkling of Vancouver. I think you need to understand that there are some very significant and important differences, experimentation in other provinces, that also merit looking at.

Yesterday, I mentioned the relationship between the health system and the welfare or social service system. That is an interface which is going to become increasingly important in the life of this country and in the life of the practicing hospital administrator. It is certainly going to be a factor in local planning agencies, local planning councils. Again, the Canadian experience is, I think, much more significant than the references in the context of this meeting would indicate.

There was brief mention of some of the issues in the manpower arena. One of the interesting phenomena in Canada has to do with the fact that manpower planning, production and so on are essentially a provincial responsibility. In fact, much of the training goes on in national resources: that is schools, programs which are, in fact, national resources. Some of them, like the University of Toronto and McGill, are autonomous in some respects.

One wonders what the resemblance is between what they do and what the nation needs. That is not an unusual experience in most countries. But it does point towards some of the things that are happening in state legislatures in this country in the education and health man power planning arena.

We are seeing increasingly the raising of the same kinds of questions about education that have been raised about health, utilization of public money, duplication of resources, acceptability and so on. The interface most directly comes in the health man power issue.

There is a real question in mind about the effectiveness of the hospital or health administrator in impacting—bringing his professional judgment to bear or to contribute to the process of policy making at that level.

In Canada we see provincial planning as a very important laboratory for examining that process.

The question of the role of these regional councils is a very interesting one. I suppose the most interesting model is one that was not discussed: that is the experience in Quebec as a result of the Castonguay Report. The community council concept has really been carried much further, I think, than it has in the Ontario experience. It is interesting that in the reor-

ganization of the British National Health Service, we also see a move into a broad regional council system. In the discussions running through the reorganization of comprehensive health planning in this country, again the same model begins to emerge, or the same basic concepts that Stan was referring to in Ontario, that we see in the United Kingdom and so on.

So the result is that of trying to bring on one hand the planning down closer to the community level; on the other hand, trying to bring it up to a viable sort of economic and geopolitical base.

There is a conflict that is very interesting in the face of the drive for consumerism and direct communication between policy makers and communities, if not neighborhoods, that would again hold a great deal of interest for policy makers in this country.

I have been intrigued by the marked difference in competence between the bureaucrats at the provincial level and the bureaucrats at the state level. In my estimation, the real strength in Canada, in terms of professional competence and administrative machinery and so on, does, in fact, rest at the provincial level. It is very intriguing that the provinces have been able to attract the kind of people that you have seen here at this conference.

There are a lot more people in Canada operating at the provincial level who are of the kind which we have traditionally not attracted to state government in this country.

Now obviously the separation of powers situation has a great deal to do with that. The provinces is where the action is.

As we move toward the development of some of these mechanisms, we define state responsibility and national health insurance and planning and so on. Again a close look at the Canadian experience and what has enabled the provinces to be so relatively successful, at least, to an outsider, is worth examining.

Then there is the resolution of key issues that face us.

There is a great deal on the Canadian scene to give us some information about.

One of the critical issues is how the insurance system is used for leverage in redistributing or re-engineering the system.

One of the bell weather services that intrigues me is home health services. We have running through the mythology of the whole

health services or medical care literature a number of assumptions about the importance of home health services about balancing the system and solving certain problems.

Yet to my knowledge, Canada has not succeeded except in a few notable instances in really establishing a viable national system of home health services. That failure would, I think, merit some very close examination because clearly the financing mechanism to make it possible is there.

As to the question of the distribution of expensive, scarce new services, there is no question that national health insurance has within it the seeds of being a retardant on innovation. It can act as a control device, and certainly that is a fear, I think, that some elements of the medical profession feel very strongly about.

For the hospital administrator, the openness of the process is a very intriguing environmental implication of national health insurance.

The budget process that Det explained, has within it some seeds of rationalization, or at least openness of resource allocation within individual institutions, among individual institutions of a kind, which, I think, makes many of our administrators very uncomfortable.

They would need to start to regear their thinking processes about the ways in which they negotiate conflicting demands within the institution, the way that they operate at a community level among themselves, kind of divvying up community resources, and just how open the Canadian system really is. Just what effect that has on managerial decision making is something that we should learn something about.

Quality control is very much on our minds in the United States. The PSRO debate and implementation have certainly provided a whole new psychological set, if you will, for administrators.

I think they are very unsure at this point just as to what their role should be, can be. The quality mechanism in Canada, it seems to me, has a number of mechanical trappings. The data base, and so on, has developed in a way that it is far advanced of anything we have here, in fact, may contain the seeds of some of the things that will make the PSRO system effective. Yet, there is a real question in mind as to how far it goes beyond the statistical measure. Does it, in fact, break down when it comes back to the same process we have here, referring back to the colleges?

Once the flagging has been done by the statistical system, how effectively do the professional peer action systems operate? Are there, in fact, any differences from the kind of closed action system that we have in this country against the background of national health insurance?

Det, I would like you to come back to the political process and to the role of the administrator in determining policy or having input into basic policy formation for reaching in the system. As you look down the pike at the American scene, do you see the administrator coming into an even more confined role than he has today? I think this has dictated some potential for expansion of that role.

MR. DETWILLER: You are giving me one specific. Let me answer it first and then get back to two or three others.

One reason why administrators who are pretty pushy people can tolerate the direction of a central authority is that it is a great game to play; you do not have the very real problems of trying to finance the institution where you ran out to the service clubs and banged the doors here and there for funding and argued with Blue Cross.

There is one authority that you submit your budget to, and God help you, if you don't have a good budget and supporting data. As I said before, the central authority knows more about you than you know about yourself. They have all the comparative statistics to show you where you are, put the facts in the budget, et cetera. In addition to that, Gary has referred to a whole new area that is really a lot of fun, and that is that you will be expected to be very knowledgeable, not just about your own hospital and your own immediate environment, but I think it is your job to try and educate your Board of Trustees about the kind of system that they are in, to begin to educate them about the realities of political life. You will do some of this on the golf course yourself. The thrust is that board which is, I think, in many ways strengthened under this kind of a system, if that is the way the country decides to go. The board is the political pressure authority towards the regional councils, the provincial government, the various hospital and medical professions, et cetera.

So I think the numbers of avenues and the kinds of avenues that open up for a hospital administrator under a national system can be very challenging. I personally have found them an awful lot of fun, but I am politically biased and finance biased.

I know that some other people might not

enjoy this. I do, but I think it is a fact that if you look back at the courses in hospital administration in the early Forties, early Fifties, these were internally oriented to run the show, and you had a little touch of the outside activity of the community.

You had the board composed of people who could give the philanthropic gift, et cetera, and it was a local institution.

The administrator of that hospital must reach out into the community. He not only reaches out to the community now. He has got to reach out to the state and the federal authority. He has to be a pretty knowledgeable guy with politics, and he also must know that he has got a board, that he has got to also try and explain this whole thing too. So I think it is very, very exciting.

I would say to the people here: you undoubtedly are going to put up the flag as we did. We are losing our autonomy. There are going to be people that will resign. There will be trustee people that will resign. The world is going to stop. It doesn't, you adjust, and you said I am becoming mellow.

Yes, I am. I am getting older, but I figure you people are in it up to your neck now, and there is no point in my saying: "Get off your butt. It's coming." It's here.

So look at us, and see how we, I think, have adjusted to it. You can have a real lot of fun in it.

You commented about the home health program. One of the problems we have had in Canada is that that kind of activity has not been shared by the federal authority. When you have pressures from local groups or provincial people to start expanded home health care programs, nursing care programs, the provincial governments, of course, sit back in a very, very better than thou attitude and say, "Now if it was only that Federal Government would share in that cost, why we would put it in tomorrow."

You know, you always blame the other guy for something you don't do. This has been a very nice political shoulder slamming gimmick.

Of course, in British Columbia where we get a lot of retired people, there is no way, but they have done it in Ontario. That is why that is the kinds of agreements we wrote into the 1958 Hospital Diagnostic Services Act; it restricted that kind of development, and that is what we have been trying to break out of for three years, and we really haven't gotten anywhere yet.

That is the problem of the financial structure overriding and inhibiting the development of the delivery pattern.

Thirdly, it's the roles of the federal people and the provincial people that I think make it possible for us to be pretty active in both fields. (You would be surprised if you went to Ottawa and saw the kinds of data that Werner Daechsel described about every physician in Canada.)

I wouldn't want you to think that the federal people aren't doing a good job. I am saying all the right things, and we hope to have better capital grants in British Columbia, but I have here the first draft, just a couple of pages, the Canada Health Man Power Inventory. Sure, everybody threw stones at it when it came out. But here is a listing of requirements, actual and need, by specialty, of all physicians in Canada, the estimates, and let's just take one line here, Quebec beside Ontario.

Quebec needs 716, and Ontario has 748 to many general and family practice. So, of course, you just simply say to 748 people in Ontario: "Move to Quebec," and we will balance off the need this way.

That is being facetious. But, in fact, when you begin to look at these statistics, these do have ramifications in the kinds of residencies that will be approved in the various teaching authorities. The national statistics that are being cranked out are not put on headlines by the federal boys. They are quietly sent out to the various provincial governments, and in this way we are able to develop our programs. It is on the basis of these statistics that we are now in British Columbia, in again these old clippings, editorially, "How many doctors are enough? Doctors galore in BC. Restrict the registration of BC."

No, that was a year ago, and yet as I said, here it is: "Our Minister and doctors to hold talks about halting M.D. immigration into British Columbia." All based on large part not only on our experience, but on that federal statistic that came out about health man power distribution. That is being cranked out now and updated continually by provincial councils based on federal statistics.

So I think we have achieved a kind of understanding relationship at the administrative level. I think it is going along really surprisingly well.

MEMBER: We heard that there would be negotiations about increasing pay for hospital employes, both professional and nonprofes-

sional, that the negotiation took place not only on the local level but on the regional level. My question is: Given that you have what would amount to an inflexible budget system, how do you meet this type of cost increase during a fiscal year?

MR. DETWILLER: In British Columbia, so that we can get a little balance here with this Ontario group, we have the bargaining for nurses, hospital employes, physicians, all conducted on a provincial basis with the provincial government in the various administration sections that are under our Minister of Health. Once these negotiations are completed, hopefully the provincial authority will then meet the negotiated increases. Sometimes they don't, and you simply adjust your hospital accordingly.

Decisions can have very far-reaching effects.

Two years ago, I was telling you there was an award called the Blair Award made to a hospital by our mediator nominated by our new Socialist Government which has just landed in Stan Martin's lap, I think three days ago. I think he said 100 million dollars or something yesterday here.

It started literally in that mountain village of British Columbia. Here is how it went: the new government was going to clear up the disparity between the sexes by saying that aides should be paid the same amount as orderlies, because they do the same thing. But, because we had a new Minister, and he didn't think through in total, the ripple effect of that, and it was authorized before it was handed down, he raised the aides up to the orderlies. In so doing, this raised the aides above the lowest units of the registered nurses. The registered nurses immediately recoiled and said, "We shall get that back," and we had a threatened strike in our province up to about three weeks ago. They were going to close down about three hospitals and asked for a 40 percent increase in one year to gain back.

Last fall our Minister raised the other hospital employes up to a minimum of $659.00 a month, for a certain group. That went right across Canada very quickly through the telegraph or the telephone. These are the kinds of negotiations that Mr. Martin has been engaged in with the hospital employes in Ontario.

You have got to stand back and ask yourself why. It is because you have a federal sharing of provincial plan costs. If it is good enough in British Columbia where we have the highest wage level in Canada, you know who is going to be pushing to get up to it—Newfoundland, which is the lowest.

MEMBER: Could you compare the push to group practices in HMOs in the two countries?

MR. DETWILLER: Yes, the HMO is sort of a self-contained middle health system. You sell the insurance. You have the physicians, the hospitals, your clinics.

If you look at Canada, you see we have now national and provincial systems for the medical payments, for hospital payments. These two systems run more or less separately. But, we do have emerging a trend. Yet, I don't know whether it is a trend because it doesn't seem to be catching on to the development of the community health center.

It really started in Quebec. It was a national recommendation, and now we have provincial reports recommending that clinics be developed.

You have got to define the clinic, and the clinic really starts back with the doctor. You put a group of doctors together, they have some nurse, and that is the medical clinic. Now you begin to input a social worker, a physiotherapist, all these other kinds of services, diagnostic services, maybe a lab, and then in some provinces you add a public health worker, a mental health worker, and you begin to expand this.

In Quebec they have expanded it to the point where now I am told you can even get mortgages for houses in the clinics. In other words, the clinic has grown from being just a medical clinic, to being a health clinic, through to being a human services clinic. Another new thing that is beginning to emerge is that health is only a part of human services.

So I think the difference is that in the United States your HMO, I think, will be concerned about the delivery of health care on a unified basis.

We still have the hospital system, but you can see the clinic beginning to grow around the physician and then bring in other health services. We may end up, I am not too sure, though, with everything being brought together. We are going another different route.

DR. MARMOR: The only point I want to make in connection with that is the need for care in

describing HMOs. The evidence I have seen suggests what we would call a prepaid group practice with a closed panel and an enrolled population.

It is very small in Canada. Often that gets confused with groups organization of physicians which is fairly substantial. We ought not to mix those two ideas and think that in fact Canada has a very extensive HMO, prepaid, enrolled group practice. It doesn't.

I know less about Health centers.

MEMBER: About what percentage of doctors practice in groups rather than as individuals?

DR. BADGLEY: I think it is about the order of 25 percent in private practice would be a reasonable estimate.

MEMBER: Is it fair to say in analysis between hospital budgeting and budgeting of fee-for-service payment for medical services that the medical service component of what we deliver in the United States, the doctor's charge, is potentially to be provided by a group of professionals organized and paid for by the doctors in the manner that we do in our HMO concept? Does this group practice, that includes social workers, and a whole list including community workers and housing coordinators, etc. get paid for under the concept of the doctor's fee?

MR. DETWILLER: No, the payment to the physician in his private office is a fee-for-service. Remember all these schedules are negotiated between the government and the medical association of the province.

That payment will be for his services plus an overhead charge of maybe 50 percent of the fee.

Now, when you start getting into grouping of doctors together, you can have a problem. The data might show Dr. So and So as receiving $625,000.00, but he was the signing authority for maybe eight doctors. They will group their overhead allowance and run their clinic. But, when you start adding a social worker or when you start adding a public health nurse, the support of those people will come through other funding mechanisms through the government, maybe a public health payment for a public health nurse.

MEMBER: How is that decision made?

MR. DETWILLER: This is a decision by the government about the kind of programs they want to encourage.

Now when you get that more refined, you then begin to group the public health authority, the mental health authority, the hospital authority, the medical authority under one minister. You begin to group it into a system where you may have one payment from the federal authority to cover all those. It can come to that.

MEMBER: How do the two systems relate, the one you just described to the hospital system? How do they decide to put the social workers, the community workers, the et cetera, on the pay roll of the doctors' group or the hospital as an institution? Which of the two sets are responsible for the continuity of care and the open intake into the system?

Is the hospital something that simply sits apart from, and takes care of, only the hospitalized patient?

MR. DETWILLER: In some provinces, yes; in others, it is becoming integrated into a regional health system, as Stan Martin described, in Ontario. This is why we have ten different systems really in Canada. Each one is at a different stage of development.

I think this is one of our strengths. We do not have a national plan imposed on us the same for everybody.

This is a strength of having grants-in-aid from a federal authority to support provincially developed plans. You can go in to every province and find a different mechanism.

The Canadian thrust is towards the community health center. The federal authority sits with 640 million dollars in the bank saying to each provincial government: "If you will go towards the community health center, we will give you some money to help you do it, but of course, you have got to sign on the per capita grant if you want to get it."

MEMBER: I was looking only for the comparison with what is happening in our system. I found that in our system, we have our community mental health centers that have developed in this model. There is lots of food for thought in the relationships.

MR. DETWILLER: We have got those, too, in some provinces.

MEMBER: I would like to ask particularly Ron and Ted to comment on the significance, if they see any, to what appears to be a movement toward rationing in this country before national health insurance rather than afterwards. You know what I am referring to: PSROs or the effort at rationing utilization in view of the efforts of rationing, as well as certificate of need laws, etc.

DR. MARMOR: I am glad you raised that point because I was thinking that the notion that Canada is foreshadowing, and that it is ten years down the line in these concerns, is belied by our own experience with Medicare.

Much of our conversation here is as if Medicare hadn't existed. I think you are quite right that what is peculiar about our debate, right now, is that we seem to be looking at questions of expanding the access to medical care rather than the way Canada was and is dealing with problems with inequities and in equality of access. But at the same time, the U.S. government, which has experienced extraordinary program cost inflation, is raising problems of cost control before national health insurance. I think without the conjunction of those two events, it would be inexplicable. The Kennedy-Mills compromise—the shift from a fairly straightforward zero, out-of-pocket national health insurance plan to the effort to combine that rationale and cost control on the supply side with some cost control on the demand side—I think was a development inexplicable in the United States four or five years ago. I don't know what else you want to make of it except that we seem to be peculiar in being last not only in having Canadian conflicts foreshadowed, but by having our earlier step, Medicare and Medicaid, present problems of expansion of demand.

MEMBER: I think it is true that the nationalization of financing has in every other instance been directly or indirectly adopted as a means for putting more resources in the system.

In this country we have an over-financed system apparently. If costs are too high, that means there is too much money going in because you cannot incur costs without spending money.

We have an over-financed system apparently in advance.

One curious thing is that this utilization distribution in plain economical levels isn't necessarily what you think it would be. The other thing that strikes me as curious is that the major discontent with health care in this country seems to be in the areas where the most money is being spent on it.

There is not much organized discontent in South Dakota and Arkansas and Wyoming. There is a lot of organized discontent in Boston and New York and Philadelphia and Chicago and Los Angeles where enormous amounts of money are being spent. It is interesting to observe in this country, which I think is another reason for the Kennedy-Mills bills, that whereas civil rights was an idea whose time had come in 1968, in this country national health insurance in many ways is an idea whose time is past. It would have made a lot of sense in 1932, but for various other reasons it seems, at least in the Canadian sense, it makes no sense at all.

MODERATOR ANDERSEN: I think that is related to the second point that I was concerned about. It seems to me that the points made about Canada suggest that a very important determinant of increasing government involvement in the financing and delivery of medical care is based on consumer demand. However we go about measuring that demand, and that increasing price per unit of service and the proportion of the GNP devoted to health was something that was almost inevitable, given these kinds of inputs of decisions that the population is making.

I have some questions about these assumptions. Certainly in the United States—I am not so sure in Canada—but we also discussed the limited effect of utilization on health and the relative trade off of other things such as housing, environmental conditions, nutrition and so forth.

Indeed there have been a number of studies in this country which have shown that in general, the priorities of the population are such that health care does not rank first, but ranks maybe third or fourth behind employment, housing and education.

Our own national studies concerning people's attitudes toward governmental health insurance, extending governmental health insurance beyond the poor and the elderly, are at best ambivalent in this respect.

I don't think that there is an overriding demand in this country at this point for the instigation of national health insurance. Certainly people want to avoid catastrophic financial effects of illness. But, I think in measuring

people's choices, they do need to be made aware of the kinds of trade offs they are making. That is, if they spend more on health, they are spending less on something else. With respect to Robin's suggestion, he said the question was biased to ask people, "Would you like more health insurance or governmental health insurance if your taxes go up?" I would like to ask if it is any more biased to ask, "Would you like free governmental health insurance?"

We are talking about demand for health services and the increase in the proportion of the GNP devoted to health services.

It was said that Congressman Roy suggested the price may go up to 15 percent. From what I know of Roy, he will be fighting all the way if it does. What I am wondering is, if we don't have kind of explicit resistance and concern and consideration of trade offs, if this trend that we are noticing isn't likely to be much more rapid with the leveling off point beyond what it would be if we didn't have conscious and continuous resistance.

MR. DETWILLER: You made reference to the gross national product. I would like to refer the group to a little publication here from National Health and Welfare, Canada which reports national health expenditures in Canada, 1960 to 1971, with comparative data for the United States. I am sure that the national authority would be pleased to sent this publication if you wrote for it.

For instance, I do know this calculation on gross national product or income is rather interesting to just look at. I will read the Canadian figures first and the United States figures second. This is the percentage of the gross national product.

In 1960, Canada, 5.3; United States, 5.3; In 1965, Canada 5.8 and the States 5.9; In 1969, Canada 6.4 and the United States 6.9; In 1970 Canada 6.8 and the United States 7.3; In 1971 Canada 7.1 and the United States 7.6.

But if you look then at the table of percentage average annual change, it is rather interesting. Canada in 1960 to 1971 was 11.8% and the United States was 11.1. In 1965 to 1969 Canada was 12.6 and the United States was 12.1. In 1969 to 1971 Canada was 13.4% and the United States was 11.5, and 1970 to 1971, the percentage change in Canada was 14.3 and the States was only 11.1.

That begins to show how our curve is going up as our national medical plan gets into effect. This is why we have got to stop all these doctors coming in. This has some very interesting statistics in it.

DR. BROWN: Several of the speakers have referred to the option of going for a co-insurance payment in any sort of plan which is adopted in the United States. The Canadian plan is usually described as one in which there is zero co-insurance in the plan in the province as far as the extent to the user. Yet initially, at least the physicians, I think, in all the provinces were given the option of charging an additional amount over and above what they received from the insurance plans to the patient.

This, of course, has relevance when you are talking about the equity question which you raised before.

I think there are some lessons to be learned from the Canadian experience, but they haven't yet been really examined as extensively as they can. In one of the provinces, Nova Scotia, the amount of extra billings to patients is, in fact, recorded. It is therefore possible to take a look at the effect on utilization patterns of the extra billing to examine the characteristics of physicians perhaps in association with the incidence of extra billings and the characteristics of the patients.

In terms of frequency, 40 to 45 per cent of fee-for-service physicians apparently bill at least some time during the year. In terms of the financial magnitude, amounts are billed to about 4% of the total insurance payments which means that for those physicians who do, in fact, extra bill, it would mean that extra billing would be about 10 percent of the insurance.

So there were some references earlier to the political dangers of implementing co-insurance in Canada as a means of rationing demand on the system, and reference to the fact that it is a politically risky business. In fact, there is rationing going on now through this extra billing mechanism.

What we don't know is just how effective it is and where the impact of it is.

MR. DAECHSEL: I think it is important to state what I understand has always been the federal position. That is, that it is universally available service. What extra charges were allowed, and I know there was a lot of soul searching when

Saskatchewan tried its experiment, was that in fact interfering with people getting service. If it was, then I think our stand would have been no, that we would not agree to it.

MR. DETWILLER: You would have disallowed it in the sharing?

MR. DAECHSEL: We would have disallowed it. It was very close. I can remember the period. It was marginal whether it was.

The problem I see then from the point of view of the consumer and from the point of view of the person that is trying to lose it as a mechanism, if, in fact, it isn't working, which is what we say, "If it works, you can use it." It doesn't really seem to solve anything from the point of view of the province.

I would disagree with respect to the physician that the extra billing is, in fact, a co-insurance. I think that most of the provinces have agreed to this arrangement only on the assumption that there will be enough physicians available who will provide the service for the people who do not want to pay the extra.

In other words, that this is a voluntary arrangement which they have agreed to, always under the assumption that there would be enough physicians (and there usually are in most provinces), that people, if they want to, can get service from some one who will not bill them extra.

MODERATOR ANDERSEN: So the judgment that was made allowing physicians to bill did not reduce the demand for services?

MR. DAECHSEL: No, that is a different question. My argument would be that the provinces who allowed some physicians to charge more on the assumption that there wouldn't be that many that would charge more, and the 4% indicates this, that the patient who wants to go to a physician who doesn't charge extra can, and therefore, doesn't have to pay it. So the coinsurance, if you want to call it co-insurance, which I don't think it is (it is voluntary on the part of the person who seeks the services). Can allow anyone to get the service without having to pay the extra.

MR. DETWILLER: Also, I think, Mr. Chairman, that these charges, this additional billing, was allowed from the beginning when the plans were implemented. The problem was when you had a hospital system that was operating and there was no billing to the patients, and then you tried to impose it.

Then you must remember you always have an opposition party who is prepared to stand up and offer me something for nothing and get himself back in office. This is what happens.

MEMBER: My question was on a different point. Ron, when you made the decision that it was okay to go ahead in Saskatchewan, did you proceed on the assumption that it was all right because it wouldn't deter utilization?

It seems to me that we have emphasized that issue exclusively. It seems to me that there are two other reasons why you might want to have co-payments. Ted, I agree with you that politically, it is very unlikely that any United States Government would say, "Don't have supplementary insurance for co-payment." If enough people buy supplementary insurance to cover co-payment, then the deterrent issue is really eliminated.

They don't take it seriously.

DR. MARMOR: It is redistributed in a different way. Unless it is universal supplementation, you reintroduce a different distribution of access than you think you have introduced with the original cost sharing.

MEMBER: No. I think you are really at my second point which is this: under voluntary insurance, and if you are trying to cover compulsory insurance, let's say, through employers, there is some inducement to keep your premium down. One way you keep your insurance premium down is by having co-payment. This is, I believe, where Canada comes in right now.

Thirdly, this was the basis for the Nixon proposal, but the third problem is something that faces most of us liberals, and it is this: there is this concern that if we raise more and more money for health services through the public revenues, we may not have this tax money when we want to spend it on things that only the public fist can pay for.

I think this is pretty much the Brookings Institute position. So I would like to ask whether we really shouldn't consider all these three considerations: one, co-payment of the deterrents to use, and what are the implications when you allow supplementary insurance to pay for the co-payment and enough people take advantage of it?; two, what about this notion of keeping

premiums down especially when you move towards compulsory insurance? I used to think that under voluntary insurance there was a good reason for having co-payment, but now under compulsory, we seem to be doing it for another set of reasons; then finally, what about this third consideration? What are the things that some of us would like society to do that could be financed only from tax money we would like to make sure that we still have, when we get to do these things. Is that a good enough reason for co-payment?

MEMBER: I was struck by the observation of one of the speakers, that hospital emergency rooms in Canada are becoming ambulatory care centers. Of course, we are familiar with that in this country. The explanation in this country is that people have trouble finding a physician. If there is a surplus of physicians in Canada and if people are not paying for them, it is hard to understand what the explantion is for emergency rooms becoming ambulatory care centers.

MR. DAECHSEL: I think the emergency centers, even before we had hospital insurance, and more so now, as relationships have changed, are the place of choice for some individuals for primary care.

This is what is happening: Many persons even in a small city like Ottawa who do not have a physician or a ready physician to call would just as soon go the emergency room. That is where they want to go. The hospitals in Canada had not been responsive in some ways to recognize this. Some have; but some haven't. Theoretically we said years ago this is what emergency departments were for, and we still don't think they should be used for that.

MEMBER: As maybe the only physician who works in emergency rooms, I can maybe add to that.

At least half the people who come to the emergency rooms have already seen a physician. They really are coming to the institution that they trust. I think this has been a growing factor for people using emergency rooms. They can trust the institutions more than they trust individual physicians that they don't know or have a relationship in the way they had before.

I want to ask Mr. Detwiller about co-insurance in British Columbia because as I remember, hospitalization had co-insurance when it first started, and this was abandoned.

Is there anything in that decision that would contribute to this discussion?

MR. DETWILLER: Co-insurance was introduced in 1951 as a revenue measure and as a deterrent. It was, as I remember, $3.50 per day for certain hospitals and graded down to $2 per day. That was a long time ago, and it began to do the job it was intended to do.

The waiting lists at the hospitals came right down very rapidly. The revenue was obtained. The fiscal catastrophe of those early years seemed to be being averted.

We then had an election in 1952. The hospital insurance service was the election. The party that was elected promised the citizenry a voluntary hospital system. Nobody really knew what that meant. They made a great point because the impact politically, of the co-insurance, was still subject to controversy; but, if they were elected, they would take it off.

They then reduced it to a dollar a day for everybody. It has been there ever since and still is. It doesn't really do anything in a deterrent. People pay it. There is no grumbling, but, as Werner said, that expenditure is disallowed as a sharing item. So every once in a while people say, "Why don't we dump the dollar a day, and we would get half of this paid back to us? If it cost us one million dollars to dump it, we would get $500,000 from the Federal Government."

That still persists. I think the significant thing is that politicians now are really seriously, for the first time, beginning to talk about a room and board charge. That is only a deterrent under another name, but it may be a more politically acceptable thing. So, we are watching that with great interest.

MEMBER: One of the concerns that are expressed about the catastrophic approach to national health insurance and growing out of some of the statistics for Medicare, is that much of the resources, particularly in hospital service, will be devoted to short-term life extension activities.

I wonder whether or not under the Canadian experience that kind of concern has been realized and whether or not that is, in fact, likely to occur when you have an open-ended

system at the top without any limitation on financing.

MR. DETWILLER: We have all these things hitting us. We solve them in a different way sometimes in the front line of the newspaper. I am not sure what you mean by short-term life extension.

MEMBER: Heroic measures to extend a man's life six days.

MR. DETWILLER: I am going to describe a case. The husband is examined, he needs open heart surgery, he is now 150 on the list.

The wife says, "I am not prepared to wait because the doctor says he may die before he gets into the system."

She hits the press and the TV. It becomes a debate in the Legislature.

We, in British Columbia, fly McKinnon and his wife to Montreal, repair the heart, bring him back. It all subsides.

What happened to the other 149? Some of them didn't make it. These things happen. I have got the whole thing in these clippings here. We have exactly the same things as you have.

DR. MARMOR: But I take it that you also have committees that anonymously decide which is a different allocation system than the one you just suggested.

MR. DETWILLER: They did.

DR. MARMOR: The point is how do you deal with the dilemma between a clear financial limit that excludes people that have reasonable claims and the problem of spending so many of your resources in that way?

MR. DETWILLER: Your financial limit is determined by the Legislature, and then you cut the pie up.

DR. MARMOR: It is global.

MR. DETWILLER: Sure.

MEMBER: But it is really a closed end system.

MR. DETWILLER: It is, very closed.

MEMBER: Then the question is: Do you have triage mechanisms at the hospital to make those trade-off decisions?

MR. DETWILLER: It is no different than your own. We have got the admitting people, the doctors, the physicians. That is where the sorting out process takes place until you get a case like McKinnon where somebody sticks their finger in and says, "Hey, take that guy." That is a political entry, not a medical decision entry. McKinnon couldn't get into the system through the usual kind of health care entry, so the wife went political and got him in.

This is the exception, make no mistakes about it, but these are the things that can and do happen and the kind of problems that you have got to watch for.

CHAIRMAN ANDERSON: I think the closing quote from Mr. Detwiller may be that the financial limit is set by the Legislature, and let's close at that point. I thank the panel and the speakers, and I thank the audience for its participation.

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