

The Canadian Health-Care Financing and Delivery System: Its Experience and Lessons for Other Nations

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Canada's system of universal public insurance for health care is by a considerable margin the nation's most successful and popular public program. Far more than just an administrative mechanism for paying medical bills, it is widely regarded as an important symbol of community, a concrete representation of mutual support and concern. In a nation subject to strong divisive forces rooted in both geography and history, the health insurance system is an important unifying idea as well as an institution. It expresses a fundamental equality of Canadian citizens in the face of disease and death, and a commitment that the rest of the community, through the public system, will help each individual with these problems as far as it can. "There is no social program that we have that more defines Canadianism or that is more important to the people of our country."¹

Perhaps as important to the establishment of national identity, the Canadian health insurance program also clearly distinguishes us from the United States, where the health-care funding process is quite different. The fact that we have developed such a different system suggests that, despite most outward appearances, we are in fact a separate people, with different political and cultural values.

Even better, our form of organization *works*, and compared to most other systems works very well, while the American alternative is generally regarded in Canada, and increasingly in the United States itself, as a disaster.² It may be difficult for anyone who does not live in a small country with a somewhat

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1. David Peterson, Premier of Ontario, Address Before the International Conference on Quality Assurance and Effectiveness in Health Care (Nov. 8, 1989); see also Robert G. Evans, *We'll Take Care of It for You: Health Care in the Canadian Community*, 117 *DAEDALUS* 155 (1988).

2. A recent poll of citizens in the United States, Canada, and the United Kingdom presented each with a short description of the form of health-care funding in each of the other two countries. Based on this comparison, *sixty-nine percent* of Americans said they would prefer the Canadian approach. Of Canadians, three percent expressed a preference for the American way. R.J. Blendon, *Three Systems: A Comparative Study*, 11 *HEALTH MGMT. Q.* 2 (1989). Eighty-nine percent of Americans said they believe that their system requires total or major reform, a view shared in the 1989 *Report of the National Leadership Commission on Health Care*, and by increasing numbers of business and labor leaders. Enthoven describes the American situation bluntly: "It would be, quite frankly, ridiculous ... to suggest that we have achieved a satisfactory system that our European friends would be wise to emulate." See A.C. Enthoven, *What Can Europeans Learn from Americans*, *HEALTH CARE FINANCING REV.* 49 (Ann. Supp. 1989).

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ill-defined identity, next to a very assertive giant neighbor, to appreciate the significance of knowing that in one very important area of social organization we are unquestionably superior, and by a large margin.

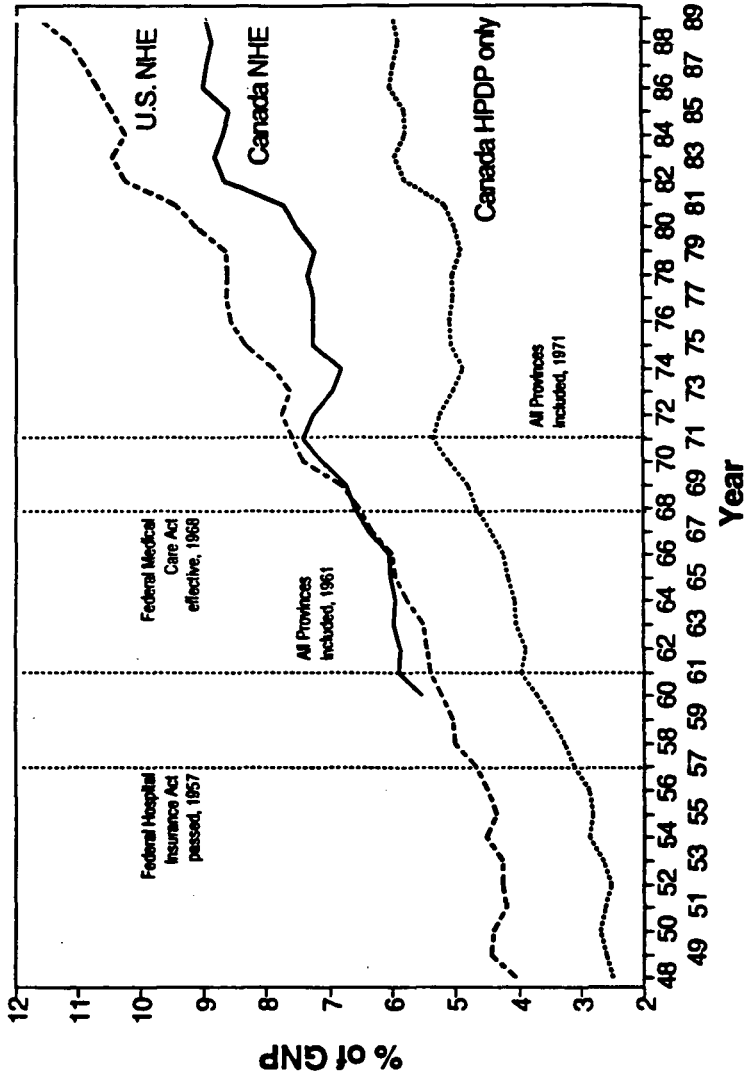
The American contrast is important, however, for reasons other than simply national pride. The North American experience with health insurance represents a vast social experiment, carried on over several decades, in which two countries, with very similar if not identical societies, have adopted very different ways of funding health care. These funding approaches have been superimposed on health-care delivery systems which were remarkably similar in Canada and the United States. The forms of organization of hospitals, and of professional practice, are almost identical, and the two countries share similar training and accreditation systems for personnel.

Thus the major differences in health system performance which have emerged over the last twenty years can be attributed to the influences of the different funding systems. We in Canada can quite reasonably infer that if we had not adopted our present public system, our patterns of performance would resemble those in the United States. We are in the unusual situation of being able to identify in some detail the effects of a major public program, because our neighbors provide us with a form of "control" or base case, showing how we would have evolved in its absence.

To make this point very clear, Figures 1 and 2 show the comparative evolution over time, in Canada and the United States, of health-care expenditures as a proportion of Gross National Product. Figure 1 shows total health-care spending (the Canadian series is only partial prior to 1960), while Figure 2 focuses on hospital care and physicians' services. It is readily apparent that prior to the 1970s, the two systems were showing very similar performance. Subsequent to the completion of the universal public plans in Canada, the two systems have increasingly diverged, and the gap is now approaching three percentage points of GNP.

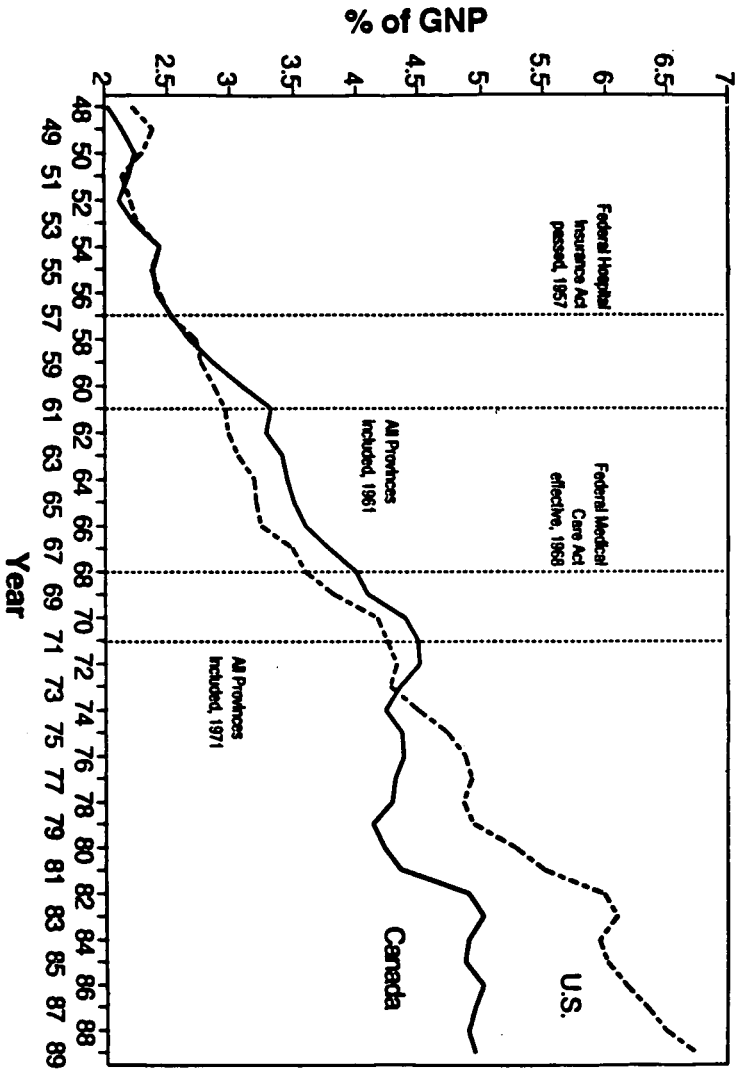
(The population of Canada is about one-tenth that of the United States, just over twenty-seven million, and total spending on health care in 1989 was about fifty-five billion Canadian dollars, out of a Gross National Product of about \$628 billion. The Canadian dollar was then trading at about \$0.85 USD).

Total Health Expenditure as Share of GNP Canada and U.S., 1948-1989



1987-1989 data are preliminary
HPDP = Hospitals, Physicians, Dentists and Prescription Drugs

Hospital and MD Expenditure as Share of GNP Canada and U.S., 1948-1989



1987-1989 data are preliminary

On the other hand, one should not conclude on the basis of the trends shown in Figures 1 and 2 that the Canadian health funding system is in the unique position (among developed countries) of having no problems or pressures of cost escalation. Figure 3 shows per capita expenditures on health care for the OECD countries in 1980 and 1989.³ It is apparent that although the Canadian performance is very different from the American, so is that in every other country. Excluding the United States as an obvious outlier, Canada actually spends more per capita than any other nation on health care, although its differences from most of the major European nations are not great.

3. OECD staff have attempted to recompile national data on a consistent basis and have converted them to U.S. dollar equivalents using estimates of purchasing power parity exchange rates. George J. Schieber & Jean-Pierre Poullier, *International Health Spending: Issues and Trends*, 10 HEALTH AFF. 106 (1991).

Health Care Expenditure Per Capita International Comparison, 1980 and 1989

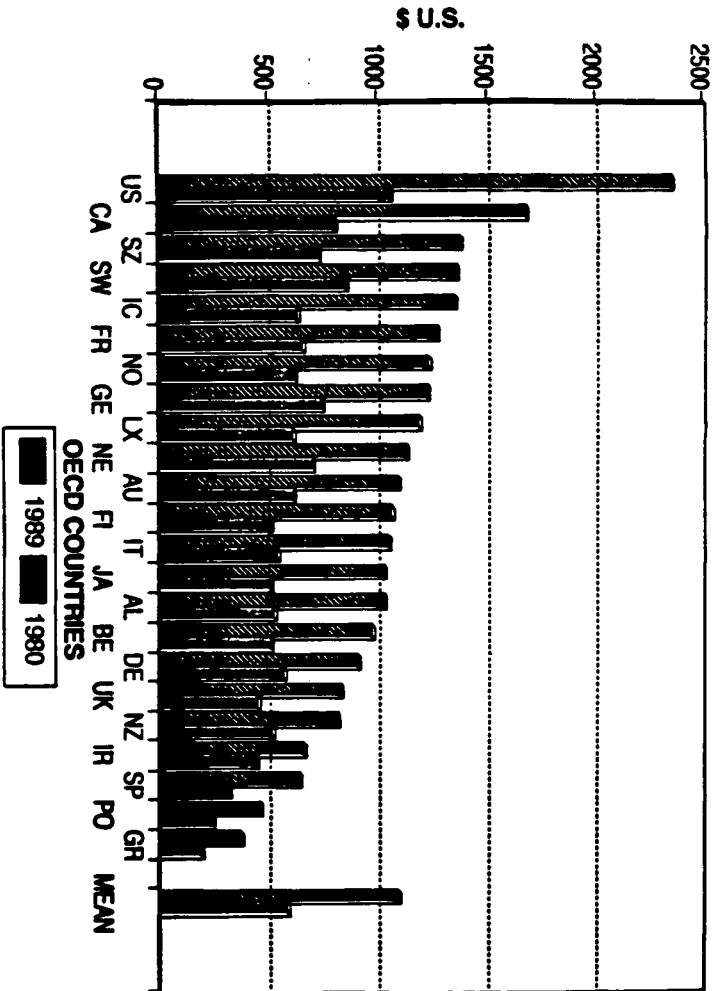


Figure 3 does demonstrate, however, that if health care in Canada is "underfunded" (as physician associations in Canada routinely claim) then the problem is even more severe in every other country in the world except perhaps the United States. And as noted above, if the United States is in any respect a model of a well-functioning health-care system that fact has certainly escaped both those who use it and those who pay for it.

What the Canadian experience shows is that it is possible to place a limit on the economic expansion of a health-care system in a North American environment without significant modification of the process of health-care delivery, by unifying the payment process through a public system. Moreover, it is possible to do so through a set of programs that are overwhelmingly popular politically.⁴

Finally, the significance of the comparison of Figures 1 and 2 is that the shift in performance in the Canadian system is specifically concentrated in the subcomponents of total health spending which are for the services of physicians and hospitals (about fifty-five percent of the total), and these are the services covered by the distinctively Canadian form of health insurance. Dental care, prescription and non-prescription drugs (when provided out of hospitals), and long-term care in facilities outside hospitals, are not included in the Medicare program.

Each of the provinces provides some form of assistance with these other forms of health care, but usually for only part of the population, or for part of the costs. There is no general pattern across the country as a whole, although there are some instructive contrasts between the practices and experiences of the different provinces, as well as between those and the various forms of United States experience.

4. Very concrete evidence of this support was shown during the Canadian federal election campaign of 1988. The central issue of the campaign was the proposed Free Trade Agreement with the United States, which was championed by the Progressive Conservative government. The opposition Liberal party, which was well behind in the public opinion polls, managed to create the fear that the Agreement would require elimination or major modification of the Canadian health-insurance program, because that program would be interpreted as a significant and "unfair" commercial advantage for Canadian business. The possibility that "Medicare" might be threatened led to a reversal in public opinion within three days, and the Liberals took the lead.

Frantic "damage control" by the Progressive Conservatives convinced voters that their fear was unjustified, and the Conservatives were eventually re-elected. But the incident dramatically drove home the point that no Canadian government can allow the basic principles of Medicare to be (or seen to be) threatened and expect to remain in power. It should be noted that all the basic federal legislation underlying the program has been passed unanimously by Parliament; no other legislation has ever been so treated. Medicare as such has no political opposition.

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I. THE CANADIAN HEALTH-CARE SYSTEM DEFINED

The Canadian public insurance program is often portrayed, particularly in the United States, as “socialized medicine.” This is quite inaccurate. What Canada *does* have, is “socialized insurance.” Public agencies in each of the ten provinces of Canada pay for all of the costs of “medically necessary” hospital and medical care received by their residents. These payments are made from general government revenues, raised through taxation. The services, however, are provided primarily by private physicians, who are in independent fee-for-service practice, and by not-for-profit hospitals which are “owned” by, or at least under the direction of, Boards of Trustees. (There are no private, for-profit hospitals, although some long-term care institutions refer to themselves as “private hospitals.”)

Every Canadian resident is covered by a provincial plan. If he feels a need for care, he may seek out the services of any physician who is willing to accept him as a patient. Both patient and provider have free choice. Normally, however, a patient will contact a general practitioner, rather than a specialist. Roughly half of Canadian physicians are general or family practitioners. The general practitioner, with whom the patient will usually have had a longer-term relationship, serves in a “gate-keeper” role, and will either provide diagnostic and treatment services himself, or refer the patient to a specialist. Specialists generally discourage “self-referral” by patients contacting them directly, because a consultation referred by a general practitioner carries a higher fee, and because general practitioners may resent such behaviour and steer their referrals accordingly.

Both GPs and specialists may refer the patient for diagnostic procedures, radiology or laboratory work, to facilities that may be privately owned, or to part of a hospital. (Practices vary from one province to another.) The results of such investigations will be reported to the referring physician, to be communicated to the patient. Either a GP or a specialist may admit the patient to a hospital, and each is entitled to continue the care of “his” patient in that environment.⁵ Larger hospitals, and particularly teaching centers, will have some salaried specialists on staff, and physicians-in-training, interns and residents, are paid salaries by the hospital.⁶ Most specialty services, however, are provided, in or out of a hospital, by private fee-for-service practitioners.

At no point in this process will the patient be required to pay a fee or make any other financial contribution. The physicians involved, including those who

5. The physician may only admit a patient if he has admitting privileges at that hospital. Most but not all physicians have such privileges at one or more hospitals; a physician without privileges at the relevant hospital must refer to one who has.

6. The chief of the hospital medical staff and the chiefs of services in larger hospitals will be full- or part-time salaried positions, as often are diagnostic specialists, and emergency room physicians.

own private diagnostic facilities, will be reimbursed according to fee schedules negotiated at periodic intervals—usually annually—between each provincial Ministry of Health and the corresponding provincial medical association. The schedule in each province is binding on all physicians working in that province, and physicians do not bill their patients additional amounts above these rates.⁷

Hospitals, on the other hand, do not receive reimbursement for particular items of service. Each hospital negotiates an annual global budget with the provincial reimbursement agency, from which it pays all staff salaries (including salaried physicians) and costs of equipment and supplies. These global budgets are to cover operating costs only; they do not include an allowance for capital costs, either depreciation or interest charges. There are separate provincial capital budgets from which contributions are made to hospitals for new construction or major equipment purchases.

The Canadian funding system is, strictly speaking, not a national system but a federal-provincial system, run co-operatively by the federal and provincial governments. The federal government has, with limited exceptions, no constitutional authority over matters of health. Thus the public insurance plans are actually operated by each of the provincial governments, which have full administrative and fiscal authority and responsibility. But the federal government makes substantial financial contributions to the provinces in respect of such plans (currently about forty percent of total costs), on condition that the provincial plans conform to certain broad federally-defined standards. It is thus possible to speak of, and describe, a "Canadian" system, even though each of the ten provincial plans has some distinctive features.

There are five federal standards to which each provincial plan must conform, in order to qualify for federal contributions. These are:

- (1) Universality,
- (2) Comprehensiveness,
- (3) Accessibility,
- (4) Portability, and
- (5) Non-Profit Administration.

Each of these is a general principle whose intent is clear enough, but whose detailed application is open to considerable interpretation. They have been the subject of much discussion and some evolution over time. The *Canada Health Act* of 1984 has replaced and modified the earlier federal legislation (the

7. These fee schedules, and the associated rules for reimbursement, differ somewhat from one province to another, but a resident of one province who receives services in another province remains fully covered. The government of the province of residence reimburses the costs of the care at the rates of the province of care. Care outside the country is reimbursed at the cost of equivalent care in the home province.

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Hospital Insurance and Diagnostic Services Act of 1957 and the *Medical Care Act* of 1966) which originally served as the basis for the federal contributions, and it is the current source for interpretation of these principles.

A. Universality

Universality was initially defined, when first the hospital and then the medical insurance programs were being phased in province by province, as “almost” all provincial residents (ninety-five percent, rising over time to ninety-nine percent). But it now requires 100% coverage of provincial populations. This is of particular importance in those provinces (now down to two) which still require their residents to pay premiums as part of the public health insurance system.

The provincial government is legally entitled to raise funds for the program any way it chooses, including through premiums. But the federal standards require that everyone in the province be insured. Thus no one can be denied services, or even charged for them, for failure to pay premiums. (Payment is legally required, and unpaid premiums are subject to collection, but payment is not a condition of coverage.) Hence the “premiums” are simply a form of poll tax, and the national income accountants have always treated them as such. Even when most provinces charged premiums, back in the early years of the programs, they covered less than half the costs of the program, and were never risk-related.

In the early years, however, when most provinces still charged premiums, there was some concern that very low risk individuals might still find it worthwhile to carry private insurance and stay out of the public plan. Since this would tend to defeat the purpose of risk-spreading over the whole population, by “creaming-off” the good risks, private insurance coverage for services covered under the public plan was made illegal. Private insurance persists for services not included under Medicare—dentistry, prescription drugs out of hospitals, and costs outside Canada above those reimbursable by the public plans—but (except for dentistry) these are relatively small amounts.

Nor is there any “private” system of health-care delivery, operating side by side with the public plan. All physicians and hospitals, like all patients, work within the public *payment* system, but the *delivery* system is still from most points of view “private.”

In some provinces it is still technically possible for a physician to withdraw from the public plan, and to see patients on a purely private basis, with neither being reimbursed by the public plan. A group of physicians could even set up their own, purely private, hospital or diagnostic facility, on whatever economic terms they chose. But their patients would have neither public nor private insurance; such care would thus appeal only to a very select group. Further-

more, the *physicians* in this situation could not simultaneously provide services to patients under the public plan. They must be "all in" or "all out." Thus private providers would have to be able to make a living *purely* in a private market, rather than playing both sides as they can in some other countries with dual systems.

In consequence, no private market has developed, even where it is permissible. This suggests a more general principle, that "private" markets in medicine can persist only where they can be supported directly or indirectly by a public system.⁸

B. *Comprehensiveness*

Comprehensiveness requires that provincial plans cover "all medically necessary" services. Such services as semi-private or private hospital accommodation, when not necessitated by the patient's medical condition, or elective cosmetic surgery, are not included under the public plans. Similarly the services of non-physicians—optometrists, naturopaths, chiropractors, and other practitioners—are implicitly excluded from the federal definition of "medical necessity," and need not be covered. A province may cover other professional services of whatever type and on whatever terms it chooses, but the federal government imposes no conditions and makes no contribution toward such care.

The increasing interest in the effectiveness, or lack of it, of much contemporary medical care could conceivably infuse more content into the idea of "medical necessity." Many of the services provided by medical practitioners, and associated stays in hospital, appear to be in part or whole unnecessary. Strictly speaking, then, they should not be covered by the public plan. In practice, however, the test of necessity of a service has been (with very limited exceptions) that a properly licensed physician was willing to provide it, and a patient to accept it.

The concept of "medical necessity" might receive further consideration in the future, if provincial governments decided simply to "de-insure" services of no demonstrable health benefit. Physicians might still offer such services as carotid endarterectomy or cardiac by-pass grafts for one or two vessel disease, but patients would be required to pay the full costs themselves. At present, however, the trend is rather to try to develop improved regulatory mechanisms to deal with these issues, in co-operation with the leadership of

8. It is conceivable that all the specialists of a particular type in one region might withdraw from the public plan, forcing patients to choose between paying privately or going without entirely. This has from time to time been threatened by small sub-specialty groups, but provincial governments have made it clear that they would use their legislative authority to force the members of such a "conspiracy" back into the plan.

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the medical profession, rather than to raise the host of difficult and potentially explosive political and professional issues implicit in such a “market” approach.⁹

C. Accessibility

Accessibility has been a particularly contentious area, encompassing two major disputes between physicians and governments: extra-billing and hospital capacity. Do direct charges to patients impede access to needed care and violate the principle? And do attempts to moderate the expansion of beds and technology constitute a form of “rationing” which effectively does the same, even if care is “free?” To date, the short answers given by Canadian opinion and practice to these questions are, “Yes,” and “Not necessarily.” The former question appears, for the moment, settled, but the latter is wide open and takes up a major share of Canadian political debate.

On the first point, practice originally varied from province to province depending on the political strength of the medical associations at the time the medical insurance plans were introduced.¹⁰ In Quebec, at one end of the spectrum, physicians who billed patients for amounts above the negotiated schedule were not reimbursed at all by the public plan, nor were their patients. At the other, in Alberta, physicians were free to collect their official fees from the public agency and then extra-bill their patients in any amount they wished—literally double-billing. Other provinces permitted some form of extra-billing but on more or less restrictive terms.

The *Canada Health Act*, however, provided that any provincial government which either charged patients for covered services, or permitted anyone else to charge for them, would lose an amount from its federal grant equal to the estimated total amount of such direct charges. Since that time, all provinces

9. It should be noted that such services as influenza vaccines or annual health examinations are “free” only for certain segments of the population—for example, vaccines for the elderly or designated high risk persons. Others are required to pay, on grounds that the service is not “medically necessary.” But extending this approach from flu shots to by-pass grafts is quite another matter.

10. Physicians consistently favour, and lobby energetically for, the right to extra-bill above the fee schedule, and to impose other forms of direct charges. This appears to be the position, not only of their professional associations, but also of a majority of individual physicians, and is not at all peculiar to Canada. If it were true, as some rather simple-minded economic conceptions of patient behaviour continue to assume, that such charges would lead to a reduction in overall rates of utilization of the services charged for, then they would tend to lower the incomes of the physicians who advocate them! The enthusiasm of physicians—at least in fee for service environments—for charges to patients is *prima facie* evidence that such charges are *not* effective in limiting overall utilization.

The comparison between the United States and Canada is also instructive, since the former has the highest charges to patients, in the OECD world at least, and the latter among the lowest. As Figures 1-3 indicate, the former has the cost explosion. In Canada, physicians advocate charges to patients explicitly in order to *increase* the cost of a system which they claim to be underfunded. Either the physicians or the neo-classical economists are very wrong in their understanding of the dynamics of health-care use, and the empirical evidence tends to support the views of physicians.

have negotiated or imposed an end to extra-billing, and removed any other direct charges for covered services.¹¹ The *Act* responded to growing concerns and some evidence (hotly disputed by physicians) that extra-billing was beginning to spread, and was becoming an increasing impediment to access to care for those in greatest need.¹²

The second issue is conceptually more difficult. Canada historically has had a relatively large supply of hospital and other institutional beds, and a correspondingly high rate of use. Nation-wide, there are about 6.75 public general hospital beds per thousand people, two thirds in short-term units and one third in long-term units or extended care hospitals. Days of care provided are about two thousand per thousand people, with just over sixty percent in short-term units—a smaller proportion of days because occupancy rates in short-term units average about eighty-five percent, in long term facilities they are over ninety-five percent.

Students of health-care utilization have generally concluded that the Canadian pattern represents overuse, relative to medical need, and public policy in all provinces has been, on balance, directed towards reducing hospital use.¹³ Similarly the introduction and dispersion of expensive new technical facilities and procedures has been restrained, through the public control of both capital

11. There is a significant exception to this penalty, however, with respect to long-term care. Patients in extended care hospitals are considered as receiving room and board services which substitute for services they would otherwise be paying for (a substitution which does not usually occur in the case of acute care). They may then be charged for these domiciliary services. Since almost all such patients are elderly, and on some form of public pension intended to provide minimum support, the allowable charges to patients in extended care are set at a level to recoup most of the public pension, leaving a basic "comfort allowance." The charges bear no relation to the actual cost of providing care, which is met from public budgets.

This exception emphasizes the point that "prices" are set and used as income distribution mechanisms, not as resource allocators. It is thus quite consistent with the penalties for extra-billing, which is also seen as a matter of income distribution, between physicians and patients, rather than a way of allocating access to services. (To the extent that such charges *do* allocate access, by "detering" use, they are generally seen as an inappropriate mechanism.)

12. The concern had several roots. Physicians describe extra-billing as a "safety valve." protecting them against overly aggressive fee negotiation by governments. What they fail to win from the government at the bargaining table, they can recoup later from the patient on the operating table. The combination of steadily increasing physician numbers—on which more below—and general fiscal stringency in the 1980s, suggested that governments were likely to become much tougher in their negotiations. If physicians simply reacted by increasing their billing of patients, provincial governments would be caught between the erosion of Medicare coverage, and the escalation of Medicare costs.

To compound the problem, the federal government in 1977 shifted its basis for financial contributions from a proportion of actual health expenditures—cost sharing—to a block grant to each province based on population and economic growth. The fiscal incentives for provinces to permit an erosion of coverage were thus substantially reinforced. One might, for example, find that physicians would accept relatively small increases in official fees in return for removal of limitations on extra-billing. But as soon as the *Canada Health Act* ensured that provinces could not profit directly or indirectly from charges to patients, treasury officials in each province immediately lost interest.

13. Certainly the Canadian rates greatly exceed the corresponding American averages, which are themselves well above the experience of populations served by American Health Maintenance Organizations. Yet Canadian physicians continue to claim that they need more beds, and occupancy rates are near the limits of *de facto* capacity.

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and operating budgets in hospitals,¹⁴ and through the negotiation process that determines what shall be included in the fee schedule.

Yet the supply of physicians has increased steadily,¹⁵ and this increase interacts with the rapid extension of technology to create a constant pressure for more and newer “tools of the trade.” Physicians’ incomes, in a fee-for-service environment, depend on their billing opportunities, and these in turn, for many specialties, depend on their access to (publicly provided) capital and associated (publicly paid) nurses and technical staff. Thus the pressure mounts for expansion, and failures to expand in line with the ambitions of the medical profession are labelled “cutbacks.” As shown in Figures 1 and 2, expenditures in Canada are in fact rising in line with national income, and as Figure 3 shows, Canada has the world’s highest rate of expenditure, after the United States; but this is not enough for providers of care, who look with envy at the steadily expanding share next door in the United States.

It is generally agreed that “access” means, not the provision of all services imaginable, for everyone, but rather services according to need. The political struggle is then over the processes by which need is to be defined. To the medical profession, need is whatever a physician says it is. If that requires more, and more costly, services then so be it. Someone—the government, the patient, the rest of the community—should raise the necessary funds. Governments, on the other hand, are arguing increasingly that the test of necessity is the demonstrable effect of intervention on health outcomes (effectiveness) not merely a physician’s opinion, professional or otherwise. Furthermore, they are becoming increasingly aware of the large and growing body of research evidence which indicates that there is often little or no connection between the physician’s opinion, and the demonstrated effectiveness (or lack of it) of the services provided.

Since this conflict between professional autonomy (and economic self-interest) and payers’ concern for value for money (and economic self-interest) is a central issue in virtually every developed country in the world, the application of the principle of access in the Canadian system is likely to remain contentious for a very long time to come.

D. *Portability*

Portability of benefits is an important principle in terms of its symbolism for national unity, but has not been particularly contentious, being largely a technical problem. Political issues have arisen only in the one or two cases in

14. GENERAL ACCOUNTING OFFICE, CANADIAN HEALTH INSURANCE: LESSONS FOR THE UNITED STATES (June 1991).

15. MORRIS L. BARER & GREG L. STODDART, TOWARD INTEGRATED MEDICAL RESOURCE POLICIES FOR CANADA 4c-6 (Centre for Health Economics and Policy Analysis Working Paper No. 91-7, 1991).

which a metropolitan region spans a provincial border, or a significant region of one province receives its tertiary care from a large city in another. If the fee schedules are markedly different, either providers or payers may object to the financial transfers involved.

More potentially troublesome is the issue of payment across the border with the United States. As noted in the discussion of accessibility, provincial governments limit the proliferation of hospital capacity and particularly of expensive diagnostic equipment, by funding them through hospital capital and operating budgets, not through fees per item of service. A hospital that wishes to acquire an MRI machine, for example, or a lithotripter, must not only receive planning approval from its provincial ministry of health, but must also convince the ministry to provide the capital funds.¹⁶ Private physicians can in principle purchase and use such equipment, but if there is no corresponding procedural item in the fee schedule, they cannot be reimbursed (by government or patient) for its use.¹⁷

The result is that physicians claim a shortage of capacity, while in the United States beds and facilities are in surplus. (The price, however, does not fall in the U.S.!) And it is certainly true that the availability and use of major diagnostic equipment, per capita, is much greater in the United States, although whether this represents a shortage in Canada (relative to the needs of the population) or a surplus in the United States (or both) is another matter.

One could imagine, then, an increased flow of patients across the border in response to the increasing gap between Canadian and American patterns of care. This would place provincial governments in the difficult position of either paying for such additional care, and thus losing control of their total outlays, or permitting the development of a *de facto* private system of care alongside the public, for those who can afford to pay the American price.

In practice, however, this does not seem to be developing as a significant problem, with the exception of one or two border cities, and one or two particularly contentious procedures. The reality of care use is that patients do not in general "demand" particular procedures; they seek the recommendations of their physicians. These latter can, and do, sometimes refer patients to the United States and then energetically publicize the incident as part of a continuing struggle with provincial governments over the availability of health re-

16. In some cases, hospitals have been successful in convincing private donors to provide funds or equipment, but then the hospital must find resources for increased operating costs within its global budget. The ministry will not usually provide increased operating resources for an unapproved capital expansion.

17. This is slightly too simple. For diagnostic equipment, there is usually both a professional and a technical procedural fee. An appropriately qualified physician can claim the professional fee for interpreting the diagnostic results, whether the equipment is owned by a hospital, a private facility, or his own practice. But if there is not also a technical fee component in the negotiated schedule, to pay for the equipment, technicians, reagents, etc., then in effect the equipment is not reimbursable outside the hospital. In addition, even when private facilities can be reimbursed for diagnostic services, there will be some form of additional licensure or other restrictions on who is entitled to bill.

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sources. But this sort of political theatre does not correspond to any large underlying movement of patients or dollars.¹⁸

E. *Non-Profit Administration*

Non-Profit Administration, the final principle, has drawn very little subsequent commentary in Canada, because in most parts of the country the private health insurance industry was relatively underdeveloped at the time the public plans were introduced. In each of the provinces there were not-for-profit insurers, sponsored originally by the hospital and physician associations, similar to the Blue Cross plans in the United States, and the hospital and medical insurance business of these plans was simply taken over by the public agencies. In some cases the provincial plans continued to work through the previous carriers as intermediaries, but this arrangement was found to be both unnecessarily costly, and inefficient.

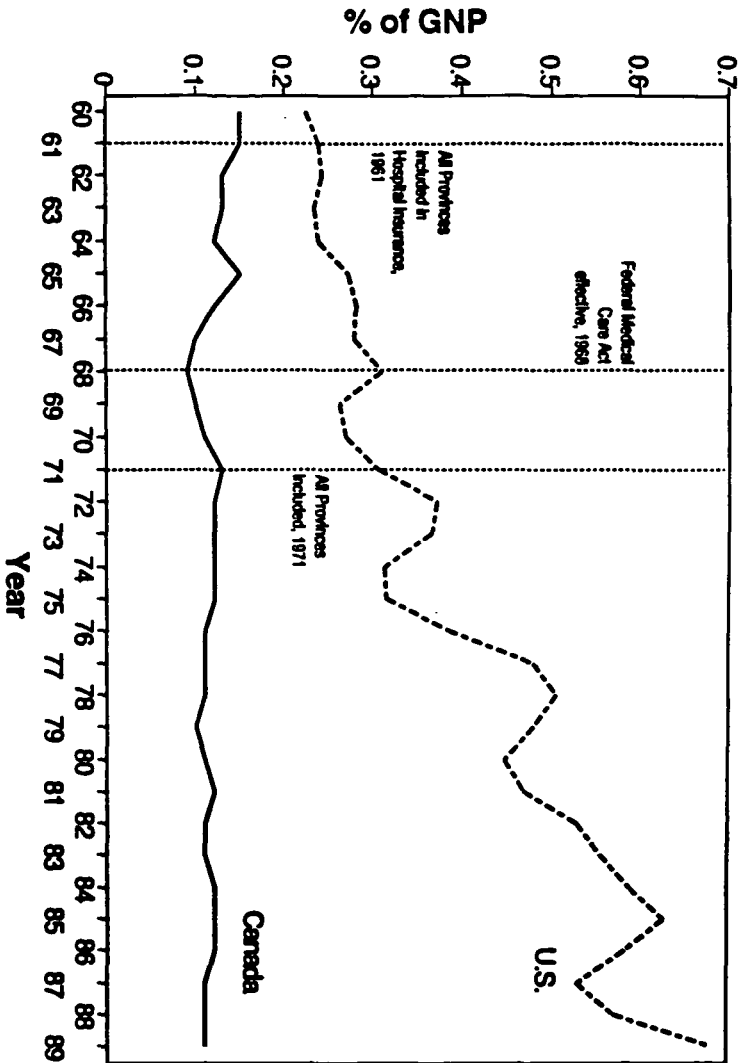
The emphasis on non-profit administration arises out of the observation in the *Report* of the federal Royal Commission on Health Services, the massive investigation which pre-dated the extension of public coverage from hospital care to physicians' services, that the private insurance plans which were then just developing paid out relatively low proportions of their premiums in benefits. What a private insurer regards as a "loss ratio," to be minimized, the rest of the community sees as the proportion of total payments to the insurer which actually goes to pay for the desired services, as opposed to being taken up in overhead costs. A "good" plan, from the perspective of both providers and patients, is one which *maximizes* the loss ratio, i.e., minimizes the cost of insurance *per se*.

The commissioners concluded that private, for-profit insurers operated under incentives that tended to increase this form of overhead cost, adding to the expense of health care without adding to the resources available to provide it. This inherent tendency is strongly reinforced in a competitive environment with multiple insurers. Regarding the costs of the insurance mechanism as unproductive overhead, the commissioners recommended centralized, non-profit administration in order to minimize them.

18. Such theatre can, however, have powerful political effects, because one or two such incidents can be very emotionally gripping. The results can be significant in terms of effects on allocations of health-care resources among particular programs.

This recommendation has turned out to be quite perspicacious. As shown in Figure 4, the costs of the insurance mechanism itself have steadily escalated in the United States, while remaining stable or falling (as a proportion of national income) in Canada. As the United States payment process has become increasingly complex, in response to the increasing efforts of payers to minimize their own liabilities, it has become correspondingly more and more expensive just to push around the pieces of paper associated with providing and paying for care.

Costs of Insurance and Administration As Share of GNP Canada and U.S., 1960-1989



1987-1989 data are preliminary

Nor is the complete story reflected in Figure 4. The administrative costs borne by hospitals and physicians' offices in the United States have gone up rapidly as they attempt to cope with an increasingly complex payment and regulatory environment.¹⁹ Thus a significant proportion of the recorded expenditures for hospital and medical care, shown in Figures 1 and 2, are in fact costs generated by the payment mechanism, though not included in Figure 4 as explicitly reported costs of prepayment and administration. An increasing share of the sums Americans *think* they are spending on hospital and medical care, are going in fact to pay for administrators, accountants, lawyers, public relations specialists, and other forms of personnel whose services are not usually considered as contributing to the health of patients.

The comparative situation on the two sides of the border may be represented metaphorically by an extension of the well-worn economic analogy of the group of diners agreeing in advance to share equally their bill in the restaurant. The usual interpretation is that each of them will then order more and more expensive, dishes, knowing that the others will have to pay most of his costs, with the net result that each will eat more, and pay more, than he would wish to if responsible for his own costs. Similarly, goes the argument, "free," or even subsidized care will lead to overuse and cost escalation.

As we have seen, the substantive "predictions" of this analogy are flatly in contradiction with reality. Universal public systems are less, not more, costly than the heavily self-pay United States system.²⁰ The reasons for the error are now relatively well understood. But to sharpen the analogy, consider not the process of ordering the meal, but the presentation of the bill. Each has ordered what he thinks he "needs," but all are shocked by the size of the bill. This happens in all developed societies—health-care cost control is a universal problem. The diners study the bill, and consider that they have been overcharged for some items, and charged for others that they did not order. Still others were ordered, but were badly prepared or cooked, and in any case were not very tasty. What to do?

In the "Canadian restaurant," the diners form a united front—more or less—and call in the manager of the restaurant for an accounting. Provincial governments, acting on behalf of the population as payers, negotiate with providers to try to hold the bill down. As we have seen, they have had some success. In the "American restaurant" next door, the diners begin to argue among themselves about who ordered or ate what, and try to redistribute the cost among themselves. They pull out their pocket calculators, but soon call

19. See generally Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 *NEW ENG. J. MED.* 1253 (1991).

20. See generally A.J. Cuyler, *The NHS and the Market: Images and Realities*, in *THE PUBLIC-PRIVATE MIX FOR HEALTH: THE RELEVANCE AND EFFECTS OF CHANGE* 23 (G. McLachlan & A. Maynard eds., 1982); Robert G. Evans, *The Welfare Economics of Public Health Insurance: Theory and Canadian Practice*, in *SOCIAL INSURANCE* 71 (L. Soderstrom ed., 1983).

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up their accountants to come and help with the argument. The debate becomes more complex and sophisticated, and also more heated. Soon the diners are calling in their lawyers, but still only to argue with each other.

All this time, the manager of the restaurant has been standing by, quite calm, because no one is arguing with him about the total size of the bill, only how it is to be split up. The cost to the diners is going up rapidly, as they must now pay for the time of their accountants and lawyers, but the restaurant bill is unchanged. The manager pities his colleague next door, forced to negotiate the bill with his patrons. How undignified!

After a time, however, the manager becomes worried. The restaurant is becoming crowded, noisy, and unpleasant, and none of the new arrivals are buying food. Moreover, the escalating costs of the professionals involved in the argument threatens to impair the ability of the diners to pay the original bill. And finally, some of the diners and their advisors *do* in fact begin to draw him into the debate in a somewhat abusive manner.

He notices that the restaurant next door is still earning a reasonable income, and that while the negotiations are sometimes rather acrimonious, they are confined to the back office, and do not seem to disrupt the other diners. Maybe things there are not so bad—at least the inherent conflict over costs is contained and managed.

This seems to be the current position of the United States. Increasing numbers of *physicians*, as well as payers and patients, are beginning to believe that they might be better off under a Canadian system. The key component of expenditure which has caught their attention is the relative cost of the insurance process—all those accountants and lawyers. Health expenditures in the United States keep going up, but providers feel, rightly, that their share is not going up as fast, yet they are bearing the full brunt of the various measures intended—so far unsuccessfully—to limit cost escalation.

Of course providers have always preferred non-profit administration. The Blue Cross/Blue Shield plans were originally established by hospitals and medical associations in the United States. What they did *not* want, however, was a *single* non-profit payer, negotiating on behalf of the public generally rather than under provider control. And officially, they still do not. The Canadian form of non-profit administration comes in combination with “socialized insurance”—sole source payment, by an agency with both incentives and authority to try to keep down the costs of care—provider incomes—as well as the costs of insurance.

But if the alternative, a fragmented payment system, inevitably leads to escalation of total health expenditures, and even more rapid escalation of the costs of the insurance mechanism, combined with ever more onerous interference from regulatory agencies and private payers, and a less and less satisfying

practice environment, then perhaps the Canadian form of payment might not be so bad.

On the other hand, in Canada the question is beginning to be raised as to whether administrative expenses might not be *too* low; one observer has coined the term "administrative anorexia" for the attitude of the provincial governments and their agencies towards spending on management. A recent analysis of the Canadian system advances the thesis that, while not underfunded—indeed in total almost certainly overfunded, it is very seriously undermanaged. They raise the same issues as underlie the debates over accessibility—which services are worth paying for, for whom, and what information and processes of analysis are needed in order to decide?

It must be emphasized, however, that these are quite different from the problems facing a private insurer, and which generate a significant part of the overhead costs of private, for profit insurance. The private insurer is forced by the laws of the competitive marketplace, to devote a great deal of effort to determining who *not* to insure—the worst risks. The private insurance market does not, cannot, cover those in most need of care.²¹

Since the universal public system responds to an explicit society-wide political choice that everyone is to be covered, this problem of identifying individual risk status disappears, and along with it the whole complex apparatus of rate-making and policy design. The private marketplace generates a multiplicity of different types of coverage—far beyond the capacity of most purchasers to comprehend—in order to minimize the extent to which those in low risk categories pay to support those at high risk. But the public insurance system expresses the community's decision to do precisely that, to use the resources of the healthy and wealthy to support the poor and ill. So the principal services of the traditional private insurance sector are, literally, worthless, because their "product" is not what the community wishes to buy.

In its place, however, is the problem of determining the needs and priorities of those to be cared for, and the effectiveness of the services offered. Provincial governments are clearly responsible for purchasing care on behalf of their populations. Achieving "value for money" in this process may well require a build-up of managerial capacity, and the creation of new administrative structures, within the overall framework of non-profit administration.

21. Unless of course they happen to be quite well off. But in general they will not be, because both illness and risk of illness are closely correlated with poverty, not wealth. The "thirty-seven" or thirty-one, or thirty-five million Americans who are uninsured, and the other ten, or twenty, or forty million who have insufficient insurance to cover the costs of any serious illness, are not an unfortunate aberration or oversight in a private insurance system, but rather a natural and inevitable outcome of the operation of competitive market forces. This point has been made very clearly by American advocates of a public system. See, e.g., RASHI FEIN, *MEDICAL CARE, MEDICAL COSTS: THE SEARCH FOR A HEALTH INSURANCE POLICY* (1986). Advocates of a radically reformed competitive private system have made the same point. See, e.g., A. Enthoven, *What Can Europeans Learn from Americans About Financing and Organization of Medical Care?*, *HEALTH CARE FINANCING REV.*, ANN. SUPP. (Dec. 1989).

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II. THE FUTURE OF CANADIAN HEALTH CARE

There are several paradoxical features to the Canadian experience, not least of which is the nature of the political controversy which seems always to surround it. On the one hand, as emphasized above, there is absolutely no doubt about the strength of the public commitment—by ordinary citizens, politicians, and even most providers—to the fundamental principles of the system. There is no support for, and indeed would be overwhelming opposition to, any attempt at abandonment or major revision of those principles. Yet on the other hand, the functioning of the health-care system is constantly in the forefront of public debate, and its management is by far the most demanding responsibility—not just in dollars but in terms of political and technical skills—carried by each of the provincial governments. Ministers of Health, and Premiers of provinces, are held accountable in the provincial legislatures and in the press for individual problems and misadventures that occur in the operation of the health-care system.

The management of the health-care system in Canada has thus become politicized to an extreme degree. And while the results of such political management are generally agreed to be relatively satisfactory, it does carry with it certain characteristic limitations. On the other hand, it is not clear that any of the other industrialized democracies, even the United States, is so very different from Canada in this respect. All such countries, except the United States, have collective systems for financing all or most of their hospital and medical care, and thus must deal politically both with decisions as to who shall be permitted to perform, and paid for, what sorts of services, for whom, and with the determination of the relative incomes of those persons who provide health-care services. And even in the United States, the critical decisions are political; the market is much more prominent in rhetoric than in reality. The principal difference is that the key political decisions tend to be more decentralized and hidden, whereas in Canada they are centralized and played out in the full glare of the media (Evans, Lomas *et al.*, 1989). European systems tend to be more similar to the Canadian, in that the political decisions tend to be centralized, but they appear to be less open to the public than in Canada.

At present, the health-care policy agenda in Canada is being driven by a set of interlocked problems, none of which are particularly new, or peculiar to Canada. On some, there is evidence of progress; on others we can see that present problems are the result of past policy failures, which being left uncorrected, will generate continuing difficulties in the future.

These problem areas can be summarized in several categories or clusters. These categories are not conceptually consistent with each other, indeed some turn out to be partial sub-sets of others. They are, however, the labels which

tend to be employed in the public debate, and under which most of the research results are assembled.

- A. Cost control
- B. Coping with the Aging Population
- C. Coping with the Extension of Technology
- D. Manpower Surpluses (Physicians) and Shortages (Nurses)
- E. Improving the Effectiveness and Efficiency of Health-Care Delivery
- F. Extending Our Concern from the Delivery of Health Care to the Enhancement of Health

As noted, none of these is unique to Canada, but the way in which they are being addressed in the Canadian system may be of more general interest.

A. *Cost Control*

The first problem area, *Cost Control*, has faced every society in the industrialized world, with the possible exception—so far—of Japan. It may be that if the modernization and growth of a country's general economy can continue to outstrip that of its health-care system, it need not be overly concerned with health-care cost control. This has not, however, been the situation in North America or western Europe, where all countries have had to wrestle, over the last decade or more, with the problem of moderating the growth of health spending in order to protect resources for other social and private priorities. And any country modernizing its health-care system would do well to consider hard how it will deal with the inherent tendency of such systems to unlimited expansion, in the absence of strongly enforced external constraint.²²

Within the last five to ten years, however, all such societies except the United States appear to have found some response, if not necessarily a permanent solution, to this problem. Sweden has actually significantly *reduced* its share of national income spent on health care, from over ten percent to about nine percent, as part of a deliberate and collectively thought out strategy for dealing with its economic difficulties in the late 1970s. The process of control, in every country, has been accompanied by considerable difficulties and political conflict, and it is always possible that the health-care system will succeed in breaking out of the controls which each society has placed on it. But for the moment a degree of stability prevails.

The processes whereby the provincial governments in Canada have imposed

22. Robert G. Evans, *Tension, Compression and Shear: Directions, Stresses and Outcomes of Health Care Cost Control*, 15 J. HEALTH POL. POL'Y & L. 101 (1990).

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this degree of control, for nearly twenty years with the exception of the “recession breakout” of 1982, are three in number. First, as noted above, the nature of the Canadian payment system permits it to function very economically in terms of administrative costs, and these have not been rising over time.

This stability explains a significant part of the difference between Canada and the United States, not only because of the less expensive payment process itself, but because a significant part of the cost escalation in hospital and physician practice budgets in the United States appears to represent, not more costly services, but simply higher administrative costs to deal with a more complex payment environment. Indeed, it appears that the American attempt to create a more “competitive” environment in health care has added significantly to these unproductive expenditures.

Secondly, the medical fee schedules negotiated between the provincial medical associations and governments have escalated much less fast than fees in the uncontrolled American environment. At the same time, the elimination of extra-billing has prevented physicians from exploiting this alternative form of fee inflation. Over time, fees in Canada have risen at a rate more or less in line with general price inflation; when physicians can set their own fees freely, fees rise substantially faster.

In response, physicians in Canada do appear to have increased their volumes of billings per physician somewhat faster than in the United States, in order to keep their incomes rising, but they have not been able to offset fully the slower increase in fees.²³ An important contributor to limiting this process appears to be the fact that fee schedules limit the reimbursement of diagnostic services outside hospitals—most physicians cannot simply set up their own laboratories, for example—and also prevent implicit “fee splitting” between laboratories and referring physicians.

On the other hand, these controls over the tendency of physicians to engage in “procedural multiplication,” particularly when fee inflation is contained, are by no means complete, and Canadian provincial governments are increasingly exploring ways of imposing more explicit “caps” on total outlays for physicians’ services. Two provinces—Quebec and British Columbia—have already done so, and despite predictable outrage from physicians, it is likely that more will follow.

Furthermore, it appears quite clear that the volume of physicians’ services billed for in a province rises more or less in proportion to the increasing numbers of fee-for-service physicians. Thus control of cost escalation is directly connected to manpower policy, and in Canada these have been seriously inconsistent. The annual number of new physicians trained has been for

23. M.L. Barer et al., *Fee Controls as Cost Control: Tales from the Frozen North*, 1 MILBANK Q. 66(1) (1988).

many years so large as to sustain a growth in physician supply (between three and four percent per year) well in excess of the rate of growth of the population (under one percent). This places continuing upward pressure on costs, but it has been extraordinarily difficult to mobilize political support for reducing the number of training places, in the face of determined resistance from the nation's medical schools.

Finally, a very important part of the control of health-care costs has been the system of global budgeting for hospitals, which enables this component of the health budget to be subjected to absolute "cash limits." The result has been a steady decline in acute-care utilization, which nevertheless remains high relative to United States experience, and a much less rapid proliferation of new and very expensive high technology interventions. Canadian provinces do acquire the most recent technology, but such equipment tends to be confined to the teaching hospital centres, and does not proliferate throughout the regional hospital system or into free-standing facilities. Thus the availability per capita of such equipment tends to be lower than in countries such as the United States, Germany, or Japan, and this is another significant contributor to the moderation of cost escalation.

B. Coping With The Aging of the Population

Coping with the Aging of the Population is perhaps the most frequently cited source of serious problems, now and particularly in the future, for the Canadian and most other health-care systems. Yet it is the area in which the rhetoric is in fact most misleading. The usual argument is that elderly people require more, and more costly, health-care services, on average, than do younger people. At the same time, it is notorious that the proportion of elderly—and particularly very elderly—people in the population is growing, as birth rates have fallen and life expectancies have risen. Both these observations are true. But the common conclusion, that the costs of caring for the elderly therefore will necessarily exceed the willingness or ability of industrialized economies to pay for them, does not follow. It is particularly misleading, indeed flatly false, to claim that such demographic trends are the source of the cost pressures being felt in health care today.

A good deal of research has been done on the changing patterns of care of elderly people in Canada, and it is all consistent. The aging of the Canadian population, and we believe of all other populations in the industrialized world, is a very important phenomenon over a time span of decades. But its effects on health-care use are very slow. In Canada, the aging of the population would add about one percent per capita per year to health costs, *if* the utilization patterns at each age remained unchanged, and only the population age structure changed. Over thirty, or fifty, years, this is a substantial impact. But one

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percent per capita per year is well within the normal, or at least historical, economic growth rates of industrialized economies, and could easily be accommodated with a constant share of such growth being devoted to health care.

What is actually happening, however, is that per capita rates of utilization, and costs, of health services for the elderly are rising, and quite rapidly, at each age. Elderly people *are* accounting for a rapidly increasing share of our health-care effort and resources. But the reason is not primarily that there are so many more of them. The increase in their numbers—and average age—makes a relatively small contribution to total costs. The real change is in how much is done to and for each elderly person—they are being subjected to many more, and more intensive, interventions, often of unproven effectiveness.

Thus the “Aging of the Population,” which claims priority of place in so many discussions of health policy, is largely a false issue. The *real* question is what benefits are being derived from the services which are being applied in increasing quantities to the care of the elderly. That takes us on to the questions of technology, of effectiveness and appropriateness of care, and indirectly to issues of manpower or personnel. The demographic transition, at least as it applies to the past decade and the next, is in fact a smokescreen that obscures more fundamental questions of the basis on which utilization decisions are made, and the costs and benefits of the results.

C. *The Extension of Technology*

Coping with the Extension of Technology is simply part of this more general set of issues. Technology per se is neither good nor bad; new knowledge and capabilities *in principle* merely expand our range of choices. The rhetoric surrounding technology often suggests that we are somehow compelled to apply whatever is discovered, at whatever expense. But the technology does *not* define its own range of application. Many, though not all, new technologies have the capability to *reduce* significantly the costs or other burdens associated with particular health problems—if conservatively applied, and limited to areas of demonstrated effectiveness. The real problem of a trade-off between technological “advance” and cost control arises when new and expensive techniques (or for that matter old and not so expensive techniques) are employed and paid for in circumstances in which there is no evidence that they will do any good.

Thus the problem posed by new technology is primarily evaluative and organizational, rather than economic. First, how do we determine whether the technique does more harm than good, and for which patients? This requires careful analysis of the biological effect of the associated interventions, but also requires developing techniques for eliciting the preferences and values of potential patients. Whether an intervention does more harm than good depends

on both—what is right for one may be inappropriate for another. (But no one needs interventions that do not work!) And second, once such information is available—“technological assessment” in a broad sense—how do we ensure that utilization decisions by providers and patients actually reflect this information?

A number of students of the benefits and costs of new technology have concluded that there is ample capacity, in the health-care systems of industrialized societies, to support all the new technology that one might want—if one could get rid of the minimally effective, useless, and harmful interventions now being provided and paid for. The problem is to find an organizational framework, and decision processes, that will lead to this result—problem category E below.

Coming back to the Canadian experience with cost control, it has been noted that the intensity of servicing, or the inflation-adjusted expenditure per person, has risen relatively slowly in Canadian hospitals. The control of hospital costs—through global budgets—has been associated with a slower rate of increase in the number of procedures performed, and/or their expense, than in the United States. Technology has proliferated more slowly in Canada.

This raises the question of the appropriateness and effectiveness of the care being provided. Are Canadians being denied potentially effective treatments which would increase the length and/or improve the quality of their lives? Or are they being protected against the over-enthusiastic application of interventions which would be useless at best, quite possibly harmful, and certainly expensive? One can find advocates of both points of view.

What can reasonably be said is that the control of global budgets rests on the assumptions (i) that physicians and hospital administrators, when they do not have enough resources to do all that they would like to do—for whatever reason—react by eliminating the least useful or most harmful services first, and (ii) although they will always claim the contrary, they really do have enough resources to do all that is worth doing, and probably more besides, and finally (iii) if (ii) should cease to be true, then other sources of information will bring this fact into the open, so that budgets can be adjusted as needed.

On the other hand, it must be admitted that detailed information on the effects both of the care that is being provided in Canadian hospitals, and of the care that is *not* being provided, is remarkably scarce (as it is in most other countries) and we might be well advised to study this area much more closely—the same point which emerges when one looks closely at the changing patterns of care of the elderly. But the growing evidence of very substantial inappropriate, and actually harmful, use of “high technology” procedures in the more richly endowed United States emphasizes that the relative limitation placed on the diffusion of technology by the Canadian funding system may

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very well be a benefit of that system, although critics present it as a negative feature.

D. Manpower Surpluses (Physicians) and Shortages (Nurses)

The least successful area in health-care policy in Canada has been the formulation and execution of manpower policy. As noted above, the supply of physicians has been rising steadily (relative to the population) and is projected to do so for the foreseeable future, on the basis of the training capacity now in place. There are now nearly sixty thousand "active civilian" physicians in Canada, or about one for every 450 people, and the ratio of physicians per capita is rising about two percent per year. This growth places continuing pressure not only on the budgets for physicians' services, but also on the available hospital bed space and associated facilities.²⁴ The "physicians per bed" ratio is rising steadily, so that each physician *perceives* a growing shortage of capacity, available to *him*.

This problem was easily foreseeable, and was in fact foreseen, in the early 1970s. The collapse of the birth rate in the mid-1960s, a drop of nearly one quarter in total births during 1962-1967 (from 471,000 per year to 367,000), has been followed by a continuing decline ever since. The population forecasts of the early 1960s were therefore grossly in error. Yet those forecasts were the basis for a significant increase in medical school capacity in the late 1960s and early 1970s. These increases were not scaled back when it became apparent that there had been a permanent and large change in population trends, although as early as 1975, changes were made to reduce drastically the rate of physician immigration.

Thus Canada's present medical school capacity was put in place to serve a population which was forecast to be, by 1991, nearly *ten million* people larger than that which is actually here. The steady increase in physicians per capita is a historical accident, arising from an erroneous forecast combined with a powerful asymmetry of political pressures. Expansion was easy—since the money was available—and everyone was in favour. Contraction seems to be virtually impossible.

Medical school representatives cloud the political issue with numerous false claims.²⁵ "More physicians are needed for an aging population." True, but aging is currently adding only about one third of one percent per year to use,

24. See generally M.L. Barer et al., *Accommodating Rapid Growth in Physician Supply: Lessons from Israel, Warnings for Canada*, 19 INT'L J. HEALTH SERVICES 95 (1989).

25. J. Lomas et al., *Paying Physicians in Canada: Minding our P's and Q's*, 8 HEALTH AFF. 80 (1989).

not two percent.²⁶ In fact the increasing physician supply is resulting in the increase in servicing rates among the elderly, as more and more physicians struggle to keep busy, and maintain their incomes. "The increasing numbers of female physicians, and changing lifestyles, will lead to more physicians being needed to provide the same services." This would result in a fall in gross fee billings per physician, after allowing for changes in the level of fees, and that is not happening.

Some reductions in training places are occurring, but slowly and painfully, because the benefits of reduction, in terms of costs saved, accrue over a number of years. The political costs are immediate. Provincial governments are, however, increasingly exploring policies to try to protect themselves from the (wholly foreseeable) fiscal consequences of past increases, and this is drawing their attention to the root of the problem.²⁷ But it is still far from solved, and we will in any case have to live for a generation with the consequences of the policy failures of the early 1970s.

Nursing manpower presents the opposite picture, of growing shortages. In this field, shortages and surpluses alternate from year to year, or even month to month, depending upon the provincial government electoral and budget cycle. When funds for hospitals are plentiful, there is usually a "shortage" of nurses to meet the new financial demand. When fiscal times are tougher, the "shortage" disappears. All that is happening is that the process of supply adjustment is less flexible than hospital budgets. But over the longer run, larger forces are at work.

There are nearly a quarter of a million nurses registered in Canada, or about one per hundred persons, but only about one half are employed full time in nursing, and about one quarter are employed part time. There are another eighty thousand nursing assistants, but only about half were employed in hospitals in 1986, and their numbers are falling. In total, nursing manpower has been barely keeping up with population growth, but the adjustment for aging has much more impact on needs for nurses than for physicians. Physician supply, however, is growing much faster than nursing.

The collapse of the birth rate in the mid-1960s has just reached the twenty-to twenty-five year old age range from which nursing has traditionally recruited, and the population in that group has fallen sharply in the late 1980s. Labour force participation rates have risen, but not enough to offset the decline. And career opportunities for females have increased greatly, and will continue to do so. Thus the demographic change *has* resulted in a long-run

26. Woods, Gordon Management Consultants, *An Investigation of the Impact of Demographic Change on the Health Care System of Canada—Final Report* (1984) (prepared for the Task Force on Allocation of Health Care Resources, Joan Watson, Chairman).

27. See generally M.L. Barer, *Regulating Physician Supply: The Evolution of British Columbia's Bill 41*, 13 J. HEALTH POL. POL'Y & L. 1 (1988).

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shortage situation for nursing, which has become apparent only very recently. (Though it, too, could easily have been forecast from the 1960s birth data.)

This problem is being exacerbated not only by the aging population, but by the persistence of traditional forms of organization in hospitals, where nurses employed by the hospital care for patients who “belong” to the private physicians who admit them. The career opportunities and professional development in nursing are simply insufficient to attract workers in a labour shortage environment, or hold them for long. The problem can only get worse, and to date there is no sign of a solution—short-term salary increases are not the answer. In the long run, it seems inevitable that we will have fewer, more highly trained and paid nurses, and fewer people will be in hospital. But how do we get from here to there?

The lack of co-operation, and sometimes even communication, between the educational and health-care systems, located in different ministries and institutions, with different cultures, objectives, and philosophies, has been a major source of the serious inadequacies in health manpower policy. In this field, errors can have consequences for a whole generation.

E. Improving the Effectiveness and Efficiency of Health-Care Delivery

Throughout the discussion above, we have noted that a number of apparently separate problems—population aging, the extension of technology, manpower—actually reduce to special cases of the more general issue—what sorts of health-care services do we wish to have produced, and for whom?²⁸ These questions, as noted, ultimately turn on a combination of technical and value information—what will particular services actually *do*, in the way of good or harm, and what do actual or prospective patients want?²⁹

To date the Canadian health-care system has addressed these questions only indirectly. “All medically necessary” services are free, implying that effectiveness, somehow defined, is the over-riding criterion. But this has been determined implicitly, as whatever a physician is willing to offer and a patient to accept. What we have discovered, as has every other country in the industrialized world, is that (i) the indirect definition of “need” is infinitely expandable within the relevant range, particularly for elderly people, and (ii) overall

28. The struggle over how much we will have to pay the producers—income shares—is largely though not entirely a separate question, though providers try hard to confuse the two. For example, it is claimed that too aggressive bargaining over fees by provincial governments will threaten the quality of care of patients. More generally, the economic and professional objectives of providers are virtually always framed in terms of ill-specified but very important effects on “quality of care.”

29. The latter is not in itself wholly decisive. Since most or all of health care is collectively funded, in every system in the industrialized world, and could not in fact be funded any other way, it also matters what the rest of us (them) are willing to pay for. But that will presumably be heavily influenced by the answers to the first two questions.

utilization rises with the availability of facilities and personnel, and tends always to press against any resource constraints, but (iii) the aggregate levels and patterns of utilization that result are highly variable, and bear no identifiable relation to any external definition of the "needs" of the population served.

The Canadian response has been to try to impose capacity constraints on the availability of facilities, sources of payment, and (much less successfully) personnel. The assumption, as noted above, is that when subjected to these constraints, the providers of health care will themselves choose to provide the services which respond to the greatest needs. Thus the payers for services can avoid the very difficult and politically very dangerous task of establishing explicit priorities and protocols, and the fiercely defended autonomy of the physician need not be challenged.

This approach is slowly changing, however, in the face of accumulating evidence that patterns of care use in Canada bear no more systematic relation to indicators of need than they do in any other jurisdiction, and more important, under the increasing pressure for more resources from the providers of health care themselves—the consequences of the physician supply increase and the extension of technology. As the relatively arbitrary limitations on facilities and resources are challenged more and more intensely by providers, provincial governments are becoming increasingly interested in the extensive research evidence of ineffective and inefficient care delivery as a basis for counter-attack.

This last point is most important. The research evidence of inefficiency and ineffectiveness of care provision, measured relative to the scientific basis for judging what interventions work, and how they might be carried out, has been available for many years—though it is certainly growing in scale and sophistication. But for most of the history of the Canadian programs, and apparently in Europe as well, the cruder forms of cost restraint which raised no awkward questions about why physicians and others do what they do, represented the politically most comfortable compromise.

That compromise appears finally to be breaking down, and governments in a number of countries—acting as regulators and payers on behalf of their citizens—are beginning to address explicitly the question of "how medicine should be practiced."³⁰ It remains to be seen how successful they will be, and particularly whether they are yet able to sustain the inevitable political counter-

30. The Minister of Health of Ontario announced, in a speech to the International Conference on Quality Assurance and Effectiveness in Health Care in Toronto (November 9, 1989), that her Ministry was undertaking to bring the Caesarian section rate in Ontario down to fifteen per hundred births, from its present rate of over twenty, within twenty-four months. These procedures are provided by private physicians, in trustee-run hospitals. But the Ministry, as payer and regulator, has explicitly taken responsibility for changing a significant component of medical practice.

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attack. But at least the questions are being raised at a much higher political level than ever before.³¹

F. Extending Our Concern from the Delivery of Health Care to the Enhancement of Health

The *Canada Health Act* of 1984 defines the objective of Canadian health-care policy as “to protect, promote, and restore the physical and mental well-being of residents of Canada, and to facilitate reasonable access to health services without financial or other barriers,” and refers to “outstanding progress” through the system of insured health services. But it also declares that further improvements will depend on a combination of improved individual lifestyles, and “collective action against the social, environmental, and occupational causes of disease.” These themes reiterate ideas expressed in a document issued in 1974 by the federal Minister of National Health and Welfare, Marc Lalonde, entitled “A New Perspective on the Health of Canadians.”

Equalizing access to health care, or at least removing the financial barriers—and significantly increasing the overall quantity of resources available—has not equalized access to, or at least the experience of, health across the population. There remain significant inequalities in life expectancy and health status across different socio-economic groups. Furthermore, there are obvious sources of mortality and morbidity which are simply beyond the reach of health-care services as conventionally defined. A public *health* policy, as different from a *health-care* policy, would have to go much deeper into the determinants of health and illness, and consider—and carry out—a much wider range of interventions than simply the expansion (or contraction) of particular health-care services.

This is clearly recognized within the federal Department of National Health and Welfare—the Ottawa Charter of 1986 was a strong affirmation of support for the World Health Organization Health for All initiative. Most provincial Ministries of Health have a similar understanding, although they are so heavily involved in the day-to-day and year-to-year operations of the health-care system that they do not always have the luxury of pursuing the broader issues. In general, however, these broader issues of inequalities in and determinants

31. In Canada, it is taken for granted that these questions of improving efficiency and effectiveness in health care will be addressed through some negotiation between governments, representing the general public as payers and patients, and the providers of care, also representing the public as patients and themselves as earners. New institutional mechanisms may be developed to assure a more effective representation of both patients and the general public, but there is no interest in a return to market mechanisms, at least not those involving patients, as ways of improving efficiency and effectiveness. Most Canadians regard the American experience as providing a decisive refutation of the market approach, although whether market mechanisms could play a constructive role in the much transformed form suggested by Enthoven remains to be seen—as does the feasibility of such a transformation!

of health have been honoured with much rhetoric—and a non-trivial amount of careful thought—but very little money.

The problem is simply that the relentless pressure for expansion from the health-care system, independent of any contribution it may or may not be demonstrated to make to the health of the population, absorbs the lion's share of both current resources and any additional resources that may become available. Thus cost containment in health care becomes a pre-condition for any new initiative in other areas of health. By a cruel irony, an over-extended health-care system may become a threat to health.

Nevertheless, despite its relatively limited constitutional role, the federal government is pressing ahead with its concerns for the promotion of health, whether in or particularly outside the health-care system. In particular, it has launched a number of surveys to accumulate a much wider body of data on the health status of the Canadian population; until recently we knew a great deal about utilization and costs of care but very little about health. Provincial governments' concerns for improved efficiency and effectiveness, though driven primarily by cost concerns, also lead quite naturally into questions as to the relative effectiveness of health care as against other public interventions in pursuing the central objective—the health of Canadians.

III. SOME CONCLUSIONS

In summary, the Canadian approach to health-care funding has been very successful in equalizing access to health-care services, though less so to health. This appears to be a common finding in the industrialized countries, reflecting the fact that population health is not determined simply by the availability or use of health care. The health status of the Canadian population, insofar as that is known (which is not very far) compares well on the usual indicators of life expectancy and infant mortality with the rest of the industrialized world, and continues to improve (though not as fast as Japan!).³²

The public insurance system has not only promoted access to health care, but has also played a very important role in “nation-building” and community solidarity, as it emphasizes a fundamental equality among citizens. Greater wealth or position buy many things, but they do not buy more or better health care; in that we are all equal. Moreover the economic burden of this system is shared, through the general tax system, according to the ability to pay of citizens. Since there are no direct payments, people who must bear the burden of illness and injury do not have to carry an additional economic burden as well. No one in Canada fears economic ruin from the cost of health care, and

32. Canadian life expectancy at birth is about 80 years for females, and 73 for males.

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no one depends on “charity,” whether public or private. The financing problems, and associated negotiations, are removed completely from the shoulders of individual citizens.

Going beyond assuring access, and improving the lives of individual citizens, the Canadian system has managed to contain the costs of health care for an extended period of time. This is a crucial test of the sustainability of a funding system; disequilibrium forces change. Furthermore it has done so in a way which has reconciled the interests of citizens as payers, and citizens as patients, and is consequently overwhelmingly popular politically. It is less popular with physicians, at least officially, though strongly supported by hospitals and other health occupations.³³

But on balance, after more than twenty years of experience, it appears that even most physicians working in the Canadian system prefer it to the known alternatives—they would just like more money (and more hospital facilities and more equipment, and the right to extra-bill patients, and...! But one should not always infer the views of the ordinary physician from the rhetoric of professional associations.)

On the basis of this experience, which is not so different from that of a number of European countries, we conclude unequivocally that centralized, public funding systems “work,” although they will require an increasing degree of explicit collective intervention in the determination of the content of medical practice. Whether this will be “public” or “private,” or more realistically the balance between the two, depends upon whether the medical profession can bring itself to develop *and enforce* scientifically based standards upon its members, or whether the public sector will have to take on this role by default.

On the other hand, we conclude equally unequivocally from the comparative United States experience that private, or “pluralistic” funding systems do not “work”; they produce neither effective health care, nor equity, nor public satisfaction, and cannot even meet the most fundamental test: stable and sustainable cost. One cannot rule out the possibility that some pluralistic system might be developed in future which would be capable of harnessing competitive forces to improve health-care system performance. But at present such systems exist only in the imaginations of those with an over-riding ideological commitment to the private marketplace—they cannot be shown to have been seriously tried, much less succeeded, in the real world.³⁴ What has been tried, in the

33. It is probable that the inherent conflict of economic and professional interest—both income and autonomy—is so sharply drawn that no system of funding which meets the concerns of the rest of the community will ever be acceptable to physicians, and conversely. Certainly the Canadian system was established over their opposition. Any search for a national system acceptable to all parties would be a nonsense exercise, a proposal to do nothing. Again, this situation is not peculiar to Canada.

34. The work of Enthoven deserves to be clearly excluded from this generalization. His proposals represent the most thoughtful and carefully worked-out example of a competitive system which takes account of the sources of failure in ordinary conceptions of “market” systems of health-care funding, and attempts to develop realistic ways of dealing with them. But his scheme is very subtle and sophisticated,

United States, has failed.

Where the Canadian system most clearly falls short, as noted above, is its inability to develop a coherent and consistent manpower policy, and this is an expensive failing. It has also, as yet, made little progress on the promotion of efficiency and effectiveness—the United States appears to be far out in front of the rest of the world on these issues (yet unable to draw the benefit from its superior information). Rachlis and Kushner's assertion that the system is undermanaged is undoubtedly correct, so that waiting lines exist and patients may sometimes suffer, not because of a scarcity of overall resources, but because those available are misused. This is in part the price of professional autonomy.

And finally, along with most of the rest of the world, we do not yet know nearly enough about the determinants of health, and why some people are healthy and others not. But we recognize the problem, and we are working on it.

and its feasibility of implementation in a highly adversarial (and often ignorant) environment is very far from clear. In any case even he offers a totally untried alternative, which may appeal where the *status quo* is generally recognized as intolerable, and such admittedly imperfect but battle-tested systems as the Canadian are ruled out on ideological grounds.