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²A. J. Culyer, "The NHS and the market: Images and realities," in Gordon McLachlan and Alan Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 38-39

³Ibid., 38-39.

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MEDICAL POLITICS AND COST-SAVING REFORMS IN ONTARIO
FROM A COMPARATIVE PERSPECTIVE

© JAMES EDWARD CARTER

A Dissertation Presented to the Graduate
Faculty of Carleton University
In Candidacy for the Degree of
Master of Arts

Carleton University Department of Political Science
October, 1988

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FROM A COMPARATIVE PERSPECTIVE"
submitted by James Carter, B.A. (Hons)
in partial fulfillment of the requirements for
the degree of Master of Arts

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November 30, 1988

ABSTRACT OF
MEDICAL POLITICS AND COST-SAVING REFORMS IN ONTARIO
FROM A COMPARATIVE PERSPECTIVE

James E. Carter

This study offers an analysis of health-care sector activities from the perspective of the theory which underpins health-care transactions and the practical health-care delivery experience in several jurisdictions. The starting point of this analysis was an examination of a set of theoretical principles underpinning health-care delivery activities, including: curative versus carative therapeutic treatment models; an examination of the term the public good, and finally; a brief commentary on the public sector provision of health-care goods and services.

Chapters III and IV turn from an analysis of health-care systems as providers of service to health-care systems as objects of political lobbying pressure. These chapters examine the health-care system as a political process, focussing on the goals and actions of physicians, consumers, insurers, and the hospital corporation.

Chapters V and VI provide a comparative perspective: in the United States, the United Kingdom, Sweden and Canada. The major health-care issues presenting themselves in each country are treated from the perspective of the theoretical principles adumbrated in the earlier chapters of this study.

In the last two chapters, Chapters VII and VIII, a diagnosis of the state of health of Ontario's health-care delivery infrastructure is provided, paying close attention to the oligarchical health-care delivery giant, Ontario's Ministry of Health (MOH). A reform proposal for attaining optimality in public provision of medical care is outlined.

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CHAPTER I

INTRODUCTION

The organization and financing of health-care systems has been a subject which has generated frequent public discussion and debate over the past decade. Canada and her fellow trading allies in the western bloc of nations employ a similar set of health-care delivery transactors and policy-making structures. Yet each nation has encountered health-care delivery failings and shortcomings which are often uniquely different from the experience of their neighbours.

This study offers an analysis of health-care sector activities from a perspective which, hopefully, captures a total set of health-care transactions which undermines the practical health-care delivery experience in several jurisdictions. The experience of the United States, the United Kingdom, Sweden and Canada will be examined while special attention is devoted to the Province of Ontario.

Summary of the Study

This study begins by examining a set of theoretical principles underpinning health-care delivery. Chapter II explores certain key fundamental questions, namely:

- How do curative (as opposed to carative) health-care treatments affect a nation's or an individual's medical consumption activities?

- What effect do health demand and health need have upon health-care policy planning efforts?
- Can public (and/or private) sector health-care programs remain attentive to the structural reforms wrought by a supplier-driven technology-oriented health-care delivery system¹?

Chapters III and IV turn from an overview of health-care systems as providers of service to health-care systems as the objects of political lobbying pressure. These chapters examine the health-care system as a political process, focussing on the policy goals and activities of: physicians, consumers, insurers, and hospital corporations.

Chapters V and VI provide a comparative perspective highlighting the experience of the United States, the United Kingdom, Sweden and Canada. The major health-care issues presenting themselves in each country are treated from the perspective of the theoretical principles adumbrated in the earlier chapters of this study.

Chapters VII and VIII offers a diagnosis of the state of health of Ontario's health-care delivery infrastructure, paying particularly close attention to the oligarchical health-care delivery giant, Ontario's Ministry of Health (MOH).

¹Richard Van Loon, "Canadian Perspective: Learning from Our Experience," in Robert G. Evans and Greg L. Stoddart eds., Medicare at Maturity. (Calgary: University of Calgary Press, 1986), 452.

CHAPTER II

THEORETICAL FIRST PRINCIPLES

Health-care, like many other public policy fields, is currently struggling to keep itself abreast of a staggering number of new technological triumphs and achievements, torn between technology-driven cost pressures and public desires for better health on the one hand and resistance to future taxation on the other.¹

An examination of the health-care industry travels in many directions at once, and includes an analysis of such topics as: curative versus carative therapeutic treatment models; an examination of the meaning of the term the public good, and finally; leads, almost inevitably, to a commentary concerning the future of public sector provision of health-care goods and services.

Before addressing each of these topics in turn, I would first like to offer a definition of the term health-care demand. Health-care demand is a concept which refers to the individual actions of consumers who internalize a group of personalized feelings which they equate with health-care quality of life and quantity of life factors or characteristics. Demand for health-care goods and services can refer to several health-care appraisal efforts or activities at the same

¹Malcolm C. Brown. Caring for Profit: Economic Dimensions of Canada's Health Industry. (Vancouver: The Fraser Institute, 1987), 91.

time.

First, health-care demand can refer to a consumer's dream-wish list reflecting the ideal health state a consumer might wish to achieve. Health demand is described in this case as each individual consumer's request for life-arranging interventions performed on their (the consumer's) behalf by physicians and other health-care personnel.²

The second approach to health-care demand is much more ideographic or de-personalized in its emphasis. The ideographic approach to health-care demand emphasizes the global or collective nature of man's search for health. In this second definitional case, individual health-care needs are determined only after consumers have compared their own unique set of health-care demands against society's universal health-care consumption yardstick measure.³

My task in this study will be to provide an in-depth examination of both aspects of the term health-care demand. The second health-care demand analytical approach will venture slightly further afield than the first definitional case. An ideographic analysis of health-care demand will specifically seek to uncover the strengths and weaknesses associated with both collective (public sector-driven) and free enterprise (private sector-driven) health-care delivery options, an effort we might initiate only after we first conduct a ground-

²A. J. Culyer, "The NHS and the market: Images and realities," in Gordon McLachlan and Alan Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 38-39

³Ibid., 38-39.

breaking survey of theoretical principles, beginning first with the curative/carative health-care distinction.

The Curative/Carative Health-Care Distinction

In order to function properly, the health-care policy process must fully acknowledge the clinical bias of its principle service providers and transactors. The clinical bias of health-care sector principals can be carefully divided into two camps, each with diametrically opposite viewpoints regarding the preferred route to take with respect to offering medical (therapeutic) interventions. The two therapeutically dissimilar medical provider camps are the curative and the carative medical treatment perspectives.

The curative or traditional health-care treatment approach emphasizes the role of the primary provider, the physician, as the gatekeeper in charge of the overall therapeutic treatment encounter. Curative medical treatment episodes are relatively simple to describe. The physician identifies a disease staging which has inflicted or troubles his/her patient. Next, the curative-oriented physician employs an immunological weapon in a battle to irradiate or unseat the disease staging before it is allowed to mount a further advance. The disease condition or illness staging is referred to by medical clinicians as a "process of disruption of the patient's normal psychological-physiological anatomical functioning."⁴

⁴J. S. Gonnella et. al., "Staging of Disease," Journal of American Medical Association. 251 (1984), 638.

The opposite model to curative health-care is the carative therapeutic treatment perspective. Carative medical care represents a medical reform movement which draws upon a team-work ethic advocating the employment of a large number of health-care personnel featuring greater human contact and more numerous and frequent psychological-sociological encounters.⁵

Among the list of additional health-care personnel requested by a carative therapeutic intervention approach are: clinical psychologists and psychiatrists, social workers, additional specialized nursing teams, plus a whole host of medical para-professionals involved in such clinical areas as physiotherapy, occupational therapy, human kinetics, nutrition and lifestyle-focused counselling programs, not to forget to mention the standard compliment of highly regarded medical practitioners (physicians).

What is readily apparent to even the most casual health-care analyst is the fact that carative medical treatment programs increasingly force organized medicine to co-operate with a wider circle of care-givers in a joint search for broader, more holistic definitions of disease and illness⁶ moving further afield from the physician's natural clinical tendency to emphasize immunological interventions over every other available course of medical therapy or treatment.

⁵Marie Haug and Bebe Lavin. Consumerism in Medicine: Challenging Physician Authority. (Beverly Hills: Sage Publications, 1983), 192.

⁶Gonnella, "Staging of Disease," 638.

Carative therapeutic interventions continually emphasize health needs in a manner which asks all of the attending medical staff, physicians included, to adopt more conciliatory attitudes towards the individual patient or consumer.

The carative health-care model reintroduces the consumer as a key health-care participant, enticed and encouraged by the team of inter-related professional care-givers⁷ to make a choice from among the bewildering array of medical treatments.⁸

The carative model is not without its own set of structural and procedural discontinuities. Carative therapeutic interventions may increase the number of health-care services offered by the medical community in a logarithmic manner, rendering cost-versus-value resource allocation decision-making efforts increasingly difficult to perform.⁹

Secondly, health prevention, a newly arrived spin-off industry to the health sector mainstream, encourages the proliferation of medical therapeutics delivering questionable clinical test results, thereby prompting an already out-of-hand health-care expenditure spiral to escalate even further. In far too many cases, the economic factors influencing health-care resource allocation determinations are shielded

⁷Haug and Lavin, "Consumerism in Medicine," 37.

⁸Malcolm G. Taylor, "The Canadian Health Care System, 1974-1984", in Robert G. Evans and Greg L. Stoddart eds., Medicare at Maturity. (Calgary: University of Calgary Press, 1986), 8.

⁹Culyer, "The NHS and the market," 41.

from the largely unsuspecting general public.¹⁰

A further limitation of the curative therapeutic approach is the fact that recent demographic studies suggest only a miniscule degree of measurable medical efficacy associated with curative health-care programming efforts in general. Measures of life prolongation causally linked to the adoption of the curative therapeutic approach are currently unavailable.¹¹

Once a medical therapeutic approach has been selected, whether it is curative or curative in nature, it may be plagued by one highly specific judgemental inefficiency or discontinuity. The selection and determination of a particular medical therapeutic intervention is generally subjected to a small-sized clinical population trial-run before it is later embraced as a treatment method of first choice by medical providers. Testing procedures of this kind, and the subsequent medical therapeutics they generate, may produce intermediate test results which neither cure nor add to the further debilitation of the patient.¹²

In such clinical cases, physicians may choose to employ diagnostic-related testing procedures in order to enhance the accuracy and/or efficacy of their medical therapeutic interventions.

¹⁰Gordon McLachlan and Alan Maynard, "The public/private mix in health care: The emerging lessons," in McLachlan and Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 545.

¹¹Ibid., 546.

¹²Greg L. Stoddart, "Rationalizing the Health Care System," in D. Conklin and G. Cook and T. Courchene eds., Ottawa and the Provinces: The Distribution of Money and Power. (Toronto: Ontario Economic Council, 1985), mimeo., 10.

However, diagnostic-related testing results rarely inform the physician that a particular patient might benefit from a certain type of therapeutic intervention. In more than a few cases, the choice of treatment dictated by the diagnostic-related testing procedure is the result of pure guess-work or chance, rather than by a one-hundred per cent guaranteed scientific interpretation.

In effect, diagnostic-related testing procedures may falsely heighten the expectations of the general public who may fall victim to the suggestion that medical science has all the answers to solve their unending lexicon of diseases, injuries and illnesses.¹³ The heightened medical cure expectations which the general public may falsely harbour could lead to an artificially raised performance of medical therapeutic interventions in general, interventions which themselves might easily outstrip what is medically demanded or ethically required.

In their haste to receive therapeutic treatments, the general public may find their health put at risk, and may in fact be subjected to medical treatment's with a poor, or possibly injurious, clinical track record. Medical provider service performance of this kind may ultimately lead to an erosion of public confidence in the health-care delivery system as a whole.

¹³Robert G. Evans, "Incomplete Vertical Integration: The Distinctive Structure of the Health Care Industry," in J. Van der Gaag and M. Perlman eds., Health, Economics and Health Economics. (Amsterdam: North-Holland, 1981), 342.

Definition of the Public Good

Few individuals would care to dispute the fact that a nation's population are undoubtedly better served if their health status can be assured on a global basis. Achieving equitable health-care distribution on a global basis is, however, easier said than done.

Not only must a polity seek an appropriately verifiable level of medical service provision for its citizenry, the polity must also supply health-care services in a manner which conforms with the citizenry's collective identification with the public good.

The public good may be referred to as a right to enjoy a good or service which occurs indiscriminantly. If one individual in a group is supplied with a good or service, all others in the group must also be supplied with the chance to enjoy the equal benefits produced by the same, or a similar, commodity or service.¹⁴

An example of the public good is the provision of any good or service which, when some of society is provided with that good or service, several individuals (perhaps all individuals in society) ultimately will benefit jointly from its provision.¹⁵

¹⁴Sandford F. Borins and Barry E. C. Boothman, "Crown Corporations and Economic Efficiency," in D. G. McFetridge, Canadian Industrial Policy in Action. (Toronto: University of Toronto Press/Vol. 4 of the Royal Commission on the Economic Union and Development Prospects of Canada, 1984), 81.

¹⁵Ake Blomqvist, The Health Care Business. (Vancouver: The Fraser Institute, 1979), 11.

The public good is, therefore, a unit of analysis which is not, by definition, contingent for its supply solely upon the amount an individual is willing to pay for it, nor can the supply of the public good be artificially raised in price because some individuals are excluded from enjoying its benefits.

Publicly-Provided Health-Care: Confronting the Future

In many western nations, medical providers (physicians) have been traditionally granted the opportunity to conduct their professional activities in a highly independent, semi-autonomous decision-making manner.¹⁶ Publicly-run medical delivery efforts have, on more than a few occasions, found themselves excluded from the medical profession's decision-making inner circle.

Public sector health-care delivery planners have attempted to overcome the largely secretive and self-regulatory nature of current medical practice standards established by the medical profession and their hospital administration counterparts by attempting to maintain good working relations with health-care providers whenever possible.¹⁷

However, the public sector has increasingly been forced to move against the medical providers and unseat physicians

¹⁶Jonathan Lomas and Morris L. Barer, "And Who Shall Represent the Public Interest? The Legacy of Canadian Health Manpower Policy," in Robert G. Evans and Greg L. Stoddart eds., Medicare at Maturity. (Calgary: University of Calgary Press, 1986), 247.

¹⁷Stoddart, "Rationalizing the Health Care System," 3.

and hospital administrators from their health-care sector resource allocation decision-making positions.

Although the public sector health-care planners readily admit that medical providers (physicians) have all too often tended to define away from the public good any resource allocation matter which might threaten the profession's self-serving pursuit of economic rent-seeking actions and activities,¹⁸ the public sector have shown a demonstrable predilection for co-opting physicians and hospital administrators in joint health-care sector resource allocation decision-making efforts.¹⁹

Physicians, on the other hand, have generally remained quite skeptical of the government's long-range health-care prioritization and sectoral planning activities. Physicians generally fear the idea that government-employed health-care administrators are intent on only one thing. That is, to make themselves privy to the confidential information contained in their medical and/or business files.

A detailed and intimate examination of physician medical records would, the profession argues, inevitably lead to the drafting of a series of yearly actuarially-averaged physician income tables which might lead to a wholesale

¹⁸Philip Slayton, "Professional Education and the Consumer Interest," in Michael J. Trebilcock, ed., Four Aspects of Professionalism. (Ottawa: Consumer Research Council, 1976), 66.

¹⁹Alan Maynard, "Regulation of public and private health care markets," in Gordon McLachlan and Alan Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 487.

erosion of the medical profession's cherished right to control their rate of payment thereby attracting the proper candidate to pursue the study and subsequent practice of medicine.

If the government steps up their regulatory interference and attempts to further undermine organized medicine's exercise of self-regulatory control over their rank and file membership, a potentially useful tripartite political alliance voluntarily entered into by physicians, consumers, and government (regulatory agency) authorities might quickly become abandoned.

In the final section of this chapter, I would like to turn to an examination of high technology and its effects upon medical provider behaviours and society's collective long-range health-care planning efforts. The health-care industry is increasingly being threatened by new technological change agents which have unleashed a powerful set of disruptive change mechanisms which are confounding the way we approach health-care prioritization and planning issues and activities in general.

Among the list of new change elements or change agents which are impinging upon the health-care sector are the following: artificially-induced manipulations of human fertility factors (occurring both in vivo and in vitro); organ transplant programs (employing both natural and artificial donor organs); the increasing threat posed by life-threatening outbreaks of communicable diseases, and; a whole host of particularly worrisome moral and ethical problems which will eventually be uncovered by the rapid advances being made in human cellular

genetic (and bio-medical) engineering activities.

These rapid technological and social transformation elements or change agents will impact upon us in our day-to-day lives in a manner which we can only barely appreciate at present. We may be forced to re-examine our nation's commitment to the principles of medicare, or may even be prompted to step up the search for new and exciting health-care delivery formulas to keep up with a constantly evolving group of disease classifications which the scientific research community are uncovering in leaps and bounds.²⁰

At the very least, we should be prepared to sponsor an intriguing set of health-care policy public debates concerning the direction in which our nation's health-care delivery program is ultimately headed to the year 2000.²¹

²⁰Stoddart, "Rationalizing the Health Care System," 10-11.

²¹Lomas and Barer, "And Who Shall Represent the Public Interest?" 243, 246.

CHAPTER III

THEORETICAL CONSIDERATIONS: HEALTH VALUATION

The Political Process, Physicians and Consumers

In the next two chapters of this study I will conduct a review of the health-care sector's health valuation process. The last chapter concluded by stating that a new high technology health-care delivery system will be needed to carry health-care transactions forward to meet the next heightened level of technological development and health-care service provision sophistication. Society, as it has often been clearly demonstrated in the past, is usually very reluctant to deal with change on such a massive scale.

In order to help health-care planners address the challenges which lie ahead, I have designed a set of questions which might help the health-care policy reappraisal effort spring into action.

- Will the next health-care policy reform initiative introduce added functional separation between health-care transactors (and their attending service programs) following the deregulatory guidelines favoured by organized medicine?
- Or, will a more fully integrated and regulated curative (government-administered) health-care service program emerge, holding as its hostage society's collective health-care decision-making effort?

- Or, will the health-care system move in two directions at once,¹ one part regulated (public sector-driven) and the other deregulated (private sector-driven)?

The very act of designing and implementing social redistribution policies or programs, at least in the minds of classical (small 'l') liberals, represents an imprecise collection of negative policy ideas and flawed policy perceptions which are, more than anything else, quite harmful to mankind's long-term political interests.

Classical liberalism favours social policy redistribution activities which are initiated through direct contact with individuals rather than through resort to institutional delivery mechanisms and public sector regulatory interventions. Rather than adjust existing budget allocation formulas to allow for the redistribution of society's net fiscal product, the small 'l' liberal would prefer that direct redistribution of economic profits be accomplished through a negative income tax system (ie. a cash-back scheme rewarding the less fortunate at the more fortunate population segment's expense).²

I have raised the logic of liberalism political argument³ at this particular point in the discussion to emphasize the difficulty which exists when the health-care analyst

¹Walter J. McNerney, "Control of health care costs in the United States in the context of health insurance policies," in Gordon McLachlan and Alan Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Hospitals Trust, 1982), 343-344.

²Maynard, "Regulation of public and private health care markets," 497.

³Ibid., 497.

is faced with the task of determining how exactly the market-driven deregulation (ie. decentralized) health-care delivery option might work.

There is one obvious shortcoming with classical liberalism's deregulation/entrepreneurialism "idealized" health-care delivery model. Many powerful pressure groups, organized medicine for one, stand ready to oppose social redistribution measures, such as the negative redistribution income tax scheme, particularly if they serve a political purpose contrary to the public policy objectives embraced by the medical profession's membership rank and file.

Organized medicine may support the logic of liberalism in their hearts, but in their minds they may actually prefer to reap the economic benefits which universal publicly-delivered health-care programs offer their professional constituency.

As long as medical providers are allowed to control the automatic forces of supply and demand via their reimbursement and manpower policy veto, something which has occurred in Canada at regular intervals up until now, organized medicine will undoubtedly favour a continuation of the current "status quo" physician-dominated health-care delivery model.

Moving to our second policy option, the advocacy of a non-market public sector health-care delivery program, the overwhelming criticism which the public sector faces in attempting to secure the success of their long-term health and welfare redistribution program is the concern that they

may be responsible for inadvertently causing the creation of an expensive, cumbersome, self-serving bureaucracy.

Publicly-delivered health-care service activities share a dissimilar set of policy challenges than the policy afflictions affecting the private sector health-care delivery model. For example, organized medicine may prove highly successful in their efforts to co-opt public sector health-care planners who may be influenced to compromise the health-care bureaucracy's long-term pursuit of an autonomous, independent health-care prioritization plan of action. Instead, a medical provider health-care delivery blue-print might be slyly substituted onto the nation's health-care priorities and planning decision-making agenda with hardly a voice raised in opposition to the action.

And last but not least, turning to the middle road option, it might be suggested that the middle road option represents the best that both policy worlds may have to offer.

The middle road option attempts to capitalize upon the strengths of the private sector health-care delivery approach, plus middle road policy strategists are optimistic that they might also ensure that market regulated health-care delivery activities function in a smooth fashion, thus gaining the support of the free enterprise-oriented business lobby.

Middle-of-the road health-care delivery strategists argue that it is possible to design health-care delivery legislation which might ensure that market mechanisms function

efficiently and equitably. Such legislation would control the power as well as circumscribe the activities of special interests (including organized medicine) who might oppose the government's right to interfere with the profession's internal regulatory affairs and practical policy pursuits which, providers argue, should remain sealed off from third party (government) supervision.⁴

There is one major failing with the middle-of-the-road strategy. It somehow overlooks or misrepresents the actual functioning of the free enterprise market. Marketeers normally boast that market-driven provision of health-care products and/or services are set at competitive price levels which guarantees that individuals will buy those products and/or services. Fair market exchange is, private enterprise proponents argue, the best possible way to organize society's productive capacity.

However, the fact that government might step in and provide health-care products and/or services to society's disadvantaged population segment at a health-care transaction price determination set deliberately below cost price⁵ suggests a far different social redistribution ethic is at work.

Middle-of-the-road health-care policy proposals, however, rarely spell-out which market distribution ethic they favour, whether it is the free enterprise health-care delivery market ethic or the collectivist (or public sector) health-care

⁴Blomqvist, "The Health Care Business," 50.

⁵Cotton M. Lindsay, "A Theory of Government Enterprise," Journal of Political Economy. 84:5 (1976), 1064.

transactions delivery model.

Without a doubt the middle-of-the-road health-care policy option walks a tight-rope between marketer and anti-marketeer ideological extremes. The important point to note is that the private sector market proponents (the physicians and their marketer political allies) and the public sector, publicly-delivered health-care proponents (anti-marketeers and/or mixed public/private sector health-care delivery program supporters) are essentially talking past one another. Both groups misunderstand or choose to misrepresent the other group's definition of the public good.

For marketers, the deliberate, unhindered freedom of individual human action must be allowed to undermine all social transactions and guide every market exchange effort in order to achieve the public good.

For anti-marketeers, the public good is enveloped within society's total holistic quest or search to advance everyman's collective well-being.⁶ Collective social action minimizes the harmful side-effects caused by an individual's undivided pursuit of interest self-maximization which, anti-marketeer's believe, raises the risk that individuals might rise to political power and subjugate other members of the social order, thereby destroying society's net productive efforts which could possibly lead to an undermining of the public good.

With the emergence of the welfare state, more decisions

⁶Culyer, "The NHS and the market," 28.

have inevitably been made at the State level. This situation stems, in part, from society's recognition that a person's right to life is just as valuable, and consequently equally worth the effort to save, as any other individual's right to life.⁷ Denying an individual his or her enjoyment of health based solely upon ability to pay criteria comes rather close to denying a fundamentally cherished illusion of equality which undermines our political and judicial value systems.

Canadians have long recognized that a society in which people come to see themselves as fundamentally different, as unequal, becomes not only ungovernable, but also creates potentially ruinous and disruptive social cleavages.

As a direct result of this observation, public sector health and welfare redistribution programs offered in Canada to date have consciously attempted to defend the idea that health-care provision be promoted as a universal public good.

The introduction of universal health and welfare redistribution measures in Canada, therefore, travelled a great distance towards partially correcting or alleviating the suffering caused Canada's poor and medically indigent population segment. Public sector health and welfare redistribution programs have generally been accepted as a resounding Canadian public policy success story up until now.

⁷Robert G. Evans, "Health care in Canada: patterns of funding and regulation," in Gordon McLachlan and Alan Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 408.

Canadians commonly subscribe to the political belief that their citizenry should not be judged harshly should they find themselves temporarily unable to contribute to their nation's economic support in as generous a fashion as society's more affluent and financially secure upper class.⁸

The Health-Care Political Process

Robert Evans (1981) has created a unique health-care sector analytical model which demonstrates health-care sector transactions in a graphically explicit manner. Evans' model identifies five independent transactors actively contributing to the health-care policy process: regulation (the political process); first-line providers (physicians); utilization (consumers); insurance; and, second-line providers, the latter including hospitals and/or other medical treatment facilities (see Appendix: Figure 1).

Evans cites a condition of incomplete vertical integration which, he suggests, occurs within the health-care industrial sector as a whole.

More specifically, Evans suggests that market exchange relationships often unleash conditions of political tension which can be either consensus-seeking or can serve to unleash bitter political confrontations depending upon the policy objectives defended by the health-care principals involved in the policy dispute (see Appendix: Figure 1 "no conflict

⁸Evans, "Health care in Canada," 408.

scenario"; and Appendix: Figure 5 "3 transactor conflict/-consensus scenario").

The health-care political process must devote considerable time and energy to regulating marketplace activities. General regulation of the health-care industry is, however, more extensive than the regulatory activities conducted in many other areas of a modern post-industrialized nation's economy. This is partially due to the fact that health-care providers and suppliers are often elevated to positions of decision-making authority⁹ which are sometimes hard to distinguish from the decision-making authority invested in the government agencies themselves. This condition often disrupts the normal (bilateral) supplier-consumer relations traditionally produced by competitive market conditions. Instead, the health-care sector must overcome several policy discontinuities and inefficiencies which are quite unique to the health-care transaction model identified by the Evans (1981) typology.

The first health-care sector transactions discontinuity is the government's handling of the pricing mechanism. Prices charged by government enterprise are typically set by political means, and are not exclusively consumer-driven or market determined events. Accordingly, government supplied services all too often demonstrate an unwillingness to reflect actual consumer price drift or change.¹⁰

⁹Evans, "Incomplete Vertical Integration," 330.

¹⁰Lindsay, "A Theory of Government Enterprise," 1065.

A second policy discontinuity often mentioned in the health economics literature is the suggestion that competitive (private sector) health-care delivery programs lack the prerequisite internal regulatory mechanism to discourage medical providers from taking advantage of the health-care payments system.

Thirdly, neither the idealized market image nor the market system currently in operation might unequivocally recreate in a serviceable enough manner the pro-competition model favouring a "proto-typical consumer shopping around for the best quality health care at the least price, and getting it."¹¹

And to round out our list of free enterprise, market-driven health-care sector policy inefficiencies or discontinuities, it has been recently suggested that health planning is an excessively value-laden process in which planning staff and hospital board members respond to pressure placed upon them by interest groups with varying abilities to mobilize political support behind their favourite cause.¹²

In the normal course of events, governments alone possess the inherent right to control the flow of public goods and services.¹³

¹¹Culyer, "The NHS and the market," 35.

¹²Barry Checkoway, "The Empire Strikes Back: More Lessons for Health Care Consumers," Journal of Health Politics, Policy and Law. Vol. 7:1 (Spring 1982), 119.

¹³Alan Ryan, "Mills and Rousseau: utility and rights," in Graeme Duncan ed., Democratic theory and Practice. (Cambridge: Cambridge University Press, 1983), 47.

However, in the health-care sector's case, governments are often overwhelmed by the rational-technical¹⁴ superiority of the medical profession¹⁵ who control the most powerful political inputs, thus dominating health policy formulation and strategic planning activities.¹⁶

If we discover that governments (the public sector) rely solely upon advice given them by marketeers, then government will quickly learn that marketeers singularly fail to provide a firm description of their overall health-care sector delivery objectives. Market outcomes, according to the private enterprise free market ethic, should not be regulated, since markets should be free to achieve whatever price level individual consumers will decide they want to pay for health-care goods and services.¹⁷

Marketeers seem happy to stake their claim in defence of the superiority of market-delivered health-care transactions almost as if the belief in the market mechanism is itself a matter of faith,¹⁸ or a nearly unshakeable religious conviction.

¹⁴Checkoway, "The Empire Strikes Back," 119.

¹⁵Carolyn Tuohy, "Conflict and Accommodation in the Canadian Health Care System," in Robert G. Evans and Greg L. Stoddart eds., Medicare at Maturity. (Calgary: University Press, 1986), 429/endnote [# 45]; Donald Ralph Kingdon, Matrix Organization. (London: Tavistock, 1973), 58.

¹⁶Stoddart, "Rationalizing the Health Care System," 12.

¹⁷Culyer, "The NHS and the market," 49.

¹⁸Maynard, "Regulation of public and private health care markets," 488.

On the other hand, if government policy is determined solely as a result of consultations conducted with anti-marketeers (collectivists), the government will quickly be confronted with a world in which men and women of goodwill set about meeting the reasonable needs of their clients in a utopian fashion, and only as an afterthought will anti-marketeers offer a strict definition of such terms as medical 'needs', medical 'demand', or attempt to suggest what level of health-care services match society's long-range health-care needs in the most appropriate and cost-effective delivery fashion.¹⁹

The challenges unleashed by the prospective global health-care re-evaluation effort, caused in part by the growing alarm associated with a burgeoning health-care expenditure crisis (see Appendix: Figure 2-6 reporting conditions in Ontario), must inevitably address the role which medical providers perform within a nation's total health-care delivery mix, a topic which I would now like to address in a more in-depth manner.

¹⁹Culyer, "The NHS and the market," 49.

The Providers (Physicians)

Organized medicine enjoys an enviable position at the forefront of the health-care leadership decision-making hierarchy. The medical profession have long believed they possess virtually unchallengeable rights or entitlements to act as a group of fully-autonomous, internationally recognized scholarly, consulting experts engaged in one over-riding collective policy pursuit. That pursuit is to create definitions of disease and formulate continually upgraded principles promoting the application of medical knowledge to specific illness episodes.²⁰

The infant medical profession, very early after their founding, decided as a group that they could ill afford divisive battles among warring, factionally-minded elements of their profession. The founding of a single over-riding medical provider organization was, however, quite difficult to achieve during the profession's formative years (1865 to 1940). Medical practitioners were divided into four different groups who each formulated a chorus of theories concerning the origins of disease.

The four medical practitioner groups were: allopaths, who believed that alleviating disease symptoms constituted curing disease; homeopaths, who viewed diseases as suitably treated with minute doses of drugs which in larger amounts create the disease's symptoms in a healthy person; osteopaths

²⁰C. David Naylor, Private Practice, Public Payment. (Kingston: McGill-Queen's University Press, 1986), 11.

(chiropractors), who practiced the art of manipulating the spinal cord and believed in controlling or altering the patient's nutritional profile; and finally, all other professional care-givers known as the eclectics.²¹

It was not until the early 1900s when germ theory became a prevailing medical orthodoxy defining the origins of disease that the profession finally coalesced around the allopathic treatment pole as the dominant form of medical therapy. Organized medicine had, by the early 1900s, adopted rules and regulations governing professional conduct and the discharge of medical responsibilities²² which were strongly enforced by the allopathic faction's highest leadership echelon. Organized medicine, effectively, became united as a fraternal organization of medical practitioners which demanded that the rank and file membership be forced to uphold a professional code of moral conduct at every turn.

Physicians were not only entreated to follow similar practice standards, they were also taught to defend the idea that the medical profession served as the self-appointed guardians of medical knowledge, an idea which was repeatedly emphasized to apprenticeship physicians-in-waiting.²³ In order to protect their special social status, inter-group discipline was rigorously maintained. Strong punishments were often delivered to delinquent practitioners to discourage

²¹Brown, "Caring for Profit," 25.

²²Tuohy, "Conflict and Accommodation in the Canadian Health Care System," 406.

²³Brown, "Caring for Profit," 24-25.

the outbreak of incidences involving professional malfeasance.

Members of the medical profession who deliberately chose to adopt professional conduct unbecoming of a physician (or, who adopted behaviour which conflicts with the profession's clinical practice norms) ultimately found themselves subjected to peer review or disciplinary committee action. In the extreme case, a repeat offender could have their medical license revoked for an indefinite period of time, or may even be expelled from a highly coveted hospital staff position, with subsequent suspension of all hospital admitting privileges in the process.²⁴ The offending or delinquent physician could also find their return to the professional fold subjected to medical association licensing board and/or internal disciplinary committee peer review actions.

Undoubtedly the onus was/(is) certainly placed squarely upon the shoulders of each individual physician to faithfully adhere to the medical association's internal regulatory rules and statutes governing their professional conduct and behaviour. Physicians are commonly mutually supportive of each other on a personal level. In relation to the general public (ie. outsiders), however, the in-group doctors are virtually united²⁵ and defend each other's actions by employing a team-player ethic reinforced by the twinned canons of reciprocity and no criticism.

²⁴Reuben A. Kessel, "Price Discrimination in Medicine," Journal of Law and Economics. I (October, 1958), 23.

²⁵Ibid., 45.

The principle of reciprocity states that no physician is allowed to offer medical services to a patient listed as a subscriber to any of their colleagues medical practices unless they first gain that colleague's permission or approval to treat their colleague's client.

Physicians caught raiding each other's medical practice for new patients receive a severe reprimand from the disciplinary and licensing board (higher echelon) medical association leadership, and may be subject to further disciplinary action if required.

The principle of no criticism is exactly what it states. Physicians can receive stiff reprimands from their medical colleagues if they publicly criticize the work of another physician, something which is frowned upon and very rarely occurs. The only reliable source for the evaluation of medical practitioners, the profession argues, can be professional peers and mentors²⁶ who are entitled to consult with one another concerning such matters in private.

Physicians are adamant that not only should their powers of self-regulation and self-governance be fully recognized by society and government, but they also insist that fiduciary and clinical relationships entered into between physician and patient should remain a private matter, protected by law if necessary, and should remain totally exempt from third party (government) interference.²⁷

²⁶Naylor, "Private Practice, Public Payment," 12.

²⁷Ibid., 12.

The medical association's approach to the lay population, (consumers and government) is somewhat problematic. The problem is that the lay community (consumers) increasingly enter into a commercial relationship with the medical professional as they might with a mechanic, a plumber or any other private businessman. The first thing the consumer expects will occur in a typical medical encounter is that they (the consumer) will become involved in a bilateral exchange relationship, negotiating as a partner (or, at best, as an almost equal partner) with the physician concerning their likely course of medical treatment.

In actual fact, such a scenario rarely occurs. The physician, as we have already noted,²⁸ effectively controls the total flow of available medical knowledge,²⁹ and therefore also controls the direction in which the medical consultation is ultimately headed.

The medical profession are not only vexed if their autonomy and/or authority is called into question by consumers, they also resent the fact consumers, who often possess insufficient information to make intelligent medical decisions, should question their clinical decisions or seek to influence the course of medical treatment they are receiving.³⁰

Physicians are particularly mistrustful of third party (government) interference in their profession's internal

²⁸See Chapter II page 5 at the last paragraph.

²⁹Evans, "Incomplete Vertical Integration," 343.

³⁰Maynard, "Regulation of public and private health care markets," 505.

affairs. The reason for the professions' protective stance regarding government intervention in policy spheres thought to involve physician professional self-regulation is primarily related to the profession's historical attempts to defend the physicians' right to control routine monetary flows within the health-care sector as a whole.³¹ In effect, this raises a third medical self-governance principle, a principle which helped build the physician-dominated health care edifice in the first place. The medical profession self-governance principle to which I am referring is the profession's extremely rigorous enforcement of a reimbursement scheme called structural pricing.

Structural pricing is a very simple concept. All medical professionals must subscribe to the same fee structure. From the earliest point in their profession's historical development, physicians recognized that they needed to unite behind a group pricing agreement which would thereby ensure that all members of the medical fraternity would enjoy an equal chance to earn a reputable income. As a result of this policy, physicians began to adopt a position of group solidarity on all financial bargaining matters affecting the economic standing of the medical profession as a whole. The structural pricing policy created and promoted a system of non-competitive market behaviour between (or among) individual medical practitioners.

³¹Odin W. Anderson, HMO Development: Patterns and Prospects. (Chicago: University of Chicago/Pluribus Press, 1985), 169.

In any other sector of a western post-industrial economy, non-competition (service monopoly) policy is simply viewed as "price fixing" writ large. In the health-care sector, however, physicians define away from the public good any prior familiarity or awareness the public might have about the value of medical goods and services.

Structural pricing, therefore, differs significantly from monopoly pricing because medical fees represent "values" professionally defined, far more than marginal costs. In effect, consumers cannot be considered appropriately qualified to offer the medical profession assistance in drafting their profession's standard medical labour fee tables.³²

The medical profession bristles at the mere suggestion that structural pricing can in any way be equated with price rigging actions and/or activities associated with monopoly pricing practises generic to large-scale business corporations. Physicians usually side-step the criticism that they (physicians) prejudicially influence medical "values" and instead attempt to disarm their critics by stressing the positive features associated with the structural pricing (service monopoly) convention.

The structural pricing mechanism involves membership-wide (closed panel) voting on scale-rated medical service ticket items. Each medical service ticket item is pro-rated according to its degree of performance difficulty. On some occasions, the fee levels the profession sets have been known to reflect

³²Brown, "Caring for Profit," 26.

additional factors, such as educational ranking, or the seniority "status" of senior medical staff receiving higher reimbursements than the more junior medical interns/residents.

Medical fees may reflect different costs assigned to the provision of curative as opposed to carative medical treatments, with the latter group constituting medical services which oftentimes earn lower financial reimbursements due to the counselling-oriented, or palliative nature of the treatment process.³³ In effect, medical provider fee assessments represent professional views concerning the prestige of provider decision-making which are, invariably, also linked to the current state of medical high technology therapeutic advance.³⁴

Price Discrimination: A Lesson in Public Relations

The analysis I have just completed suggests organized medicine has endeavoured to keep the inner workings of the medical profession hidden from public view. In addition, the profession have even gone so far as to monopolize the payments process via the non-competition (structural pricing) policy measure. Physicians argue they are entitled to implement structural pricing in order to protect their profession against unwanted competition from medical charlatans or clinical imposters. However, there is more to the argument than this.

³³Naylor, "Private Practice, Public Payment," 11.

³⁴Brown, "Caring for Profit," 26.

Nothing rankles the medical profession more than the suggestion they have failed to act as good public citizens. Yet the good public citizen angle has to be raised, particularly since it was they (the medical profession) who were the ones to deliberately draw attention to their activities pursuing charity health-care service provision on behalf of the poor and medically indigent in the first place.

The charity hypothesis states that doctors, in their role as the principal pre-medicare era health merchants, performed medical service work on behalf of the poor and medically indigent which was offered free of charge.

Physicians have historically referred to their charity medical service performance as an example of non-discriminatory medical service provision. Non-discriminatory servicing involves not only an abstention of medical fee collection activities by physicians, it also translates roughly as follows: the physician performs charity work caring for indigent clients knowing very well that the indigent client lacks the financial means to pay for the medical services they receive.

The non-discrimination factor enters into the discussion since physicians claim that they do not discriminate (ie. do not withhold medical services from the poor) based solely upon ability-to-pay criteria.

Charity work, therefore, was deemed a highly satisfactory form of medical service provision for the poor and medically indigent population segment because, according to organized

medicine's editorializing on the issue, the costs of charity work were always subsidized from charges levied against the wealthier groups in society who were more than willing to pay a little extra loading charge included in their regular office visit fee assessment³⁵ to cover the cost of the physician's charity sector medical service provision activity.

We should not be deceived by this argument. Kessel (1958) reminds us that North America's organized medical associations are supplying a circular form of reasoning to defend a highly controversial method of economic redistribution activity which, quite literally, lies outside the jurisdictional reach of the profession.

The North American health-care historical record for the pre-medicare period fails to confirm the somewhat shaky defence provided by physicians to shore up their "charity" medical servicing activities argument. As Kessel so sagely notes:

- a) doctors do not charge each other for medical care;
- b) the volume of free medical care, particularly surgery, has declined substantially in the last twenty years (1930s to 1950s) yet no change in provider fee determinations has occurred to adjust to the changes in per capita income earnings attributable to the poor and indigent, a socio-economic class who are often left ravished by society's unyielding onslaught of rising economic inflation and worsening employment prospects;

³⁵Kessel, "Price Discrimination in Medicine," 45.

c) no administrative machinery exists for matching the receipts and financial payments received by physicians in support of the medical profession's allegation that they had, indeed, performed charity work.

In addition, wealthier patients - contrary to the reports made by North American organized medicine - commonly agree that they were not informed of the magnitude of the loading charges supposedly imposed upon them by their physician to subsidize the medical profession's "charity" medical service provision activities.³⁶

Professional Governance and the Public Good

Physicians have long been eager to demonstrate their profession's commitment to the public good. However the medical profession must first come to grips with the fact that the large amount of public relations activity which the profession has devoted in an attempt to educate the general public concerning the myriad number of sacrifices made by physicians on the general public's behalf are not being believed in as wide-spread and unquestioning a manner as they once were.

The most glaring deficiency of the pre-medicare North American health-care systems is the little disputed fact that the main health-care decision-maker on the supply side, the doctor, has no incentive to economize in his/her clinical prescribing activities, especially since they have no idea

³⁶Kessel, "Price Discrimination in Medicine," 24.

of the cost of the treatments which they routinely perform and/or prescribe.

If the doctor fails to economize in their production/-function activities, the patient is in absolutely no position to do anything but follow their physician's lead.

Although it must be kept in mind that many health care services represent types of goods where patients cannot function as agents on their own behalf and therefore must seek advice from those possessing the necessary technical expertise, the question most asked in the Canadian context is whether or not doctors exploit their agency role to foist unnecessary services on patients when paid on a fee-for-service basis,³⁷ or whether a number of undesirable practice habits arise as a result of the current fee-for-service medical delivery status quo arrangements.

Among the common Canadian physician fee-for-service practice habits which generally promote rapid growth in the number of recorded medical services are:

- (1) time-shuffling, where patients are deliberately treated after hours in order to increase the fee;
- (2) upgrading, where the paying agency is billed for services more extensive than those provided;
- (3) injury enlargement, where the severity of the health problem treated is overstated;
- (4) ping-ponging, where the patient is referred to another physician without questioning the 'need' factor involved;

³⁷Brown, "Caring for Profit," 89.

- (5) service splitting, where a procedure is artificially separated into many parts for billing purposes;
- (6) phantom treatment, where bills are submitted for operations or procedures not performed, and;
- (7) assembly line production, where patients are processed at a rate that makes adequate clinical treatment impossible.³⁸

The process of service splitting, in particular, has allowed average fee rates to remain slightly depressed while actual health-care provider servicing performance may actually lag behind the sizeable fee increases physicians have managed to maintain on a yearly basis.³⁹

The Canadian provincial medical associations will, almost certainly, openly campaign for the maintenance of the "status quo" fee-for-service (solo) practice health-care delivery model. The profession will remind us of the positive features associated with the current health-care delivery arrangements.

The fee-for-service medical service model currently favoured in North America will be cited as a less rigid practice format, allowing a greater number of consumers assurance that they will receive the medical attention they demand. The fee-for-service (solo) practice format possesses the uncanny ability to: allow physicians an opportunity to set up their medical businesses in locations of their

³⁸Brown, "Caring for Profit," 72.

³⁹Ibid., 26, 141.

own choosing; reassures the general public that medical providers will design appealing work settings accomodating the oftentimes conflicting work schedules of their clientele, and thirdly; offers the consumer an opportunity to establish a life-long relationship with a private clinician of their personal choice.

The North American medical profession can be expected to argue that the professional-client relationship will suffer if the fee-for-service (solo) practice model is suddenly replaced by an alternative delivery format. The evidence to support this claim seems to be more symbolic than anything else, since direct causal evidence supporting the advantages of the physicians' favoured fee-for-service practice model⁴⁰ have so far failed to materialize.

Perhaps the real truth of the matter is that physicians cringe at the possibility they might become typecast as inferior manager types,⁴¹ should a bureaucratized or third party (government-administered) health-care delivery format receive wide-spread public acceptance in the near future. Medical association spokespersons argue that centralized (bureaucratic) planning would not only fail to break through

⁴⁰J. E. F. Hastings, "An interim report on the Sault Ste. Marie study: a comparison of personal health services utilization," Canadian Journal of Public Health 61 (July - August 1970): 289-296; Gordon H. DeFriese, "On Paying the Fiddler to Change the Tune: Further Evidence from Ontario Regarding the Impact of Universal Health Insurance on the Organization and Patterns of Medical Practice," Milbank Memorial Fund Quarterly 53 (Spring 1975): 117-148.

⁴¹McNerney, "Control of health care costs in the United States," 344.

its own set of cumbersome decision-making hierarchies. Centralized (bureaucratic) health-care planning would also represent a poor match to the medical profession's historically superior corporate organizational form which, the profession maintains, offers the best possible means of organizing medical production functions and is the best mode of transmitting medical information.

To shore up their argument and enable themselves to mount a spirited and lively counter-attack against bureaucratic (government-administered) medical delivery schemes, medical associations have borrowed the image of individual competition from businessmen and re-fashioned its ideological sentiment to fit their needs. By choosing to ally themselves with anti-corporatist sentiments in their public pronouncements,⁴² we [the people] are led to the rather hasty conclusion that fee-for-service (solo) practice medicine is the best possible medical delivery system available.

In fact, the very organization which chooses to portray itself as an anti-bureaucratic force to be reckoned with is itself one of the oldest "corporate" organizational forms currently in existence in Western Europe and North America.

What the profession have accomplished with this highly unusual line of political argument is that they have recast the "new" corporate image of the medical profession. After all, in politics it is image and image alone which counts.

⁴²Jeffrey L. Berlant, Profession and Monopoly. (Berkeley: University of California Press, 1975), 257.

The current battle which is being waged between the profession and its opponents is, we can safely predict, as much a war of wits as it is of wills. Before we allow ourselves to rush to the defence of our physicians, I suggest we first examine the health-care policy interests of consumers. Our health-care system's future, indeed our very health itself, demands nothing less than this from us.

The Consumers

The medical providers (physicians) and consumers represent two camps with fundamentally opposed positions with regards to defining what constitutes the public good. One industry analyst has even suggested that providers (physicians) subscribe to the belief that as long as individual professional-client relationships operate for the client's benefit (as professionally defined), the public interest is served.⁴³

Up until now this study has only briefly addressed the position of the consumer within the overall health-care transaction process.⁴⁴ In contrast, I have analyzed the medical profession in a very detailed and in-depth manner. I would like to rectify the current analytical imbalance and will now turn my critical attention to one of the more satisfying analyses of medical consumerism offered in the literature.

⁴³Stoddart, "Rationalizing the Health Care System," 36/endnote [# 15].

⁴⁴See this chapter page 31 at the first paragraph.

Haug and Lavin (1983), the authors of a recently completed study investigating medical consumerism, suggest that there are four typical therapeutic stages which routinely occur in a physician-consumer medical treatment encounter. They are: a) diagnosis; b) definition of the medical situation; c) treatment and; d) prescription for further medical treatment or therapeutic follow-up.

In a typical medical encounter, a self-styled consumer-oriented patient might be willing to acquiesce to physician decisionmaking power and control at the diagnosis stage (stage 'a') in what the authors describe as the physician's exercise of health-care transactor cultural authority.

The consumerist challenge is launched once the patient realizes that they have not been allowed the right to negotiate as an equal (or almost equal) partner with the physician during the ongoing professional-client therapeutic encounter.⁴⁵

Haug and Lavin suggest medical consumerism is, essentially, a patient-instituted form of rebellion which resists the continuation of the physician's unquestioned dominance over the medical treatment encounter from the medical therapy stage (stage 'c') through each repeat series of medical treatment.⁴⁶

Whether or not a patient continues to dispute the physician's social authority or chooses to acquiesce to the physician's more superior decision-making status is probably

⁴⁵Haug and Lavin, "Consumerism in Medicine," 39.

⁴⁶Ibid., 192.

of only secondary concern to the profession at either stage 'c' (the treatment stage) or stage 'd' (the medical follow-up). However, physicians would become increasingly alarmed if medical consumerism were ever to escalate into a major consumerist-inspired challenge undermining the physician's social image.

Physicians have always feared the day when patients might be persuaded to lose faith in their more superior medical training and practical clinical experience, no more so than to-day with organized medicine poised to enter a new high technology phase of their profession's development. The fact that the erosion of consumer confidence in the services of medical providers has not become more widespread is subtly overshadowed by the rising cost of health-care delivery which is occurring more frequently, particularly in Ontario (see Appendix: Figure 2-6 and 2-7).

It is not consumer anxiety or uncertainty concerning the reputable nature of the profession which has prompted government to increase their regulatory activities within the health-care service sector as a whole,⁴⁷ but is instead the growing cost spiral of health-care services which has challenged government to re-examine the role of physicians within the overall health-care mix.

⁴⁷Haug and Lavin, "Consumerism in Medicine," 35.

Consumerism Full Circle: The Role of the Private Sector

At this stage in the discussion, it would be very helpful for us to return and re-examine the marketeers' argument offered earlier to defend private sector (entrepreneurial) market-driven health-care service provision. Maynard (1982) suggests that the private sector enthusiasts who believe in the existence of market efficiency and the ethic of free enterprise⁴⁸ have always maintained that every social order leaves some level of unmet need unaddressed, no matter what economic sector or market-exchange relationship we may care to select for an intensive economic study.

If we turn to the health-care industry to test the marketer's argument, the introduction of private sector health-care service provision should be allowed to openly pursue their search for market share as long as the health merchants agree to comply with all of society's health-care regulatory standards. The private sector health-care merchants must ensure that their "medical" product is properly labelled and meets all ethical and proprietary requirements and cannot in any way inflict harm upon the targeted clinical (ie. consumer) audience.

As far as the specific utilization of health care services is concerned, it is apparent that health-care service purchasing decisions are partly the consequence of consumer demands and partly the consequence of health practitioner recommendations

⁴⁸Maynard, "Regulation of public and private health care markets," 488.

and decisions.⁴⁹ Health practitioner recommendations and decisions, in particular, should be able to bend to the will of the consumer, since it is the consumer who should be entitled to select an appropriate package of health-care medical goods and services if they so desire.

It is very hard to argue with the consumer-based argument which suggests consumers with financial means should be entitled to purchase health-care goods and services unreservedly. What we need to realize, however, is that Haug and Lavin's consumerist challenge carries the potential of someday becoming politically united with private enterprise enthusiasts who might joint together to launch a renewed attack against their favourite political targets, whether they be medical providers or the medicare system itself.

It is quite conceivable that private enterprise enthusiasts will combine the argument that western society's growing financial indebtedness, plus the medical consumer's lowly status being forced into a "queue" to receive medical attention, demands a drastic restructuring of the nation's health-care infrastructure in a decidedly deregulatory servicing direction. The most basic issue which the private sector enthusiasts/medical consumerist radicals might conceivably promote via a common health-care political action coalition is the suggestion that "health" is a commodity which the consumer (and/or the market entrepreneur) has the right to purchase (or sell) as they see fit, a topic befitting our next group of transactors.

⁴⁹Brown, "Caring for Profit," 89.

CHAPTER IV

THEORETICAL CONSIDERATIONS: HEALTH VALUATION

The Insurers and the Hospital Corporation

Insurers and hospitals are attempting to fashion their own unique set of health-care sector demands and inter-relationships in response to the evolving modern-day health-care delivery environment.

Universal health insurance has, in particular, drastically altered the manner in which the insurance sector and the hospital corporations interact with one another.

Traditionally, insurers and hospitals have been involved in producing medical outputs which are either used by consumers under the direction of first-line providers (physicians), or they have been directly involved in the production of health-care outputs used by first-line providers in the treatment of medical illness.¹

¹Evans, "Incomplete Vertical Integration," 330-331.

The Insurers

By its very nature, medical insurance planning and purchasing decisions involve a subjective valuation effort. A consumer purchases health (and hospital) insurance as a guarantee against the spectre they might suffer financial loss and ruin should they ever become gravely ill or fall victim to a serious, crippling or life-threatening physical injury.

Insurance purchase and planning decisions require a calculating investment of both intellectual time and energy as well as a sufficient commitment of financial resources to deliver the expected long-term result.

The price the consumer pays for medical insurance coverage, to cite a hypothetical point of purchase example, should never exceed the financial outlay they (consumers) might make to pay for the health-care services they would receive if they became gravely ill or were seriously injured.

In effect, determining the financial investment break-even point which applies in the case of health (and hospital) insurance decision-making scenarios is an extremely difficult contract pursuit which involves a complex fiduciary agreement entered into between both the insurer and the consumer.

For the consumer, the objective involved in the medical insurance fiduciary contract bargaining process is to achieve the greatest degree of moral hazard. Moral hazard is defined as the financial condition or economic state in which each insured individual free rides the insurance system by buying

the most appropriate medical insurance package available. The 'free ride' is achieved as a result of the consumer being relieved of the duty of bearing the full cost of a prospective medical treatment. Instead, the consumer finds him/herself comfortably positioned at the margin, paying only a portion of the full burden of costs² associated with receiving the optimal level of health-care services.

The insurance company or its agent, on the other hand, have there own set of financial constraints to consider. For one thing, insurance companies must adjust their insurance policies to adequately compensate for the moral hazard condition which accrues to individual medical insurance policyholders. The adjustment procedure is itself referred to by the term marginal value.³

Marginal value is a popular term appearing among the insurance industry vocabulary which refers to two subjective valuation exercises which occur simultaneously when an insurance purchase decision is arrived at. First, the prospective medical insurance policyholder must arrive at a definition of the utility or self-maximizing potential they attach to their particular medical insurance program. Secondly, the prospective medical insurance consumer's health valuation effort will inevitably be saddled with a recognition that they (the consumer) hold a social obligation to support society's global (or collective) economic order, as well

²Brown, "Caring for Profit," 65.

³Culyer, "The NHS and the market," 35.

as support their own self-serving quest to achieve personal economic gain or interest self-maximization.

Obviously it would be totally naive to expect the individual and collective social transactor in us all to have identically concentric, neatly over-lapping "health" valuation experiences. Nonetheless, the creation of a concentric juxtaposition of our individual (and society's collective) long-term medical insurance goals throws off the decision-making balancing act which underpins our medical insurance purchasing decisions in the most basic and fundamental manner.

When we assess medical insurance purchase behaviour, one thing seems quite clear. A fully insured individual possesses the inherent ability to assess the trade-offs between trying to stay healthy versus not worrying about falling ill. The uninsured individual, on the other hand, represents an entirely different analytical subject.

The uninsured individual is often a member of society's indigent, non-productive social underclass. Not only are society's economically disadvantaged population segment forced to carry a burdensome load of negative self-esteem and guilt, imprinted upon them by the socialization process of the day, they are also placed at risk since many of their number are unable to defend themselves against ill-health.

Dr. A. R. Munroe, a senior member of the Canadian Medical Association (CMA) and a pioneering voice championing the cause of universal medical insurance, argued in the early 1900s that public sector health and welfare social redistribution

programming activities were urgently required in Canada at the time.

In an address to the 1914 meeting of the Canadian Medical Association (CMA), Munroe proposed the idea that some form of publicly-delivered and administered medical insurance coverage was long overdue. Although rejecting a British proposal of the day which advocated full government subsidization and organization of the health-care delivery function, Munroe travelled at least part of the distance towards embracing universal medicare by suggesting his own four-point commercial methods (medical insurance) plan:

- i) services of the whole medical profession were to be made available to the whole public;
- ii) no individual should be made the object of charity;
- iii) average medical incomes should be raised, and;
- iv) the basis of all future medical payments (reimbursement) schemes were to borrow from actuarial tables based on standardized medical fee scales.

Munroe specifically applauded the suggestion that health insurance was worth every man's study, an opinion not shared by many of his professional colleagues. One of the more vociferous critics of the Munroe universal medical insurance plan was prompted to offer the following bristling retort several years later,

"Why not give everyone a decent living and the money wherewith to pay for the needed (medical services) attention supplemented if necessary by some insurance scheme?"⁴

The underlying theoretical issue which underpins the latter policy request is, quite simply, a recognition of the free-rider problem more than anything else.

A free-rider is defined as any individual who receives maximum benefits from, for example, health-care service programs yet who may not have contributed any financial support during their lifetime in exchange for their having received the benefits provided by health and welfare social redistribution programs and activities.⁵

In order to tame the wide-spread increase in the number of social service program free-rider beneficiaries, a society's citizenry must be encouraged to find the economic means to productively support the existing social order. Financial support for a society should be offered through the payment of school board levies and municipal (or local government) property taxes, payment of national income taxes, or by meeting any other economic commitments demanded of a nation's citizenry by the State.

⁴Naylor, "Private Practice, Public Payment," 34, 39.

⁵Culyer, "The NHS and the market," 28.

An Unsettling Profile: The Eclipse of Private Sector Insurance

In a field as value laden as health, in which access to care is often perceived, rightly or wrongly, as critical to life itself,⁶ the design of an effective universal medical insurance program can prove an attractive public policy program generating wide-spread voter appeal, particularly welcome news to a nation's beleaguered group of health-care policy architects.

Not surprisingly, a majority of the western bloc countries have fallen in step to proclaim their support for public-delivered medical insurance programming. In one bold brush stroke initiated in England following the Second World War, and repeated soon after by several other western nations, private sector medical insurance schemes were reduced to a mere shadow of their former powerful selves.

The undeniable attraction of public sector-sponsored medical insurance programs is that they offer a universal level of health-care service provision to all of society regardless of their income, age, sex, or state of illness (or wellness).

Publicly-delivered medicare programs were, in large part, destined to challenge the ungainly market behaviour practised by the private sector medical insurance sector. Private sector insurance plans, admirable for their dedicated pursuit of efficiency goals and objectives, oftentimes failed to achieve or even acknowledge universal health-care servicing

⁶Evans, "Health care in Canada," 408.

policy goals and targets.

The unique difference distinguishing public sector medical insurance ventures from their private sector program counterparts is the fact that private sector insurance programs offer the consumer a choice fro. among a set of competing enrollment opportunities with differing levels of risk built in to each insurance option. The healthy medical insurance consumer, for example, often selects lower premium cost plans while the medically ill usually tend to select an insurance plan with a higher up front loading charge or premium cost, designed to grant them wider, more comprehensive insurance coverage than they might otherwise hope to receive.⁷

In addition, the private medical insurance sector usually depend upon large numbers of actuarial planners and statisticians to collect and collate an amazing amount of aggregated statistical data each year. This data is assembled into a sophisticated grid of actuarial tables employed to calculate the degree of risk accruing to an individual policyholder's insurance agreement during a particular timeframe.

As a direct result of their actuarial accounting activities, private insurers have succeeded in dividing up the insurance pool into more and more fragmented, and unruly, portions. Many individual policyholders have been left wondering aloud whether or not their insurance coverage carries the level of protection it advertises, or whether they may be the victims of an unduly compromised contractual agreement which

⁷Culyer, "The NHS and the market," 35-36.

cannot protect their (the policyholders) health needs should a medical demand situation ever arise.

The private sector medical insurance fragmentation process has been aided by two extremely effective medical utilization screening mechanisms. The two widely used screens, termed adverse selection instruments, are known as community rating and experience rating plans.

Community rated insurance plans are just what the name implies. A population is sub-divided according to smaller and smaller segments, each segment containing a certifiable level of health risk or financial (and medical) liability. If a population segment matches an economic risk profile, all individuals drawn from that population sample are offered an identical medical insurance premium assessment rate. In actual practise, community rating has succeeded in allowing large groups of the workforce⁸ to be assessed identical medical insurance premium enrollment fees at more affordable prices that they might otherwise normally receive.

In order to appease the public's growing perception that the private sector has not properly responded to the consumers insurance needs, experience rating programs may be touted as the consumer's medical insurance answer.

Experience rating translates roughly as follows: if a policyholder (or subscriber) stays with one insurer over a lengthened or extended period of time, that individual

⁸McNerney, "Control of health care costs in the United States," 358.

will be assessed lower premium charges than would normally occur. The lowered premium charges, termed pro-rating, allows each private insurance company to protect their client base without calling into question the competitive, adversarial market-drive of their medical insurance industry competitors.

Experience rating has succeeded in meeting the demands of the wealthier population segment who have had their insurance premiums reassessed or lowered to reflect the lower enrollment service charges paid by "group" medical insurance plan subscribers.

The two premium assessment approaches I have outlined, community rating and experience rating, both suggest serious operational shortcomings associated with the private insurance industry as a whole. In particular, both premium assessment programs have failed to address the health-care needs of society's social under-class who receive no medical insurance coverage whatsoever.

We should remember, however, the somewhat sobering fact that no matter which insurance system we adopt, be it public or private sector medical insurance delivery programs, consumers will still often lack sufficient information to make consistently sound and well-informed health-care consumption choices.⁹ In fact, if ill enough, consumers have no choice but to get care (and medical insurance coverage) as quickly

⁹Walter McClure, "The Competition Strategy for Medical Care," in S. E. Berki ed., Annals of the AAPSS: Health Care Policy in America. (Beverly Hills: Sage Publications, [July] 1983), 46.

as possible.

Health insurance systems serve a vital social function. Not only can medical insurance protect the health interests of every individual citizen, they might also help rid society of the cost of supporting the health-care expenditure generated by a majority of her citizens.

The challenge facing health-care system financeers is to decide how to underwrite the cost of our future health-care delivery infrastructure without sacrificing or injuring our most basic health-care needs or demands in the process. Health care needs and demands requiring an in-depth evaluation include: the free rider problem; the protection of consumer dignity tied to an equally convincing commitment to protect the right of medical providers to choose optimal clinical therapies, and thirdly; the administration of health-care services in a cost-effective manner. Several of these tasks ultimately may be delegated to the policy and planning teams found resident in the hospital service sector.

The Hospital Corporation

From the 1860s through to the middle of the last century, hospitals were primarily designed to serve as philanthropic and humanistic organizations. The hospital's earliest service mandate was devoted almost exclusively to administering health services to a select group of individuals, society's impoverished and medically indigent population segment.¹⁰

The poor and medically indigent have traditionally been considered the charges and responsibilities of municipalities.¹¹ However, the increasing debt crisis brought on by cash-flow problems encountered during the interwar years' depression threatened to erode the municipalities once unchallenged decision-making control exerted over routine hospital sector financial planning and administrative activities.

The hospital is somewhat of an organizational anomaly. Hospitals specialize in providing a neutral service setting which allows physicians the chance to ply their medical craft in an undisturbed manner. A physician attempts to move his/her patient through the various stages of illness which will, perhaps, culminate in the subsequent hospital discharge of a healthy and fully recovered patient. The hotel services portion of the hospital bill, generated during an episode of hospitalization, is paid directly by the patient (and/or their insurer) to the hospital general accounts department, while the physician's professional fee is charged

¹⁰Brown, "Caring for Profit," 23.

¹¹Naylor, "Private Practice, Public Payment," 59.

the patient (and/or their insurer) under separate cover.

Many of the hospital's day-to-day hospital management decisions are scrutinized by a small management committee called the medical advisory committee (MAC). The MAC usually has a medical director who is also, invariably, the most powerful administrator found within the hospital corporation's internal organizational chain of command.¹²

The highest ranking lay person contributing to hospital management activities, normally outranked by the medical chief of staff, is the hospital chief administrator. The hospital chief administrator is neither a salaried executive officer reimbursed through earnings calculated to reflect a per centage draw calculated against the hospital corporation's total profits window (a familiar salary determination in the private sector), nor is the hospital chief administrator an owner of hospital capital stock.

Instead, hospitals are usually run as non-profit, publicly-owned and operated institutions, suggesting that the hospital chief administrator is usually employed in a salaried capacity.

Management by Committee for Non-Profit: Mastering the Improbable

The hospital chief administrator encounters several decision-making difficulties or discontinuities which are unique to hospital administration employment itself. First, the hospital chief administrator is subject to constant power plays and political lobbying shifts which subtly occur

¹²Brown, "Caring for Profit." 22-23.

around them, and are themselves determined by different political jockeying efforts conducted by individual groups of physicians intent upon wrestling a larger share of the hospitals' operating budget.

For example, the operating room and short stay surgery facilities may compete with radiology and/or angiography departments for badly needed operating funds. In addition, neo-natal units or intensive care departments might conceivably join the competitive fray and demand their fair share of available sectoral resources.

Each hospital unit or division usually allies itself with a different physician authority figure who is expected to extract the largest share of the hospital's global operating (and capital equipment) budgetary allocation possible from the chief of medical staff and hospital chief administrator.

As we might well guess, this highly abbreviated summary of the hospital corporation's internal political hierarchical in-fighting¹³ presents one of the main decision-making challenges which hospital administrators must learn to master.

The hospital administrator can rarely effect change from within a hospital's total internal services 'mix', a situation which Newhouse (1973) suggests forces the hospital corporation to adopt goals which are oftentimes in direct conflict with the efficiency goals prescribed for them by

¹³Brown, "Caring for Profit," 23.

the hospital's accounting department.¹⁴

For example, hospital managers must attract well known physicians to practice at their facility. Surgical and medical specialists demand very high salary lines to maintain their medical practices in high-cost medical trauma units and technologically-oriented surgical centres.¹⁵

Once a hospital manager has assured the reputation of their hospital's trauma units/surgical suites, supplying all of the necessary diagnostic and outpatient department support staff and capital equipment required to maintain a fully recognized high quality health-care "output", the hospital chief administrator must next attempt to appease price sensitive buyers.

Price sensitive buyers may be insured patients paying insurance plan deductibles (Ontario Hospital Insurance Premiums) for receipt of the medical treatments they (the consumers) receive, or they may be financial contributors to a co-payment medical insurance plan (U.S. Blue Cross/Blue Shield Hospital Premium Assessment Plans).

In effect, the price sensitive buyer demands that the hospital corporation provide them with the best, most cost-effective service mix which meets their unique set of medical needs.

¹⁴Joseph P. Newhouse, "Toward a Theory of Non-Profit Institutions: An Economic Model of a Hospital," American Economic Review, 63 (1973), 64-73.

¹⁵Brown, "Caring for Profit," 17.

In order to satisfy their targeted patient population, the successful hospital administrator must attempt to read the external environment in which their hospital's physical plant is located. The hospital's overall service mix, therefore, must create a favourable impression upon the population-at-large.

Hospitals which achieve the right blend or mix of service and price competitiveness can, Newhouse suggests, benefit the most from their internal production/function (economy of scale) health-care delivery challenges and opportunities.

The basic weakness uncovered by Newhouse's analysis, however, concerns the surgical and medical physician manpower component. Alterations to the employment status of physician staffers are only rarely initiated by a hospital chief administrator, and only after the medical staff have collectively approved such action. In fact, doctors tend to perceive hospitals as their personal co-operatives which must allocate institutional resources according to the dictates of the medical profession, and ought to consult consumers¹⁶ concerning hospital matters only as an afterthought.

The power to change medical provider behaviour has, therefore, remained firmly under medical advisory committee (MAC) control.

¹⁶Brown, "Caring for Profit," 23.

Operation Forward Integration: The New Curative Agenda

The hospital delivery project of the future must attempt to shift the hospital's management role away from the self-serving behaviour so long characteristic of the medical advisory committee (MAC),¹⁷ and instead must be forced to embrace a new outlook and new health-care delivery policy plan of action.

The hospital corporation is increasingly moving away from being a provider of inpatient services and is fast becoming a total health-care center, mixing inpatient and outpatient services in all sorts of novel and revolutionary ways.

What the new, more elastic, decentralized hospital service transformation entails, to put it mildly, is a movement away from principally curative treatment processes and procedures revolving solely around in-house hospital delivery programs. Instead, it entails vigorous movement towards a roving, highly transportable health care treatment approach which adapts to the patient's changing individual health-care demands and responds to a more flexible and transportable therapeutic environment.

The new treatment approach will augment the hospital's somewhat strait-jacketed medical servicing profile by offering new service expansions in such areas as: home dialysis, nutrition, psycho-social counselling, and physiotherapy services.

¹⁷Evans, "Incomplete Vertical Integration," 346.

The new (or next) hospital plant renovation plan might include satellite health facilities built in close geographical proximity to the main plant, and may involve movement of an entire unit of hospital personnel to the actual sight where the medical service is required, even if that entails building and staffing a sophisticated communications dispatch centre to direct the flow of medical staff directly to the health-care service provision site where they are needed.

In a market of decreasing census which concurrently features the United States' and United Kingdom's aggressive promotion of reduced financial health-care expenditure commitments in general, restructuring of hospital acute and chronic care facilities is a development which may have overtaken the western industrial world at last. The challenge facing the hospital sector will be one of attempting to remain at or near the forefront of the new and exciting health-care service provision expansion effort.¹⁸

Whether or not a new hospital services mix will see the light of day will depend upon the flexibility and imagination of the health-care sector principals themselves. Let us hope they are fully capable of measuring up to a difficult task which lies ahead.

¹⁸Anderson, "HMO Development: Patterns and Prospects," 139.

CHAPTER V

CROSS-NATIONAL EXPERIENCE

The United States and the United Kingdom

This chapter presents the first of two parts of a four nation, two continent comparative health-care policy review. Each of the countries selected for study will be analyzed via a unique blending of theoretical first principles and empirical facts and figures drawn together to form a composite picture capturing that nation's particular health-care delivery program in its most revealing light.

At the beginning of Chapter's V and VI, I will offer national GNP health-care expenditure summary statements for each nation. Theoretically speaking, GNP figures can be misleading if they are used in isolation from other information sources which might provide a more accurate or satisfying portrait of a nation's practical day-to-day health-care delivery efforts.

United States

The United States represents a unique case for our comparative health-care policy study. In macro-economic-terms, the U.S. doubled their overall health-care expenditures from 4.5 per cent in 1950 to 9.0 per cent in 1979. (see Appendix: Figure 3-9 and Figure 4-1).

In 1982 the U.S. spent 10.5 per cent of its GNP on health,¹ up from the 1980 health expenditure figure of 9.7 per cent.²

Public funding of health care constituted 42.7 per cent of the U.S.'s overall (1975) health-care expenses, the lowest figure achieved among our four nation sample. U.S. health-care expenditures received the lowest general tax revenue contribution from among the four nations surveyed (73 per cent; see Appendix: Figure 4-3). On the other hand, the U.S. routinely allocated 27.1 per cent of total consumer (private sector) financial sources directly towards the nation's global health-care expenditures (see Appendix: Figure 4-4).

Private sector health-care financing has risen dramatically in the past decade from (1975) 27.1 per cent to an all time high of (1982) 58 per cent.³

¹Canadian Medical Association, Health: a need for redirection. (Ottawa: Canadian Medical Association, 1984), 98-99.

²Canada, "Improved Program Delivery: Health and Sports," in A Study Team Report to the (Neilson) Task Force on Program Review. (Ottawa: Supply and Services, 1986), 39.

³Canadian Medical Association, "Health: a need for redirection," 98-99.

U.S. Provider (Physician) Dominance

Physicians command a strong position within the United States' health-care decision-making hierarchy. Physicians are the U.S. health-care system's first-line providers or gatekeepers. In their gatekeeper or directorship capacity, physicians determine health resource allocation decisions in a virtually uncontested manner, an event which is even more remarkable considering the fact physicians are non-governmental actors.

Without a doubt, the U.S. health-care sector today follows a deregulatory, market-driven health-care delivery ethic, an ethic which serves to reinforce the commercial control exerted by medical providers through a series of thinly disguised service monopoly pricing arrangements analyzed earlier in this study.⁴

The service monopoly health-care delivery strategy favoured by U.S. physicians, quite simply, imposes barriers to competitive entry and jacks up the income of those who are thereby protected,⁵ a situation showering handsome financial gain upon the strategically well-situated U.S. medical provider (physician) community.

It is extremely important to note from the outset of our analysis that both the U.S. health-care insurance function and the role U.S. physicians play as the nation's dominant medical gatekeepers share a similar historical background.

⁴See Chapter III "Price Discrimination: A Lesson in Public Relations," 34-37.

⁵Culyer, "The NHS and the market," 31.

Before I offer an in-depth examination of the U.S. medical insurance system, I would first like to review the growth of private health (and hospital) insurance in the U.S. up until the present.

The deregulatory, pro-competition health-care delivery model which the U.S. has historically favoured essentially attempts to promote the forward integration of health-care providers engaged in the health-care delivery process (see Appendix: Figure 3), while encouraging consumer's to exercise their own highly individual "choice" selecting from among competing medical insurance programs.

All individuals falling outside the private insurance system who are unable to afford to buy medical insurance are regarded as candidates for social assistance offered as a form of charity by the State.⁶ The charity medical insurance scheme which the State administers subjects the U.S.'s underprivileged population segment to a means test in which the poor and medically indigent must establish their state of impoverishment in an irrefutable fashion.

In the United States, hospital (and health) insurance came much later than in Western Europe. Blue Cross was the first hospital insurance program implemented in the United States. Blue Cross was designed as a hospital insurance program designed to finance the capital and service expansion programs underway in the early 1900's throughout the U.S.'s then

⁶Robert G. Evans, "Hang Together, or Hang Separately: The Viability of a Universal Health Care System in an Aging Society," Canadian Public Policy, XIII:2 (1987), 169.

infant hospital sector.⁷

Blue Cross was designed to be a community focused scheme: the same premium was assessed each policyholder irrespective of their age or health status. The 'Blues' soon were forced to succumb to market pressure, however, and redesigned their premium assessments by adopting risk-rated, or discriminatory, fee assessment practices. The change was allegedly caused by the presence of a growing number of competitive, or 'upstart' independent private sector insurance carriers willing to undercut the premium assessments offered by Blue Cross in a frantic bid to lure away Blue Cross subscribers.⁸

The Blue Cross/Blue Shield confrontation came to a head in the State of Oregon in the 1930s and 1940s. The Oregon battle proved to be the pivotal testing grounds which would forever change the face of medical insurance programming in America. The physician-controlled hospital insurance grant (Blue Cross of Oregon) was pitted in mortal battle for subscribers against an up-start private sector-sponsored hospital insurance firm, Oregon's Blue Shield.⁹

What actually transpired was that the small commercial carrier, Blue Shield, in its attempt to siphon-off Blue Cross subscribers, had launched what Blue Cross charged was a risk-rating subscription battle which quickly mounted into a full-fledged confrontation of epic proportions.

⁷Brian Abel-Smith, Value for Money for Health Services. (London: Heinemann, 1976), 20.

⁸Ibid., 21.

⁹United States v. Oregon State Medical Society, 343 U.S. 326 (1952).

The Oregon doctors possessed a clear-cut vested interest in determining the outcome of the dispute, since many Oregon physicians were shareholders in the Blue Cross Plan. The Oregon physicians launched an all-out ideological assault against the small-scaled, competitive commercial carrier, the Blue Shield Insurance Plan. Oregon doctors remained steadfastly determined that they, and they alone, would set the terms of trade governing the State's medical insurance service provision, and began to institute across-the-board servicing slowdowns and boycotts whenever they encountered a Blue Shield patient.

The physician-instituted boycotts, in effect, limited the range and scope of available health-care delivery activities offered Oregon's population, which fueled tempers dramatically.

Unfortunately for Blue Shield of Oregon, the upstart insurance company were a poor match against the powerful American Medical Association (AMA) which had assembled an impressive political lobbying effort in fraternal support of the Oregon physicians' political campaign.

The American Medical Association (AMA) attacked Blue Shield of Oregon by arguing that Blue Shield were allegedly pursuing a policy objective which favoured a radical alteration of the health-care delivery status quo. Blue Shield of Oregon were charged with the transgression of demanding a total dismantling of the medical profession's legally recognized right to arrange their internal medical affairs as they saw fit.

Blue Shield of Oregon, the U.S. Medical Association charged, were attempting to determine the level of future medical provider fee assessments without seeking the prior consent of organized medicine.

The Oregon physicians contributed to the confusion surrounding the political melee by charging that Blue Shield had drafted a secret long-term social health and welfare redistribution agenda, an allegation which was never conclusively substantiated but nonetheless served to discredit the small insurance carrier in the eyes of the general public. Blue Shield of Oregon were totally defeated, and were unable to survive an extremely lengthy litigation period, nor were they able to maintain the confidence of their policyholders.

The Oregon test case provides one undeniable lesson. The U.S.'s private sector medical insurance activities would, from this point forward, remain firmly under the decision-making control of organized medicine. Any future private insurance activities would need to be cleared with the medical associations directly. An unwritten code of conduct was quickly circulated among prospective private sector medical insurance carriers which, in effect, stated the following bottom-line terms of trade:

- (1) commercial competitors to Blue Cross must fully comply with the health-care resource allocation decisions handed down by organized medicine, including a demonstration of prompt willingness to honour and uphold any/all physician fee assessment rulings, and;

(2) all commercial competitors to Blue Cross must enforce the profession's internally determined medical service pricing arrangements and must allow the medical profession "first chance" opportunity to solve fee disputes via closed panel (self-governance) regulatory mechanisms not open to lay body interventions and/or interference. In effect, the Oregon test case spelled an end to third-party (private insurance industry) sponsored medical sector resource allocation policy planning decision-making efforts.

Private, small-sized insurers were left with a very narrow window of opportunity from which they were allowed to conduct their commercial medical insurance transactions. In no time at all the Blue Shield program became a spent force, and was eventually amalgamated as the united Blue Cross/Blue Shield Health Insurance Company.

To this day, not one third-party cost control mechanism has successfully challenged and defeated the physician lobby on a globally consistent basis within the continental United States.¹⁰ Organized medicine in the United States exercise the same unrestrained command over the U.S. health-care decision-making apparatus today as they successfully achieved with their winning verdict in the Oregon test case handed down in the early 1950s.

Although it has been suggested recently that 89 per cent of U.S. physicians currently receive at least 50 per

¹⁰Clark C. Havighurst, "Controlling Health Care Costs," Journal of Health Politics, Policy and Law. Vol. 1:4 (Winter 1977), 479.

cent of their incomes from fee-for-service payments,¹¹ and therefore are succumbing to 'alternative' fee payment procedures in an increasing number of cases, we should not jump to the conclusion that U.S. physicians are somehow willingly abrogating the collective decision-making power they won with their successful verdict handed down in Oregon in 1952.

Among the group of physicians who receive half their income from the new Health Maintenance Organization (HMO or group) alternative medical practice delivery schemes, a majority of participating physicians have received a prior assurance that they would be entitled to receive a flat retainer fee and/or might continue to enjoy their own independently-controlled fee-for-service billing privileges.

Unfortunately, the current U.S. HMO (group) practice health-care delivery program lacks a uniform coast-to-coast organizational framework, and therefore cannot be easily compared with the traditional fee-for-service (solo) practice model. The analysis I have offered to date is fundamentally at odds with Evans pathway 'h': direct influence (ownership or control) of independent insurers on providers (see Appendix: Figure 3).

Evans (1981) readily admits that the ideal health-care transactions model (see Appendix: Figure 1), which depicts consumers voluntarily entering into medical insurance purchasing decisions at arm's length from private, for-profit medical

¹¹John Dawson, "The end of the doctor/patient relationship: The American Perspective," Ontario Medical Review Vol. 55:7, (July 1988), 40.

insurance firms who conduct their commercial insurance activities independently from medical providers¹² is, indeed, a hypothetical situation which does not currently exist in the United States.

It is certainly quite clear that the U.S. consumers' utilization of medical care depends on their insurance status. The individual consumer's medical insurance policy, however, assigns all health-care resource allocation decision-making control to medical providers (physicians), thus continuing the tradition established by the Oregon test case.

Insurers and medical providers (physicians) have no direct dealings with one another with respect to health-care resource allocation deliberations or policy determinations. Physicians in the U.S. control the flow of payments within the country's health-care market, raising their prices and/or the level of their production/function outputs at their leisure.¹³ Therefore, pathway 'h' depicts a spurious set of health-care transactor interactions or relationships.

The progressive HMO (group) practice health-care delivery format would like to propel the insuring organization into the health-care policy forefront, allowing the insuring organization an opportunity to determine the cost of medical outputs and set a pre-arranged fee schedule governing medical provider fees which might, therefore, force a group of physician conscripts to practice their medical service provision activities within a tightly controlled, fiscally responsible budgetary

¹²Evans, "Incomplete Vertical Integration," 330.

¹³Ibid., 338.

framework. If such a delivery scenario were to be successfully implemented, pathway 'h' would become an accurate transactor pathway depicting a shift in health-care resource allocations decision-making away from front-line medical providers (physicians) and favouring, instead, a re-assignment of decision-making powers to either the State and/or a "new" user/insurer market substitute organizational structure.¹⁴ This hypothetical health-care services delivery scenario has, to date, failed to transpire.

Instead of creating a universal coast-to-coast HMO (group) practice user/insurer market scheme, the U.S. has permitted the increased occurrence of health-care delivery fragmentation, producing an alarming incidence of medical service contracts entered into between competitive insurers and physicians¹⁵ which has left a large proportion of the high-risk U.S. patient population stranded outside the conventional health-care service/medical insurance marketplace.

In effect, the 'group' (HMO) alternative health-care clinics have tended to offer the most attractive enrollment rates to the healthy population segments in the United States, which is causing additional strains to be felt within an increasingly profit-driven health-care delivery infrastructure,¹⁶ a subject I will now examine in closer detail.

¹⁴Evans, "Incomplete Vertical Integration," 341.

¹⁵Ibid., 342.

¹⁶Ibid., 338-339.

The Insurance Function

Defenders of the U.S.'s pro-competition, highly fragmented market-driven health-care delivery model frequently allude to the fact that no single standard and style of care can be considered appropriate for all Americans.¹⁷ Instead, pro-competition market proponents overwhelmingly agree that private health (and hospital) insurance schemes should offer policyholders a choice from among several competing medical insurance packages. The exercise of free choice in selecting and purchasing a medical insurance plan allegedly upholds the public good in the minds of the U.S. general public.

The function of private medical insurance in the U.S. today, in theory at least, is to promote a minimal amount of direct governmental interference within the nation's global health-care delivery setting.¹⁸ If the pro-competition model succeeds in solidifying public sector/private sector health-care delivery partnerships, or if greater health-care decentralized planning is achieved, so much the better.¹⁹

The one overwhelming failure characteristic of the U.S.'s pro-competition health-care delivery model is the fact that the market-driven U.S. health-care system promotes the proliferation of highly unacceptable and inequitable levels of health-care service provision.

¹⁷Havighurst, "Controlling Health Care Costs," 491.

¹⁸McClure, "The Competition Strategy for Medical Care," 40.

¹⁹McNerney, "Control of health care costs in the United States," 359-360.

Private (and group) medical insurance plans offered in the U.S. today routinely force a sizeable proportion of the nation's population to assume personal economic liability for a wide-range of prospective health calamities. The list of potentially devastating uninsured medical service provision items include: terminal cancer therapies; select organ transplants; bone marrow replacements, and artificial heart transplantation and/or coronary bypass surgery²⁰.

A second inequity associated with the U.S.'s private sector-administered medical insurance system is the fact that the insured portion of the U.S. population are routinely forced to purchase medical insurance packages with many low-priced medical service items covered by performance excluding clauses. In effect, policyholders remain uninsured and must meet the cost for cosmetic surgery, routine birthing care, and tonsillectomies as out-of-pocket (noninsured) health-care expenditures. As a result, few U.S. citizens will readily agree that they are well-served by the current U.S. medical insurance health-care delivery "status quo" model.²¹

Beginning in the middle 1950s, and continuing through the egalitarian 1960s and 1970s, equal available care, or equal voluntary access to care, became the political rallying cry for both American health care consumers and health care

²⁰Havighurst, "Controlling Health Care Costs," 483-484.

²¹Ibid., 484.

providers alike.²²

The U.S. federal government, concerned that they were being forced to relate the distribution of health care services "need" to a clear-cut public sector medicare policy program, reluctantly agreed to allow the drafting of a medicare proposal which would primarily cover major costs associated with episodes of acute (or short-lived) illness.²³

The U.S. medicare program was never intended to be a wide-sweeping, nation-wide social security policy instrument similar to the Canadian or West European models. Indeed, only late in the day was the U.S. medicare legislative proposal broadened to include social assistance programming efforts designed to provide specific medical relief for the nation's impoverished social under-class.

U.S. medicare never tried to hide the fact that it was intended to relieve private insurers of the responsibility of underwriting the health-care costs incurred by the aged, the medically infirm and the nation's poor.²⁴ Private sector medical insurers found it distasteful that the unemployed chose to publicly complain that they could

²²S.E. Berki, "Health Care Policy: Lessons from the Past and Issues of the Future," in S. E. Berki ed., Annals of the AAPSS: Health Care Policy in America. (Beverly Hills: Sage Publications. Vol. 468 [July] 1983), 40.

²³Judith R. Lave and Herbert A. Silverman, "Financing the Health Care of the Aged," in S. E. Berki ed., Annals of the AAPSS: Health Care Policy in America. (Beverly Hills: Sage Publications, [July], 1983), 151.

²⁴Theodore Marmor, The Politics of Medicare. (Chicago: Aldine Publishing Company, 1970), 122.

never afford the cost of medical insurance.²⁵ For this population segment, medicare was a godsend. U.S. medicare would, it was thought, provide equal available care (or equal voluntary access to care) for all low income Americans, thereby moving the U.S.'s poor and disadvantaged population segment back into the U.S. health-care delivery mainstream.²⁶

The medicare program architects certainly hoped that the medicare proposal would be deemed a rational, nearly complete solution²⁷ to alleviate the ills which plagued the U.S.'s health-care delivery infrastructure. In particular, the fact that 90 per cent of the U.S.'s total pre-medicare era hospital charges had been routinely paid for by private health insurers²⁸ offers a chilling reminder of the two-track health-care service provision arrangements which had plagued the U.S. health-care sector for far too long. The size of the health-care underservicing problem was greatly underestimated by U.S. legislators when they drafted the first national medicare bill. Accordingly, Medicaid was added to the total medicare legislative package to specifically address the needs of the nation's chronically ill quite late in the day.

²⁵Eugene Feingold, Medicare: Policy and Politics. (San Francisco: Chandler, 1966), 170.

²⁶Philip R. Lee and Carroll L. Estes, "New Federalism and Health Policy," in S. E. Berki ed., Annals of the AAPSS: Health Care Policy in America. (BEverley Hills: Sage Publications, [July] 1983), 106.

²⁷*Ibid.*, 106.

²⁸William A. Rushing, Social Functions and Economic Aspects of Health Insurance. (Boston: Kluwer Academic Publishers, 1986), 94.

Medicaid (1966) is actually three programs rolled into one. It provides health insurance for poor children from single-parent families and for their parents (a group which totals 63 per cent of all Medicaid recipients and accounts for 28 per cent of Medicaid expenditures). Secondly, Medicaid provides health care funding for the blind, the physically disabled, and the mentally retarded (less than one fifth of total recipients, totalling 31 per cent of Medicaid expenditures). Thirdly, Medicaid supports the elderly who represent 16 per cent of total Medicaid plan beneficiaries, yet who account for almost one-half of all Medicaid expenditures in 1981, a circumstance which is largely caused by the fact that so many of the elderly succumb to chronic illness which may lead to increasingly frequent periods of institutionalization, a burden any society would find increasingly difficult to manage.²⁹

For a program designed to cost no more than \$ 1 billion dollars annually, Medicaid now costs the U.S. Treasury \$ 32 billion a year and represents the major federal government social assistance program offered in the United States today.³⁰ Medicaid is essentially a state-run program, and most of its program features involve routine administrative handling charges assessed by state or local government authorities.³¹

²⁹Drew Altman, "Health Care for the Poor," in S. E. Berkied., Annals of the AAPSS: Health Care Policy in America. (Beverley Hills: Sage Publications, [July], 1983), 107*.

* N.B. Figures from DHSS [U.S.], 1981.

³⁰Ibid., 107, 109.

³¹Ibid., 107.

Medicare, on the other hand, is a program which covers nearly all persons aged 65 and over (about 95 per cent of all of the elderly in the United States are currently covered by Medicare health-care service provisions),³² and consists of two separate but complementary insurance programs. They are Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). HI enrollment is automatic upon reaching age 65, while SMI (which funds physicians services, home health visits, etc.) is only received if the recipient elects to pay a premium.

In the U.S. today, the federal government has taken over only a part of the insurance function, principally the unprofitable components portion of the nation's total available health-care service provision delivery effort.

Markets and Consumers: The U.S. Health-Care Policy Dilemma

Employers, insurers, and the government pay the lion's share of the U.S.'s total hospital and physician health-care service expenditures. This situation is carefully nurtured by a steady stream of subscribers who routinely receive group health (and hospital) insurance enrollment plans provided by their employers and deducted as an employee pre-tax benefit from their weekly or bi-weekly paychecks.

Group medical insurance plans are popular with both employers and employees alike, particularly due to the fact

³²Lave and Silverman, "Financing the Health Care of the Aged," 151.

that they boast extremely low, financially attractive subscription rates which individual medical insurance schemes can only rarely match.

Current U.S. tax laws encourage employers and employees to buy group medical insurance coverage. The problem with the group enrollment insurance plan is that it provides extremely "shallow coverage", coverage which is only designed to fund mainly routine medical services and treatments, but which cannot meet the costs of long-term (chronic) or life-threatening illness.³³

Employers in the United States, however, have little reason to complain. In effect, they have been awarded a lucrative financial prize. U.S. employers can routinely set aside a portion of their employees wages which counts towards the purchase of medical insurance. In the bargain, the employer's net taxable income (corporate capital gains) is also appreciably lowered. Therefore, employee wages can be calculated within the rubric of the employers' net end-of-year taxable income projections and calculations.

Should the U.S. consumer choose to purchase a further amount of individual (private) medical insurance coverage to augment the coverage they already own with their group insurance scheme, physicians will become the net beneficiaries since they will have secured an additional source of funding to pay for their professional labour.³⁴

³³Havighurst, "Controlling Health Care Costs," 476.

³⁴Ibid., 484.

Since the launching of Medicare by the U.S. government in 1965 (followed by Medicaid a year later) U.S. physician incomes have shown a dramatic and startling increase.³⁵

The one over-riding weakness which haunts the U.S.'s health-care infrastructure is the fact that the United States presently lacks a single health care planning body which could effect change from within that nation's total health-care service environment, and possibly one day impose a ceiling on physician incomes. This fact far overshadows the ideological battle which is currently raging between the pro-regulatory (collectivist) and pro-competition (deregulatory) market advocates trying to determine the long-term policy for the nation's health-care industry.

The unfortunate and inescapable conclusion which the current U.S. health-care policy debate currently chooses to ignore is the fact that U.S. consumers are the real losers in today's health-care sector resource allocations tug-of-war. The United States' health-care delivery arrangements have led to the generation of sizeable cost overruns, and routine reports of medical provider servicing inefficiencies abound, which provides additional proof that consumer health-care purchasing power is a concept which is either inadequate in theory and practise or else is merely ignored by U.S. health-care planners. The \$ 8 billion (1977) tax subsidy³⁶ which the U.S. Treasury grants employers on an annual basis

³⁵Evans, "Hang Together, or Hang Separately" 168; Theodore Marmour, "The Politics of Medicare," 123.

³⁶Havighurst, "Controlling Health Care Costs," 476.

to fund group medical insurance schemes is, itself, a wasteful exercise.

What the U.S. has demonstrated with the group insurance tax holiday policy is an abrogation of the nation's right to collect tax dollars to fund universal health and welfare social policy redistribution program measures and activities.

As long as the insurance structure is controlled by medical providers (backward-linked) either directly (via provider influence brought to bear upon Blue Cross/Blue Shield payment schedules), or indirectly through the influence providers exert upon insurers in the fragmented, arm's length insurance market, then few significant sectoral cost-containment improvements are ever likely to see the light of day.³⁷

Figure 3 hides one plausible reform measure which might potentially free the pro-competitive market-driven U.S. health-care sector from its current economic performance strait-jacket. That reform program is identified by Havighurst (1977) as "constrained consumer choice". Consumers, and not providers (or insurers), should be granted the ability to direct their personal savings towards the purchase of health-care services unhindered by excessive levels of public sector social assistance pandering or excessive regulatory interference.

The two culprits identified by Havighurst as the major factors responsible for the U.S.'s seemingly endless inflationary health-care expenditures spiral, neither of which has been widely recognized as the pernicious influence it is, are:

³⁷Evans, "Incomplete Vertical Integration," 342-343.

2

- (1) tax law treatment of health insurance premiums, and;
- (2) provider dictation of the type of insurance plans available to consumers.³⁸

Havighurst (1977) advocates the introduction of a system of limited tax credits which would make it possible for larger medical insurance purchases to receive full tax credit against the individual tax payers net pre-tax income. The lower-income U.S. taxpayer would receive a financial rebate via Havighurst's tax credit reform scheme. The lower-income U.S. taxpayer would benefit from the receipt of medical service vouchers entitling them to an annual taxation refund or tax rebate "bonus" to compensate their yearly health-care expenditures and/or provide sufficient funds for the purchase of private medical insurance coverage.

The government would calculate the cost of medical services based upon the vouchers filed by each individual taxpayer following progressive taxation methods,³⁹ the details of which remain to be determined.

Although Havighurst is somewhat vague about the actual manner in which the tax credit/health-care voucher system might operate, the plan is at least progressive, income-indexed, and at the very least introduces an upper limit which might "cap" employer-paid medical insurance premium contributions thereby redirecting badly needed taxation revenues to the U.S. Treasury.

³⁸Havighurst, "Controlling Health Care Costs," 475.

³⁹Ibid., 476.

The constrained consumer choice reform proposal has one obvious shortcoming which is difficult to overlook. Havighurst's tax credit/health-care consumption voucher system will prove costly to administer. The U.S. health-care financing system operates in a truly decentralized fashion already which, in effect, suggests that the U.S. government is quite restricted in terms of choosing the degree of regulatory control it might bring to bear upon medical provider (physician) prescribing behaviour.⁴⁰

The U.S. currently spends an estimated 16 per cent of its total health-care expenditures on administrative expenditures alone.⁴¹ Once Havighurst's constrained consumer choice reform proposal is brought on-line, U.S. health-care administrative expenditures will automatically increase, introducing an additional source of strain to an appreciably over-burdened health-care financing system.

Before we turn our attention to the next country on our list, the United Kingdom, I would first like to make one small observation concerning the overall economic performance of the U.S. hospital sector. U.S. hospitals are burdened with the task of seeking financial reimbursement through their annual budgeting efforts for both the operating and capital costs incurred in their normal business conduct. Prior to October 1983, American hospitals were rewarded

⁴⁰Evans, "Incomplete Vertical Integration," 338.

⁴¹Weller and Manga, "The Push for Reprivatization of Health Care Services in Canada, Britain and the United States," Journal of Health Politics, Policy and Law. 8:3 (1983), 500. [quoting: Hall Report - 1980].

at service (or case) reimbursement rates calculated to cover both their operating and capital budgetary expenses.

Beginning in October 1983, U.S. hospitals experienced a radical change in their payment system. Medicare patients, as well as many "group" insurance plan (non-medicare) patients, soon discovered that the government (and or their insurer) had negotiated a ceiling which would limit the actual timeframe during which a patient might remain hospitalized. The government began refusing payments charged for hospitalization episodes running beyond the administrative cut-off point.

Almost overnight, the government (and many private sector insurance carriers) had arbitrarily decided that patient compensation/hospital reimbursement ceilings would be widely instituted which, in effect, caused quicker patient processing turn-arounds than had occurred in the pre-October 1983 timeframe.⁴²

Since the U.S. lacks a centralized funding mechanism to monitor hospital (and all other) health-care service sector program expansion efforts, what the U.S. hospitals now face is a situation in which health-care costs are not being adequately covered by either the government and/or insurers. In effect, admission-based reimbursements allegedly curb the spread of unnecessary health-care sector service provision expansions and, the government hopes, might begin to discourage the increasing incidence of physician-induced

⁴²Anne B. Fisher, "The New Game In Health Care: Who Will Profit," Fortune (March 4, 1985), 138.

utilization (servicing overperformance).⁴³

Unusual as it may seem, the 'big ticket' capital equipment service provision programs which many analysts might normally attribute as the biggest culprits causing inflationary spending in the U.S. hospital sector have actually performed very moderately, and in a generally fiscally responsible manner in 1978, the last year for which data was available.

Those 'big ticket' medical capital equipment/service items include: computer tomography scanners, which cost the U.S. \$875 million (0.4%) annually; coronary artery bypass surgery costing \$1.5 billion (0.7%) per year, and; electronic foetal monitoring which cost \$411 million (0.2%) of the nation's annual global health-care budget.⁴⁴

The real victim of this scenario, setting aside the consumer interest for the moment, may be the U.S. federal government. The U.S. federal government must deal with an increasingly unruly deregulatory service environment, yet must also remain true to the ideological premise that multiple service practice standards accurately reflect America's long-term health-care delivery program commitment. If the U.S. succeeds, and makes the deregulatory health-care delivery model work, it will represent a health-care delivery success story unlike any other achieved to date in the western world.⁴⁵

⁴³Evans, "Hang Together, or Hang Separately" 168, 172.

⁴⁴H.D. Banta and B. McNeil, "Evaluation of the CAT Scanner and Other Diagnostic Technologies," Health Management Review 3 (1978), 7.

⁴⁵McClure, "The Competition Strategy for Medical Care," 46.

The United Kingdom

The United Kingdom is the one country represented in our comparative health-care policy review with the longest uninterrupted track record featuring a half century's experience promoting equal access to minimal care (universal medicare) health-care delivery program objectives.

The U.K. raises (1975) 92.6 per cent of the financing required to fund her total health-care delivery program from public funding, a figure which is slightly larger than Sweden's (1975) 91.6 per cent public funding figure. General taxation provides (1975) 94 per cent of the financing required to administer the U.K.'s universal medicare program.

(see Appendix: Figure 4-3). Over 80 per cent of the U.K.'s National Health Service (NHS) revenue sources are generated by direct taxation with 10 per cent of that total received from weekly National Insurance subscriptions paid by employees and employers. The remaining 3 to 4 per cent of general taxation health-care funding comes from direct charges and/or consumer user fees collected for pharmaceutical prescriptions and dental and/or ophthalmic goods and services.⁴⁶

Rounding out our group of macroeconomic measures, the U.K. collected (1975) 5.8 per cent of the nation's total health-care expenses from direct consumer (private funding) sources (see Appendix: Figure 4-4).

⁴⁶Rosemary C. R. Taylor, "State Intervention in Postwar Western European Health Care: The Case of Prevention in Britain and Italy," in Stephen Bornstein ed., The State in Capitalist Europe. (London: George Allen and Unwin, 1984), 105.

One feature which is curiously characteristic of the U.K. health-care delivery process, and does not reoccur in any other country drawn from our four nation sample, is the fact that British private sector medical insurance carriers do not insure against risks incurred by individuals falling victim to episodes of medical illness, nor are medical insurance premiums designed to reflect an experience rating system. In addition, chronic illness is only rarely treated as either a public sector and/or a private sector medical insurance expense in the United Kingdom. This fact helps to explain why the U.K.'s annual GNP funding figures (1955 - 1979) remain essentially below the levels recorded by Sweden and Canada, two other countries which both offer government-run (universal medicare) health-care delivery programs (see Appendix: Figure 3-9).

Collectivism: The Government-Provider Health-Care Alliance

The United Kingdom is uniquely different from the other nations selected for this study. The U.K. has resisted the temptation of mimicking the pre-medicare North American (and/or Swedish) health-care delivery experience in which health-care delivery program activities are defined as a narrow policy pursuit reflecting the health needs of the middle class who were expected to pay for the health-care services they received.⁴⁷

⁴⁷Anne Crichton, Health Policy Making. (Ann Arbor: Health Administration Press, 1981), 256. [quoting: Abel-Smith, 1976 - Chpt. 3].

Instead, the British have traditionally preferred to promote equality of opportunity social policy ventures designed to liberate the individual from their conditions of financial and social impoverishment. The British overwhelmingly favour social welfare redistribution measures which avidly encourage the achievement of greater social equality at the expense of further outbreaks of needless and costly episodes of social disintegration.

State intervention in the health-care sector was instituted in the U.K. in the early part of the twentieth century. The National Health Insurance Act (1911) was the first legislative document which established the idea that compulsory health insurance should be routinely paid for by a flat-rate universal subscriber contribution.⁴⁸ The 1911 legislation provided general practitioner services for low-income workers (but not for their dependents). At the same time, the National Health Insurance Act foresaw the need for increased medical service provision to aid Britain's poor and disadvantaged population segment and generally granted the downtrodden social under-class greater access to municipal hospital facilities and/or entitlements to receive medical care from physicians, reimbursed for their labour via local and/or municipal taxes.⁴⁹

The National Health Insurance Act gave the British government practical policy experience supervising the nation's

⁴⁸Abel-Smith, "Value for Money in Health Services," 20.

⁴⁹Rosemary Taylor, "State Intervention in Postwar", 103.

total health-care delivery program for the first time. The British government effectively became that nation's official health-care mediator offering impartial advice on all fee disputes and/or adjudicating matters involving medical provider incompetence, malpractice or malfeasance.⁵⁰

At the end of World War II, the entire British health care system found itself labouring under increased strain which the existing health-care legislation had not properly addressed. The wide-spread destruction caused by the bombing raids of the second world war, plus the regional maldistribution of specialist physicians and general practitioners in various regions of the country created inequitable or differential health-care service provision which threatened to leave the British health-care delivery system in an administrative shambles. The cost required to finance, let alone rebuild, war-ravished U.K. hospitals (and other primary care facilities) was consuming an ever-increasing proportion of the country's stagnating GNP.⁵¹

In response to the country's pressing health-care delivery problems, the British Labour Party were called into action. The National Health Service Act (1948), piloted through the House of Commons by the social service crusader Aneurin Bevan, introduced a new public sector health-care delivery prescription to meet the nation's unquestioned medicare program needs.

⁵⁰Rosemary Taylor, "State Intervention in Postwar," 103.

⁵¹Ibid., 103.

The National Health Service Act (1948) had three major policy objectives. First, the National Health Service Act declared medical care would, for the most part, be provided free of charge to all British subjects. Secondly, health-care should be made equally accessible to all British subjects. And thirdly, Britain's renowned medicare commitment would create a comprehensive medical service scheme which, few would argue, intended to promote nationally uniform delivery of all requisite health-care benefits.⁵²

In order to overcome the criticisms levelled against Bevan's medicare proposal and secure the legislation's orderly passage through the House of Commons, the legislation's author devised an ingenious and totally effective political plan of action.

Bevan's first task was to secure the co-operation and support of Britain's specialist physicians (the hospital consultants) who were subsequently assigned the task of formulating proposals to cover the finer administrative details associated with the reform plan. The specialists were personally assured by Bevan that their medical peers and rivals, the U.K.'s more numerous General Practitioners, would be effectively excluded from occupying a decision-making position which might distract the reformers from their long-range goals during the program's early embryonic planning period.

Bevan's handling of the specialist physicians was masterful. Bevan had very deftly determined that the specialist physicians

⁵²Rosemary Taylor, "State Intervention in Postwar," 104.

primary political energy was reserved for the tactical defence of their position as acting department heads in their respective hospital (and/or primary care) facilities.

In effect, Bevan had cleverly co-opted the specialist physicians as highly vocal supporters of his general reform proposal. Bevan rewarded the specialist physicians by establishing a separate hospital salary reimbursement scheme for hospital consultants (specialist physicians), while GPs were offered a capitation reimbursement scheme which had the effect of moving the general practitioner away from the hospital sector's influential decision-making centre.

Specialist physicians, and not GP's, quickly became the health-care system's policy advocates and served notice to the nation that the terms of universal medicare would be implemented nationally in an orderly fashion.

The Department of Health and Social Services (DHSS) was created as the peak institution assigned the task of regulating the full complement of sectoral health-care activities which were borne under the terms of the National Health Services Act (1948).

Health-care budgeting and planning exercises in the U.K. were, very quickly, assigned the specific macro-economic policy preserve of the newly created Department of Health and Social Services (DHSS),⁵³ a unique institution which was equal parts health-care service provider/purchaser and

⁵³Alan Maynard, Health Care in the European Community. (Pittsburgh: University of Pittsburgh Press, 1975), 209.

health-care infrastructure planner and financier.

The U.K.'s DHSS and the Chancellor of the Exchequer combined to form the economic planning team possessing the unrivaled decision-making power to determine the politico-economic merits of the various health-care delivery programs presenting themselves for government financial policy and planning appraisal or review.⁵⁴

Although the DHSS has a broad legislative mandate and more jurisdictional power and spending authority than any other health-care bureaucracy in existence in the western world, it is an inherently conservative financial institution. For example, approximately 98.5 per cent of the U.K.'s annual health-care budget is pledged to finance the previous years' budgetary and accounting health-care program estimates. Therefore, the political in-fighting which has been known to spill-over from the DHSS into other realms of the U.K. economy can, at best, only address a tiny fraction (1.5 per cent) of the DHSS's total administrative health-care service budget.⁵⁵

The National Health Service (NHS) has routinely registered very low administrative costs throughout the 1970s, spending a respectable 2.6 per cent of the U.K.'s total health-care expenditures on departmental administration and nation-wide health-care regulatory activities. In comparison, France annually spends 10.8 per cent of total health-care expenditures on administrative costs, Belgium's health-care administration

⁵⁴Maynard, "Health Care in the European Community," 187.

⁵⁵Ibid., 209.

costs were 10.6 per cent of the nation's total health-care budget, the Netherlands spent 6.5 per cent of budget on administration, while Germany spent 5.0 per cent of the national health-care budget on program administrative expenses.⁵⁶

It is quite remarkable that the modern-day NHS remains essentially unchanged in its basic organizational form from the institution first introduced by Aneurin Bevan in 1948. The NHS has now become the third most expensive social service program in Great Britain after social security and education and employs close to 1 million people or 4 per cent of the U.K.'s working population.⁵⁷

The U.K., unlike many other countries in the world, revelled in the creation of a fully integrated health-care delivery model (see Appendix: Figure 4).

The principal reason explaining Britain's early health-care delivery triumph is the fact that the DHSS had effectively combined under one roof both revenue collection and resource management prioritization and planning activities.⁵⁸ The U.K. had also assumed state ownership of many hospitals, medical practices, and the insurance function, which merely solidified the DHSS's strangle-hold over the U.K. health-care sector (see Appendix: Figure 4).

Comparison of Figures 3 and 4 indicates that Britain's insurers (some of whom were formerly medical practitioners)

⁵⁶Maynard, "Regulation of public and private health care markets," 493.

⁵⁷Rosemary Taylor, "State Intervention in Postwar," 105.

⁵⁸Maynard, "Regulation of public and private health care markets," 493.

conduct their duties in a significantly different manner from the insurers operating in the idealized "constrained consumer choice" health-care delivery model employed to capture the future health-care delivery system advocated by Havighurst for the United States. Pathway 'h': direct influence (ownership or control) of independent insurers on providers is conspicuously missing from the U.K.'s health-care delivery model⁵⁹ (see Appendix: Figure 4).

Capitation

The most extensive use of the capitation fee reimbursement system known in the world today is employed by Britain's NHS to reward General Practitioners for their professional labour.⁶⁰ Before we can analyze how the capitation system operates, we must first note that the fee schedules employed to pay doctors result, in part, from rational planning by experts and by committees. In addition, fee schedules are arrived at as a direct consequence of the internal political manoeuvring adopted by rival clinical specialities found resident within the medical profession itself.⁶¹

In 1948, the U.K.'s GPs viewed the arrival of Bevan's reworking of the medicare system with a certain amount of public consternation and trepidation. It is singly important that we note that the British GP occupies an extremely vital

⁵⁹Evans, "Incomplete Vertical Integration," 342.

⁶⁰William A. Glaser, Paying the Doctor. (Baltimore: John Hopkins Press, 1970), 82.

⁶¹*Ibid.*, 55.

decision-making role as the nation's front-line medical service gatekeeper. British GPs are routinely asked to process 90 per cent of all NHS health-care service transactions on a day-to-day basis,⁶² both in 1948 and today.

Since the U.K. GPs enjoy(ed) a decisive measure of administrative control over the nation's health-care resource allocation decisions, British GPs were consequently somewhat reluctant to surrender their independent, semi-autonomous solo practice positions in exchange for a promise that they become fully salaried employees of the public sector.

The U.K.'s GPs soon bowed to the inevitable forces of change. In exchange for their promise to co-operate with the implementation of Bevan's medicare reforms, the GPs demanded and received a concession from the government. The U.K.'s GPs would institute a capitation fee system devised to protect the General Practitioner's professional autonomy yet, at the same time, would minimize the government's attempts to regulate the profession's private, internal practice affairs.⁶³

To understand how the capitation system operates, we must first note that each GP is assigned a protected list numbering approximately 3,500 patients⁶⁴ by the NHS. Each GP is entitled to supply medical services only to the patients appearing on their assigned lists.⁶⁵

⁶²Norman Ellis, "Grappling with the public/private health-care mix," Ontario Medical Journal (July/1988), 36.

⁶³Glaser, "Paying the Doctor," 82.

⁶⁴Maynard, "Health Care in the European Community," 196.

⁶⁵Rosemary Taylor, "State Intervention in Postwar", 104.

In addition to receiving their capitation fee, GPs are paid a basic practice allowance (ie. a salary) if they elect to join a group practice, and individual GPs may qualify to receive an equalization payment if they elect to practice medicine in an economically less attractive periphery service area.⁶⁶ (The periphery service entitlement fee or bursary is added regularly to a GPs total annual capitation practice allowance).

General Practitioner capitation payments are intended to cover the cost of physician labour only. General Practitioners are directly reimbursed for rent, and for any expenditure required to support their ancillary, general office service staff and support personnel.⁶⁷

There are two outstanding considerations which often cause the capitation fee negotiations process to become slightly unhinged. The U.K. GP's capitation fee schedule is determined via a fixed budgetary negotiation which does not allow Britain's GPs to be directly involved in fee negotiations with the DHSS.

Secondly, determinations concerning what might be the desirable annual income level assigned the U.K.'s GP population are usually derived from national income statistic actuarial tables which attempt to keep doctors incomes at parity with the performance of other professional income earners in the United Kingdom. The national income actuarial tables

⁶⁶Glaser, "Paying the Doctor," 82.

⁶⁷Blomqvist, "The Health Care Business," 70.

rarely take into account the fact that other professional groups, such as accountants, and attorneys, may enjoy the opportunity of augmenting their incomes via part-time employment in other sector's of the nation's economy, a channel which is usually regarded as strictly off-limits for physicians by the British Medical Association.⁶⁸

The regular capitation fee performance reviews which are independently conducted by medical providers (GPs) and government health-care regulators (the DHSS), essentially at arm's length from one another, usually focus upon four common health-care delivery themes. Those four health-care delivery themes are: the over-bureaucratization of the family practice delivery setting; the protection/erosion of consumer choice; the flexible/inflexible nature of the fee reimbursement system per se, and; the flexible/inflexible delivery of GP health-care service provision in the periphery regions of the United Kingdom.

I would like to review each of the four health-care delivery themes in order, allowing the critics of the capitation funding method an opportunity to present their case first, followed by the DHSS defence of the current GP capitation fee reimbursement program.

The U.K.'s General Practitioners have been widely quoted in the past few years for mounting a highly vocal attack against the overall degree of decision-making authority

⁶⁸Glaser, "Paying the Doctor," 91.

invested in the DHSS bureaucracy.⁶⁹ The U.K.'s GPs commonly claim that capitation fee schedules are set in far too autonomous a manner, and fail to properly integrate general practitioners into the nation's total national health-care decision-making infrastructure.⁷⁰

Capitation, much to medicare's disadvantage, makes little effort to recognize exemplary work. In addition, capitation fails to introduce a prerequisite degree of innovativeness⁷¹ required to keep the U.K.'s GPs fully attuned to the health-care demands of the future.

The U.K.'s GPs often cite the fact that patient hospitalization episodes inevitably lead to a situation in which the patient becomes the clinical ward of specialist physicians who rarely have the time to build up the proper professional-client rapport which the British health-care consumer has come to expect in a normal physician-client encounter. All too often, the British GP is dealt out of the health-care decision-making process.

Once the patient moves from ambulatory (out-patient) status to in-patient admission status, clinical responsibility (and payments for services rendered) shifts to the specialist physician team⁷². General Practitioners argue that capitation is at fault when they find themselves swamped with an excessive number of patient medical treatment requests,

⁶⁹Weller and Manga, "The Push for Reprivatization," 500.

⁷⁰Glaser, "Paying the Doctor," 57.

⁷¹Ibid., 275.

⁷²Ibid., 272.

which occurs in a fairly predictable and routine manner with the onset of influenza season and/or following a large-scale accident or medical emergency.⁷³

Thirdly, capitation is often criticized for failing to adequately keep pace with baseline population changes which General Practitioners commonly observe in their geographic regions.⁷⁴ In effect, capitation lists are reappraised far too infrequently thus forcing some General Practitioners to work harder than others should new patients creep into their medical offices.

The fourth point, the flexible/inflexible nature of the current GP-based health-care delivery servicing arrangements identified in the nation's periphery regions prompts GPs to argue that capitation is unresponsive to the medical needs of the periphery region,⁷⁵ a point well taken considering the fact the DHSS is a metropolitan-based organization.

The DHSS has 14 Regional Hospital Boards in England, subdivided into 36 teaching Hospitals (26 of which are located in the Greater London Area alone) and 205 Local Executive Councils⁷⁶ which represents a highly fractious and oftentimes quarrelsome group of competing health-care administrations who collectively complain they are rarely consulted concerning the drafting of the nation's long-term health-care policy prioritization and resource allocation planning effort.⁷⁷

⁷³Glaser, "Paying the Doctor," 275.

⁷⁴Ibid., 105.

⁷⁵Weller and Manga, "The Push for Reprivatization", 500.

⁷⁶Maynard, "Health Care in the European Community," 187.

⁷⁷Rosemary Taylor, "State Intervention in Postwar," 104-105.

In defence of the capitation system, the DHSS routinely suggests that salaried systems do not encourage the growth of unnecessary (or inefficacious) medical therapeutic treatments, and rarely leads to a condition of physician-induced utilization (servicing overperformance).⁷⁸

The DHSS's health-care resource decision-making process, as I stated earlier,⁷⁹ usually attempts to judge a prospective health-care program for its overall politico-economic merit alongside all other government spending activities. Capitation fees must, therefore, receive the government's undivided critical attention in order to ensure the nation achieves its health-care delivery targets.

In answer to the charge that capitation is an overly bureaucratic form of salaried reimbursement which threatens the status of professional-client relationships, the opposite result has seemingly occurred. Capitation allows close personal bonds to form between patient and physician. Capitation has one further noteworthy feature. Capitation fee reimbursement schemes bring stability and predictability to the physician's personal financial planning activities, a benefit which government regulators and general practitioners alike can jointly applaud.⁸⁰

Thirdly, the allegation that capitation reimbursements provides inflexible financial compensation to medical providers can be easily dispelled. The fact of the matter

⁷⁸Glaser, "Paying the Doctor," 252-253.

⁷⁹See this chapter page 95 at the first paragraph.

⁸⁰Glaser, "Paying the Doctor," 96-97.

is that the U.K.'s GPs have routinely gained far more in their fee negotiations with the public treasury than have almost every other income earning group in British society.⁸¹ The available evidence clearly demonstrates that the NHS has bent over backwards to make payments to the U.K.'s GPs fair and equitable.

In the mid-1960s alone, the government offered doctors the option of selecting either salaried (capitation) reimbursement or increased experimentation with fee-for-service payment schemes. The profession chose capitation.

The U.K. Parliament has even been known to intervene on behalf of the interests of the nation's GPs. The British House of Commons took it entirely upon itself to create a public corporation to give capital grants or loans to doctors in order that they might be enabled to improve their practice facilities. This unprecedented move was intended to enhance or bolster the public image of the U.K. GP as well as provide GPs with more satisfying work environments.

During the mid to late 1970s, a period in which the U.K. experienced a crippling national recession and had instituted wage and price controls as a national austerity measure, GPs received a large pay increase.⁸²

Concerning the fourth and final point, the alleged flexible/inflexible nature of health-care service provision in the nation's periphery region, the capitation payment

⁸¹Glaser, "Paying the Doctor," 137.

⁸²Ibid., 107.

scheme has not caused underservicing to occur. Capitation has remained finely attuned to the medical needs of the nation's outlying regions, and has resettled doctors into periphery regions with relative ease.⁸³

General Practitioners are generally paid an additional periphery region service entitlement or bursary, as mentioned earlier, if they willingly relocate their medical practice to a remote part of the United Kingdom. As a consequence of these salary reimbursement modifications, the average GP derives a substantial proportion (perhaps as much as 50 per cent) of his income from sources other than the capitation allowance wage rate alone,⁸⁴ a fact which suggests the individual U.K. GP has become quite accustomed to the existing status quo financial arrangements which the capitation reimbursement plan has created.

Perhaps the most convincing argument favouring the implementation of capitation reimbursement schemes is the fact that the system has protected the U.K.'s GP medical sub-speciality from suffering a decline in their enrollment, a situation which is occurring at an alarming rate in many other western nations. General Practitioners continue to number approximately 50 per cent of Britain's physician stock,⁸⁵ a significantly higher proportion than GP figures reported for the U.S., Sweden or Canada.

⁸³Glaser, "Paying the Doctor," 252-253.

⁸⁴Ibid., 82.

⁸⁵Arnold J. Heidenheimer and Nils Elvander, The Shaping of the Swedish Health System. (New York: St. Martin's Press, 1980), 234.

Our examination of the U.K.'s GP capitation fee system cannot hide the troubling fact that waiting lines for health-care service provision exists in the U.K. today, estimated at approximately 750,000 Britons at present.⁸⁶ The incidence of untreated minor illness in the U.K. is reportedly on the rise,⁸⁷ and far exceeds comparable untreated illness reports made available by the United States, Sweden or Canada.⁸⁸

In addition, the 220 local health planning agencies found in the U.K. today are assigned inflexible cash allocations expenditure envelopes which are determined by national health-care funding formulas taking into account regional population, demography, historic costs and morbidity figures which the local authorities cannot influence.⁸⁹

Not only are the local health authority (LHA) cash incentives prompting a frugal rationing response of available health-care sector capital and manpower resources, they are also providing a perverse incentive which has led to a direct reduction in the frequency and number of medical services offered an increasing proportion of the U.K. population. The British citizenry are increasingly venting their frustration with the status quo health-care servicing arrangements which they perceive are being caused by wide-spread underfunding

⁸⁶Norman Ellis, "Users fees best medicine for ailing system?" Ontario Medical Association, July 4, 1988, 5.

⁸⁷Glaser, "Paying the Doctors," 124.

⁸⁸Robert G. Evans, "Finding the Levers, Finding the Courage: Lessons from Cost Containment in North America," Journal of Health Politics, Policy and Law. Vol. 11:4 (1986), 587-588.

⁸⁹Ellis, "Grappling with the public/private health-care mix," 27.

of the nation's health-care delivery infrastructure.⁹⁰

Appendix: The Netherlands' Case Payment Alternative

In a recent study which exhaustively reviewed physician payment systems currently employed in the world, it has been suggested that the "foreign" physician payment schemes denounced by one country's doctors usually are customarily accepted, without major objection, by the medical profession somewhere else.⁹¹

Whereas British GPs abandoned the fee-for-service reimbursement system, the Netherlands' hospital specialists successfully persuaded their government that the resource intensive, high cost nature of modern-day medicine⁹² essentially demanded further differentiation between routine medical services provided by GPs as opposed to the more sophisticated ambulatory and inpatient⁹³ medical treatments offered by hospital-oriented specialist physicians.

There are two essential components built-in to the Netherlands' specialist physician case payment scheme: they are the case payment component and the fee-for-service component.

The case payment component is, quite simply, an alternative physician (or hospital service) reimbursement scheme which offers a fixed payment to a doctor in exchange for his/her

⁹⁰Ellis, "Grappling with the public/private health-care mix," 36.

⁹¹Glaser, "Paying the Doctor," 136.

⁹²Stoddart, "Rationalizing the Health Care System," 18.

⁹³Glaser, "Paying the Doctor," 50.

personal promise to attend to the total medical needs of a select group of patients during a specified, renewable medical treatment timeframe.

The Netherlands' case payment "fee-for-service" component, on the other hand, is designed to reflect the actual medical labour performed by the attending hospital specialist physician in their day-to-day clinical practice. The Netherlands' case payment "fee-for-service" component is designed to provide a rigorous itemization of each and every medical treatment performed by a hospital specialist physician during a specified treatment timeframe.

To understand how the Netherlands' case payment system works, we must first note that the Dutch hospital specialist physician is reimbursed according to the following service benefits program: the third party payer (a centralized payer and/or insurer) pays the doctor a fixed fee for the performance of a month's worth of treatment administered on behalf of their assigned patient.

The Dutch patient, on the other hand, is exempted from paying for their medical services at the point of entry⁹⁴ and proceeds calmly through the hospital admissions process. In order to allow hospital specialists a suitable timeframe in which they might complete their medical treatments, Dutch specialist physicians are entitled to issue their patients a renewal card allowing them to continue to remain under their medical care.

⁹⁴Glaser, "Paying the Doctor," 25.

The Netherlands' renewal or "transfer" card program, named because it allows the GP to transfer responsibility for the patient's welfare directly to the hospital specialist, proves to be a one-of-a-kind health-care delivery scheme which is troubled with a unique resource allocation performance discontinuity.

The Netherlands' case payment system is burdened with an administrative loophole which has permitted an alarming increase in physician induced utilization. The chronic care patient can be renewed at the specialist physician's prerogative in what sometimes approaches an endless cyclical loop. As soon as the hospital specialist realizes their patients are approaching the end of the "transfer" period, the normal reaction of the hospital physician is to issue a renewal card automatically.

Attempts have been made to limit the incidence of routine transfer card renewals for high volume/low technology patient treatment/classification types in the following clinical sub-specialties: gastroenterology, rheumatology, psychiatry, allergy and ENT/opthalmology. Fees set for this group of medically-treated patients are usually set low enough that they reflect the fast turn-around processing periods which are a trademark feature of this high volume/low health-care treatment technology group of medical treatments and clinical procedures.

Specialist case reimbursement fee schedules are set slightly higher for internists, pediatricians and cardio-

logists who depend upon high rates of 'transfer' card renewals in order to complete their intellectually demanding, diagnostically-lengthened period of medical therapeutic patient assessment and/or treatment.

Hospital specialists who have issued renewal cards in excess of the renewal factor allotted for their clinical sub-speciality may be punished by the Dutch sickness fund (the centralized payer/insurer) who are empowered to reimburse the offending physician for labour devoted to a pre-arranged number of transfer card renewals.⁹⁵ All hospital specialist billings amassed in excess of the sub-specialty "ceiling" remain unpaid.

The Netherlands' case payment (specialist physician) fee-for-service reimbursement system has certainly succeeded in revolutionizing the Dutch health-care delivery system. Dutch health-care planners, however, did not adequately budget for the long-range development which saw hospital specialist physicians prolonging their patient's length of hospitalization in order to capitalize upon their rent-seeking capability. As Dutch hospital costs continue to escalate, the medical service provision overperformance problem will increasingly demand a public sector cost-containment response,⁹⁶ although the actual policy measure required to curb the physician induced utilization problem is not yet known.

⁹⁵Glaser, "Paying the Doctor," 53.

⁹⁶Gordon McLachlan and Alan Maynard, "Introduction" in The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 144-145.

Further Deliberations: U.K. Health-Care Public/Private Mix

A respected analyst of the British health-care scene has recently reported that the transfer of ownership of hospitals to the State and the institution of tax finance to fund health-care services in the U.K. in 1948 changed some of the fabric of the health care shop but it did not immediately lead to a radical change in the production or distribution of the wares of the shop.⁹⁷

In recent months the British government have openly encouraged the U.K. population to increase their purchasing of private sector medical insurance. The increased interest in private sector medical insurance plans will launch what the U.K. hopes will be a decidedly "pro-market" (deregulatory) health-care servicing response possibly signalling a long-awaited rearrangement of the wares of the U.K.'s health-care shop.

Before we can attempt to uncover the British government's view towards private sector sources of medical insurance, we must first remind ourselves that in the U.K. medical insurance purchases are not generally recognized for their ability to provide medical illness risk reduction.

Instead, the British view private sources of medical insurance as an alternative financing method employed to: secure a more acceptable choice of specialist physician; or, to receive hospital care without having to wait in a queue. In response, the U.K.'s public policy is uniquely

⁹⁷Maynard, "Regulation of public and private health care markets," 502.

geared to reflect the country's somewhat unique national character traits.

For example, the British population are world reknown for their unique national ability to adopt a self-disciplined, non-emotional contemplation of their impending mortality. Accordingly, the British tend to reject prolonged and costly treatments for medical illness.⁹⁸

Private sources of medical insurance, therefore, provides the British consumer with the luxury of being able to schedule "cold care" ambulatory surgery when convenient, conducted under pleasant surroundings and offering the individual policyholder greater access to private pre-operative and post-operative accomodations and facilities then they might otherwise be allowed⁹⁹ under the country's heavy-handed health-care service rationing system.

In 1980 the total number of provident association (private medical insurance) subscribers was 1.6 million members. By comparison, the U.K.'s total trade union membership (1979) was 13.289 million members,¹⁰⁰ suggesting that only a fraction of the nation's working population subscribe to private medical insurance plans.

Although there were 3.5 million provident association subscribers (a figure which includes family dependents)

⁹⁸Ellis, "Grappling with the public/private health-care mix," 36.

⁹⁹Evans, "Incomplete Vertical Integration," 404.

¹⁰⁰Ken Coates and Tony Topham, Trade Unions and Politics. (London: Basil Blackwell, 1986) 7.

covered by provident association plans in the U.K. in 1980,¹⁰¹ overall growth within the private sector medical insurance market has been somewhat less than spectacular.

Fifty-three per cent of the 1.6 million provident association medical insurance schemes operate as group medical insurance plans.¹⁰² The British United Provident Association (BUPACARE) is the current U.K. market leader registering the largest number of group medical insurance subscribers. BUPACARE subscribers normally receive their medical insurance subscriptions as a partially paid (or fully paid) wage benefit.¹⁰³ U.K. provident associations annually contribute approximately (1980) 1.09 per cent of the financing employed to support the U.K.'s total health-care budget.

British Medical Association (BMA) officials optimistically predict that limited coverage, private health care (provident association) medical insurance plans will likely peak at an enrollment level contributing approximately 20 per cent of the nation's total health-care funding by the middle of the next decade,¹⁰⁴ a significant growth prediction which would need to shift 19 per centage points (up from the 0.06 per cent GNP health-care expenditure contribution level achieved in 1980) in order to achieve its intended growth

¹⁰¹Alan Maynard, "Private health care sector in Britain," in Gordon McLachlan and Alan Maynard eds., The Public/Private Mix for Health. (London: The Nuffield Provincial Hospitals Trust, 1982), 143.

¹⁰²Ibid., 139.

¹⁰³Ibid., 136-137.

¹⁰⁴Ellis, "Grappling with the public/private health-care mix," 36.

target.¹⁰⁵

The DHSS are much more guarded in their public pronouncements regarding the future growth of the U.K.'s private health insurance (provident association) market. Part of the reason for the NHS's somewhat conservative predictions concerning provident association growth is undoubtedly linked to the fact that 80 to 90 per cent of the U.K. populace support nothing less than "free at point of entry" publicly-delivered health-care service provision arrangements. Therefore, it is only natural for the DHSS to be somewhat pleased with the current status quo U.K. health-care delivery system.¹⁰⁶

It has recently been suggested that the number of hospitals operating in the U.K. in the last eight years has increased by 35 per cent. However, in actual fact, the number of patients presenting themselves to British hospitals for treatment has not grown in corresponding leaps and bounds.¹⁰⁷

Part of the lack of growth in the hospital sector is due to the fact that hospital specialists have maintained a relatively static employment level at approximately 43,000 salaried physicians. The United Kingdom's hospital specialists are, however, the medical provider group who are presently most desperately searching for a method to protect their dwindling control over the U.K. health-care delivery market.

¹⁰⁵Maynard, "Private health care sector in Britain," 141.

¹⁰⁶Ellis, "Grappling with the public/private health-care mix," 36-37.

¹⁰⁷Ibid., 35.

Cost-containment strategies are currently championed by a growing number of the U.K.'s salaried specialist physicians as a way to protect their health-care delivery market share. One of the more popular cost-containment approaches is called clinical budgeting. Clinical budgeting and functional budgeting must not be confused. Functional budgeting involves a group of budget managers who become the designated supervisors of a hospital department (such as x-ray, pharmacy or nursing) and subsequently endeavour to control their department's total budgetary operations.

Functional budget managers are seldom empowered with the ability to restrict clinicians' practice behaviours or prescribing patterns, which means clinicians can drive up hospital costs almost at random.¹⁰⁸

Clinical budgeting, on the other hand, demands that front-line hospital consultants or specialist physicians receive their own budgets and be held strictly accountable for their department's overall manpower and capital equipment resource allocations performance.

The clinical budgeting plan of action is, essentially, a departmental medical service provision performance plan which co-opts all of the department's clinicians in pursuit of the achievement of "economy of scale" health-care servicing activities.

¹⁰⁸Iden Wickings, "Review of clinical budgeting and costing experiments," British Medical Association (Feb. 12, 1983), Vol. 286, 575.

The crucial link which ensures the clinical budgeting program's success is the effort spent enlisting the full-fledged support of the department's total complement of staff physicians. Financial incentives (and/or career advancement) rewards may be offered to acknowledge exemplary physician work performance and/or to ensure total compliance with the overall clinical budgeting effort.

Wickings (1983) has reviewed the many clinical budgeting trials conducted to date in the public sector involving medical (and non-medical) public service provision applications. Clinical budgeting programs have proven successful in the following hospital sector service provision applications: x-ray and pathology; out-patient clinics; pharmacy; nursing; food and beverage catering facilities, etc.¹⁰⁹ Wickings concludes by suggesting that clinical budgeting is superior to functional budgeting based upon the available historical data and his own institutional experience.

I would like to offer one final remark before I move on to an analysis of Sweden's health-care delivery system. Since the mid-1970s, the United Kingdom has largely ignored an all-party agreement which favours a shift of health-care spending away from acute care (hospital sector) medical service provision programs and instead would like to see the U.K. increase health-care funding for "Cinderella services" (ie. health-care service provision for the elderly, the

¹⁰⁹Wickings, "Review of clinical budgeting and costing experiments," 576-577.

mentally ill, the chronically ill, and the handicapped).¹¹⁰

Few analysts would seriously dispute the fact that the average Briton currently earns a per capita income lagging well in arrears of the income earnings potential of a Swede, an American or a Canadian.¹¹¹

Indeed, only isolated segments of the U.K. population are living in apparent affluence, caused in part by generous occupational pensions and/or inflated property values. The remaining much more sizeable majority of the British population are alarmingly unconcerned by the prospect that they might one day become financial wards of the State requiring financial hand-outs which may include charitable "Cinderella" health-care services.

What the U.K. population undoubtedly needs today is a forward-looking private citizens coalition ready and willing to encourage the general public to invest their personal savings in private (or publicly-delivered) retirement insurance schemes targeted to provide nursing care services for the current work force upon reaching 65 years of age and/or once they voluntarily seek premature retirement. Without such strong policy measures, it is hard to imagine how the next generation of British senior citizens might ever afford a comfortable standard of living during their post-employment retirement twilight years.

¹¹⁰Maynard, "Private health care sector in Britain," 155.

¹¹¹Blomqvist, "The Health Care Business," 67.

CHAPTER VI
CROSS-NATIONAL EXPERIENCE

Sweden and Canada

In this second chapter of our four nation, two continent health-care policy review the concept of equal access to minimal care will be challenged by two uniquely different health-care policy national treatments.

Sweden's universal medicare program differs in dramatic organizational fashion from Britain's health-care system, and does not feature a sole monopsonist health-care bureaucracy equivalent to the U.K.'s Department of Health and Social Services (DHSS). Instead of designing a monopsonist health-care bureaucracy which functions in a dual capacity as provider and purchaser of medical services while concurrently maintaining what many analysts' regard as a heavy-handed service rationing approach, Sweden bases the nation's long-term health-care financial planning activities upon clear-cut statements of national medical need and health-care services demand. In the process, Sweden accomodates the health-care needs of a larger cross-section of the country's population.¹

Canada, in a similar fashion to Sweden, has allowed the public sector to administer the country's hospital and medical insurance delivery programs in a manner which has, at least partially, curbed physician price formation activities

¹Heidenheimer and Elvander, "The Shaping of the Swedish Health System," 182.

through the federal and provincial governments' control of the payments process.²

Canada has developed a unique health-care delivery model quite dissimilar from the pioneering medicare delivery perspectives employed either by the U.K. or Sweden. Canadians, very early on in the nation's development, recognized that a health market could not be left to rationally plan itself by the invisible forces of supply and demand. The Canadian federal government, in particular, has been generally reluctant to allow consumers an opportunity to select the optimal level of health-care consumption based solely upon the principle of informed consumer choice.³

Instead, the Canadian federal government has opted to create a medicare program which protects the nation's citizenry against the uncertain and potentially disastrous cost of illness. Canada has adopted a public-administered first-dollar coverage medical insurance program⁴ which is generously funded by consumers (see Appendix: Figure 4-4) yet also receives a sizeable proportion of public funding from general tax revenues (see Appendix: Figure 4-3).

²Evans, "Incomplete Vertical Integration," 338.

³Abel-Smith, "Value for Money in Health Services," 155.

⁴Stoddart, "Rationalizing the Health Care System," 1.

Sweden

Macroeconomic indicators reveal that Sweden leads our four-nation sample in terms of the nation's overall commitment of GNP financing employed to support universal health-care program policy objectives (see Appendix: Figure 3-9). Sweden marginally trails the U.K. in terms of the country's total public sector commitment to fund the nation's (1975) overall health-care budget (see Appendix: Figure 4-1).

Evans (1987) provides an updated report for our four country health-care expenditures profile which reveals that Sweden's spending on health-care was 9.6 per cent of the nation's (1983) Gross Domestic Product (GDP), a figure which sits comfortably behind the U.S.'s 10.8 per cent (1983) GDP health-care performance measure.⁵ (Gross National Product health-care spending figures currently available for the U.S. suggest 10.63 per cent of the U.S.'s (1985) GNP was devoted to health-care expenses, indicating a continuation of the U.S.'s inflationary health-care expenditures spiral⁶).

Sweden's drop from the top of the list to second place behind the United States as OECD leader in health-care (GNP) spending is partly attributable to the nation's implementation of a nation-wide health-care sector cost-containment strategy, a strategy which partially benefits from the country's sparse population-to-physician coverage ratio.

⁵Evans, "Finding the Levers," 588.

⁶Ibid., 585.

An OECD report has recently suggested that Sweden is currently ranked 22nd among OECD nations in terms of the country's population-to-physician coverage ratio, yet the country has managed to lead OECD countries in terms of its national per capita health-care spending during the same timeframe (1969-1975).⁷

Sweden trails the U.K. and Canada in terms of general taxation funding employed to support the nation's health-care expenditures account. In 1975, Sweden's general taxation revenues supported 86 per cent of health expenditures, versus the U.K.'s (1975) 94 per cent and Canada's (1975) 88 per cent (see Appendix: Figure 4-3).

Sweden collects 8.4 per cent of national health-care expenditures from consumer user fees, a figure which places the country third behind the U.K. and the U.S. By contrast, the U.S. collected (1975) 27.1 per cent of total national health-care expenses directly from consumers while the U.K. collected (1975) 19.5 per cent of the nation's overall health-care financing from private sector health-care user fees.

The Medical Profession's Role Re-defined

Sweden is the one country selected from our four country comparative health-care policy sample which has encouraged the gradual evolution of the nation's health-care infrastructure away from the highly traditional physician fee-for-service

⁷Howard Leichter, A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations. (London: Cambridge University Press, 1979), 97.

(solo) practice model towards a completely hospital-based health-care delivery model featuring the employment of physicians as salaried employees of the State.

As recently as the late 1930s, less than one Swedish doctor in three held a public post, and most General Practitioners and hospital specialists provided most of their ambulatory medical care from the privacy of their private offices or from offices located on hospital premises. Today, in comparison, close to 90 per cent of Sweden's ambulatory medical consultations are handled by publicly-employed physicians operating from public sector-owned and operated primary care treatment facilities.⁸

There are two main classes of health-care providers (physicians) employed in modern-day Sweden. The first group are the General Practitioners, operating in private practices or as fully salaried public sector employees. The other group of physicians are salaried medical officers (hospital specialists) or salaried medical administrators.

Contrary to the medical practice standards I have already cited for the U.S. and the U.K., Sweden's GPs are employed as part of a medical team which includes other physicians, community health counsellors, nursing staff, and homecare and/or nursing home personnel who work together as a highly integrated medical diagnostic and/or therapeutic (medical

⁸Leichter, "A Comparative Approach to Policy Analysis," 97.

management) team.⁹

A recent Swedish government publication reveals that 53 per cent of all physician consultations conducted in Sweden occur within hospital (and other primary care) facilities, 30 per cent of the nation's doctor visits occur in primary care (publicly-funded) clinics, while the remaining 17 per cent of physician consultations are managed from a physician's private office.¹⁰

The Swedish health-care delivery network has not always performed in the highly centralized manner I have just documented.¹¹ At the turn of the century, both the Swedish health-care delivery network and the nation itself were governed by extremely fractious political forces, carved up into what might be described as a patchwork pillow of highly decentralized and politically subdivided semi-autonomous governing units or regions, called lans. Each lan was governed in a totally independent manner from their nearest neighbour.

Local and regional health care programs were controlled by the lans, and quickly evolved into a sophisticated delivery network consuming approximately 75-80 per cent of the lan's total expenditures.¹²

From the 1890s-1910, the lans each introduced their

⁹Bo Soderholm, SPRI: Some Facts About Health Care in Sweden. (Stockholm: The Swedish Planning and Rationalization Institute, # 151 [May] 1987), 10.

¹⁰Sweden. Facts Sheets on Sweden: The Health Care System in Sweden. (Stockholm: The Swedish Institute, [September] 1987), 2.

¹¹Ibid., 1.

¹²Heidenheimer and Elvander, "The Shaping of the Swedish Health System," 11.

own version of a combination of health-care insurance and social insurance which was designed to grant their citizens a measure of health-care risk reduction. The early medical insurance schemes pioneered by the individual county councils (the lans) obliged employers to make contributions on their employees behalf according to formulas devised to reflect the size and complexity of the employer's workforce.¹³

Problems quickly arose. The highly decentralized health-care programs were soon left adrift in a sea of debt as the country tottered towards a recession caused by the international world-wide trade imbalances of the 1920s.

In response, the Swedish State was called into action to assist the lans. Faced with a fractious group of local county councils which were clearly disorganized and could hardly be expected to decide amongst themselves what economic relief proposal was in order, the Swedish public sector served notice that the country would follow a centralized public policy reorganization effort which would introduce universal, comprehensive health and welfare social redistribution programs to match the country's overall social health and welfare reconstruction objective.

The first step in pursuit of this massive public sector reorganization program was accomplished with the election sweep of the SAP (the Socialdemokratiska Arbertarparti or Swedish Social Democratic Party) in 1928, an election which the SAP won handily with 42 per cent of the popular vote

¹³Abel-Smith, "Value for Money in Health Services," 12.

under conditions of grave mass unemployment.¹⁴

The highest priority on the SAP's political reform agenda was to achieve a national consensus involving a voluntary, corporatist-styled collective bargaining process featuring the LO (Landsorganisationen or Swedish Trade Union Confederation), the nation's peak trade union organization and the government.

The SAP were extremely successful with their negotiations with labour and began a gradual movement to implement the terms and conditions of their new public policy social redistribution and economic reconstruction organizational campaign. Among the first stated policy objectives unleashed by the SAP economic restructuring program was to introduce a national, fully comprehensive social security scheme which would equalize the pension status and overall economic standing of the entire Swedish workforce.¹⁵ Secondly, as an additional political bonus, the new social security plan would slowly begin the laborious process of replenishing the State's Treasury.

In 1930, the SAP introduced compulsory medical insurance on a nationalized scale which had an immediate and dramatic public policy effect. Almost overnight, the number of medicare beneficiaries rose to a record-breaking level.¹⁶ The cost of the collectivist (or corporatist-styled) restructuring

¹⁴Gosta Esping-Andersen, Politics Against Markets. (Princeton: Princeton University Press, 1985), 50-51.

¹⁵*Ibid.*, 108.

¹⁶Heidenheimer and Elvander, "The Shaping of the Swedish Health System," 62.

program would not be cheap. Payroll taxes levied against employers and employees in Sweden beginning in the 1930s (and rising steadily ever since) are undoubtedly high by North American, or even U.K., taxation standards. In addition, the SAP still faced a potentially worrisome political rival in the form of the local county councils (the lans).

The lans, however, carried an enormous debt load incurred as their souvenir from the fiscally draining 1920s, a debt burden which was fast approaching financial maturity. In order to escape bankruptcy during the late 1940s and early 1950s, the lans turned to the central government for assistance retiring their loans. Sixty-five per cent of the lans' loans, a large part attributable to health-care expenditures, were finally retired.¹⁷

The SAP were finally ready to move against the lans with a penultimate political initiative launched in the mid 1950s. The first plank in the SAP's 1950s social legislation reform package came with passage by the Swedish Parliament of a wide-sweeping social security reform proposal in 1955. The landmark 1955 legislation represented a significant turning point for the country. Sweden's central government were now slowly consolidating their political control over the nation's entire health-care infrastructure.

The 1955 social security proposal included an extremely specific health-care legislative reference which very subtly

¹⁷Heidenheimer and Elvander, "The Shaping of the Swedish Health Care System," 62.

stated that fees charged by physicians in private practice (solo) office settings would be subject to an out-of-pocket user fee surcharge, a surcharge which could run as high as 25 per cent of the total cost of the patient's private practice-based consultation.¹⁸ On the other hand, all other medical treatments received within public hospitals (or on-site at a publicly-administered primary care medical treatment facility) would be fully reimbursed by the State. In effect, the central government had committed itself to a comprehensive medicare program thereby ensuring the long-term financial viability of the nation's fiscally strapped hospital health-care service sector.

The 1955 medicare reforms very quickly transformed Sweden's total physician medical manpower complement away from the fee-for-service delivery model and towards State-funded (salaried) employment positions. To demonstrate how solidly entrenched the 'new' medicare program had become, by the late 1970s fees collected by non-salaried (full and part-time) private practice physicians were approximately 1 per cent of total national health-care expenditures.¹⁹

Although Sweden had impressively implemented most of the nation's social security and economic health and welfare redistribution program activities and objectives by the late 1950s, one further health-care structural reform measure remained to be announced.

¹⁸Blomqvist, "The Health Care Business," 142.

¹⁹Ibid., 142.

The final health-care infrastructure reform measure was the Seven Crowns (Health-Care Policy) Reform Plan unveiled under a cloud of secrecy in early 1969.

The Seven Crowns Reform proposal was the brain-child of the nation's newly established (1963) triad of government health-care planning agencies: the Ministry of Health and Social Welfare, the Department of Social Affairs, and the National Social Insurance Board (with further assistance, when required, from the Director of the Board of Occupational Safety and Health).

The Seven Crowns Reform (1969) granted the Swedish central government full regulatory and supervisory powers over the nation's total health-care infrastructure, including the undisputed and unchallenged authority to determine the nation's long-term health-care policy prioritization and resource planning exercises.

The Seven Crowns Reform (1969) ushered in dramatic change at the county council level. The lans, in particular, watched in stunned disbelief as the new health-care delivery guidelines were introduced by the central government without initiating public discussion or parliamentary debate, nor offering a national referendum on the subject. Local government, health-care planners and medical providers alike were now completely cast in a subservient decision-making role behind the State's health-care planning administration.²⁰

²⁰Heidenheimer and Elvander, "The Shaping of the Swedish Health System," 107, 109.

Among the changes immediately introduced following the announcement of the Seven Crowns Reform was a planning directive which demanded that each county council would no longer be permitted to detrimentally compete with one another to provide specialized medical services in such clinical areas as thoracic surgery, neuro-surgery and plastic surgery. Instead, a new health-care program was afoot, a delivery program which can best be described as regulation by deterrence.

Deterrence as Regulation

In Sweden to-day, the relative lack of emphasis placed upon General Practitioner (primary care) health-care service provision has led to a higher rate of hospital utilization and a lower level of physician (and hospital servicing) deterrent persuasion than is found in many other countries included in this study. The fact that Sweden has such a remarkable list of insured medicare treatment benefits makes the regulation by deterrence philosophy that much more remarkable to study and analyze.²¹

Sweden has a higher incidence of hospital utilization, yet commensurately fewer practicing GPs than either the U.S., the U.K., or Canada.²² In fact, Sweden's physician shortage may actually constitute a brilliant health-care cost-containment strategy in disguise, since the nation's

²¹Blomqvist, "The Health Care Business," 143.

²²Sweden. "Fact Sheets on Sweden: The Health Care System," 3.

current physician manpower deficit occurs among the following short-listed group of clinical specialities: general practice, psychiatry, geriatrics, and among certain diagnostic/laboratory medical specialities.²³

Sweden's shortage in primary care-oriented geriatric specialists and psychiatrists may reflect a deliberate policy action since Sweden has pioneered the use of "carative" para-professionals as a medical delivery alternative to the somewhat costly, long term institutionalized chronic care treatment perspective. Long-term or chronic care patients, although cheaper to look after on a per day hospital admission basis than acute care patient admissions,²⁴ may prove cheaper and even less expensive to care for if billeted at home and attended by medical (and non-medical) "carative" health-care personnel.²⁵ Not only are geriatric specialists and psychiatrists more expensive to train and hire than their para-professional counterparts, but appreciable health-care cost savings may result from a deliberate health-care resource allocation strategy which seeks to minimize the number of routinely occurring chronic-care (hospitalization) treatment episodes.

Sweden's shortage of diagnostic physicians and specialist laboratory clinical staff might actually constitute a skillful

²³Sweden. "Fact Sheets on Sweden: The Health Care System," 3.

²⁴James T. Bennett and Manuel H. Johnson, "Tax Reduction Without Sacrifice: Private-Sector Production of Public Services," Public Finance Quarterly. Vol. 8:4 (October, 1980), 380-382; Lindsay, "A theory of government enterprise," 1061-1078.

²⁵See Chapter II page 6 at the second paragraph.

manpower manoeuvre which is intended to side-step the elevated incidence of physician-induced utilization encountered with diagnostic testing procedures in both the U.S. and Canada.²⁶

Diagnostic treatments rapidly deplete a nation's capital resource stock, particularly in such high cost health-care service provision areas as diagnostic imaging, x-ray, and laboratory diagnostic/therapeutic clinical areas. In addition, many diagnostic testing procedures may demonstrate limited clinical efficacy in solving all but the most routine medical diagnostic problems,²⁷ which serves to underscore Sweden's remarkable success curbing diagnostic testing procedure overutilization to date.

If there is one manpower policy staffing decision which was critically important to the Swedish health-care planning committee, that decision concerned how to deter the population's historic overutilization of Swedish GPs.

The nation's private practice-oriented GPs, as we have already noted, were the targets of a highly symbolic deterrence user fee scheme. However, deterrence as regulation also served two quite unique policy objectives.

First, GP user fees slightly lowered the net health-care sector financial servicing load. And secondly, GP user fees achieved a stated public policy objective which was to effectively discourage individual consumers from over-utilizing their local GPs as a deliberate point of entry

²⁶Banta and McNeil, "Evaluation of the CAT Scanner," 7.

²⁷See Chapter II page 9 at the second paragraph.

to the nation's centrally controlled health-care delivery system.

At present, patients are charged approximately \$ 3.00 (U.S.) per GP visit as a deterrent fee. Upon consulting a doctor, the patient receives a receipt showing the assessed fee and the treatments which are eligible for reimbursement from the nation's sickness fund. Ambulatory patients are free to consult a doctor at his/her private office as fee-for-service patients as long as they agree to pay the out-of-pocket user deterrence surcharge.²⁸

Sweden has the shortest medical provider fee schedule reported among the nations included in our four country sample. Swedish health-care planning authorities routinely publish the list of procedures that a skilled medical practitioner can perform upon ambulatory patients, treatments which may include: simplified medical testing procedures (minimum exam/minimum treatment); medical counselling activities (with/without blood pressure, reflex testing interpretations, etc.), and thirdly; simple or routine medical treatments (advanced exams with/without minor ambulatory surgical interventions).

If the doctor performs two procedures in the same visit, physicians are paid by the state for the slightly higher fee category activity. Double billing (ie. billing for the performance of multiple category activities simultan-

²⁸Glaser, "Paying the Doctor," 46.

ously) is disallowed.²⁹ Swedish health-care planners believe that peer disapproval effectively curbs deviant medical provider billings irregularities, and rarely has the Swedish government felt sufficiently compelled to impose stronger social sanctions to stem the spread of systematic medical provider rent-seeking abuse.³⁰

Sweden automatically guarantees sickness fund compensation for all income losses suffered by a patient as a consequence of their having sustained a serious illness, injury or accident, and even pays 90 per cent of an employee's normal salary during periods of medical convalescence.³¹ Fifty per cent of all outpatient medications are reimbursed by the national sickness fund³², while drugs of a life-saving character are provided free of charge.

Sweden's state-run parental insurance program allows twelve months leave of absence (with compensation for loss of income) to a parent during episodes involving the new-born. Sweden underwrites all necessary medical care required by the disabled (including provision of technical aides) free of charge. In addition, health-care coverage is extended in a fully comprehensive manner for all alien residents living in the country.³³

Sweden's health-care system is generally recognized

²⁹Glaser, "Paying the Doctor," 146, 47.

³⁰Ibid., 152.

³¹Sweden. "Fact Sheets on Sweden: The Health Care System," 2.

³²Blomqvist, "The Health Care Business," 142.

³³Sweden, "Fact Sheets on Sweden: The Health Care System," 2.

as an exceptionally high quality delivery system. The nation routinely reports the lowest average mortality figures reported anywhere in the modern world.

Hospital Reform: Regionalization and Deinstitutionalization

Sweden's health-care system is sub-divided into six medical care regions, or medical service corridors, which each cater to a population averaging more than one million inhabitants.³⁴ The nation's six regional health-care service corridors share eight major regional hospital treatment facilities, with each major regional treatment facility located within a four hour drive of most Swedish citizens thereby ensuring optimal catchment area patient population coverage.³⁵

In early 1981, the Swedish Planning and Rationalization Institute (SPRI) publications began highlighting how the nation's long-range health-care planning activities were being conducted. For example, Sweden's complement of future coronary care units (CCUs) were allocated according to the available evidence revealing past coronary care patterns and projections for the future rate of incidence of the disease.

First, population densities for one of the six regional health-care service corridors are calculated according to age-specific, and sex-specific rates of heart disease.

³⁴Sweden. "Fact Sheets on Sweden: The Health Care System," 3.

³⁵Abel-Smith, "Value for Money in Health Services," 162.

Next, the CCU disease incidence data base is aggregated to arrive at estimates of demand for the medical service in question, allowing for the maximized travel time convenience of the targeted health-care service corridor population to be factored "in" to the overall utilization projections.³⁶

Outpatient care is currently organized into primary care districts each serving approximately 5,000 to 50,000 inhabitants. A primary care district may have one or more nursing homes for long-term care, and a full complement of medical hostels for the use of general medical care, psychiatric, and intellectually handicapped patients.³⁷

The Swedish government regulates pathway 'f': direct public control over insurance functions, and pathway 'i': (non-market) patient influence over providers by virtue of the fact that Swede's are allowed some choice in selecting their private physician.

The government can integrate backwards if it chooses, and directly influence front-line providers (hospitals) by controlling the nation's overall level of medical provider prescribing behaviour.³⁸ Or, the government health-care regulators may integrate forwards through the insurance function lever to regulate second-line provider (private

³⁶Roberta LaBelle, "Planning for the Provision and Utilization of New Health Care Technologies," in David Feeny ed., Health Care Technology: Effectiveness, Efficiency, and Public Policy. (Montreal: Institute for Research on Public Policy, 1986), 156.

³⁷Sweden. "Fact Sheets on Sweden: The Health Care System," 2.

³⁸Evans, "Incomplete Vertical Integration," 336.

practice-based physician) prescribing behaviours (see Appendix: Figure 4).

Most recently, Sweden's health-care planning team have stated that the nation's next health-care delivery program would be leaning towards a public policy planning objective which would increasingly provide care to Swede's in deinstitutionalized service settings.³⁹

Sweden's deinstitutionalization health-care delivery program demands that the nation's health-care transactor principals be even more flexible in terms of accepting novel work assignments/arrangements. Although Swedish health-care planners have demonstrated remarkable success controlling the nation's medical manpower staffing activities in the past, Sweden's deinstitutionalization health-care delivery program may increasingly cause a redirection of medical manpower away from marginally productive small sized (and a few medium sized) hospital centres, and it may reroute care-givers towards an expanded role acting as "extended care"/homecare delivery program supervisors and administrators.

Although Sweden boasts a very high population to bed ratio, reporting a national average of 16 beds per 1,000 inhabitants (which dwarfs Canada's (1970s) 5.24 beds per 1,000 patients⁴⁰), it must be remembered that Sweden has

³⁹Thorsten Thor, SPRI's Working Programme. (Stockholm: The Swedish Planning and Rationalization Institute, 1982), 1-24.

⁴⁰Woods-Gordon, Assessing the Performance of Canadian Hospitals: A 'Business-Like' Approach. (Toronto: Woods-Gordon, 1984), 68.

deliberately chosen to implement a regionalized health-care delivery program requiring a network of more numerous small (and medium-sized) hospitals and primary care facilities to service the remote areas of the country.

The deinstitutionalization program objective has attempted to lower the nation's total health-care bill while also lowering the bed-to-population ratio, two policy goals which are well on their way to achieving their full intent. One-third of the medical (institutional) therapeutic cases which in the past were routinely considered hospital in-patient admissions are now being treated as homecare medical treatment episodes.

Sweden has registered approximately 156,500 acute and chronic care medical treatment (inpatient/outpatient) admissions in each of the last five years. Sixty-seven per cent of those admissions were treated in hospital and nursing home locations, 1 per cent involved patients receiving care in special intensive care units, and the remaining 32 per cent received medical care administered to patients directly in their homes.⁴¹

Sweden's health-care planners are now confident they can sustain the deinstitutionalization effort into the second phase of what SPRI are calling the normalization health-care restructuring effort. Phase two of Sweden's health-care delivery normalization policy prioritization effort will provide additional medical treatment facilities in the form of: medical care catering to the medical needs of the elderly;

⁴¹Bo Soderholm, "SPRI: Some Facts About Health Care," i.

the establishment of further centres for treating substance abuse/communicable disease treatment stagings, and; will offer increased programming to attend to the medical demands of the mentally and physically handicapped, and the industrial (and or environmentally-related) disease-afflicted population.⁴²

The normalization segment of Sweden's health-care sector deinstitutionalization program addresses each of the health-care challenges itemized earlier under the sub-title the "new carative agenda".⁴³ Swedish health-care planners are continually reappraising the nation's total health-care commitment. They have recently compiled a list of upcoming medical service sector challenges which are subject to continuous monitoring, including: 1) a continuation of the nation's commitment to the upgrading of specialized high-technology health-care servicing installations; 2) a restatement of the national commitment to health-care education/health-care prevention programs, and; 3) Swedish health-care planners share a public awareness that they are morally-bound to remain undisputably in charge of the nation's total medical (and applied science) research and development effort.

Sweden's medical (and applied science) research and development activities must continue to thrive in an exploratory environment sponsoring the transfer of clinical advances from laboratory to hospital setting as quickly as possible

⁴²Sweden. "Fact Sheets on Sweden: The Health Care System," 2-4.

⁴³See Chapter IV "Operation Forward Integration: The New Carative Agenda," 63-64.

with a minimal amount of bureaucratic interference or delay.

The third health-care delivery challenge I have listed is an area in which Sweden is currently recognized as a world leader. The Swedish medical (and applied science) research community receives generous government funding at a figure which has been conservatively estimated in excess of \$480 million (U.S.).⁴⁴

⁴⁴Sweden, "Fact Sheets on Sweden: The Health Care System,"
3.

Canada

Canada is a nation with a federal form of government which finds itself immersed in fractious political bargaining which can be analyzed from two opposing critical perspectives. Canadian federalism can be viewed as constituting either a centralizing or decentralizing governing process, depending upon one's point of view.⁴⁵

Canadian federalism is considered a centralizing phenomenon if the political analyst accepts the idea that the Canadian federal government enjoys the right to dictate how the nation's total social program efforts might operate. The centralizing fiscal federalism viewpoint essentially argues that the federal government possesses full constitutional and jurisdictional authority to determine how the nation's total tax burden is assessed before it is used to fund such activities as health care service provision or education.

Accordingly, if the Canadian provinces discover they must rely upon the federal treasury to fund their social programs, the provinces must, in order to receive their portion of the nation's revenues, accept the federal government's social policy guidelines and program delivery frameworks virtually without question.⁴⁶ On the other hand, Canadian fiscal federalism proponents might adopt the opposite argument, the decentralizing fiscal federalism position.

⁴⁵John Graham, "The Canada Health Act and Federalism," in William G. Watson ed., Report on the Policy Forum on Medicare in an Age of Restraint. (Kingston: Queen's University Press, 1984), 39.

⁴⁶*Ibid.*, 39.

The decentralizing fiscal federalism viewpoint argues that the Canadian constitution defines health as a social policy matter falling under the provincial government's jurisdictional and/or autonomous decision-making control. Therefore, the provinces should be enabled to pursue their own health-care policy program activities irrespective of the political wishes expressed by the federal government concerning the matter.

The Canadian provinces, following the logic of the decentralizing fiscal federalism viewpoint, believe they should enjoy the right to dictate the design of their health-care delivery programs and must only be held directly accountable for ensuring that their social programs, health-care among them, conform to provincial regulatory statutes and program guidelines in as accurate a legal manner as possible.

Although it might be easily argued that Canada has become relatively accustomed to the routine inter-governmental feuding which the centralizing versus decentralizing fiscal federalism debate unleashes, the constant release of political tension can itself prove damaging to the nation's overall social policy program delivery effort. The fiscal federalism debate might actually distract the general public long enough that it might, in effect, be lulled into thinking that health-care program re-design (or structural reform initiatives in general) are, presently, not a pressing social policy issue demanding immediate political attention.

If indeed Canadian medicare has failed us, then the areas in which it must be considered slightly suspect are: 1) medicare's failure to perform routine, long-term sectoral planning exercises; 2) the absence of sector-wide health-care planning activities within either provincial or federal health-care departments and; 3) medicare may have amassed a dismal prioritization and planning track record which seemingly ignores the implementation of cost-containment policy measures.⁴⁷

Turning to macro-economic indicators, Canada's total proportion of GNP devoted to health-care expenditures nearly doubled from 4.0 per cent in the nation's pre-medicare years (1950) to 7.1 per cent in 1970, 1975 and 1977 (see Appendix: Figure 3-9 and Figure 4-1).

Recently, Canada's ratio of GNP devoted to health-care increased from 7.5 per cent in 1980 to 8.4 per cent in 1982,⁴⁸ indicating the launching of a period of somewhat inflationary health-care sector spending. Public funding for health-care products and services in Canada has routinely contributed approximately 75.4 per cent of the nation's total (1975) health-care budgetary expenses. The personal health care sector in Canada, comprised of institutions, professional

⁴⁷Michael Ozerkevich, "The Extra-Billing Controversy," in William G. Watson ed., Report of the Policy Forum on Medicare in an Age of Restraint. (Kingston: Queen's University Press, 1984), 4.

⁴⁸Douglas Angus, "The Long-Term Budgetary Prospects for Health Care," in William G. Watson ed., Report of the Policy Forum on Medicare in an Age of Restraint. (Kingston: Queen's University Press, 1984), 26.

services, and drugs and appliances, exhausts almost the entire 88 per cent general taxation funding figure⁴⁹ (see Appendix: Figure 4-3).

In the United States, 86 per cent of overall health-care expenditures are devoted to personal health care, of which the government funds only 40 per cent of that figure. The remaining 46 per cent of U.S. personal health care (institutional, professional service, drugs and medical appliance) expenditures⁵⁰ originate from non-governmental, private sector sources including personal savings. Whether or not the Canadian provinces will be forced to mimic the U.S.'s public/private health-care service mix, entailing a possible abandonment of health-care provision via non-profit agencies or government bureaus acting in a non-profit manner, remains to be determined. (Ontario's Deputy Minister of Health cautiously predicted recently that the Canada Health Act requires public funding, but not necessarily government-administered health-care service provision,⁵¹ an admission which constitutes a veiled challenge to the Canada Health Act itself and might signal a policy shift welcoming increased private sector involvement in the province's health-care delivery effort).

Earlier in this study I reported that the U.S. collects 27.1 per cent of health-care costs directly from consumers (see Appendix: Figure 4-4). Canada, on the other hand,

⁴⁹Angus, "The Long-Term Budgetary Prospects," 26.

⁵⁰Ibid., 26.

⁵¹Dawson, "The end of the doctor/patient relationship?" 32.

publicly finances a relatively smaller proportion of total health expenditures from direct consumer-based financial sources. Despite the fact that Canada (and the provinces) finance most of the nation's hospital and medical service expenditures through national health insurance, Canadians rely upon private funding channels to receive dental services, pharmaceuticals, prostheses and nursing home care⁵² (see Appendix: Figure 4-4). In Canada, over 90 per cent of the population's total health-care expenses are paid through provincially-run medical insurance plans, leaving less than 2.5 per cent of health-care sector medical insurance activity to fall under the direction of the private medical insurance sector.⁵³

Universality and Accessibility: The National Medicare Agenda

The federal government officially introduced Canadian universal medicare with the passage of the Medical Care Act in 1966. The Medical Care Act created five health-care sector delivery guidelines or principles which Canadian provincial government ministries of health were forced to recognize. The Medical Care Act called for health-care service provision which was: comprehensive, universal, accessible, and portable from province to province, and which must be administered via non-profit agencies or government

⁵²Brown, "Caring for Profit," 42; Thomas MacKenzie (and Douglas Angus), "The Long-Term Budgetary Prospects," 32.

⁵³MacKenzie (and Angus), "The Long-Term Budgetary Prospects," 32.

bureaus acting as the general public's health-care service provision intermediaries and health-care plan administrators.⁵⁴

In order to qualify for federal funding to support provincial medicare delivery efforts, each province was forced to demonstrate their compliance with all five of the Medical Care Act program guidelines. The federal government believed it was offering an open-ended health-care funding mechanism to accompany the Medical Care Act which would entice the provinces to introduce medicare programs in a uniform manner.⁵⁵ The federal government proposed to fund an amount equal to 50 per cent of the per capita cost of insured medical services offered by all Canadian provinces multiplied by the average number of insured persons found resident in a particular province.⁵⁶ The federal government anticipated that the medicare funding mechanism would ensure all provincial governments were treated equally, regardless of their differently-sized provincial budgets.

What particularly pleased the provinces when they were presented with the terms of the Medical Care Act (1966) was the fact that they (the provinces) could order their health-care expenditures to reflect provincially-determined health-care delivery priorities. However, the provinces initial enthusiasm quickly wore thin, particularly when

⁵⁴Graham, "The Canada Health Act and Federalism," 40.

⁵⁵Pierre Bergeron, "Commentary: Manpower Policy," in Robert G. Evans and Greg L. Stoddart ed., Medicare at Maturity. (Calgary: University of Calgary Press, 1986), 331.

⁵⁶Constantine Kapsalis, Block-Funding and Provincial Spending on Social Programs. (Ottawa: Economic Council of Canada, Discussion Paper # 210, 1982), 5.

it was realized that the federal government's medicare cost-sharing funding mechanism had been tied to acute-treatment care hospital utilization rates and did not include extended (hospital 'chronic care') service figures in its financial forecasts or growth projections.

The provinces lamented the fact that their health-care resources were tied up with acute-treatment care, and that they were forced to employ acute-treatment beds in an extended-care treatment capacity,⁵⁷ a development which might conceivably lead to greater health-care service provision discontinuities over the long-term.

One other shortcoming encountered with the Medical Care Act was the fact that it essentially "locked in" existing patterns of delivery⁵⁸ by fully underwriting the cost of physician-instigated treatment episodes, the most costly of all forms of medical service provision. What both the provincial and federal health-care planners had assumed was that the nation's medical needs, and the accompanying health-care services resources required to address those medical needs, were objective and measurable entities. Once the nation's medical needs were sufficiently met, demand and utilization would level off.⁵⁹ This, quite simply, failed to occur. Medical demand and medical utilization rates continued to rise without end in sight.

⁵⁷Graham, "The Canada Health Act and Federalism," 40.

⁵⁸Tuohy, "Conflict and Accomodation in the Canadian Health Care System," 403.

⁵⁹Bergeron, "Commentary: Manpower Policy," 331.

As the Canadian medicare system's utilization levels edged higher and higher, cost overruns increased in a parallel fashion, prompting a call for policy adjustments. A noted health-care analyst has recently suggested that once it is determined that health-care funding is too open-ended, a realization which first surfaced during the early 1970s, the only way to rectify the overtly open-ended health-care funding approach is to resort to political action.⁶⁰ Indeed, the political action was not long in coming.

In the mid 1970s, the federal government proposed to move medicare financing in a decidedly de-integrated (or decentralized) funding direction, shifting a larger proportion of the program's funding responsibility onto the shoulders of the Canadian provinces.

On the positive side, by 1977 the federal medical care and hospital insurance fiscal arrangements statutes and rulings had achieved their intended social policy objectives. The country had achieved medicare program universality and comprehensiveness.⁶¹ Since the costs of the "provincial" medicare programs were clearly recognized and well established, all that remained for the federal government to do was to determine a new set of medicare funding arrangements.

The new medicare funding mechanism which the federal

⁶⁰Pranlal Manga, "What Role for User Charges?" in William G. Watson ed., Report of the Policy Forum on Medicare in an Age of Restraint. (Kingston: Queen's University Press, 1984), 25.

⁶¹Canada, Fiscal Federalism in Canada (1981), Annex 11-C: Health Programs, 54.

government hoped to quickly foist upon the provinces was designed to offer the provinces a revision of the terms governing the federal contribution to support health-care programs in Canada in general. The proposal which finally surfaced was incorporated as part of the Established Programs Financing (EPF) intergovernmental fiscal planning agreement of 1977.

Under the 1977 EPF agreement, medicare cost-sharing financing became transformed as medicare "block-funding" financial planning. The value of federal government contributions to provincial health-care programs was no longer automatically calculated to reflect the size of a province's individual health-care delivery effort.⁶² Instead, the 1977 EPF agreement stated that the federal government's health-care funding commitment would increase only in proportion to the growth in GNP and population, signalling "closure" and an end to the 1970s medicare program fiscal open-endedness. In addition, the 1977 EPF agreement stated that the federal government would meet half of the medicare programs funding commitment from the transfer of tax points, while the other half would be provided through cash payments.

The 1977 EPF medicare cash payment program was designed to fund 50 per cent of the national per capita average spent on three program areas: hospital insurance, medical care insurance, and education. As long as provincial spending on health increased at the same rate as GNP, the matching

⁶²Kapsalis, "Block-Funding and Provincial Spending," 1.

rate would remain at a 50 per cent funding level.⁶³ In addition, the 1977 EPF agreement offered a 20 dollar per capita unconditional annual payment to each province to fund the creation of additional units of "extended care" health-care services, prompting expanded growth for nursing homes and other chronic care medical treatment programs.

The real problem encountered with the 1977 EPF medicare funding proposal lay with the 'principle of equalization' theory which underscored the transfer of tax points from the federal government to the provinces. The federal government had hoped it was offering a measurable level of financial assistance to the poorer provinces who were allowed additional "tax room" as a result of the federal government's parallel reduction in national (personal and corporate) income taxes.

The federal government felt they were being extremely generous by granting a tax transfer to the provinces totalling one per cent of federal personal income tax, plus one per cent of federal corporate tax. The reduction in federal tax rates was designed to allow poorer provinces a chance to raise their tax rates and thus generate more income to fund provincial health-care programs. Instead, the immediate effect of the tax transfer program accompanying the 1977 EPF agreement was to favour the wealthier provinces,⁶⁴ leaving the poorer provinces in a more worrisome financial predicament.

Unfortunately for the provinces, the new economic hardtimes

⁶³kapsalis, "Block-Funding and Provincial Spending," 11.

⁶⁴Graham, "The Canada Health Act and Federalism," 40.

ushered in during the 1970s dampened their health-care sector spending aspirations, and many provinces began to restrict their budgetary outlays for social policy programs which inevitably included the funding of health-care program expansion efforts in general. A few provinces began to apply a ceiling on the rate of income increases granted physicians through their fee schedule negotiations,⁶⁵ a measure which angered the nation's physicians thus causing some of their members to take matters directly into their own hands and begin to charge their patients extra fees as a means of supplementing their incomes. In Ontario alone, physician extra-billing rose from 13.5 per cent in 1972 to 18 per cent in 1979,⁶⁶ a policy which placed the extra-billing physicians squarely on a confrontational path with federal government politicians, the self-appointed defenders of Canadian universal medicare.

Mr. Justice Emmett Hall was commissioned by the federal government to study the matter, and submitted his findings in September 1980. Mr. Justice Hall (1980) found extra-billing compromised the delivery of health services in Canada, and particularly adversely affected the health-care services offered to lower income Canadians. Against this political backdrop, the federal government felt compelled to spring into action.

The federal government quickly introduced the Canada

⁶⁵Pranlal Manga, The Political Economy of Extra Billing. (Ottawa: University of Ottawa - Faculty of Administration, 1983),

6.

⁶⁶Ibid., 6.

Health Act (1984), legislation designed to be instantly elevated to a lofty position at the head of the nation's health-care agenda.⁶⁷ The Canada Health Act has been described by an analyst familiar with the workings of the Canadian health-care system as a document providing a set of virtuous generalizations which attempts to direct the nation's ten provincial health-care sectors to all march in line behind the federal government's health-care decision-making effort.⁶⁸

The Canada Health Act (1984) was highly specific on one policy matter. The Canada Health Act reconfirmed the federal government's commitment to the preservation of medicare's fundamental principles at a time when the Canadian general public had begun venting their political antagonism towards physician extra-billing and/or the implementation by a few provinces of hospital user fee payment schemes.⁶⁹

We should not overlook the fact that the Canada Health Act (1984) insists Canadian physicians be compensated adequately and that adequate funding for hospital services be guaranteed.⁷⁰ Yet the Canadian federal government had, in effect, cleverly shifted the focus of the public's attention away from an earlier (1982) announcement which stated that they intended to reduce federal contributions to health and post-secondary education by approximately \$5.7 billion over the next five

⁶⁷Evans, "Health care in Canada," 405.

⁶⁸Tuohy, "Conflict and Accommodation," 416.

⁶⁹Pranlal Manga, "Preserving Medicare: The Canada Health Act," Perception, 7/#3, 1984, 12.

⁷⁰Thomas Courchene (and John Graham), "The Canada Health Act and Federalism," 44.

years.⁷¹ Instead, the Canadian general public became preoccupied with their quest to defeat extra-billing, which left the provinces in the uncomfortable position of unwittingly appearing to have fallen under the political tutelage of provincial medical associations who, demanding larger and larger pay increases, infuriated the private citizenry even further.

Under the Canada Health Act (1984), the federal government had, for the first time, specifically included a punitive regulatory instrument which was intent upon curbing the practise of physician "extra-billing/hospital user fees" billings procedures. The federal government had threatened to levy penalties against all future health-care (EPF) transfer funding payments headed to provinces who refused to halt physician extra-billing and hospital user-fee payments violations.

If a province continues to permit the practise of physician extra-billing/hospital user-fee payments violations, the penalties assessed by the federal government would be placed in escrow for a period of up to three years, thus allowing the delinquent province a suitable timeframe in which they might respond by altering their delinquent behaviour and thereby qualify for receipt of their medicare payments.

The trust fund proposal represented a financial as well as a political challenge to the provincial ministers' of health, not to mention the fact it suggested the federal government was attempting to determine health-care administrative

⁷¹Weller and Manga, "The Push for Reprivatization," 507.

policy matters in a manner which may possibly lie outside the federal government's constitutional power and authority.⁷²

The Canada Health Act successfully pitted the provinces against their physicians. However, since none of the provincial governments felt they could afford the loss of federal transfer payments which, in Ontario's case, totalled 53 million dollars,⁷³ the provinces soon capitulated to the federal government's demands and agreed to stop physician extra-billing/hospital user-fee practises within the legal timeframe provided by the Canada Health Act.

In conclusion, the provinces have increasingly grown to resent the penalties prescribed by the Canada Health Act. The provinces particularly resent the fact that the Canada Health Act imposes limitations upon their ability to launch health-care cost-containment strategies within their respective health-care sectors, sectors which should remain firmly under provincial government planning and prioritization control.

The introduction of low-cost community-based medical clinics, alternative health-care delivery projects which the Province of Ontario currently champions, might one day cause a legal challenge to be mounted against the Canada Health Act provisions. However, to date not one Canadian province has yet taken the federal government to court to

⁷²Pranlal Manga, "Preserving Medicare: The Canada Health Act," 13.

⁷³Ontario. Ministry of Health. Fact Sheet on OHIP Fee Schedule, (dated April 2, 1986), 1.

seek to overrule the terms established by the Canada Health Act.⁷⁴

Manpower Policy

With few exceptions, Canada has adopted a pay the bills philosophy with respect to financing the country's universal medicare program. Which health-care services, offered in what amount, produced how, by whom, and where have been historically viewed as the legitimate decision-making domain of physicians and hospital administrators by the provincial departments of health responsible for administering the universal medicare program on a day-to-day basis.⁷⁵

Not only has the country as a whole experienced a surge in physician supply since the introduction of public medical insurance in Canada in 1966, but the provincial governments have generally chosen to adopt a cautious yet conciliatory fee negotiating stance when dealing with physicians.⁷⁶

The truth of the matter, however, is that the provincial medical associations represent an extremely efficient political lobbying machine who have increasingly sought legal refuge behind "service monopoly" competition statutes such as the Combines Investigation Act.

A careful examination of the Combines Investigation Act, s. 23(6) [amended in 1976] specifically states that

⁷⁴Canada. "Improved Program Delivery: health and sports," 70.

⁷⁵Stoddart, "Rationalizing the Health Care System," 3.

⁷⁶Ozerkevich, "The Extra-Billing Controversy," 7.

physicians are exempt from federal government (and/or judicial) prosecution regarding any/all medical professional housekeeping arrangements (such as fee determinations) which are subject to routine professional self-governance and self-regulatory control exerted by the medical profession over their membership.

The Combines Investigation Act cannot protect the medical profession's fee fixing activities, particularly if the profession selectively argues that physicians merely "suggest" fees, but do not require that consumers honour the profession's fee "recommendations" and stipulations. The courts have rejected this type of legal defence where evidence clearly suggests that the profession's self-governing fee-fixing actions were recommended in form only, while in substance they amounted to service monopoly pricing arrangements in the prima facie case.⁷⁷

As a general rule, provincial medical associations have tended to limit themselves to bolstering their service monopoly "competitive" position by seeking protection via legal statutes attacking any/or all non-traditional health-care delivery methods. The profession fears that the increased use of alternative health-care delivery models could erode the status of the current fee-for-service (solo) practice model,⁷⁸ and may assign physicians a professional position

⁷⁷T. R. Muzondo and B. Pazerdka, Professional Licensing and Competition Policy: Effects of licensing on earnings and rates of return differentials. (Ottawa: Consumer and Corporate Affairs/Competition Policy Bureau, Research Monograph # 5, 1979), 168.

⁷⁸Brown, "Caring for Profit," 26.

as second-rate health-care service providers. (Such a threat may prove readily apparent particularly if the new high technology medicine alters the current health-care delivery model beyond recognition).

Under the Canadian universal medicare system, the provincial governments control both the medical insurance function (pathway 'f') and the hospital sector operation and capital formation delivery functions (pathway 'e') which provides a substantial vehicle for government integration into the total health-care delivery environment. Provincial governments possess the legal mandate to control the medicare schedule of payments/schedule of benefits decision-making process (see Appendix: Figure 5).

Provincial governments currently engage in first-line medical service provision activities in areas such as public health and immunization (pathway 'b'), services which have traditionally been considered the specific private practice realm of Canada's medical providers (see Appendix: Figure 5).

The public administration of universal health insurance creates a vastly different set of structural linkages (see Appendix: Figure 5). Provincial governments may integrate forward and effectively control the insurance function, since they possess the power to limit the spread of private insurance activities (pathway 'h': direct influence of independent insurers on providers - see Appendix: Figure 3 & 5). In addition, provincial governments may directly ration

hospital outputs, a prized public sector responsibility at present (pathway 'e' - see Appendix: Figure 5).

Patient accomodation in hospitals (and/or the scheduling of medical treatments), whether for surgical or other medical purposes, is usually negotiated jointly between patient and his/her medical provider.

The choice of physicians is a right which is protected by the Canada Health Act. No evidence currently available suggests Canadians will pay more for access to health-care services, a practice which is currently outlawed by the Canada Health Act (1984).

The Canadian consumer's preference for health-care services bears, at best, an indirect influence upon providers (pathway 'f' - see Appendix: Figure 5). In several provinces, bed-to-population ratios are severely restricted, which allegedly creates problems for individuals seeking elective surgery, however the magnitude of the problem is somewhat unknown.

Political conflicts erupt fairly regularly within the Canadian health-care service industry. Physicians are the primary targets in the health-care allocations tug-of-war, and usually exercise decision-making supremacy over the following set of health-care transactions: self-governing powers (pathway 'b'), agency (pathway 'a'), and management or supervisory control exercised vis-a-vis the Canadian hospital sector (pathway 'c'). These three health-care

transactions oftentimes set the medical profession on a political collision course with the provincial government ministries of health. Alternatively, the provincial ministries of health demonstrate their supremacy over the following set of health-care transactions: the medical insurance mechanism (pathway 'f') and the hospital sector's global budgeting process⁷⁹ (pathway 'e' - see Appendix: Figure 5).

Global Budgeting and the Health-Care Funding Debate

The Canadian health care system is not one system, but is in fact ten systems representing ten different provincial health-care sectors, each enjoying their own history⁸⁰ yet attempting to conform to the health-care delivery objectives established by the Canada Health Act (1984).

Approximately 40 per cent of total provincial health-care delivery (medicare-related) expenditures⁸¹ are currently reimbursed to the provinces from the federal Treasury. The provinces, on the other hand, must raise the additional funds required to support their sizeable health-care budgets through the generation of their own health-care revenues or by diversion of funds from other ledgers in the public financial accounts.

⁷⁹Evans, "Incomplete Vertical Integration," 340.

⁸⁰Morris L. Barer and Greg L. Stoddart, "Riding North on a South-Bound Horse? Expenditures, Prices, Utilization and Incomes in the Canadian Health Care System," in Robert G. Evans and Greg L. Stoddart eds., Medicare at Maturity. (Calgary: University of Calgary Press, 1986), 67.

⁸¹Canada, "Improved Program Delivery: health and sports," 12.

Ontario's health-care delivery program, for example, receives a partial funding assist from a provincially-administered health-care premium assessment program. Three quarters of the province's total health-care premiums are currently paid for by private and public sector employers on their employees' behalf.⁸² In addition, the Province of Ontario has recently raised provincial sales tax from 7 to 8 per cent, a tax increase which allegedly will retire Ontario's health-care budgetary deficit of \$1.2 billion.⁸³

Ontario currently boasts a global health-care budget which has grown to \$12.7 billion in 1988-89,⁸⁴ with hospital sector expenditures totalling (1987-1988) \$5.1 billion, a figure which alone is comparable in size to many entire provincial budgets.⁸⁵

Ontario is not alone among Canadian provinces struggling to tame a health-care funding crisis. By the late 1970s, a growing number of provincial governments had increasingly discovered they had placed too much emphasis on in-patient hospital care. Instead, many Canadians are beginning to

⁸²Greg L. Stoddart and James R. Seldon, "Publicly Financed Competition in Canadian Health Care Delivery: A Proposed Alternative to Increased Regulation," in J. A. Boan ed., Proceedings of the Second Canadian Conference on Health Economics. (Regina: University of Regina, 1984), 139/ endnote [# 4].

⁸³Pat Whealan, "Health Care: Medicine and money," The Windsor Star. July 25, 1988, A6.

⁸⁴Ontario. 1988 Ontario Budget. "Budget Paper D: Ontario Expenditure Profiles - Health Care and Education," (dated April 20, 1988), 73

⁸⁵Martin Barkin, "A Matrix Organization for the Ministry of Health," (Toronto: Ontario Ministry of Health, [May] 1988) mimeo., 3; Ontario, "1988 Ontario Budget," 75.

voice their concern that future health-care resources should be re-directed to finance preventive health-care programs, health promotion activities and the provision of non-institutional medical care.⁸⁶

The Ontario 1988 budget, for example, does not reveal the amount spent by the province on long-term medical care ("extended care" or homecare) servicing for the province's elderly population. At present, Ontario nursing homes are financed from a combination of provincial funding and patron (or client) savings, while homes for the aged are financed principally via government revenues.⁸⁷

The most recent study examining health-care costs for the elderly in Ontario suggests that Ontario spends slightly over three-quarters of its entire geriatric medical treatment budget on institutional (chronic-care copayment) medical service provision schemes.⁸⁸ Comparisons between the United States and Ontario reveal the province spends (1981) 31 per cent more per capita than the U.S. on institutional care targeted to meet the medical needs of an aging population segment.⁸⁹

Ontario fully recognizes that care for the elderly must take into account the complexity of treatment, the

⁸⁶Taylor, "The Canadian Health Care System 1974-1984" 8.

⁸⁷M. John Gross and Cope W. Schwenger, Health Care Costs for the Elderly in Ontario: 1976-2026. (Toronto: Ontario Economic Council - Occasional Paper # 11, 1981), 37.

⁸⁸Ibid., 35.

⁸⁹Canada. "Fiscal Federalism in Canada - Annex II-C: Health Programs," 143.

intensity of treatment and the frequency of treatment required by the aged 65 (and over) population segment.⁹⁰ Demographic figures alone suggest that "extended care" (homecare) service demands will increase by approximately 1.5 to 2 per cent per capita per year⁹¹ just to keep pace with the ever-increasing geriatric patient population segment found resident in Ontario.

The problem society must increasingly address is the fact that the delivery of "extended care" medical treatments for the elderly constitutes both a public sector as well as a private sector economic responsibility. If the costs borne by society to provide care for the elderly are considered the responsibility of both the public and private sector, then the private sector portion of our nation's geriatric health-care bill should be realized by the private savings of the elderly patient, their family, and/or their dependents.⁹²

An additional, far bigger problem Ontario (and all other Canadian provinces) must face is the fact that hospitals are themselves saddled with ineffective resource allocation planning and budgeting procedures. Canadian hospitals currently operate under an annual fiscal global budgeting expenditures review process. However, the current Canadian hospital budgeting and expenditure review process only reimburses the hospital's operating expenses portion of their overall institutional budget. Hospital capital funding expenses

⁹⁰Brown, "Caring for Profit," 74.

⁹¹Evans, "Hang Together, or Hang Separately," 167.

⁹²Canada, "Fiscal Federalism in Canada - Annex II-C: Health Programs (1981), 143.

must be requested through a separate budgetary process involving municipal as well as provincial governments and, to a lesser extent, private philanthropy.⁹³

What the Canadian hospital global budgeting process fails to do is to properly distinguish between fixed (capital and/or manpower) costs and variable financial costs, forcing the hospitals to bill the provincial medicare plans for equivalent patient day (EPD) charges which do not reflect major shifts in their actual patient health-care service provision loads.⁹⁴

There are two major problems which the Canadian hospital sector would like to see addressed. First, Canadian hospitals would like to be allowed to change their financial planning procedures in an attempt to more accurately gauge the actual cost for each individual medical service or therapeutic treatment performed upon their physical premises which, it is anticipated, might prompt doctors and patients alike to become more cost-conscious in their health-care consumption/-prescribing activities.⁹⁵

Secondly, Canadian hospitals have asked that the equivalent patient day (EPD) funding formula favoured by the provincial ministries of health be terminated.⁹⁶ Instead Canadian hospitals would like to see the immediate implementation

⁹³Robert G. Evans, "The Welfare Economics of Public Health Insurance: Theory and Canadian Practise," in L. Soderstrom, Social Insurance. (Amsterdam: North-Holland, 1983), 72.

⁹⁴Woods-Gordon, "Assessing the Hospitals," 3.

⁹⁵Blomqvist, "The Health Care Business," 98.

⁹⁶Woods-Gordon, "Assessing the Hospitals," 9.

of a "units of service" payment scheme which has been unmeritoriously shunned by provincial ministries of health up until now.⁹⁷ The provincial ministries of health prefer the maintenance of the "units of service" hospital expenditure reimbursement scheme largely for political reasons. Provincial governments might risk antagonizing one region of the province to the detriment of a neighbouring provincial region, particularly should health-care prioritization and planning decisions be brought to the attention of the general public.

I believe Canadian hospitals should be encouraged to step-up their pursuit of independent, semi-autonomous budgeting/-resource allocation prioritization and planning activities employing all of the necessary management tools to allow them to properly gauge the actual costs associated with supporting their in-house health-care service mix. Once medical demand for all types of hospital (and/or institutional) care has been properly assessed, then the provinces might realistically acquire the prerequisite expertise to consider launching a comprehensive "extended care"/homecare treatment program similar to the program Sweden is currently developing. It may even prove feasible for the provinces to include "extended care" health-care programming as a medicare schedule reimburseable benefit,⁹⁸ although it is not certain where the additional program financing might originate to fund such an ambitious program addition.

⁹⁷Woods-Gordon, "Assessing the Hospitals," 16.

⁹⁸Manga, "What Role for User Charges?", 20.

CHAPTER VII

THE ONTARIO MINISTRY OF HEALTH

Matrix Organization: The Environment for Reform

It has recently been announced by the Deputy Minister of Health for Ontario, Dr. Martin Barkin, that Ontario's Ministry of Health (MOH) would soon complete a management transition which would lead to the MOH's adoption of a new matrix organization decision-making format allowing the Ministry to perform conceptual and analytical decision-making tasks with far greater accuracy and clarity than had occurred in the past. The MOH would abandon the overly prescriptive and descriptive decision-making efforts¹ characteristic of previous administrations.

The traditional hierarchical decision-making model which Dr. Barkin chose to publicly criticize and subsequently replace with a new matrix organizational model represents an unusually bold policy initiative for an incoming Deputy Minister to propose.

What is even more remarkable is that the revolutionary management reforms the Deputy Minister has introduced were embraced with a high degree of departmental enthusiasm, suggesting a more open-minded decision-making philosophy was taking root within the MOH as a whole, a development

¹J. L. Gray, "Matrix Organizational Design as a Vehicle for Effective Delivery of Public Health Care and Social Services," Management International Review. 14:6, 81.

which shocked more than a few long-time MOH senior staffers.²

The 'new' Ministry of Health (MOH) which the matrix organization reforms proposed to launch would feature a team-work management approach emphasizing a heightened degree of inter-departmental communication. The MOH would be subdivided into three major decision-making areas or line departments: individual health, community health, and institutional health.³ These three policy areas or line departments are each assigned a peak decision-making leader, the line department Assistant Deputy Minister (ADM). The line department manager (ADM) will receive administrative inputs from the professional and non-professional MOH staffers operating at more junior levels⁴ further down the management pyramid.⁵

The three decision-making sub-units - individual health, community health, and institutional health - will allegedly adopt a project-oriented management approach fully committed to the idea that they must keep their junior staffers keenly motivated in order that junior (and senior) staffers might voluntarily participate in the stimulating new work assignments the department hopes to generate.⁶

The three line department Assistant Deputy Ministers will be joined by a fourth Assistant Deputy Minister, the

²Interview with Mr. David Bogart. Director, Information Resources and Services Branch - Ministry of Health for Ontario. (May 26, 1988).

³Barkin, "A Matrix Organization for the Ministry of Health," 2-3.

⁴Gray, "Matrix Organizational Design," 81.

⁵Stanley M. Davis and Paul R. Lawrence, "The Matrix Diamond," The Wharton Magazine, Vol. 2:2 (Winter 1978), 26.

⁶Gray, "Matrix Organizational Design," 76.

ADM for Policy and Planning, who will be assigned the task of supervising the research activities performed by a second decision-making level which Dr. Barkin planned to introduce. The second decision-making matrice will feature an array of special research groups pursuing studies designed to cut across the old line department jurisdictional boundaries.

The new special project study groups or task forces have been assigned individual responsibility to assess the MOH's policy and planning prioritization efforts for the following areas: Women's Health Issues; Multicultural/Franco-phone/Native Health and Health in the North Delivery Programs; an AIDS Special Project Task Force, and; Special Projects Task Forces studying Emergency Services, Mental Health, and in the near future, Cancer and Rehabilitation Medicine Research and Delivery Programs.⁷

Each of the special project study groups will receive their own team leader, titled the Executive Co-ordinator, who will be responsible for supervising and chairing task force meetings and will serve as a public relations officer initiating two-way contacts with Area Planning (Regional) Health-Care Co-ordinators, District Health Councils, medical and hospital association lobbyists and a large number and variety of consumer groups and political action committees.

In the recent past, the MOH have received numerous complaints that the department fails to ensure sufficient

⁷Barkin, "A Matrix Organization for the Ministry of Health," 6.

access to MOH study teams and research committees for prospective health-care lobbyists and political action committee representatives. The Deputy Minister remains confident that the new special project matrix reorganizational effort will encourage more frequent communications between MOH staffers and the community-at-large than has occurred in the past.⁸

The success of the MOH's matrix organizational program will remain highly dependent upon the willingness of junior staffers to complete their special projects on time with a maximum amount of creativity and effort. Special project team leaders must ensure that their staffers work within budget and perform their duties in a manner which promotes the group's best interests.⁹

The very top position in the matrix diamond or decision-making pyramid is reserved for the Deputy Minister and the Minister of Health, who will jointly attempt to bring unity and cohesion to the MOH's total "priorities and planning" exercise. The Deputy Minister and the Minister of Health anticipate the dispersed activities routinely occurring below them at all administrative levels will constitute a fluid matrix pyramid decision-making structure.¹⁰

At the present time, the Treasury and Management Board

⁸Barkin, "A Matrix Organization for the Ministry of Health," 7.

⁹Kingdon, "Matrix Organization," 153; Davis and Lawrence, "The Matrix Diamond," 19-27.

¹⁰Davis and Lawrence, "The Matrix Diamond," 19-27; Gray, "Matrix Organizational Design," 81.

of Ontario maintains a tight control over the Ministry of Health's long-term fiscal management decision process, and it is highly unlikely that that arrangement will soon change. The Ontario Treasury and Management Board are directly involved in all decisions relevant to the determination of how the federal government health and education transfer funds are allotted.¹¹

The Ministry of Health's matrix organization reform program cannot, in light of the preceeding remarks, be considered an all-encompassing or total structural reform initiative, since many MOH activities prove to be consolidative decision-making efforts which lie outside the matrix organization rules and operational plan of action. For example, matrix reform will not affect the MOH's fee negotiations process involving the province's physicians, hospital management teams, and OHIP (the Ontario Health Insurance Plan, the provincial medicare billing and payments agency). Indeed, a high proportion of MOH bureaucratic activity involves the pursuit of highly "routinized" care-taker tasks or work projects¹² which require bureaucratic firmness and resolve, not additional policy-making flexibility and innovativeness.

Dr. Barkin remains fully cognizant of the fact that his medical colleagues, the Ontario Medical Association (OMA), might deliberately provoke the MOH to reveal their long term health-care prioritization and planning activities

¹¹Barkin, "Matrix Organization for the Ministry of Health," 1.

¹²Gray, "Matrix Organizational Design," 78.

in an effort to mount their own public policy counter-attack to sway the province to adopt their own highly coloured health-care delivery policy prescription. The Deputy Minister may, therefore, deliberately step out of harms way and avoid a direct political show-down with the province's medical association as he searches for policy recommendations to solve the province's current health-care funding crisis.

Although Dr. Barkin quite candidly admits that the MOH may be forced to pursue an extension of the current funding freeze, or even implement controlled service roll-backs, - particularly in the hospital sector - should the saga of long-term provincial health-care funding indebtedness continue in the near future,¹³ the Deputy Minister falls back on a familiar MOH closure tactic and fails to provide the specifics outlining the actual delivery format the province will adopt in the next phase of its current budgetary cost-containing management effort.

The Deputy Minister's public policy dilemma is essentially the following:

- Should the MOH react to Ontario's health-care delivery demands in a reactive manner?

¹³Barkin, "A Matrix Organization for the Ministry of Health," 9.

- Or, should the Ministry of Health (MOH) vigorously attempt to mould or shape¹⁴ Ontario's health-care delivery environment in a proactive manner, meeting the challenges which lie ahead in a visibly forceful decision-making effort?

If the Ministry of Health (MOH) decides to adopt the latter policy approach, and chooses to act proactively and decisively by setting in motion a comprehensive health-care sector performance appraisal review (part of which might already be termed "work-in-progress"),¹⁵ then the MOH will have to consider all of the underlying practical and theoretical considerations which will ultimately coalesce to produce the province's health-care structural and reorganizational reform program geared to offer Ontario health-care leadership to the year 2000.

Capital Budgeting and Manpower Policy: The Agenda for Reform

The key problem any government must face in attempting to control the health-care service industry is the task of ensuring that health-care service provision activities do not travel in different directions simultaneously, producing a highly fragmented health-care decision-making environment.¹⁶

Medical sector decision-making efforts are that much easier to accomplish if they are rigorously controlled by

¹⁴W. A. J. Armitage, "A Structural View of Welfare Organizations," Social Worker Vol. 37 (July 1969), 175.

¹⁵Ibid., 175.

¹⁶Abel-Smith, "Value for Money in Health Services," 156.

a centralized governing body, such as the Ontario Ministry of Health (MOH), in order to ensure the long-term success of the department's management strategy.

In addition to their duties and responsibilities setting the province's health-care delivery agenda, the Canadian provincial ministries of health must also dictate the fees paid to medical providers, and monitor the financing of capital equipment acquisitions and oversee hospital construction and management activities.

Ontario's Ministry of Health (MOH) has been extremely successful in each of the above policy areas. The MOH has adopted an extremely conciliatory attitude towards the province's physicians over the years. Physicians in Ontario have generally benefited greatly from government health-care servicing and financing interventions.

Canadian doctors can interface extremely fluidly with provincial health departments as policy planning co-equals, largely due to the fact that federal government statutes extend comprehensive legal protection to the medical profession. Physicians are, therefore, very instrumental in shaping the health-care delivery decisions which the provincial health departments ultimately adopt.¹⁷

In theory, the physician fee-for-service (solo) practice format encourages physicians' to pursue their medical delivery activities in an autonomous fashion. However, fee-for-service delivery schemes have one readily apparent weakness or structural

¹⁷Naylor, "Private Practice, Public Payment," 15.

flaw. The physician fee-for-service payment scheme singularly encourages physician induced provision (medical service overperformance).¹⁸

It is particularly interesting to note that the two countries in our cross-national study which employ the fee-for-service delivery format, the U.S. and Canada, show identically elevated levels of physician induced provision. The U.S. and Canadian physician induced provision condition occurs despite the fact that one country's physicians (Canada) charge "zero" out-of-pocket physician consultation fees, while the other country's physicians (the United States) routinely permits their physicians to collect approximately one-third of the cost of private practice office consultation fees directly from the patient.¹⁹

The reports of physician cost escalation cited prior to Canada's adoption of universal medicare, and the alleged cost-containment exercises introduced after universal medicare's much heralded Canadian arrival, have primarily led, in most cases, to a rise in physician income levels at approximately 3.25 times the national average recorded throughout the early 1950s. Physician income levels escalated further, reaching approximately 5.5 times the national average in 1971.²⁰

¹⁸Glaser, "Paying the Doctor," 153.

¹⁹Evans, "Finding the Levers," 594

²⁰Alan D. Wolfson, Physician Incomes in Canada: Background Report for the Task Force of Mr. Justice Emmett Hall, (1980).

Not only must the MOH wrestle with cost-inflating physician income level increases, they must also address the changing role performed by the hospital corporation within the province's overall health-care service mix.

Before 1969, hospital budgets in Ontario were negotiated on a line-by-line, non-formula basis. Since 1969, global budgeting has widely become commonplace, prompting the Ministry of Health's Institutional Health-Care Division to attempt to establish (or quantify) the prices of inputs used by the province's total hospital sector.

Part of the problem encountered by the Ministry of Health's Institutional Health-Care Division was the fact that the global budgeting forecasting/accounting procedures which the Institutional Health-Care Division were being asked to adopt were artificial accounting conventions which, quite frankly, proved incapable of measuring the naturally occurring levels of in-house (hospital) patient treatments.²¹

The Ministry of Health's Institutional Health-Care Division has forced the hospital sector to adopt the accounting convention known as equivalent patient day (EPD, or per diem fee rates) macro-economic priorities and planning forecasting approach which is vitally flawed in its design.

In effect, the equivalent patient day (EPD) funding formula attempts to determine the projected rise in hospital

²¹Greg L. Stoddart and David Feeny. "Policy Options for Health Care Technology," in David Feeny ed., Health Care Technology: Effectiveness, Efficiency, and Public Policy. (Montreal: Institute for Research on Public Policy, 1986), 244.

sector fuel prices, food prices and prices of capital goods, as well as the prospective wage settlements for non-physician labour. These figures are then aggregated into a province-wide annual percentage figure which becomes the base figure used to calculate the province's long-term hospital corporation expenditure commitment. This forecasting procedure constitutes "Part A" of the Ontario provincial hospital budgeting process.

Next, individual hospital administrations are allowed the opportunity to formulate micro-level operating budgets reflecting the service mix offered by their particular institution. Each individual hospital prepares a projected annual operating budget for their facility which is entitled "Part B" of the total hospital funding process.²²

Since 1977, new (or special) hospital service program expansions have been normally listed under "Part B" of the hospital budget. The list of special or 'new' hospital service program expansions includes life-support servicing for: neo-natal intensive care, dialysis, cardiac pacemaker surgery, total parenteral (nutritional feeding) programs, and chemotherapy therapeutic program activities.²³

Thirty per cent of each individual hospital facility's total funding sources are usually dedicated to funding capital equipment expansions and/or capital plant improvement programs.

²²Alan S. Detsky, "The Effectiveness of a Regulatory Strategy in Containing Hospital Costs: The Ontario Experience, 1967-1981." The New England Journal of Medicine. 309:3 (1983), 152.

²³Stoddart, "Rationalizing the Health Care System," 22.

The remaining 70 per cent of an individual hospital's budget has, on average, been set aside to cover the institution's total operating budget expenditures.²⁴

There are several troubling difficulties currently confronting the MOH's current hospital funding process. First, the macro-level funding procedure (Part 'A' of the overall budgetary process) is based upon per diem or EPD hospital utilization measures which, as I briefly noted earlier, fail to take into account the severity of individual illness episodes and the cost of the corresponding therapeutic treatments which has duly prompted a frightening increase in 'activist' surgical interventionism, and quite possibly encourages hospitals to maximize revenues by manipulating the sequence of medical diagnostic procedures.²⁵

However, we must remember that Ontario's hospital sector is quite accustomed to being ruled in a pluralistic fashion²⁶ by a group of physicians exempted from performing regulatory policing activity which might control the profession's utilization of the ever-depleting store of hospital capital (and equipment) resources.²⁷

The current hospital sector budgetary reform proposal tabled by the Joint Ontario Council of Administrators of Teaching Hospitals and the Ontario Hospital Association

²⁴Woods-Gordon, "Assessing the Hospitals," 3.

²⁵Donald R. Cohodes, "Hospital Capital Formation in the 1980s: Is There a Crisis?" Journal of Health Politics, Policy and Law. Vol. 8:1 (Spring 1983), 166.

²⁶Brown, "Caring for Profit," 131.

²⁷Barer and Evans, "Riding North on a South-Bound Horse," 148.

(OCATH/OHA) Growth Committee favours changing the current per diem/equivalent patient day (EPD) funding formula to help rectify the hospital sector's current budgetary dilemma.²⁸

The Joint Ontario Council of Administrators of Teaching Hospitals and the Ontario Hospital Association (OCATH/OHA) Growth Committee favour the sub-division of in-patient treatment days in a manner which more successfully reflects the actual medical treatments sustained by the patient. Patient treatments should be routinely statistically recorded according to the type of care offered (acute care, chronic care or rehabilitative care). In addition, medical hospitalization episodes should reveal a further set of disaggregated statistical measures designed to reveal the total number of diagnostic and therapeutic treatments sustained by the patient over the entire hospitalization therapeutic episode.²⁹

The problem with the current per diem/EPD hospital funding formula is that it rewards longer patient stays, even if the medical services performed are unnecessary and inefficient.³⁰ In effect, hospital growth incurred through new expanded program ventures is not tracked separately so that a hospital might be in a better position to determine if they are being either over-funded or under-funded.³¹

To correct this perilous situation, the Joint OCATH/OHA Growth Committee suggest peer group comparisons be performed

²⁸OCATH/OHA Growth Committee. Report of the Joint OCATH/OHA Growth Committee. (Dated February 28, 1986), 3.

²⁹Ibid., 4.

³⁰Ibid., 6.

³¹Ibid., 7.

which ensure that average length of stay (ALOS) hospital utilization records are routinely compiled so that like-minded institutional samples might be compared to promote a more equitable proportioning of the MOH's total hospital funding effort. The ALOS figures would need to be designed to reflect changes in a hospital's case mix on a routine basis, not to reflect a randomized projection of their budgetary needs based on average reimbursement predictions which prove inherently unreliable.³²

In addition, the Joint Ontario Council of Administrators of Teaching Hospitals and the Ontario Hospital Association (OCATH/OHA) Growth Committee recommend the institution of a consistent appeal mechanism which might be made available to Ontario hospitals wishing to pursue special re-evaluations of their overall growth funding allocation,³³ a procedure which is currently extremely difficult to initiate with Institutional Care Division (MOH) senior staffers.

The MOH hospital sector funding reimbursement restrictions which continue to cause the Joint OCATH/OHA Growth Committee such grievous alarm are, in part, the result of a deliberate MOH policy advocating a province-wide hospital bed freeze which has lasted the better part of two decades.

In 1972, the bed-to-population ratio was 4.0/1,000 for Southern Ontario and 4.5/1,000 for the North.³⁴ By

³²OCATH/OHA Growth Committee, "Report of the Joint OCATH/OHA Growth Committee," 9.

³³Ibid., 10.

³⁴Detsky, "The Effectiveness of a Regulatory Strategy," 152.

comparison, in April 1981 the hospital catchment area, or bed-to-population ratios, were reduced to 3.75 for Southern Ontario, and 4.25 for the North.

Ontario has certainly made significant strides during the past decade to limit the number of acute care beds and regionalize the province's hospital delivery system in general. Yet internationally, the Ontario health care system still exhibits relatively high bed-to-population utilization rates.³⁵

Ontario's hospitals have increasingly found their base operating budgets adjusted downwards, even despite the fact that each institution's total number of acute care beds may have actually exceeded the MOH's pre-assigned target level for their particular geographic catchment area. In metro Toronto and in some surrounding high-growth areas, catchment area constraints have been impossible to implement because of the fact that individual hospital's find it exceedingly difficult to hold their total number of employee working hours at a constant level.³⁶

The difficulty metro Toronto (and other metropolitan population center) hospitals are facing is, of course, predicting the optimal size of their hospital facility which might service an ever-expanding (and/or contracting) population base which demands quality health-care services irrespective of the actual cost involved.

³⁵Detsky, "The Effectiveness of a Regulatory Strategy," 152.

³⁶Ibid., 152.

Hospital planning and budgeting teams face an almost impossible if not insurmountable task. Hospital budgeting teams must make a deliberate policy trade-off between two factors: the cost of the care they offer versus the quality of the medical service 'mix' an institution might be encouraged to deliver.³⁷

However both of these factors, quality and cost, seem to take a perennial back seat to the much more visible manpower planning component, particularly given the fact many providers are competing amongst themselves to get staff positions (and admitting privileges) at the hospitals in their community.

In the hospital sector, Ontario has shown a steady increase in relative average cost per patient-day from the time that global budgeting was introduced (1969) up until 1976. The largest annual increase occurred between 1974 and 1975, coinciding with a 13.9 per cent salary increase for hospital staff over and above the rate of inflation, the result of an unprecedented hospital sector (non-physician) labour dispute.³⁸

Increases in relative average cost per patient-day can be divided into two components: increases in inputs employed per patient-day and increases in the prices paid for those inputs (ie. wages) over and above the consumer price index. The Ontario hospital sector's macro-economic

³⁷Labelle, "Planning for the Provision and Utilization of New Health Care Technologies," 151.

³⁸Detsky, "The Effectiveness of a Regulatory Strategy," 154.

performance indicators measured in this light reveal a 13.9 per cent rate of growth versus the United States' unprecedented 81 per cent growth rate during this same timeframe (1968-1979/80).³⁹

In actual fact, prices paid for Ontario's hospital service inputs grew 4 per cent faster than the general rate of inflation during the entire 1968 through 1979/80 study period.⁴⁰

Turning to the theoretical model, managerial decisions conducted within the hospital's physician-dominated physical plant are captured by the pathway 'c': prescriptive power of first-line providers directing patient utilization pathway arrow, which appears in all figures (see Appendix: Figures 2 through 5 conclusive).

Hospitals can also implement their own internal staffing decisions in response to individual patient demands and/or in response to global budgeting exercises depicted by pathway 'q': patient influence on providers, an extremely weak relationship captured by the dotted arrow (see Appendix: Figure 5).

The pathway 'e': government regulates and subsidizes hospitals (and other 'care' facilities) might become the host of further political confrontation involving physicians, consumers and the MOH's Institutional Health Division (see Appendix: Figure 5).

³⁹Detsky, "The Effectiveness of a Regulatory Strategy,"

154.

⁴⁰Ibid., 155.

Any shift by the MOH towards more aggressive funding of chronic-treatment deinstitutionalized health-care service provision (ie. "extended care"/homecare programs) could relieve the MOH's Institutional Health Division of the momentary burdens incurred through loss-leader funding of marginally productive hospital facilities. The MOH Institutional Health Division could then concentrate on the task of funding the teaching hospitals (and other metropolitan hospital centres) who are badly in need of medical high technology transfers involving new, sophisticated equipment and components and a new complement of skilled staff members⁴¹ demanded to administer the new medical therapeutic discoveries as they come on stream.

The whole universal medicare insurance scheme, and the type of relationship instituted in each of the Canadian provincial ministries of health to date, has been based upon an aura of gentlemanly cooperation between physicians and the provincial ministry of health. However, the overall impact of medical provider (physician) practice behaviour upon hospital resource use has remained, essentially, unaddressed.⁴²

⁴¹Helwig, "New medical mall will cost \$120 million," 5.

⁴²Bergeron, "Commentary: Manpower Policy," 331.

3 of/de 3

MINI-LED

CHAPTER VIII

EXTENDING THE BOUNDARIES

The Next Health-Care Sector Reform Initiative: Health For Ontario to the Year 2000

A commonly held public policy perception, subscribed to by many social policy analysts in Ontario and elsewhere around the globe, is the belief that we are currently besieged by a health-care cost crisis. Although the perspective is partly the consequence of domestic conditions (see Appendix: Figure 2-6 and 2-7), it is also partly the consequence of importing international perceptions, particularly from the United States where the proof for a health-care cost crisis is far more convincing.¹

Examples of highly inflationary health-care spending actions and activities which prove particularly unsettling include: increases in the number and supply of physicians; a marked escalation in the profusion and diffusion of cost-inflating technologies; inefficient and uncoordinated capital and manpower planning exercises and activities; an exorbitant rise in organized medicine's remuneration levels (particularly with respect to the fee-for-service delivery mode) and finally; a sky-rocketing increase in the number of unwarranted, unnecessary (or at best, marginal) medical diagnostic and/or surgical

¹Brown, "Caring for Profit," 40.

hospitalization episodes in general.²

An alarming increase in the supply of physicians is a particularly troubling prospect facing Ontario's health-care resource planning team. Recent reports from the Ontario Ministry of Health suggest that medical provider income levels and medical manpower (physician) staffing targets are growing at a precipitous level.

Ontario's physician fees have increased dramatically over the last five years. The number of physicians billing the provincial health insurance agency (OHIP) has grown from (1983) 13,888 physicians to (1988) 17,245 physicians, an increase of about 24 per cent. Ontario Health Insurance Plan (OHIP) payments to physicians have doubled over the last five years from (1983) \$1.8 billion to (1988) \$3.6 billion³ (see Appendix: Figure 2-6).

Ontario's Minister of Health, Elinor Caplan, has recently suggested that physician fee-for-service payments actually encourage utilization of the health-care delivery system. Last year alone the negotiated physician reimbursement fee schedule increase was 4.8 per cent, but because there is no cap on doctors' billings in Ontario, the actual impact of tariffs on OHIP (through utilization) was more like 12 per cent.⁴

One of the principal challenges which the province's

²Weller and Manga, "The Push for Reprivatization," 500.

³Matt Maychak, "OHIP task force too slow for Caplan," The Toronto Star, (October 13, 1988), A-29.

⁴Elinor Caplan, "Health: The Caplan prescription," Ontario Medicine, (September 19, 1988), 10.

next health-care resource planning team must overcome is assessing the province's runaway physician-induced utilization spiral. Physician-induced utilization is, it could easily be argued, a deliberate policy strategy wilfully promoted and adopted by organized medicine's rank and file membership. It serves two policy objectives. First, it allows physicians to increase their eventual reliance upon (or exploitation of) new and expensive research and development technological breakthroughs⁵ which might translate into larger medical provider incomes.

Secondly, physician-induced utilization essentially forces the Ministry of Health (MOH) to recognize the fact that physicians - through their medical manpower labour component - control the future profitability of any/all prospective health-care technology therapeutic advances. If physicians choose to ignore the new high technology medical treatments, or if physicians purposefully block their embrace, the technologies themselves will ultimately languish on the shelf, causing the population-at-large to suffer the ultimate loss.

Moving well beyond the physician reimbursement controversy for the moment, the charge or allegation that high technology must be supported at whatever cost⁶ (and certainly irrespective of the effect such actions might have upon provider incomes),

⁵Brown, "Caring for Profit," 67.

⁶David Blumenthal, "Federal Policy toward Health Care Technology: The Case of the National Centre," Milbank Memorial Fund Quarterly/Health and Society, Vol. 61:4, 1983, 587.

seems a slight exaggeration of what is, I admit, an extremely complicated policy matter.

It is safe to say that the marked profusion and diffusion of cost-inflating technologies will certainly not decrease in Ontario's immediate future. However, that is not to say that health-care policy analysts should be encouraged to abandon their right, or the right of government regulators, to control high technology transfers within the medical service sector.

In certain sectors of the traditional health-care delivery and/or medical service sector, a blanket policy advocating stepped-up public sector funding of high technology transfers may sound rather utopian, if not impractical and impolitic. For example, Nuclear Magnetic Radiation (NMR) currently costs between \$1 million and \$1.5 million to install, depending on the radiological field strength of the equipment. The specially designed non-ferrous structures which house NMR units currently cost \$1.5 - to \$2.5 million (U.S.), plus they require full-time employment of a medical physicist.

However, policy-makers should be heartened to note that the fine tuning required to optimize the image quality produced by NMR is far less "automatic" than achieved through a more conventional CAT scanner, even with NMR in the post-

development testing stage.⁷

The lesson to be learned from the NMR experience is, I admit, hypothetical at the moment since NMR has not yet reached commercial production. However, if the MOH's Institutional Health Division allowed itself to be "sold" by the private sector on the virtues of NMR, and agreed to purchase several NMR installations, the tax payers of Ontario would be left with an extremely expensive, marginally useful health-care capital equipment acquisition.

Probably the most important point I would like to make regarding "disembodied technological medical service alterations" (or, health-care therapeutic high technology transfers and/or servicing advances) is the fact that medical service provision alterations are almost always totally funded by drug companies or equipment manufacturers operating in the private sector. What appeals to the private sector (in commercial or financial terms) does not always conform to society's health-care delivery prioritization efforts.

To cite an example which reveals the true nature of the current high technology transfer problem, if Ontario's teaching hospitals become enamoured of a particular high technology innovation, it is next to impossible for the provincial ministries of health to curb their use. The

⁷Gordon Guyatt and Michael Drummond, "Clinical and Economic Evaluation of Diagnostic Technologies: The Cases of Impedance Plethysmography and Nuclear Magnetic Radiation," in David Feeny ed., Health Care Technology: Effectiveness, Efficiency, and Public Policy. (Montreal: Institute for Research on Public Policy, 1986), 191.

reason for this is that provincial third party payers, such as Ontario's OHIP, directly fund the use of new technological innovations with only the most occasional payments disqualification⁸ which, unfortunately, only rarely restricts the employment of health-care therapeutic transfers as likely candidates promoting the proliferation of specific medical service provision advances.

The only tried and true method to ensure that the Ministry of Health (MOH) controls the total uptake of new high technological research breakthroughs is for the MOH to fund the high technology research effort directly as a public sector health-care expenditure. This, in fact, is exactly the research and development technological transfer policy which Sweden has championed over the years, achieving a string of stunning clinical successes which have attracted the attention and envy of the rest of the world health-care community.⁹

⁸David Feeny, "The Diffusion of New Health Care Technologies," in David Feeny ed., Health Care Technology: Effectiveness, Efficiency, and Public Policy. (Montreal: Institute for Research on Public Policy, 1986), 26.

⁹See Chapter VI page 138-139.

It is herein proposed that the Province of Ontario's Ministry of Health (MHO) consider implementing the following set of resource allocation/manpower policy cost-saving reforms:

Reform #1) - Adopt a capitation physician fee reimbursement scheme. Such a scheme would either be designed and implemented through a joint MOH/Ontario Medical Association (OMA) consensual bargaining process or, if necessary, through a legal route demanding passage of provincial enabling legislation/statutory decrees which would force the pace for change somewhat on the physician supply issue.¹⁰

Reform #2) - Implement a program designed to perform clinical budgeting evaluations of new health-care therapeutic transfers (and servicing advances) within appropriate medical service treatment facilities throughout Ontario under the direct financial and operational control of the Ontario Ministry of Health (MOH).¹¹

¹⁰Van Loon, "Canadian Perspective: Learning from Our Experience," 472.

¹¹Stoddart and Feeny, "Policy Options for Health Care Technology," 241.

Reform # 3) - Hospital payment methods must be immediately altered to fully conform with the Ontario Ministry of Health's new "funding medical outputs"¹² philosophy.

It is essential that all hospital funding data be fully disaggregated to isolate shifts in relative prices from the underlying changes in quantities of services provided and used.¹³

Reform # 4a): - Government (federal and provincial) should introduce a 'favourable tax treatment' program to allow the general public to optimally plan their 'health' futures.

Since the mid-1960s, provincial governments have increasingly funded dental care, chiropractic, optometry, podiatry, osteopathy, prescribed drugs, and nursing home care (to name only some of the more important items) yet these programs have not been linked with national health insurance, nor are they covered under the hospital and medical insurance acts.¹⁴ The matter deserves further study.

¹²Barkin, "A Matrix Organization For the Ministry of Health," 4.

¹³Barer and Evans, "Riding North on a South-Bound Horse," 145.

¹⁴Brown, "Caring for Profit," 37.

Reform # 4b) - Government (federal and provincial) should introduce a 'favourable tax treatment' program to allow the general public to prepare for their (or their family members and dependents) retirement.

Hidden costs which need to be addressed include the varied and multifacted political ramifications which may be unleashed should a son/daughter be demanded to remain at home and administer homecare to a parent (and/or other aging dependent), thus abandoning an opportunity to contribute financially through personal pension plan contributions to their old-age retirement plan.

Cost-savings figures alone, figures which might soon reveal that a package of homecare/"extended care" program services could be provided to mildly incapacitated senior citizens for approximately 10 per cent of the current nursing home budget,¹⁵ must be reassessed in light of Ontario's changing population, employment and aging demographic profile.

¹⁵Brown, "Caring for Profit," 84.

In conclusion, the level of satisfaction with Ontario's health-care delivery network is undoubtedly high, however there is unease about the future,¹⁶ a future which should increasingly prompt Ontario's health-care transactors to ask themselves if they can act in a proactive as opposed to a reactive manner¹⁷ in response to the critical challenges which face Ontario's health-care industry over the months and years to come.

¹⁶John E. F. Hastings and Eugene Vayda, "Health Services Organization and Delivery: Promise and Reality," in Robert G. Evans and Greg L. Stoddart eds., Medicare at Maturity. (Calgary: University of Calgary Press, 1986), 374-5.

¹⁷Anderson, "HMO Development: Patterns and Prospects," 150, 204.

Figure 1. Hypothetical free market model: free choice among independent transactors.

***Key:** ---/ /--- Arm's-length market exchange relationship, independent transactors. ---- regulatory environment/market relationship.

*Adapted from Robert G. Evans, "Incomplete Vertical Integration: The Distinctive Structure of the Health-Care Industry". In Health, Economics, and Health Economics, ed. J. Van der Gaag and M. Perlman (Amsterdam: North Holland, 1981), 329-354.

*Figure 2. Fully professional, pre-medicare (Canada/U.K./U.S.) health-care delivery model: all transactions directly influenced and controlled by first-line providers.

*Key: Direct administrative influence or control:
primary location of administrative power - two or more imply institutional conflict;

- (a) agency - direct influence of providers over utilization;
- (b) self-regulation - providers collectively regulate individuals;
- (c) prescriptive power - first-line providers (pharmacy, hospital outpatient etc.,) direct patient utilization;
- (d) providers directly influence insurance function;
- (e) Government regulates and subsidizes hospitals (and other second-line health-care providers (ie. community health clinics, ambulatory surgicenters, etc.) under first-line provider control.

*Evans, "Incomplete Vertical Integration," 332.

*Figure 3. U.S. (post medicare) "constrained consumer choice" health care delivery model: competitive insurers influence or control all other suppliers.

*Key: Direct administrative influence or control;
primary location of administrative power - two or more imply institutional conflict:

- (a) agency - direct influence of providers over utilization;
- (b) self-regulation - providers collectively regulate individuals;
- (c) prescriptive power - first-line providers (pharmacy, hospital outpatient etc.,) direct patient utilization;
- (d) providers directly influence insurance function;
- (e) Government regulates and subsidizes hospitals (and other second-line health-care providers, (ie. community health clinics, ambulatory surgicenters, etc.,) under first-line provider control;

plus:

- (g) Patient influence on providers behaviour - non-market;
- (h) direct influence (ownership or control) of independent insurers on providers.

*Evans, "Incomplete Vertical Integration," 341

*Figure 4. Public delivery ("socialized") model, e.g. U.K. (post-medicare) service system plus [Add dotted lines] Sweden's insurance-based system: government consolidates all insurers and suppliers.

*Key: Direct administrative influence and control,
primary location of administrative power;

- (a) agency - direct influence of providers over utilization;
- (b) self-regulation - providers collectively regulate individuals;
- (c) prescriptive power - first-line providers (pharmacy, hospital outpatient etc.,) direct patient utilization;
- (f) direct public control of insurance, and thereby providers;
- (g) Patient influence on provider behaviour - non-market;

plus:

- (i) [Sweden's] direct public control of providers through fee reimbursement schedule.

*Evans, "Incomplete Vertical Integration," 341.

***Figure 5.** Universal public health insurance (Ontario, Canada) model: public [via insurance] and professional influence coexist or conflict.

Key: Direct administrative influence or control;
primary location of administrative power -two or more imply insitutional conflict;

- (a) agency - direct influence of providers over utilization;
- (b) self-regulation - providers collectively regulate individuals;
- (c) prescriptive power - first-line providers (pharmacy, hospital outpatient etc.,) direct patient utilization;
- (d) providers directly influence insurance function;
- (e) Government regulates and subsidizes hospitals (and some second-line provision (community health clinics, etc.,))

plus :

- (f) direct public control of insurance, and thereby providers;
- (g) Patient influence on provider behaviour - non-market.

*Evans, "Incomplete Vertical Integration," 332.

FIGURE 2-6

FIGURE 2-7

SHIFT IN MINISTRY EXPENDITURE DISTRIBUTION

Hospital Operating Expenditures
1977-78 to 1987-88

Growth in Laboratory Services
1981-82 to 1986-87

OHIP EXPENDITURES
1977-78 to 1987-88

FIGURE 2-8

	Canada		United States			United Kingdom		Sweden		
1950		4.0		4.5		3.9		3.4		
1955		4.3		4.4		3.4		4.1		
1960		5.6		5.3		3.8		4.7		
1965		6.1		6.2		3.9		5.6		
1970		7.1		7.6		4.3		7.4		
1975		7.1		8.6		5.5		8.5		
1977		7.1		8.9		5.2		9.8		
1978				8.9		5.2				
1979				9.0		5.2				

Source: Table 3-1.

Adapted from Maxwell, 1981

Figure 3-9. Trends in Total Health-Care Spending as a Percentage of GNP

Source: Table 4-1.

Figure 4-1. Sources of Finance for Health-Care Expenditures: The Mix between Public and Private in 1975 as a Percentage of Total

Source: Calculated from table 4-1.

Note: The United Kingdom figure is for fiscal 1974-1975. For 1975-1976 the percentage of general tax revenues dropped to 91 percent, with a corresponding increase in National Health Service contributions.

Figure 4-3. The Composition of Public Health-Care Expenditures in 1975

Source: Table 4-1.

Figure 4-4. Direct Payment by Consumers in 1975, Excluding Voluntary Insurance (Percentage of Total Health-Care Expenditures)

Table 3-1
Trends in Total Health-Care Expenditures (percentage of GNP)

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Year	Canada	United States	United Kingdom	Sweden
1950	4.0	4.4	3.9	3.4
1955	4.3	4.4	3.4	4.1
1960	5.6	5.3	3.8	4.7
1965	6.1	6.1	3.9	5.6
1970	7.1	7.6	4.3	7.4
1971	7.4	7.8	4.3	7.9
1972	7.2	8.0	4.5	8.0
1973	6.8	7.9	4.4	7.8
1974	6.7	8.2	5.1	8.1
1975	7.1	8.6	5.5	8.5
1976	7.1	8.7	5.4	8.8
1977	7.1	8.9	5.2	9.8
1978		8.9	5.2	
1979		9.0	5.2	

Sources: The sources of these time series are basically the same as those used in the national summaries, and are therefore comparable with the 19 figures in table 3-1. However, I have not researched them in the same detail as I have the national summaries. They should be reliable as an indicator changes over time in the country concerned, but not necessarily for comparison across countries in a particular year.

Adapted from Maxwell, 1981

KEY:

1. **Canada:** All figures were supplied by Health, and Welfare Canada, Health Economics and Data Analysis Division. 1977 figures are rough estimates only.

2. **United States:** The U.S. series is from R.M. Gibson, "National Health Expenditures, Fiscal Year 1979" *Health Care Financing Review* (Summer 1980): table 1.

3. **United Kingdom:** The U.K. expenditures for fiscal 1974-1975 and 1975-1976 are calculated in detail in the national summary. I have adjusted them approximately to a calendar-year basis, as explained in the notes to table 3-1, by taking an approximate fraction of each fiscal year's expenditure, and relating the resulting health-care expenditure per capita to GNP per capita for the calendar year. My estimates include (besides National Health Service expenditure) spending on medical care for the armed forces, medical research funded outside the NHS, the costs of private medical care incurred by U.K. residents, and spending on nonprescribed drugs. Expenditures for 1950-1974 inclusive have been estimated from government figures for NHS expenditures and direct payments by patients, Lee Donaldson's figures for private insurance (for example Lee Donaldson Associates *UK Private Medical Care: Provident Schemes Statistics 1978* (London: July 1979)), and Office of Health Economics figures for OTC drugs. These figures account for 97-97.5 percent of totals in the years for which my estimates are complete. I have assumed the same relationship in earlier years. 1977 and 1978 are estimated from *National Income and Expenditure*, 1979 edition, for NHS expenditures and updated figures for each of the other elements included in my estimates for 1975 and 1976. 1979 is similarly estimated from *National Income and Expenditure*, 1980 edition.

4. **Sweden:** The complete series was supplied by the National Central Bureau of Statistics in Stockholm to comply with the definitions used in this study. The series was calculated in terms of GDP, because of lack of consistent information for GNP. However, analysis for 1974 and 1975 (see the national summary) shows that the difference between GDP and GNP was extremely small for Sweden in those two years.

Table 4-1
Health-Care Expenditures by Source of Finance
(percentages of total expenditure)

	Australia (1974-1975 Fiscal)	Canada (1975)	France (1975)	West Germany (1975)	Italy (1975)	Netherlands (1974)	Sweden (1975)	Switzerland (1975)	United Kingdom (1974-1975 Fiscal)	United States (1974-1975 Fiscal)
1. Public										
a. General taxation (including subvention payments to public insurance schemes)	62.7	66.3	7.0	14.6	23.8	15.1	78.5	41.7	87.3	(31.0)
b. Public insurance	1.7	9.1	69.0	62.3	67.5	56.0	13.1	24.8	5.0	(11.7)
c. Other	—	—	—	—	—	—	—	—	0.3	
d. Total public	64.4	75.4	76.0	77.1	91.3	71.1	91.6	66.5	92.6	42.7
2. Consumers										
a. Direct payment	21.1	19.5	19.6	12.5	8.7	27.3	8.4	33.3	5.8	27.1
b. Private insurance	13.8	2.5	3.0	5.3	—	—	—	—	1.2	25.6
c. Total consumers	34.9	22.0	22.5	17.8	8.7	27.3	8.4	33.3	7.0	52.7
3. Other	0.7	2.6	1.4	5.1	—	1.6	—	—	0.4	4.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Notes:

1. **Sources of data:** The sources are the national summaries for each country, with their supporting notes.

2. **Weaknesses in the data:** The table is reasonably complete and reliable. Some payments are known to be excluded in certain countries (see table 2.1 in the text). The break down between direct payment and private insurance is unreliable for several countries (such as Canada), since for them it is frequently adjusted to a constant by deducting incomplete data on private health insurance.

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