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LESSONS FROM AWAY:An interdisciplinary collectionof studies exploring whatCanada may learn from othercountries' experiences withhealth care reforms

Colleen M. Flood
Dalhousie University

Preface

Colleen M. Flood*

LESSONS FROM AWAY:
An interdisciplinary collection of studies exploring what Canada may learn from other countries' experiences with health care reforms

The Canadian health care system is considered a shining example of what it is to be Canadian: to aspire to social justice goals and to achieve those goals at a reasonable cost.[1] Canadians take great pride in that, by any measure, their health care system is superior to the piece-meal, expensive, and unjust U.S. health care system.[2]

Given the understandable yet nonetheless myopic preoccupation with the U.S. health care system, it is easy to see why Canadians often overlook that the U.S. is an anomaly amongst developed OECD countries. All of these latter countries seek to achieve the social justice goal of ensuring access to a core range of health care services by their citizens on the basis of need. Thus, continual comparisons with the U.S., in which the Canadian system always looks superior, tend to cloud the crucial questions of how well and how efficiently the Canadian system serves the health needs of the population. This perspective also tends to lead to maintenance of the status quo in terms of the configuration of the system. However, anything more than a cursory critical analysis of the Canadian system reveals a number of serious problems, many of which are intensifying in their nature given the recent and rapid deinstitutionalization process.

Although comparisons can be difficult because of differing contexts, there is the prospect that Canadians can learn from the successes and

* Associate Director, Health Law Institute, Dalhousie University.

1. Or, one may say, without chilling the workings of a capitalist economy through high taxation rates.

2. In 1996, there were 40.6 million uninsured U.S. citizens: K. E. Thorpe, "Incremental Approaches to Covering Uninsured Children: Design and Policy Issue" (1997) 16 Health Aff. 64 at 65. In 1994, the U.S. spent 14.5% of its GDP on health services compared to 9.8% in Canada: OECD data as reported in National Forum on Health, "Striking a Balance. Working Group Synthesis Report" in *Canada Health Action: Building on the Legacy, Volume II, Synthesis Reports and Issues Papers* (National Forum on Health: Ottawa, 1997) at 3.

failures of reform initiatives in other countries, particularly those that also seek to achieve universal access to a core range of health services. This theme issue of the *Dalhousie Law Journal* is dedicated to assessing health reform initiatives internationally. Contributors were asked to focus on the impact of reform on vulnerable populations and what lessons might be learned by Canada from experience with reform in other countries. The result is a rich collection of papers looking beyond the United States to Europe (particularly the United Kingdom and the Netherlands), Israel, and New Zealand. Analysis of the design of a health care system necessitates an interdisciplinary approach in which the disciplines of law, economics, and political science all provide valuable tools for analysis. In this regard, this volume provides a strong contribution to the literature, with articles by lawyers, economists, and health policy analysts.

A traditional legal scholar might ask what legal analysis can offer in the area of health care reform, but in fact the law is integral to the success or otherwise of an institutional arrangement.[3] Both international and domestic laws may prescribe individual entitlements to health care services and affect what is perceived as being the range and quality of health services necessary to satisfy the demands of distributive justice. For example, in the recent case of *Eldridge* a successful *Charter* challenge was made to the British Columbia Medical Commission's decision not to provide sign-language interpretation in hospitals to those patients living with a hearing disability.[4] Furthermore, legislation is passed to create new institutional arrangements and prescribes the power and responsibilities of health care providers, purchasers, patients, interest groups and citizens. Administrative law is clearly important to ensure fair decision-making processes on the part of government and its agents. Legal liability imposed through the common law (particularly tort law) on health care providers, purchasers, and patients will affect their behaviour and affect both the costs and distribution of health services in society. Supply contracts are a vital element of some reform models, and existing contractual norms and laws need to be examined to see if they are effective in ensuring the efficient supply of an adequate range of health care services of acceptable quality. Competition or anti-trust law may become important where reform requires the consolidation of purchasing power, but the response of providers is to attempt to consolidate market power on the supply side.

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3. See generally, *What's Law Got To Do With It? Health Care Reform in Canada, The Canadian Bar Association Task Force on Health Care* (Ottawa: Canadian Bar Association, 1994).

4. *Eldridge* v. *British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.

It is helpful to articulate clearly at the outset why reform of the Canadian system should be considered, given that some readers may consider any attempt to improve upon the present health care system tantamount to gilding the lily, while others may assume that the only problem with the present system is a lack of government funding. There are problems within the Canadian health system and, as with most health systems in the world, they relate to access and cost-effectiveness.[5]

In terms of access to healthcare, the Canadian system is far from comprehensive. Twelve percent of the population are without any form of insurance coverage for pharmaceuticals used outside of hospitals.[6] Medical equipment and goods used outside of hospitals such as artificial limbs, hearing aids, and wheelchairs are not consistently publicly funded. There is no national approach to the provision of publicly-funded home care services, and provincial variations in access to such services have the effect of shifting the burden of informal caring increasingly to unpaid female family members.[7] To some extent these access problems are contributed to by the *Canada Health Act*.[8] The Act sets out five principles (public administration, comprehensiveness, universality, portability and accessibility) with which provincial insurance plans must comply before qualifying for a full cash contribution from the federal government.[9] These principles only apply, however, to "hospital services" and "physician services" as defined in section 2 of the Act. Thus, the present system is not oriented to the health needs of Canadians as such, but to where and by whom health services are supplied.

Of particular concern is the lack of access by vulnerable populations to services that satisfy their health needs. Although the infant mortality rate of Aboriginal peoples has declined in the past few decades it is still

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5. See generally the Organization for Economic Co-operation and Development, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*, (Paris: OECD, 1994).
6. National Forum on Health, "Directions for a Pharmaceutical Policy in Canada" in *Canada Health Action: Building on the Legacy, Volume II, Synthesis Reports and Issues Papers*, (Ottawa: National Forum on Health, 1997) at 3.
7. In 1996, 19% of women in the 45-64 age cohort provided care to those suffering from long-term health problems or physical limitations, whereas 11% of men in the same age cohort provided this type of care; K. Cranswick, *Canada's Caregivers, Canadian Social Trends* Ottawa: Statistics Canada, 1997). For a discussion of the nature of costs incurred as a result of informal caregiving to the elderly at home, see J. E. Fast et al., *Conceptualizing and Operationalizing the Costs of Informal Elder Care, Final Technical Report to the National Health Research Development Program (NHRDP)* (Edmonton: University of Alberta, 1997) at 4-11).
8. *Canada Health Act*, S.C. 1984, c.6, s. 7.
9. *Ibid.*

double that of the non-Aboriginal population.[10] Moreover, the National Forum notes that "death rates for Indian infants from injuries are four times the rates from other causes such as birth defects, and low birth weight and respiratory illness are consistently and significantly higher among Aboriginal infants and children when compared to the non-Aboriginal population."[11] Lower socioeconomic groups have greater health needs yet the Canadian health care system does not always respond to individuals within these groups in a manner proportionate to their needs. For example, a study of residents in Winnipeg found that whereas those in lower income quintiles had a greater need for surgical services than individuals with higher incomes, utilization rates were similar across these different income groups.[12]

With respect to cost-effectiveness, health economists both within Canada and internationally have contended that many health services supplied are of no proven therapeutic benefit.[13] Stoddart et al. note that estimates of the cost of physician-generated inappropriate use vary, but are sometimes as large as 30-40% of all health services.[14] There are variations between provinces with respect to the utilization of health services that would not seem justified on the basis of differing health needs.[15] Economists have emphasized that physicians prescribe drugs, diagnostic tests, the use of various technologies and admit patients into hospitals, yet have no incentive to be sensitive to the cost-effectiveness of the various services they recommend. Thus some economists advocate reductions in health expenditures, particularly in terms of reducing the number of acute-care beds and cutting patients' length of stay in hospital, claiming that such reductions will not adversely impact on Canadians'

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10. National Forum on Health, "The Need for an Aboriginal Health Institute in Canada" in *Canada Health Action: Building on the Legacy, Volume II, Synthesis Reports and Issues Papers*, (Ottawa: National Forum on Health, 1997) at 5.

11. *Ibid.*

12. N. P. Roos & C. A. Mustard, "Variation in Health and Health Care Use by Socioeconomic Status in Winnipeg, Canada: Does the System Work Well? Yes and No" (1997) 75 Milbank Q. 89 at 102 found that specific components of the system, namely acute medical admissions to hospitals and care provided by general and family practitioners, do seem to fulfill the goal of allocating on the basis of need.

13. R. G. Evans, "Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform" (1997) 22 J. Health Pol. Policy & L. 427 at 460 notes that students of health care system believe that there is a great deal of "inappropriate, unnecessary, and sometimes downright harmful care being paid for in all modern health care systems." He goes on to note that the key question becomes one of moving closer to production frontiers.

14. G. L. Stoddart et al. *Why Not User Chargers? The Real Issues – A Discussion Paper* (Toronto: The Premier's Council on Health, Well-being and Social Justice, 1993) at 6.

15. For a discussion see National Forum on Health, "Creating a Culture of Evidence-Based Decision Making in Health" in *Canada Health Action: Building on the Legacy, Volume II, Synthesis Reports and Issues Papers*, (Ottawa: National Forum on Health, 1997) at 20.

"health."[16] The focus on "health" rather than health services supplied by physicians, and the shift from institutional care to home and community care, have also been supported by groups keen to see a shift away from the purely "medical model" to a more integrated, holistic approach.

Internationally, reform has been driven by concerns over the increasing size of government expenditures on health and the resultant impact on public sector deficits. It could not be expected that high growth rates in health expenditures would abate without reform measures, given the aging of the baby-boom generation and high expectations within this group as to their entitlements to high quality health care services. Reform has also been driven by a general ideological commitment in many countries to rethink the role of government and to privatize and deregulate where possible. When it has not proven politically or economically feasible to privatize or deregulate, private sector tools have often been used to rethink the internal structure of government departments or government enterprises.

The work of health economists has dovetailed with the desire of governments in many countries to constrain the level of increases in government expenditures on health services. In Canada, the key health reform initiative has been to reduce the flow of resources into the system on the assumption that when faced with limited resources, physicians and other health providers will direct resources to the greatest need and eliminate inefficiency and waste. For example, more than one-quarter of Nova Scotia's hospital beds have been cut.[17] Over the last four years, Canada has been successful in pursuit of its general policy of expenditure reduction and has reined in the total amount spent on health in terms of real total health expenditures ($1,895.86 per capita in 1992 to $1,860.72 per capita in 1996).[18] The total spent on health services as a percentage of GDP has fallen from 10.2% in 1992 to 9.5% in 1996.[19]

The Canadian cost-containment approach to reform is problematic for at least three reasons. First, the approach assumes that physicians have good information as to what is or is not a cost-effective means to respond to a particular health need. Second, simply restricting the resources available to a system will not necessarily result in selection of the most

16. See, for example, D. E. Angus et al., *Sustainable Health Care for Canada, Synthesis Report* (University of Ottawa: Ottawa, 1995).
17. C. Nicoll, "Three Hospitals Slated to Close: Stewart Chops $15 Million From Budget:" *The [Halifax] Daily News* (13 May 1994) at 4.
18. See *Total Health Expenditures – Summary, Canada 1975-1996* at http://www.hcsc.gc.ca/datapcb/datahesa/hex97/table 1.jpg.
19. *Ibid.*

cost-effective service in response to any particular health need nor in the appropriate prioritization of health needs. For example, the common criticism of the present mix of health services supplied is that there is too great an emphasis on acute care and advanced technology at the expense of primary and preventive care; however, it does not appear that there is any less emphasis on acute care in a low-spending country like the U.K. than a high-spending country like Canada. Simply reducing the amount of public funding available to the system also leaves open many opportunities for cost-shifting on the part of physicians and other health providers who find it much easier to continue their old patterns of practice. Instead of shifting to more cost-effective practices, providers may simply shift costs on to private payers or patients through longer waiting lists or times, or otherwise less responsive service. Third, and most importantly from the perspective of the impact on vulnerable populations, the Canadian cost-containment approach assumes that a system should be geared towards "health" as a measurable outcome. This approach offers the prospect of greater emphasis on prevention but it also may discount processes where outcomes are not readily or easily measurable. So, for example, the provision of "caring" services such as nursing, which may significantly help a patient through the illness process but may not necessarily have any impact in terms of faster discharge times from hospital or faster recovery, are seriously discounted.[20] Such an approach also potentially discounts services for the dying, the disabled, and the chronically ill, where the provision of health services may do little to add to the population's "health." The approach is also insensitive to the distribution of costs. The shifting of care outside of hospital walls and into homes and communities has resulted in increased private costs for patients and their families in terms of drugs, medical equipment, and the direct and indirect costs of informal or formal care-giving services.

Many countries are seeking to reform their health systems either by introducing more competition into what were publicly-operated delivery systems or reconfiguring public and private roles in pluralist, insurance-based systems.[21] Examples include Finland, Sweden, Germany, Israel, the U.S., the Netherlands, the U.K., New Zealand, and the countries

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20. See generally C. M. Flood, "Conflicts Between Professional Interests, the Public Interest, and Patient's Interests in an Era of Reform: Nova Scotia Registered Nurses" (1997) 5 Health L. J. 87.

21. R. V. Saltman & C. Von Otter, *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems* (Buckingham: Open University Press, 1992) at 15-16 and W. P. M. M. van De Ven, R. T. Schut & F. F. H. Rutten, "Editorial: Forming and Reforming the Market for Third-Party Purchasing of Health Care" (1994) 39 Soc. Sci. & Med. 1405.

comprising the former U.S.S.R. The goal is to increase tension on the demand side of health service markets through the creation of proactive purchasers. These approaches envisage shifting at least some of the responsibility for allocation decisions away from the "black-box" of clinical decision-making. In the case of internal market reform, this decision-making power is shifted into the hands of government-appointed regional health authorities and in the case of managed competition reform, the power is shifted into the hands of government-regulated insurers offering managed care plans. However, it is often overlooked how to ensure these new purchasers have the skills, resources, and incentives to make allocation decisions that balance the interests of society with the interests of those with health needs. The consequences of bad decision-making are the same whether made by health professionals or by the new purchasers in reformed systems.

The common theme of the articles in this volume is that the competition-oriented models are not a panacea for the twin problems of access and cost-effectiveness that beset most health care systems, including Canada's. The very mixed results emerging from these reform initiatives do not negate the value of closely analyzing in detail aspects of the reform process. No system is perfect and there is no easy solution to what constitutes the optimal institutional design. The problems that have been experienced in other jurisdictions do, however, clearly warn of the dangers of hasty implementation of reform. The advantage of reform implemented quickly is often touted to be that vested interest groups have little opportunity to mobilize to resist change. However, change must often, by necessity, be incremental, responding to and/or building upon what often may be accidents of history or earlier policy decisions. More importantly, the health system is a service industry and service requires continuity and a meeting of expectations though some may consider these expectations ill-conceived. Notwithstanding this caution, a paradigm shift is needed so that the Canadian health system can constantly and incrementally evolve in response to changing technology and changing needs. The goal must be a system that is truly and not merely rhetorically oriented to health needs.