# Wrong answers at the wrong time?

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Just as generals are always fighting the last war, the people who devise Canada's health policy are always implementing reforms to address yesterday's problems with answers based on yesterday's assumptions.

Canadian medicare has been described as a "qualified success."[1] Our system of universal hospital and medical care insurance has improved health care accessibility, at least for insured services, yielded good health outcomes and been popular with the public. However, it has also encouraged "silos" of services, emphasized relatively costly inpatient and physician services at the expense of community-based care, and left cracks through which many Canadians could and did fall.

For more than 30 years Canadian health policy analysts have been urging a shift to community care. This would be accompanied by a reallocation of resources from those with "too much" — "those" usually referred to some combination of hospitals, physicians, sickness care, the affluent and urban dwellers — to those with "too little."


One favoured mechanism long advocated to achieve these goals was to replace the independent solitudes of hospitals, physicians and community agencies with regional boards that could integrate and coordinate care.[2] It has also been suggested that funds should be allocated to these boards based on the population's needs instead of existing practices, utilization or wants. This approach, which also borrows from developments in the United Kingdom and New Zealand, was prescribed in a series of provincial and task force reports in the 1980s.

It has sometimes been said that the greatest curse is getting what one wants. After decades of planning, Canada — with the notable exception of Ontario — has been swept by a wave of regional reforms.[3] Across Canada, researchers are busily trying to develop formulas to ensure that funding and resource allocation will be equitable and based upon need; Alberta and Saskatchewan are already poised to implement such approaches. How could one object?

One dilemma created by our move toward community care is "made in Canada." The Canada Health Act (CHA) requires comprehensive coverage of medically necessary care but defines this only in terms of physicians and hospitals — a considerably narrower definition than that found in most of the other industrialized countries belonging to the Organization for Economic Cooperation and Development (OECD).

The CHA therefore gives special status to care provided within hospitals or by physicians. Although provinces that impose user fees for medically necessary hospital or physician care are subject to federal penalties, care that is shifted to the community has no such protection and can be deinsured.

Today the provinces increasingly speak about "determinants of health" at the same time they are downgrading and deinsuring services that are not protected by the CHA. Even within the narrow scope of medical services, provinces have been limiting coverage for vision and rehabilitation care, cutting public-health dentistry where it exists and imposing higher copayments for prescription drugs. The propor-

tion of health care expenditures coming from public sources had been forecast to fall to 68.7% in 1997, considerably less than the average for the OECD's other member countries. This has affected both access and cost control.

The funding retreats are extending far beyond the health care sector. Many provinces have been curbing their involvement in financing affordable housing, cutting welfare benefits, reducing the number of subsidized day-care places and so on. Today, a sizable proportion of the homeless people seen in major cities appear to have problems related to mental illness and/or substance abuse.

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The recommendations of the National Forum on Health stressed the need to redefine and reinforce the public sector's role in health care.[4] Can we be sure that the new regional bodies will reallocate resources to reflect the new ways of delivering services, or will they use this as an excuse to shut down hospitals and place more of the burden of care on individuals and their families?

A second dilemma arises from the emphasis on needs-based planning. As Saltman has noted, there is an inherent contradiction between responding to needs and being "consumer oriented."[5] Needs, by definition, are determined by experts; consumers have demands that experts may or may not agree should be met. If the procedure being demanded will be useless or even harmful, then better patient education should lead to agreement between patients and providers. In most cases, however, people demand services that are likely to be helpful but are judged to be of lower priority than other needs.

Judging from international experience, systems built upon a combination of "we know what's best for you" and "take it or leave it" are unlikely to enjoy continued public support. On the one hand, a demand orientation would increase both the scope of coverage — for example, alternative and complementary therapies would almost certainly be included — and the total cost. On the other hand, a needs-based orientation may evoke hostile reactions from those whose demands are not being served. It is noteworthy that health care reform has been an issue in most recent provincial elections and that governments trying to defend these reforms have not fared well on voting day.

A third dilemma is the irony of timing. These regional planned models are coming into being at precisely the time they are being abandoned in other parts of the economy. Revolutions in communications technology have redefined the meaning of distance. As Negroponte has observed, older methods of communication required us to move "atoms" physically across a distance, while new methods let us move "bytes" electronically at far greater speed and far less cost.[6] Telemedicine means that people in remote communities can be linked with and treated by providers located thousands of kilometres away. At the same time, we continue blithely planning on the basis of arbitrary lines drawn on the map, with little attention being paid to how people actually move about and seek care. Around the world, borders are breaking down. In health care, we are reinforcing them.

It's sad. The reform models have finally won acceptance after so much hard work by so many respected health services researchers at precisely the moment when they have become somewhat obsolete. Indeed, they may represent a barrier to the new reforms likely to become necessary as we move into the 21st century.

## References


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