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A Third Option for the Heath Care debate:
Think community and courage

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Have you wondered why your town is so short of family doctors? Why so many people rely wholly on walk-in clinics or hospital emergency wards for treatment that could be provided by a family doctor? Why people in the local seniors' residence go by ambulance to a hospital emergency department when a home visit from a doctor could serve just as well? Why you can't phone a doctor who knows you and your family, but may phone a nurse whom you've never met?

These dilemmas once were the lot of isolated communities. Not any more. It's standard fare for residents of Canada's smaller cities and even the neighborhoods of some metropolitan areas.

Canada's health care system, created 40 years ago expressly to ensure that all Canadians could receive the same high-quality care regardless of their province, territory, or income level, is in trouble. Some of us get ready access to timely, multidisciplinary group practices using modern information systems. Others wait for hours in emergency wards. If admitted to hospital, we may find ourselves parked in a corridor and treated by stressed and tired medical staff.

Sick people suffer disability and discomfort while waiting for essential services. Some get administered the wrong prescriptions due to incomplete or illegible records. Men in rural Canada can expect to live nearly three years less than their urban counterparts; Aboriginal men seven years less than the national average.

This is not what the champions of Medicare had in mind. They believed that people should not be denied care due to an inability to pay. Today, you may very well be denied care because your neighbors (as taxpayers) are unable or unwilling to pay for the care you require. The "single-tier system" of affordable, excellent care for all envisaged by Tommy Douglas, Woodrow Lloyd and Emmett Hall is degenerating into a system that is single-tier for price only – not for quality.

It is also costing us a bundle. About 45% of government program spending (federal, provincial, and territorial) is currently directed to health care, or 9.6% of Canada's GDP. While about mid-way between Finland (7.3%) and the United States (14.6%) among industrialized countries, that still corrals an enormous amount of government expenditure at a time when other critical agendas – the environment, public infrastructure, housing – receive short shrift.

Demands on the health system will climb drastically over the next generation with the retirement and increasing frailty of the baby-boomers. We must improve health care delivery.

Unfortunately, our political leaders, the news media, and many of the organizations currently active in the health system are convinced that we have only two

possible ways forward. They say that we can either award great or greater power in health care delivery to organizations controlled by the government, or to organizations owned by individuals.

There is also often a subtext to that stark choice. The public sector option connotes “nonprofit (read ‘benevolent’) delivery”; the private sector option means “for-profit (read ‘greedy’) delivery.” Common to both is the additional suggestion that the complexity of health care necessarily makes it the domain of people with specialized knowledge, whether medical, administrative, managerial, or financial. They deliver; the rest of us consume.

All this is not entirely unjustified. We have arrived at this crossroads for some of the best of reasons and intentions, as well as some of the worst. Nevertheless the choice we are expected to make is false and the subliminal messages only make it more difficult to think the problem through. There are not two choices. There is a third option as well. It involves engaging in health care the power and insight and devotion to people of a third stakeholder, largely relegated to the margins of our current health system: Canada’s communities.

What’s Gone Wrong?

Actually, the “either public or private” dichotomy is as old as our health system. The construct was mistaken 40 years ago too, and we are living with the consequences today.

Back in 1950, government stood on the sidelines of a health system that was the purview of private practitioners, insurance companies, and nonprofit or charitable organizations. Half the population of Canada had no insurance whatsoever for medical or hospital services. When suffering serious injury or illness, uninsured people of average means faced some very unpleasant options. They could go deeply into debt, rely on charity, or go without professional care.

To fix that, the Medical Care Act (1966) and the Canada Health Act (1984) planted government squarely in the driver’s seat of our health system. Government at the federal and provincial levels was appointed the sole insurer of a wide range of health services, including medically-necessary services delivered by doctors, in person, anywhere in Canada and almost all services provided in hospitals. Doctors’ practices, hospitals, and other providers of health care were to remain largely private, that is, their assets were the property of private citizens or associations. They were to depend on government to pay almost all the bills, however.

From its position as the “single payer” for services, government evolved into the *administrator,* the *regulator* of their cost and quality, and the *monitor* and *evaluator* of how they were provided. Unlike other sectors, when it comes to health care, Canadians decided it was practicable and even praiseworthy for one and the same party to exercise tremendous power over just about every aspect of the supply chain. It is a near-monopoly that places intolerable demands on government.

Firstly, it cannot guarantee a wide range and abundance of service. Government designates which services it will insure and for what price. It changes its mind (or refuses to) with an eye to a vast range of political and economic priorities, not only to the needs of sick and injured Canadians living in places of every size and description across the country.

Take visits to the doctor, for example. Under most provincial medical plans, such visits are insured. Here in Nova Scotia, it’s $28. That is supposed to cover the full cost of all the services you enjoy during that visit, directly or indirectly – not just those of the doctor, but the uninsured services of the nurse, secretary, custodian, and even the landlord (rent). It varies little if illness is simple or complicated or if you bring several problems to a single visit. The same unrealistic pricing applies in most provinces to fees for home visits, hospital care by general practitioners, and visits to nursing homes.

As a consequence general practice in this country is starved of practitioners. Doctors go do other types of medicine that offer better compensation and better hours. As the single payer, government was supposed to be able to oversee the fair distribution of an abundance of services across a vast spectrum of people and places. Instead, government has found itself with a scarcity of important services that must be rationed so everyone can get at least some. Second, government cannot guarantee service quality. The party paying for the service is the same one that ultimately determines when and where the service is up to standard. Thus, governments across Canada

have not insisted that health organizations provide regular and reliable reports about access to care and the benefits of that care. Instead, government has sought regular and reliable reports about the cost of that care, as if cost were the sole determinant of value. We have placed government in a conflict of interest that makes a rigorous level of accountability extremely unlikely.

And if the service repertoire in a community falls in range or quality? Well, some citizens put up with it; they believe that they cannot or should not pay for services that government does not insure. Some citizens speak up, but their complaints fall on deaf ears. Even when regional or provincial health authorities are sympathetic, they are unable to alleviate the situation. Improving quality of care or access to care does not increase the revenue of a health authority or a hospital; all it does is increase costs – a losing proposition.

This two-way division of power assigns to the private sector a curious role. It is the major provider of medical and hospital services, through private clinics and hospital corporations. Yet much of its capacity for experimentation and creativity is confined to the services that, by definition at least, are *not* medically necessary. So entrepreneurial initiative in the health sector often merely answers the call of the highest bidders – urban consumers with more money and clout, not the rural or the poor.

Consider this: Canadians can spend whatever they like to go to the head of the line for cosmetic surgery. As a result, a patient with a curious limp (and the necessary cash or insurance) can get prompt hip replacement surgery because the surgery is not regarded as medically necessary. In contrast, the patient who needs the same surgery to reduce pain or improve function is free to wait. While the supply of medically-necessary services is unresponsive to Canadians' needs, the supply of so-called "unnecessary" services is very responsive, and in some cases very remunerative too.
In addition to cosmetic services, medical notes for employers, licensing examinations, and insurance medicals can be had with little fuss and no waiting. The same applies to drug prescriptions, occupational therapy, medical appliances, and the services of non-physicians, for which Canadians commonly pay out-of-pocket or, increasingly, through private insurance. In fact, a significant proportion of health care spending occurs when private sources (employers, employees, and individuals) decide to purchase a larger menu of insured services than provincial medical plans provide.

The last 30-40 years of health care have brought about one other "adverse reaction." A public perception has grown up that health services are primarily about addressing ill health, not maintaining or promoting good health. This creates some very real expectations about the setting, expertise, and costs of health services, and who has to provide them. There is little sense nowadays of sharing responsibility for health services between lay and medical person, between citizen and government, or between local and centralized authorities. Although "health" is considered a personal responsibility, "health services" are largely something that a professional does for us when we're ill or after we're injured, with pricey pharmaceuticals and equipment, often in a clinic or hospital.

In the "house" of our current health care system, you could say, publicly insured services are the bricks. There never seems to be quite enough of them, but the inhabitants have learned to wait for someone else to supply them. Private health services form the mortar that some can afford to stuff in the cracks that the wind would otherwise whistle through. In any case, we are given to understand, various amounts of these two materials are all we have to work with. Is that really the case?

A Third Player: The Community

Imagine with us for a moment. You and your neighbors band together to hire a family doctor or other health professional. As a group, you agree to pay for what you feel is missing from the current menu of insured services. Email and telephone consultations, for example; house calls; visits by your own doctor to the emergency department if someone is taken seriously ill or injured; the availability of that doctor for calls from you after office hours.

Your organization/business takes the form of a co-operative. To cover the cost of these services, the members pay an annual fee and a deductible – say $300 per year. Additional co-op revenue comes from the delivery by co-op staff of health services that the government insures. Membership fees might also top

up the fees for services that the government insures, but inadequately.

Through your control over the menu of services, the revenue flow, and, to a degree, the price paid for care, your community-owned facility is in just as good a position to deliver quality care as one funded solely by government. Better even. You know exactly which types of service local people want, and which are not so important. You can insist that administrators provide timely and pertinent information about access to care and the outcomes of care, and can set the standard you want achieved, not the standard some distant bureaucrat considers good enough. Moreover, whatever your co-op chooses to buy, it keeps.

Sound possible? It is. There are over a hundred health care co-ops operating in the country today, especially in Québec and Saskatchewan. They are incontestable evidence of the determination and ability of ordinary people – people without medical training – to have a say in the design, delivery, and evaluation of health services that they and their neighbors receive.

That is one expression of community control in health care delivery. Community health centers are another, with mandates that commit them to defining and satisfying the health needs of specific populations and neighbourhoods.

All are asserting the principle of subsidiarity; that decisions should be made at the level of organization that is closest to the people whose lives they affect. A central authority should undertake only those tasks that cannot be performed more effectively at a local level.

This is not to suggest that government withdraw from health care, by any means. Canadians, left, right and center, value high-quality care for everyone, and government must remain an important insurer and an independent source of regulation. It must help maintain the essential balance between local authority in health care delivery, for the sake of flexibility and accountability, and central authority, for the sake of universal access to excellent service.

In fact, is it possible to imagine a substantial increase in community engagement in health care any time soon without the some direct participation by government agencies?

A Right & A Duty

In short, community-controlled organizations are a way to enhance our health system and benefit all Canadians – not to replace it. This model will help Medicare reconnect to the wants and needs of rural and disadvantaged Canadians and reduce the health disparities that they already experience in our health system.

Community ownership of health care solutions will also help governments extricate themselves from the role of manager and evaluator and unleash an entrepreneurial way of thinking on the delivery of services that are medically necessary. It would engage in health care a third stakeholder that, in combination with the other two, could help us achieve a system that will be sustainable and provide excellent service to Canadians, rich and poor.

As the World Health Organization concluded at the International Conference on Primary Health Care in Alma Ata, in 1978, "people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

Community-controlled, user-centered health care deserves the full attention of the Canadian public and decision-makers in the debate over the future of our health care system.

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