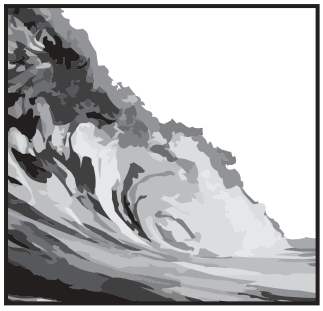

A Third Way Forward

Canada's communities can, should, & must intervene in health care delivery

By David Zitner & Dianne Kelderman

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 neighbourhoods 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 neighbours (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 Way forward. 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.

Our political leaders, the news media, & many organizations active in the health system are convinced that we have only two possible ways forward. There is a Third. It involves engaging in health care the power & insight & devotion to people of a third stakeholder, largely relegated to the margins of our current health system: Canada's communities.

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. (See "A Big Job, Getting Bigger," p. 17 of this edition.)

From its position as the "single payer" for services, government evolved into their *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. (See "Re-Evaluating Health Care," p. 25) 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. (See "*Complete* Solutions," p. 7.)

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

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

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

* It is worth noting that the private sector is not the only one investing in such "executive class" health services. Workers compensation patients and members of the military and RCMP can often obtain health services for which the medical practitioners are paid more than the standard fee. Thus, even government appreciates that sometimes "the norm" is just not good enough.

(photo, left) The Community Kitchen at Wabano Centre for Aboriginal Health, Ottawa. Credit: Linda Pearson, Wabano staff. (inset) Staff and supplies of the Harm Reduction Program at South Riverdale Community Health Centre. Credit: Christopher Dew and SRCHC.

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 neighbours 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. E-mail 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 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. (See "Community Ownership of Health Care Assets, p. 33.)

Sound possible? It is. There's over a hundred health care co-ops operating in the country today, especially in Québec and Saskatchewan. (See "Primary Health Care at the Crossroads," p. 12, and "Come Together Now," p. 43.) 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 neighbours receive.

That is one expression of community control in health care delivery. Community health centres are another, with mandates that commit them to defining and satisfying the health needs of specific populations and neighbourhoods. Like Healthy Communities supporters, many community health centres understand their responsibility to the health of local people in the broadest sense, and engage in planning, advocacy, housing, and employment initiatives that are very similar to those of community economic development (CED) and social economy organizations. (See "Natural Allies," p. 29.)

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. (See "The Co-op Experiment," p. 48.)

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? Regional Health Authorities frequently take the role of the "bad guys" in matters of community control. They are the ones who close local hospitals and appropriate local assets. Yet, they are still the "least centralized" of government health bureaucracies and their office-holders (our neighbours) the most subject to public pressure. They are a feature on the health care landscape that local innovators will drive their initiatives around, over, beneath, or – with good management – through. In the building of a movement to achieve greater community control, the ability to perceive and create partnerships across sectors will be crucial. (See "Thinking Globally, Acting Locally," p. 35.)

CED practitioners understand that. They also understand that some of those partners may be private businesses and corporations, for-profit and nonprofit. Are they "community controlled"? No, but they may be *locally* controlled, and have a handle on how to shape an array of local needs into a market, and how to make the satisfaction of that market a workable proposition for providers and consumers. Their innovations are points in the local system of health care delivery on to which co-operatives and

making waves discusses the principles and practice of economic development that is expressly geared to rebuild the hope, pride, and power of endangered or deteriorating communities. It is published quarterly by the Canadian Centre for Community Renewal (CCCR), a nonprofit organization dedicated to building creative, inclusive, and sustainable communities in Canada.

editor: Mike Lewis ~ managing editor: Don McNair ~ design/layout: Don McNair ~ translation (this edition): Canadian Rural Partnerships ~ advertising: Sara-Jane Brocklehurst ~ advisory council: Ethel Côté, Michael Toye ~ contributing editor: Stewart E. Perry.
Direct correspondence to the editor, **making waves**, CCE Publications, PO Box 1161, Port Alberni, B.C. V9Y 7M1, (toll-free) 1-888-255-6779, ccelewis@island.net. Direct articles and photos to mcnair@cedworks.com, (tel) 250-542-7057. Direct advertising to sjbjoat@shaw.ca, (tel) 250-247-7390. On the internet: **www.cedworks.com** – go to **making waves**

Subscriptions: phone (toll-free) 1-888-255-6779, or visit www.cedworks.com ~ Rates: individuals and nonprofits – C$36/US$44 (1 year), C$59/US$75 (2 years); governments, corporations, and institutions – C$48/US$56 (1 year), C$83/US$99 (2 years); students and unemployed – C$24/US$32 (1 year) ~ Newstand price (this edition only) C$5 ~ Prices subject to GST/HST for Canadian subscribers. International subscribers, add C$18/year.

ISSN 1192-2427. Canada Post Publication Agreement No. PM40051559.

making waves is indexed on-line at The CED Digital Bookshop (cedworks.com), by Alt-PressWatch (softlineweb.com), and by the Alternative Press Center (altpress.org). Reproduction of any content is subject to terms set by the copyright holder. Phone first for information. The views expressed by contributors are not necessarily those of the CCCR.

Government must remain an important insurer & 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, & central authority, for the sake of universal access to excellent service.

other community organizations can latch as they make their way into this sector. (See "Community Connections," p. 53.)

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. (See "Health Co-ops & the Future of Medicare," p. 40.)

Community development and 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.

But the need to make this option clear to our political leadership and to the public at large – now well-versed in the old terminology of "private versus public" – is urgent. It will take a combination of action by the whole great spectrum of community practitioners – co-operators, community health and Healthy Community advocates, medical professionals, and CED and social economy activists of every stripe – to get governments to look at this Third Way seriously, rather than curiously. (See "The Best Way to Predict the Future is to Invent It!" p. 58.)

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-centred health care deserves the full attention of the Canadian public and decision-makers in the debate over the future of our health care system.

DIANNE KELDERMAN is Chief Executive Officer of the Nova Scotia Co-operative Council and President of Atlantic Economics. She is also a member of the Canadian Community Economic Development Network (CCEDNet). Contact her at diannefk@tru.eastlink.ca or 902-896-7291.

DAVID ZITNER is Professor and Director of Medical Informatics at Dalhousie University, Halifax, and a family physician. He is Co-Principal Investigator of HealthInfoRex, a project exploring patient empowerment and the enhancement of physician services through the use of the internet. He and his co-authors at the Atlantic Institute for Market Studies are twice recipients of the Sir Antony Fisher International Memorial Award, for "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System" (1999) and for "Definitely NOT the Romanow Report" (2002). Reach him at 902-494-3802 or david.zitner@dal.ca.