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Rationing Health Care in Canada*

*Murray G. Brown***

This article examines how access to health care is managed in Canada's publicly financed healthcare system. It describes the evolution of new public sector management strategies designed to preserve Canada's "free," universal, and comprehensive healthcare programs during difficult economic times. The central theme is that dispassionate macro-rationing decisions throughout the healthcare system indirectly influence micro-rationing decisions at the clinical level, which in extreme cases involve highly emotive and value-laden choices about which patients shall, or shall not, receive vital healthcare services.

CANADA'S HEALTHCARE SYSTEM

Societal Values Regarding Equity and Efficiency

Canada's healthcare system reflects Canadian societal values and beliefs about the nature of healthcare services, about equity, and about how best to achieve equitable access to necessary health care. Societal beliefs include assessments of the relative efficiency and acceptability of funding and delivering healthcare services through the public sector, the private sector, or some hybrid system. In some of these matters, Canadian and United States values, beliefs, and assessments differ considerably.

Canadians view health care as something to which all Canadians should have equal access. Canadians are also pragmatic in pursuing public policy, embracing public sector initiatives as well as public sector/private sector joint ventures when it is advantageous to

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do so.[1] The Canada Health Act of 1984[2] requires that provincial Medicare programs be "*comprehensive, universal, portable, publicly administered and accessible.*"[3] The 1992 *Consensus Report on the Constitution, The "Charlottetown Agreement,"* addressed federal-provincial fiscal equalization objectives by stating that, to promote equality of access by all Canadians to necessary healthcare services, "*Parliament and the Government of Canada are committed to making equalization payments so that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.*"[4] Underlying these explicit equity goals regarding access to health care and public funding is the imperative to manage scarce public sector resources efficiently.

In order to understand Canada's healthcare system, its evolution, and the balance of forces that preserve and threaten its continued viability, one needs to understand something of Canada's constitutional division of powers and federal-provincial fiscal relationships. Program cost-sharing by federal and provincial governments, in one form or another, is the glue that binds the separate provincial programs into something that can be legitimately described as a "national" healthcare system. Through cost-sharing "carrots and sticks," Canada's federal government has been able to induce all provincial and territorial governments, which have constitutional responsibility for health under the Constitution Act of 1867,[5] to implement basic healthcare programs that are comprehensive, universal, portable, publicly administered, and accessible.

1. MALCOLM G. TAYLOR, INSURING NATIONAL HEALTH CARE: THE CANADIAN EXPERIENCE (1990). While individuals may disagree with some of the specifics of the Medicare system, such as the nature of healthcare services and the equity of service distribution, the federal health legislation and corresponding provincial and territorial government health legislation has been consistent with the five Medicare principles.

2. Canada Health Act of 1984, R.S.C. 1985, c. 6.

3. "Comprehensive" implies entitlement to a broad, but not unlimited, range of required health services, with no upper limits; "universal" means that provincial plans cover all legal residents in a province; "portable" means that health insurance coverage continues without interruption when a person's official residence is transferred from one province to another or when a resident travels outside the province; "publicly administered" is as stated; "accessible" in this context has come to mean that health services must be "free" at the time of utilization, i.e., there shall be no direct money cost to the patient.

4. GOVERNMENT OF CANADA, CONSENSUS REPORT ON THE CONSTITUTION, THE "CHARLOTTETOWN AGREEMENT" (Ottawa: Queen's Printer Aug. 28, 1992). The Charlottetown Agreement failed to pass a national referendum in October, 1992, but for reasons unrelated to clauses that reaffirmed commitment to the five principles underpinning Canada's health care system.

5. CONSTITUTION ACT, 1867, (U.K.), 30 & 31 Vict., c.3.

Basic Federal/Provincial Health Programs

Canada's basic health programs, often referred to collectively as "Medicare," cover hospital care, diagnostic services, and medical care (Figure 1). These are provincial programs jointly funded by federal and provincial governments.

FIGURE 1: CANADIAN HEALTH CARE PROGRAMS

	Basic Health Care "Canadian Medicare"	Supplementary Health Care
Program	• Hospital care • Diagnositc services • Medical care	e.g. - Nova Scotia's • Children's Dental Plan • Seniors' Pharmacare Plan
Principles	• Universality • Comprehensive coverage • "Free" access • Publicly administered • Portability within Canada	• Targeted populations • Selected coverage • User copayment ≥ 0 • Publicly administered
Jurisdiction	• Health care—provincial/federal • Medicare plans—Provincial	• Provincial
Similarity	• All provinces—very similar basic programs	• Differ across provinces
Funding	• Provincial $ • Federal equalization $ • Federal Established Program funding Medicare $ (Canada Health Act 1984)	• Provincial $ • Federal Equalization $

At the patient level, "accessible" care means "free" care when Medicare services are utilized. Patients, as taxpayers, know that "free" Medicare services are paid for through taxes. At the federal-provincial level, "accessible" care is fostered by fiscal transfers weighted in favour of poorer provinces. Federal cost-sharing takes two forms. First, the Canada Health Act and its antecedents provide for specific federal fiscal transfers to the provinces to support Medicare programs, contingent upon adherence to the five Medicare principles. Second, more general federal-provincial agreements provide for fiscal equalization payments to poorer provinces to enable them to offer "reasonably comparable levels of public services at reasonably comparable levels of taxation."[6] These equalization transfers augment provincial general revenues without strings attached, enabling poorer provinces to provide

6. Canada Health Act of 1984, R.S.C. 1985, c. 6.

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more public services, including Medicare programs, than would otherwise be possible.

It is misleading to regard Canada's Medicare system as a purely public sector system. Instead, it is a mixed system characterized by highly centralized public sector funding and a global management system that is combined with a decentralized healthcare delivery system. For example, included in the delivery system are not-for-profit hospitals; Red Cross blood service; other non-governmental organizations ("NGO"s); private practice fee-for-service physicians; physicians compensated on other bases; other health professionals; and private sector firms supplying goods and services used as inputs in producing hospital, diagnostic, and medical care services. Provincial governments directly deliver certain healthcare services such as mental health and long term chronic care. In addition, both federal and provincial departments of health provide a broad range of public health and population health programs that do not deliver direct patient care.

Parallel to Canada's publicly financed/mixed delivery system is a small but growing private market that complements the publicly funded system by providing services not covered by Medicare. Various administrative and economic barriers currently limit the range of healthcare services that can be offered, or offered profitably, in competition with Medicare programs. Whether Canada's secondary private market will be permitted to compete across the full range of Medicare services in the future is a sensitive political issue. A two-tiered healthcare system is anathema to those strongly committed to principles of equal access to necessary healthcare services for all Canadians.

Supplementary Provincial Healthcare Programs

Besides basic federal-provincial Medicare programs, provincial governments provide supplementary healthcare entitlement programs. The principles underlying these supplementary health programs differ from Medicare's five principles. Supplementary healthcare entitlement programs typically (1) are targeted at particular groups, (2) cover selective rather than comprehensive benefits, and (3) are "free" but, more frequently, include user copayment fees. For example, supplementary programs that provide drug coverage, dental coverage, and specific services of importance to targeted illness groups differ greatly from province to province despite similar health needs across Canada. This disparity in supplementary healthcare programs mirrors the substantial

inter-provincial differences in per capita income and tax revenue that exist even after substantial federal equalization payments to the poorer provinces.

Having briefly described Canadian values regarding equitable access to health care and the basic structure of federal-provincial Medicare programs and the supplementary provincial health programs that are the centerpieces of Canada's healthcare system, this article will next examine the necessity of rationing, in general, and the rationing mechanisms used in Canada's healthcare system.

RATIONING IN PRINCIPLE

What Is Rationing?

How is it possible to reconcile the equitable principles underlying Canada's Medicare programs—which appear to promise all Canadians "free" access to unlimited health care—with the need to ration Canada's limited economic and healthcare resources? Realities of resource scarcity necessarily temper Medicare's goal of providing "free" access to comprehensive health care for all Canadians. Medicare's equitable principles, however, help to guide the allocation of scarce Medicare resources among competing uses and users.

Societies ration healthcare resources in ways that reflect their own societal values, beliefs, institutions, and history. In pure price-rationing systems, market forces determine who has access to healthcare services, with rationing determined by the distribution of purchasing power. Non-price-rationing systems adopt other entitlement criteria to determine who has access to available healthcare services while relying on charitable donations or public taxation to fund healthcare services. Hybrid rationing systems combine non-price entitlement criteria with user copayment pricing policies.

Decisions that "ration" healthcare resources within a publicly funded healthcare system, such as Canada's, occur at many levels. Rationing at the macro (managerial) level is implicit in government decisions about the overall size of healthcare budgets and allocations to Medicare and competing health programs. Macro-rationing decisions at each successive level of management set the stage for micro-level rationing decisions involving individual patients and healthcare providers.

At the macro level, rationing is performed in the abstract: governments allocate scarce resources among competing uses and

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users. At the micro level, patients and providers are usually unaware of the many macro management decisions that indirectly affect patient/provider behaviours and utilization of Medicare services. Neither patients nor providers show much interest in macro allocation issues when patient access to non-urgent healthcare services and provider workloads are reasonable. However, in more dramatic cases, micro rationing at the patient/provider level involves highly emotive and value-laden decisions about who gets access to scarce services that may be vitally important to either the length or quality of the patient's life.

Equity, Effectiveness, and Efficiency in Theory

All Canadians are entitled access to "necessary" Medicare services. Medicare's equal access principle includes both a horizontal and vertical interpretation of equity or fairness. Horizontal equity implies that persons having comparable health problems and comparable prospects of health status improvement if they receive healthcare services are equally entitled to those services. Vertical equity implies a priority ranking of persons entitled to healthcare services, with priority given to persons having greater healthcare needs for which effective treatment exists.[7] Medicare's universal entitlement principle is interpreted to mean equal access, taking into account the urgency of healthcare needs, the effectiveness of treatments available, and the expected yield of health benefits. This interpretation is expected to guide both macro-level and micro-level decisions about the allocation of scarce Medicare resources.

To maximize the improvements of Canadians' health, evidence of the comparative clinical effectiveness, cost-effectiveness, and efficiency of the healthcare system is essential. To maximize program and clinical benefits, Medicare managers and clinical care providers need information on the relationship between healthcare service utilization and health outcomes, as measured by change in health status. In principle, only "medically necessary" healthcare services of proven effectiveness are covered under Canada's Medicare programs.[8]

Under ideal conditions, public sector health resources would be

7. The ranking of health services needs, from both equity and efficiency perspectives, should take into account the net present value of health benefits expected in present and future time periods from the full spectrum of demonstrably effective health care services, i.e., diagnostic, curative, management, rehabilitation, palliative care, prevention services, and health promotion services.

8. This determination is a source of contention. *See* Margaret A. Shone, *Health, Pov-*

allocated among competing health programs and services so that incremental health benefits would be the same for the last dollar spent on each program and service. If such conditions were attained, it would be impossible to increase further the total health benefits by reallocating resources from one health program or service to another. Applying similar efficiency criteria to all public sector programs, available public sector resources would be optimally allocated when, at the margin, the perceived value of health program benefits per dollar spent are similar to those of all other public sector programs, such as education, justice, or defense. The optimal size of the public sector versus the private sector is achieved in principle when the expected gain from public sector programs financed by a marginal tax dollar is equal to the expected loss of benefits from private sector consumption foregone.

Before turning from the discussion of rationing under ideal conditions to rationing in practice, it is important to note that the universality and equity principles that guide Canadian Medicare and other public sector health programs serve to clarify the objectives of health resource managers. The principle of "equal access to all" directs both macro-level and micro-level managers of public sector health resources to focus on health outcomes, independent of socioeconomic or other characteristics of individual Canadians eligible to receive healthcare services.

RATIONING IN PRACTICE

The gulf between how scarce healthcare resources should be allocated in theory and what is possible in practice is considerable. Efficient managerial decision making at both macro and micro levels is severely limited by the extent to which relevant data is unavailable, incomplete, or imperfect. Even when valid and reliable data exists, its value as an indicator of the most fundamental of relationships between health service inputs and health outcomes is uncertain. The current state of scientific knowledge about the comparative clinical effectiveness, cost-effectiveness, and program effectiveness of alternative interventions for various acute and chronic states of ill health and various health promotion and prevention programs is incomplete at best. This reflects substantive difficulties in measuring functional relationships between healthcare services and health outcomes for many types of health services and health problems. Even when clinical effectiveness is carefully

erty and the Elderly: Can the Courts Make a Difference?, 29 ALTA. L. REV. 839 (1991) (noting uncovered medical needs of the elderly and poor).

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measured and positive health benefits are demonstrated statistically, the results for individual patients are often uncertain, encompassing a wide range of health outcomes. Given such uncertainty at the clinical level, there is increasing recognition that it is necessary for the clinician, acting as the patient's agent, to take patient values into account when making clinical decisions in order to achieve appropriate utilization of health services.[9]

Triage Rationing

In practice, non-price rationing within Canada's public sector health programs is based on a form of "triage:"[10] when health resources are inadequate to meet all demands for health services, resources are explicitly or implicitly ranked and rationed by the degree of "need" for effective health care. "Need" is a slippery concept, of course.[11] If an extremely broad definition of "health" is adopted, for example a definition incorporating physical, psychological, social, and spiritual dimensions, then almost any health service, including placebos and purely compassionate care, may contribute to better health. But even if one accepts in principle a broad definition of "health," there are enough genuine problems of ill health in the population, together with opportunities to provide demonstrably effective acute care, illness prevention, and health promotion services, that health program managers may focus on health "needs" nearer to the "important" end rather than the "trivial" end of the health program "needs" spectrum. By considering both the importance of particular health problems and the effectiveness of available prevention and treatment strategies for particular health problems, healthcare services and programs may be ranked roughly in terms of their expected health outcomes and cost-effectiveness. Available data on the costs and benefits of alternative health enhancement strategies, despite its flaws and incompleteness, is used implicitly or explicitly to allocate (ration) available healthcare resources following triage principles.

The amount of health care to provide for purely compassionate and humanitarian reasons cannot be resolved by reference to scientific evidence of clinical effectiveness or economic efficiency. Once

9. Relevant patient preferences and values include attitudes toward risk avoidance, time trade-offs, and the patient's expected treatment results.

10. *Triage* [Fr. "sorting"] the sorting and classification of casualties of war or other disaster, to determine priority of need and proper place of treatment. DORLANDS ILLUSTRATED MEDICAL DICTIONARY (25th ed. 1974).

11. Alan Williams, *Need—An Economic Exegesis*, *in* ECONOMIC ASPECTS OF HEALTH SERVICES (A.J. Culyer & K.G. Wright eds., Oxford: Martin Robinson 1978).

again, societal values emerge as the ultimate reference point in getting the right balance of public sector healthcare resources allocated for improved health outcomes versus those allocated for purely compassionate care. For example, how much palliative care or care for persons with incurable mental or physical handicaps should be given?

Public Administration as a Cost Containment Strategy

Canada adopted a publicly funded and administered Medicare system because it was, and is, perceived to be a more effective, efficient, and equitable organizational structure for achieving Canada's healthcare goals than alternative systems characterized by less centralized control. Evidence comparing the evolution of the healthcare systems in Canada and United States over the past three decades indicates, at least to Canadian observers, that Canada's more centralized system of health policy formulation, universal coverage, tax-based funding, and program management at the macro level combined with a decentralized healthcare delivery system in which arms length not-for-profit institutions and independent private physicians manage the delivery of healthcare programs at the micro level has important economic advantages in managing healthcare resources. Whether future historians will agree that the organizational structure of Canada's Medicare system is comparatively effective and efficient is an open question.

Canada's public sector management of basic healthcare programs derives substantial cost savings in five ways: (1) avoidance of health insurance marketing costs, which are a significant portion of costs incurred by private healthcare insurance companies, (2) avoidance of private insurance company costs of screening "high risk" applicants, (3) very low costs for central administration and claims processing for Canada's medical care and pharmacare programs (about three percent of total program costs), (4) mechanisms for centrally managing the capacity and total cost of the healthcare delivery system in ways unavailable to private sector insurers, and (5) avoidance of the substantial accounting, billing, and collection costs incurred in price-rationing systems, which provide each patient with an itemized invoice for all medical care utilized. These are the more obvious direct cost savings associated with a non-price-rationing system.[12]

12. Robert G. Evans, et al., *Controlling Health Expenditures—The Canadian Reality*, 320 NEW ENG. J. MED. 571-77 (Mar. 2, 1989).

From "Open-Ended" Expenditures to "Managed Growth"

Canada's publicly financed healthcare entitlement programs have evolved over recent decades from programs characterized by "open-ended" access and costs to programs characterized by "managed growth" of both capacity and costs. This evolution reflects the need to develop public policy and management mechanisms to reconcile expenditures on healthcare entitlement programs, which programs appear to promise open-ended access to health care with the economic realities of limited resources available for such programs.

Strategies designed to limit Medicare program expenditures to acceptable rates of growth consistent with their respective fiscal capacities were initiated by the federal government and all ten provincial governments. Because health care is within provincial jurisdiction, the federal government is limited to offering fiscal cost-sharing carrots and sticks. The provinces, as managers of the Medicare programs mandated by provincial legislatures, have a broader range of program management tools available to them. These tools include (1) redefinition of program entitlements, (2) health sector capacity management, and (3) financial management strategies. Because provincial management options are fewer for Medicare programs governed by the Canada Health Act of 1984 than they are for provincial supplementary health programs, it is instructive to compare the managed growth strategies applied to these two classes of healthcare programs.

Federal Managed Growth Strategies

The Canadian government offered large financial incentives to induce the provinces to establish Medicare programs that adhere to Medicare's five principles through legislation such as the Hospital Insurance and Diagnostic Services Act of 1957,[13] and the Medical Care Insurance Act of 1966.[14] The federal government initially offered to share about one half of Medicare costs, paying a higher portion of costs in poorer provinces. In the 1970s, the federal government insisted on new cost-sharing arrangements that limited total federal fiscal liability for Medicare costs by linking growth of federal contributions to growth in population and gross national product.[15] Since then, federal cost-sharing has continued to fall

13. Hospital Insurance and Diagnostic Services Act, S.C. 1957, c. 28.
14. Medical Care Insurance Act, S.C. 1966-67, c. 64.
15. Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, S.C. 1976-77, c. 10.

given low real economic growth, the worst economic recession since the 1930s, and a large and growing national debt. Federal government-established Program Financing Contributions/transfers to provinces were frozen and are now falling; they no longer grow with the economy as a whole and the amount of cash transferred in tax credits is falling even further.

The replacement of open-ended federal cost sharing agreements with formulae that have progressively limited total federal fiscal liability for Medicare, in both real and proportional terms, has increased provincial incentives to contain Medicare costs, as intended.[16] However, by progressively reducing federal cost-sharing of Medicare programs, the threat of the termination of such funding is greatly reduced, thereby weakening the federal government's capacity to induce all provinces to continue to provide basic healthcare programs that conform to Medicare's five principles.

Provincial Managed Growth Strategies: Medicare Programs

Provincial strategies to manage the growth of Medicare program expenditures include modification of program entitlements, management of the size of the province's healthcare system, and financial management.

Program Entitlements

Provincial government initiatives to modify or reinterpret fundamental Medicare principles are limited by the federal/provincial cost-sharing agreements included in the Canada Health Act of 1984 and its subsequent revisions. No province has challenged Medicare's principles of universality, public administration, and portability. What constitutes comprehensive coverage, however, is open to various interpretations and revisions. This is not surprising given the difficulties noted earlier in defining "necessary" medical care, for whom, when, and where. As fiscal conditions have

16. The Established Program Financing Act ("EPF") removed the distorting effect of "50 cent Medicare dollars," whereby provincial healthcare managers bore only approximately 50% of program cost increases under the initial federal/provincial cost-sharing formula. By moving to a system whereby provincial treasuries bear the full cost of marginal increases in Medicare program costs, apart from specific cost increases borne by the federal government under the EPF cost-sharing formula, the incentive to contain costs increases.

Provinces considering the introduction of selective user copayment fees as a cost-containment strategy are discouraged from such experimentation. The Canada Health Act of 1984 requires the federal government to deduct $1 of Medicare payments made to a province for every $1 in Medicare copayment fees collected in that province, either by physicians or by the provincial government.

deteriorated, provincial Medicare program managers have deinsured certain healthcare services.[17]

In principle, criteria for determining which healthcare services to insure or deinsure should be based on valid and reliable evidence of comparative clinical cost-effectiveness. In reality, such evidence for the thousands of hospital, diagnostic, and medical care services covered by Medicare programs is scarce, uncertain, incomplete, and frequently inconclusive. Hence, even well-informed evaluations of which services are least cost-effective and hence prime candidates for deinsurance are subject to challenge. However, the need to revisit the question of what constitutes "comprehensive" Medicare coverage illustrates that the definition of what is "necessary" health care is a function of changing fiscal constraints as well as of expected health benefits and costs.

Periodic reexamination of what constitutes "necessary" medical care is appropriate considering the optimization criteria discussed earlier in the section entitled "Equity, Effectiveness, and Efficiency in Theory." The boundaries between "necessary" and "unnecessary" healthcare services are not fixed in stone, but rather will expand or contract as conditions change. For example, when Medicare resources were expanding in the 1960s and 1970s, Medicare coverage expanded to incorporate new services and cost-effective medical technologies without displacing other healthcare coverage. The negligible growth in real income per capita since the 1970s has curbed the rate of growth of Medicare resources. Under such conditions, it appears appropriate to deinsure those healthcare services judged to have low marginal contribution to improved health outcomes in order to redirect scarce funds to other existing or new health services judged to be more cost-effective.

Canada's federal government has not challenged the recent deinsurance of selected healthcare services by various provinces. This may be because the deinsured services constituted such a small part of total Medicare coverage. However, if provincial economies continue to deteriorate, the question of what healthcare services are in fact "necessary" is certain to recur. In a world of continuing and rapid change, program optimality boundaries also undergo continuing change.

17. For example, Nova Scotia's Medicare benefits cover a routine annual eye examination every 24 months, rather than every 12 months, effective 1992. In cases where more frequent eye examinations are deemed medically necessary, however, Medicare continues to cover all such examinations.

Capacity Management Strategies

In publicly funded healthcare systems such as Canada's, where a consumer price system is not used to determine the overall size of the system, management of the system's capacity to produce healthcare services and management of the cost of inputs is tantamount to management of total healthcare costs. Say's Law, which posits that "supply creates its own demand,"[18] drives total healthcare system costs when needs are ill-defined, the effectiveness of alternative treatments is difficult to measure, evidence of comparative cost-effectiveness is scarce, and the propensity to utilize services is governed by the degree of convenience to patients tempered by micro-rationing decisions of healthcare providers. In such systems, the increased capacity to provide healthcare services results in increased utilization at both the extensive and intensive boundaries of healthcare needs.

Canadian provinces manage the capacity of their healthcare systems in much the same way as would managers of a prepaid Health Maintenance Organization ("HMO"). Of course, provinces have more tools to manage capacity than their private sector counterparts. Provinces also have public health goals that are served by the full spectrum of health programs, from acute care through health promotion, and are facilitated by the contribution to health of many other public programs besides those housed in health departments. The examples of capacity management provided below will be restricted to hospital-based services and to physician services, which together account for about eighty percent of provincial healthcare service expenditures.

Hospital Capacity

The capacity of the hospital sector is directly or indirectly controlled by provincial governments. Capacity management includes the number and location of provincial not-for-profit hospitals, the number of beds, the role of the hospital (e.g., acute or chronic care; local, regional, or tertiary care; inpatient or outpatient services; range of diagnostic services), and the amounts of capital equipment and staffing. Hospital operating budgets depend almost entirely upon provincial government grants, which reflect the hospital's provincially defined role. Capital budgets to expand or update hos-

18. The French economist Jean-Baptiste Say (1767-1832) developed his theory in a different context; however, observers of healthcare systems have long recognized connections between growth in capacity and growth in utilization at both macro and micro levels.

pital capacity are dominated by provincial contributions but do include funds raised in communities. However, the provinces' control is not absolute. Provinces no longer cover hospital operating deficits as they once did. In addition, while the range of services offered by hospitals is constrained by their role and their global budgets, the way in which healthcare services are to be delivered is determined by the hospital board, its administrators, and its professional staff.

Another technique used by provinces to control capacity involves hospital-based physicians. Few hospital-based physicians are hospital employees. Almost all are independent fee-for-service practitioners who seek hospital appointments in order to use certain hospital facilities and services when serving their patients. These appointments require them to perform some unpaid functions within the hospitals. As part of their capacity management strategy, some provinces are taking increasing interest in whether new medical staff appointments, particularly specialist appointments, are consistent with a hospital's role and budget.

Physician Supply

The growth in the utilization of physician services in Canada is closely linked to the growth in the number of physicians. The capacity of Canadian medical schools was increased by fifty percent in the 1960s, when provincial Medical Care Insurance programs were introduced. In retrospect, not all of this increased capacity was needed, as Canada's population increased less rapidly than anticipated and immigration of foreign trained physicians increased more rapidly than anticipated. Consequently, the number of physicians per capita has more than doubled over the past twenty-five years, despite restrictions placed on the immigration of foreign-trained physicians in 1974. Federal/provincial ministers of health first publicly acknowledged an excess supply, or at least an excessive rate of growth, of physicians in Canada in 1992. The rate of growth of the number in physicians in Canada is being cut ten percent by reducing enrollments in Canadian medical schools effective 1993 and by a similar reduction in the immigration and licensing of foreign trained physicians.[19]

19. British Columbia's attempt to limit physician numbers, by restricting a physician's choice of practice location, was struck down as a breach of the physician's Charter Rights in Wilson v. Medical Services Commission of British Columbia, 2 W.W.R. 1 (B.C.C.A. 1989), leave to appeal refused.

Financial Management Strategies

Managed growth strategies for public sector programs funded by global budgets, such as hospital services, have not had to be particularly innovative. As fiscal conditions have deteriorated, the growth of Medicare program budget allocations has been reduced, eliminated, or cut in terms of real purchasing power. Operating deficits are no longer sanctioned retrospectively, as in more prosperous times.

More innovative management initiatives have been required to manage the rate of growth in expenditures on "open-ended" health programs, where expenditures are driven by utilization of services provided by private practitioners. Cost containment strategies have focused on Medical Care Insurance programs, which are the largest of the "open-ended" programs. Bilateral fee schedule negotiations between the provinces and provincial medical associations moderated the escalation of medical fees, relative to United States medical fees, during the 1970s and 1980s, but did not control or fully offset growth in expenditures due to increases in the volume of billings for insured services per physician (and per patient) and increases in the number of physicians per capita. In the past decade, all provinces have attempted, in different ways, to modify their open-ended medical care programs so that they are constrained by a global cap or ceiling on expenditures, similar to that of most other public sector programs. Typically, if a global expenditure cap will be exceeded, fees paid to providers of insured services are reduced just enough to assure that expenditures do not exceed the global cap.

Global capping puts considerable stress on medical associations as their membership adjusts to this new zero-sum-game environment. The result is a renewed interest in tackling perceived fee schedule inequities and large differences in inter-specialty earnings. Some provinces have introduced caps on individual gross earnings within selected specialty groups. One positive result of these global capping initiatives is the evolution of joint management committees comprised of provincial health department and medical association representatives. These committees are formed in recognition of the fact that cost-effective delivery of medical care services within a regime of global expenditure caps calls for new joint management strategies. The mandates of these joint management committees extend far beyond annual fee schedule negotiations to include issues such as medical manpower planning, licensure, quality assurance, and public accountability.

Provincial Managed Growth Strategies: Supplementary Healthcare Programs

Provincial supplementary health programs, in contrast to Medicare programs, are characterized by (1) targeted population coverage, (2) selective healthcare coverage, and (3) user copayment fees. Like Medicare, supplementary healthcare programs are publicly funded and administered, but services are typically delivered by nongovernmental entities and private practitioners. Eligibility for particular programs is restricted to residents of the province.

Provinces enjoy much greater freedom when developing managed growth policies for healthcare programs supplementary to federal/provincial Medicare programs. These supplementary programs are created by the legislatures of each province and are financed entirely from provincial revenues. Thus, they differ greatly from province to province. Such programs are therefore subject to modification in all respects as the financial circumstances of each province change.

Examples of changes in supplementary health program entitlements in Nova Scotia are: (1) the targeted population entitled to Children's Dental Plan benefits was reduced from children up to age 16 to children age 12, (2) the benefits covered under the Children's Dental Plan and the Seniors' Pharmacare Plan were reduced, and (3) user copayment fees were increased for the Seniors' Pharmacare Plan and for a subsidized ambulance transportation program. Similar examples may be drawn from other provinces. When provinces are free to do so, as with their supplementary health programs, they adopt both price and nonprice cost containment strategies.

Difficult Choices

Difficult choices as to who will have access to available healthcare services are inevitable, given the scarcity of resources relative to healthcare needs. Enlarging or contracting the healthcare sector simply shifts the boundary conditions where these choices arise. Societies are reluctant to acknowledge that difficult and sometimes "tragic choices" must be made and may mask how such choices are made.[20] When possible, governments avoid formulating explicit rules governing these choices.

In matters of medical care, where dramatic choices of life and death are involved, the choice of criteria for deciding who will get

20. GUIDO CALABRESI & PHILLIP BOBBITT, TRAGIC CHOICES (1978).

access to care that is in critically short supply has traditionally been left to the providers of health care. Given the principles of universal and equal entitlement to Medicare services, this leaves Canadian physicians free to rank all patients using criteria of expected health outcomes.[21] If macro-level managers of publicly funded health programs conclude that rationing criteria other than expected health outcomes should be used, they must explicitly state such criteria.

SUMMARY

Canada's experience with its universal, comprehensive, and accessible ("free") publicly financed healthcare system has been comparatively successful over the past several decades in achieving its stated health system objectives while constraining the growth of health system costs. The following observations are drawn from this experience.

The comparative success of Canada's Medicare programs is due in large part to the structure of Canada's healthcare system, which is comprised of a fortuitous combination of centralized tax-based federal/provincial funding; decentralized macro-level management of ten provincial Medicare programs, as required by Canada's constitutional division of powers; and decentralized micro-level management of the delivery of healthcare services through contracts with various nongovernmental organizations, private practitioners, and private sector firms that operate at arms length from government. The cost savings associated with public sector funding and management of this universal, comprehensive, and accessible healthcare services system have been substantial.

Recent stresses within Canada's healthcare system are largely fiscal in origin. Slow real economic growth compounded by a severe economic recession, the cost of servicing a growing public debt, and the rapid expansion of expensive technology and treatments have forced both federal and provincial governments to make politically difficult decisions designed to reduce the rate of growth of public programs in general and of health programs in particular. Once the economy recovers, Canada's health sector will undoubtedly continue to grow in absolute terms. However, if government managed growth objectives are achieved, the health sector will not grow as a percentage of public sector expenditures or the Gross National Product.

21. This inherently creates a tension for the physician between his or her role as patient advocate and his or her role as gatekeeper.

Problems inherent in (1) evaluating changes in the health status of both individuals and populations, (2) measuring the effectiveness of health care, diagnostic, disease prevention, and health promotion services, and (3) measuring the relative value of health improvements of individuals suffering from different types of health problems exist and will persist given the difficult nature of such measurements. In the absence of valid, reliable, and complete scientific data on the clinical effectiveness, cost-effectiveness, and comparative worth of all insured healthcare services and other health programs, it is impossible to compare the efficiency of Canada's (or any other) healthcare system with an established "gold standard." Consequently, even well-informed observers may disagree about the comparative advantages of Canada's healthcare system and whether available resources are appropriately managed at the macro and micro levels.

Canadians are strongly supportive of their healthcare system. They take satisfaction in the egalitarian objectives and achievements of Medicare and other publicly financed health programs and they appreciate entitlement to basic healthcare services through a public sector system that pools risks and costs among all Canadians. Access to basic healthcare services is generally regarded as satisfactory.

Rationing of health resources occurs indirectly through the public sector budgeting decisions at the macro level and through decisions of clinical service providers at the micro level. In principle, clinical care providers and other micro level managers in Canada's publicly financed healthcare system try to ration patient care at the margin using "triage" principles based on expected health outcomes. Macro-level managers try to ration available health resources among competing health programs so as to maximize benefits to Canadians collectively.[22]

Budgetary decisions by Canadian politicians and other macro-level managers implicitly take into account available scientific data on the health benefits and costs of insured healthcare services. These macro resource allocation decisions include implicit normative judgements concerning the (largely unmeasured) relative worth to Canadians of these publicly financed healthcare services

22. In practice, macro-level and micro-level decisions about resource reallocation may stray substantially from the principles described. For details on how decisions were made regarding the assessment and founding of new health technology in one province, see Adam L. Linton, *Organized Medicine and the Assessment of Technology Lessons from Ontario*, 323 NEW ENG. J. MED. 1463-67 (Nov. 22, 1990).

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and programs. However, difficult choices inevitably arise in all health systems, given resource scarcity. The specific boundaries where tragic choices manifest themselves will shift following the expansion or contraction of the healthcare sector, or following the reallocation of resources among competing health programs. Nonetheless, the difficult and sometimes tragic choices cannot be avoided.

Appreciation of Canada's societal values, institutional framework, and social history helps to explain current widespread support for Canada's publicly financed healthcare system, which is based on principles of universality, comprehensiveness, accessibility, public financing and public administration. Such an appreciation also suggests that Canada's healthcare system is unlikely to be suitable *in toto* for any other country because it reflects specific Canadian values, institutions, and history of healthcare services financing and delivery.

How best to ration health resources in any country raises questions that cannot be resolved by examining only scientific evidence on the relationship between healthcare service inputs and health outcomes. Consideration must also be given to normative issues concerning how (and whose) relative values are assigned to different health outcomes, to equity issues about who should be entitled to access various types of healthcare services, to funding issues about how best to fund various types of healthcare services and how to spread the financial risks of catastrophic illness, and to industrial organizational issues about how to efficiently integrate public sector and private sector roles in order to achieve a country's health policy objectives.