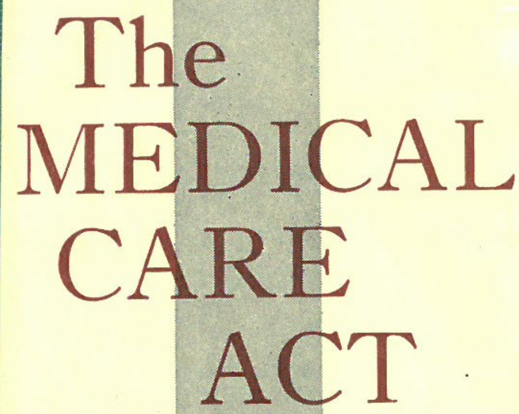

The MEDICAL CARE ACT

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Comments and Recommendations
by the Canadian Welfare Council

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Prepared by the Committee on Health Aspects of Welfare
Canadian Welfare Council
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THE MEDICAL CARE ACT

Comments and Recommendations

FOREWORD

The Canadian Welfare Council is on record as supporting a broad, government-operated personal health services program for Canadians.(1) Its Board of Governors expressed regret, in a resolution to the Government of Canada,(2) when the initiation date of the federal Medical Care Act was postponed from July 1, 1967 t July 1, 1968.

However, in the same statement, the Board urged that the interim period before implementation of the Act be effectively used by the provinces to prepare to "take full advantage of the provisions of the Act as soon as it becomes operative", and that the federal government assist by making available consultative services. The Board also stressed "that mere financing of health services is insufficient in itself, and that if needs are to be met, any financing measure must be accompanied by concurrent measures that will lead to greatly strengthening and augmenting Canada's health manpower and to improving the distribution and quality of personal health services".

The Council has now examined in detail the Medical Care Act, 1966. Comments and recommendations arising from this examination are addressed to both the federal and provincial governments. The latter will carry responsibility for the establishment of medical care programs

(1) *Health Services for Canada:* A Critique of the Report of the Federal Royal Commission on Health Services. The Canadian Welfare Council, Ottawa, July 1965, p. 9 (hereinafter referred to as *Critique*).

(2) November 3, 1966.

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in accordance with the Act, and will be engaged, in the period before its initiation, in devising new and revising existing programs to take advantage of the Act's provisions; the Council therefore presents certain principles which it believes should be taken into account during this period. The Council also presents suggestions to the federal government, to assist this process.

First, however, the Council wishes to strongly commend the expansion of the provisions of the Act, during its passage through Parliament, to permit the inclusion of services additional to those of a physician.[1] This opens the way to the development, under one Act, of a broad program of personal health services.[2]

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(1) *The Medical Care Act, 1966,* section 4 (4).

(2) The scope of health and related services under the Canada Assistance Plan is of interest here. The CAP health services eligible for federal cost-sharing approximate closely to those proposed by the Royal Commission on Health Services as a health services program for all Canadians and in certain respects (e.g., preventive services) are more specific. Not only the services of a physician but other direct health services and a number of related ones (e.g., home care and homemakers) are included. The list includes: health care services, which means "medical, surgical, optical, obstetrical, dental and nursing services, and includes drugs, dressings, prosthetic appliances and any other items or health services necessary to or commonly associated with the provision of any such specified services, but does not include insured services within the meaning of the Hospital Insurance and Diagnostic Services Act or any other prescribed hospital care services" (Canada Assistance Plan, section 2 (c)). In addition, such ancillary services as social work (e.g., family counselling) can be made available under the Plan. Any services provided on a universal basis under provincial legislation in accordance with the Medical Care Act would be eliminated from the Canada Assistance Plan, the health provisions of which are clearly stated to be *interim only* until included in provincial medical care programs.

The following statement, then, presents considerations which in the Council's opinion are necessary to the planning and implementation of the Act, if our goal of providing better health care for all Canadians is to be realized.

INTEGRATION OF PROGRAMS

The Report of the Royal Commission on Health Services[1] stresses the importance of a coordinated approach to all health services. For example, it relates its proposals for personal health services to federal-provincial hospital programs and to other organized community services.

The Canadian Welfare Council supports this view. For example, the opportunity afforded by the Medical Care Act to include additional personal health services in one piece of legislation is welcome, although the Council recognizes that introducing such additional measures may call for some degree of "staging" in an over-all program. The Council believes it important to establish the principle of integration and coordination of the programs made possible by the Medical Care Act with *existing* and *future* programs in other areas of health (hospital services, public health, dental care). In addition, there should be the closest possible cooperation between health and social welfare. The Council has many times reiterated the view that: "The objectives of health and social welfare programs are so interdependent as to be, in most cases, inseparable".[2]

Although not specifically stated in its wording, the Medical Care Act implicitly offers the opportunity for the development of an integrated program of all health services, which has already been endorsed by the Canadian Welfare Council.[3] *The Council therefore recommends*

(1) Hereinafter referred to as the *Hall Report* or Hall Commission.

(2) See inter alia, *Better Health Care for Canadians:* Summary of Major Findings, with Recommendations of the Submission by the Canadian Welfare Council to the Royal Commission on Health Services, May 1962, p. 2; and *Critique*, p. 3.

(3) *Critique*, op. cit.

that, in developing provincial plans under the Act, the following principles be adhered to:

a. *An integrated and coordinated program of comprehensive health services is the desirable goal for the people of each province.*

b. *As provinces implement the provisions of the Medical Care Act, planning should encompass the closest possible coordination of existing, new, and future services to the end that this goal of a unified, comprehensive program will be attained.*

c. *There should be the closest possible liaison and coordination in the development of health and social welfare programs.*

QUALITY OF HEALTH SERVICES

The Medical Care Act is in effect a financing mechanism to enable the federal government to share the costs of provincial insurance programs for personal health services. Accordingly, it is up to each province to determine whether its personal health services program will deal solely with payment for services or whether it will be concerned with their quality.[1]

The Council believes that the governments must be concerned with the quality of health services, as well as with the payment for them. The setting of standards is clearly a provincial obligation under the federal Hospital Insurance and Diagnostic Services Act, which requires the provinces "to make such arrangements as are necessary to ensure that adequate standards are maintained in hospitals . . .",[2] and "arrangements for maintaining records and providing statistical reports . . ." to the federal government.[3]

Undoubtedly, provincial initiative in a program that is largely implemented in the offices of individual medical practitioners is a somewhat more delicate problem than when one deals with institutions. Encouragement and as-

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(1) As used here, the term "quality" includes not only able, well-trained health personnel for all types of service, but also facilities and equipment which meet high technical standards, health services which encompass the best knowledge of modern medical science and which ensure availability and continuity of care, the timely provision of services without economic deterrents either for patients or practitioners, and sound administrative organization and operation, designed to promote efficiency and economy of service. (Based on a definition of the American Public Health Association.)

(2) *Hospital Insurance and Diagnostic Services Act, 1957;* Section 5 (b).

(3) Ibid.: Regulations, 1958; Section 4 (g).

sessment of good standards of service by practitioners must rest basically with the professions concerned. However, there are ways in which government, working with the health professions, can assist in improving standards: through promoting and supporting developments in the training of all health services personnel, through demonstration projects, through research and collection of statistics, and through evaluation of the effects of the program. Provincial governments would have primary responsibility for such activities, but the federal government could also assist, e.g., by providing technical consultative services, as it does now to provincial hospital service administrations (with the current shortage of skilled personnel, there are great advantages in having available a "pool" of experts that can be called upon, if desired, by any province), by assistance (through the National Health Grants) for employment of experts by the provinces themselves, by taking the initiative in formulating principles and methods for the collection of statistics and the evaluation of programs, etc.[(1)]

The Council believes that:

a. the standards of service in medical care programs are a responsibility of provincial governments; it urges that provincial governments give continuing emphasis to the steady improvement of these standards;

b. the federal government should make available consultative and other appropriate services to assist such action in every way possible;

c. substantially increased amounts of money should be made available through the National Health Grants, through the provinces, and through voluntary organizations, to en-

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(1) For further discussion of these points, see pages 15-16.

able the carrying out of demonstration projects, studies and research related to the quality of services.

Availability of service must also be the concern of government. Two factors are involved here: *payment for* and *distribution of* services.

a. *Payment*

i. The Medical Care Act states that the provincial plan should "provide for the furnishing of insured services . . . by the payment of amounts in respect of the costs of insured services in accordance with a tariff of authorized payments established or in accordance with any other system of payment authorized by provincial law, on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons."(1)

Since the meaning of the word "reasonable" is not defined for either of its uses above, it is wide open to varying interpretations. It is obviously intended that the tariff (fee scale) of payments to doctors and other health personnel should be set by the provinces. Obviously also, these scales will have to be based on negotiations with the professions concerned, which have every right to fair compensation for their services.

Equally, however, the provincial government, to discharge its responsibility to its citizens, must make the best possible use of public money. The interpretation of what is a "reasonable" as well as a "just" tariff may

(1) *Medical Care Act, 1966,* section 4 (b). In this context, "reasonable access" means *financial,* not *distributive* access.

well differ as between a provincial government and the professions.

The answer must lie in a fair-minded and, at the same time, a practical and sensible approach to the problem.

The Canadian Welfare Council believes that the aim in fee scales for payments to medical practitioners under the provincial medical care programs should be to establish a level which would encourage participation in the plan by all practitioners, and would discourage the practice of "extra billing".

ii. In considering "fee for service" in medical care, we normally think of a practitioner's fee for a particular service rendered to an individual patient. However, the Medical Care Act allows for "a tariff of authorized payments established pursuant to the provincial law or *in accordance with any other system of payment authorized by the provincial law . . .*"(1)

Clearly, this leaves the provinces free to interpret methods of payment (for the purpose of federal cost-sharing) in a very broad way.

The Council commends the flexibility thus permitted by the Medical Care Act. It is vital that "medical practitioners" (as defined by the provincial law) who wish to practice in a setting other than that of the individual, self-employed person, should be included in provincial plans under the Act. (Such health personnel might include, for example, salaried physicians in hospitals, doctors in group practice, and salaried personnel practising in isolated areas.) Such types of practice seem likely to expand and to make a real contribution to the availability of services, in both their financial aspects and their dis-

(1) Ibid. (italics added)

tribution, and thus merit recognition and support through the provincial programs.

The Council recommends that the provincial governments make use of the principle of flexibility in defining the system of payment of health personnel that may be included in provincial medical care plans.

iii. The Medical Care Act[1] excludes from its concept of provincial costs any co-insurance or "deterrent" charges. This appears to indicate that the federal government discourages such charges, which could have the effect of impeding "reasonable access to insured services by insured persons". The Hall Commission came out strongly in opposition to co-insurance or deterrent payments, on the grounds that it "would simply deter the poor and have no effect on the unnecessary demands of those in middle – and high-income categories. Such a policy would mean that Canada was simply continuing to ration health services on the basis of ability to pay . . ."[2] This position was endorsed by the Canadian Welfare Council.[3]

The Council repeats its view that the principle of no co-insurance or part-payment at the time of service should be adhered to.

b. *Distribution*

The matter of payment may affect the distribution of services, from the individual's viewpoint. However "distribution" also involves geographic and community factors.

i. Establishing facilities is an important aspect of availability. Government contribution to the "plant" for hospitals and community health centres has long been ac-

(1) Section 5, (4), (c) and concluding paragraph.

(2) *Hall Report*, Volume II, p. 6.

(3) *Critique*, p. 20.

cepted, and recent federal legislation provides for help in training health personnel and for health research. However, little attention has been paid to encouraging the increase and better distribution of services through capital assistance to other types of health facilities, e.g., for group practice sponsored by public or non-profit agencies or by private groups.

The Council believes that, where circumstances call for it (e.g., in urban renewal, rural and isolated areas) the principle of providing "social capital investment" (with regard to land, buildings and fixed equipment) should be accepted in relation to facilities for all types of health services, including group practice, and that: (a) encouragement should be given, possibly through a publicity campaign, to public and private bodies to take advantage of any existing provisions that would provide such assistance, and (b) additional measures to this end should be instituted, through amendments to the National Housing Act or otherwise.

ii. The Council also believes that the provision of services in isolated parts of the country is of such urgency that preferential incentives should be offered to encourage the "providers" to work in such areas.

The Council recommends that preferential treatment in the arrangements for incentive payments for services and in financial assistance for physical facilities be offered under the Medical Care Act, or by other means, to encourage health services personnel to work in isolated areas of the country.[1]

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(1) See also *Critique*, pp. 18-19.

iii. The Council urges that cognizance should be taken of the recommendations of the Hall Commission (endorsed by the C.W.C.) with regard to "the employment, on a regional basis, of certain types of scarce para-medical personnel, such as dietitians . . . medical social workers . . . physiotherapists . . ."[1] The Council went further, suggesting that the same principle be considered for "basic medical and surgical specialists" to provide regional consultative services.

The Council recommends that serious consideration be given to developing the regional use of selected health services personnel as a means of dealing more effectively with unmet needs.

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(1) Ibid.

ADMINISTRATION

One of the criteria for federal cost-sharing in a provincial program under the Medical Care Act is that:

> "The plan is administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province (hereinafter referred to as the provincial authority), that is responsible in respect of the administration and operation of the plan to the government of the province or to a provincial minister designated by the government of the province for such purpose, and that is subject in respect of its accounts and financial transactions to audit by such person as is charged by law with the audit of the accounts of the province."[1]

It is obvious that conditions will vary from province to province and initial decisions will have to be made accordingly. However, care should be taken not to lose sight of long-range goals. The problem of the "patchwork quilt" approach that has for so long dominated the development of public programs in the social welfare field should serve as a warning in this comparatively early stage of developing a health services program.

If the provincial programs concern themselves with the quality of services and with a truly integrated health services pattern, the form of provincial administration becomes very important. Intermediary agencies with government financial auditing control only would not be sufficient to ensure that these objectives are attained.

The Council believes that:

a. The form of provincial administration established should be based on the long-term

(1) Section 4, (1), (a).

aim of achieving a broad, integrated, "quality" health services program;

b. to attain this end, provincial administration should be a "public authority" in the fullest interpretation of the phrase.[1]

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(1) The Hall Commission recommended a provincially operated program and this was endorsed by the Canadian Welfare Council (*Critique*, p. 9).

EVALUATION OF PROGRAMS, HEALTH RESEARCH, AND STATISTICS

All programs, particularly public ones, should be subject to continuing evaluation to test their effectiveness. It is important to measure the improvement (or otherwise) of the health of the people, to relate such measurements to what is actually happening under the programs, both as to content and administration, and thus to assess remaining needs and how to meet them. Necessary or desirable steps in such a process would be:

1. National standards for health statistics should be established (such as now exist internationally) so that comparisons may be made across the country and complete information made available for the whole of Canada.
2. The federal government should convene federal-provincial technical meetings to design common procedures for the collection and dissemination of statistical data, to make possible comparable information for the assessment, comparison and interpretation of provincial programs.
3. There should be broadly-based surveys to measure health needs and the extent to which they are being met. (For example, there has not been a national "inventory" of the incidence of ill health since the Canada Sickness Survey of 1951.)

Because of the need for comprehensive knowledge on a national scale, the Council believes the federal government should take a strong lead in these matters and should share in the provincial costs incurred in such a research and evaluation program.

The Council therefore recommends that the federal government, in cooperation with the provinces, provide the initiative for and coordinate:

a. a system of uniform statistical reporting of provincial medical care programs (like the system considered indispensable under the hospital insurance program); and

b. a nation-wide program of research into, exchange of information about, and evaluation of health programs and related matters.

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