Letter from . . . Eastern Canada

Health care in Ontario

MICHAEL C BRAIN

British Medical Journal, 1976, **2**, 464-465

Like other western countries hit by inflation, Canada has introduced measures to control prices and wages and is trying to control public expenditure. Health and education take the biggest proportion of the budget of the Province of Ontario. Although the problems created by inflation are universal and all too familiar to doctors in Britain, the organisation and funding of physicians, hospitals, and other health services are sufficiently different to warrant discussion of the problems and of the measures proposed.

During the past 20 years most people in Canada have enjoyed an expanding economy and an enviable standard of living. Expenditure per head on education and health has been the second highest in the world after Sweden. Schools and universities have been expanded, new hospitals have been built, and existing hospitals enlarged. Yet it may be questioned, and is being increasingly so by politicians, whether Canadians are either better educated or more healthy than citizens of less fortunate countries. There is increasing and regrettable scepticism about the value of medical research and a trend towards supporting preventative medicine by improving the environment and the mandatory wearing of car seat-belts.

Funding health care

The attempts to control expenditure on health can be understood only if the ways of funding health care are explained. The Federal Government encouraged the introduction of universal health care through supporting public health insurance schemes and agreed to a cost-sharing arrangement with the provincial governments. The Federal Government has contributed half of the funds but has had little or no control over the rising costs. Faced with the need to reduce expenditure it is now passing legislation to limit the size of their contribution to the rise in productivity and change in population of the provinces. Faced with the prospect that half of the rising costs can no longer be recovered from the Federal Government and unwilling to increase the proportions of their budgets used for health, the provincial governments have no alternative but to control health care costs or increase taxes. In 1975-6 $2·9 billion, 28% of the budget for Ontario, will be spent on health.

Although the need to control the cost of health in Ontario is self-evident, the application of restraint is difficult. The problems are partly due to the two separate funding mechanisms for health services. Hospitals, and the diagnostic services they provide, are funded by one mechanism through controlled finite budgets, whereas physicians' services and non-hospital outpatient diagnostic services are provided on a fee-for-service basis at an agreed fee schedule and are funded through a separate agency of the Ministry of Health.

The Government has controlled hospital services by restricting the increase in the funds allocated and more recently by decreeing the closure of hospital beds or entire hospitals to reduce the number of active treatment beds to 4 per 1000 of the population in southern Ontario. The fee-for-service basis for paying physicians has led to no shortage of doctors; indeed some think one doctor to 585 people is adequate.

Laboratory services

The dual-funding mechanism has led to competition between the hospitals and the private sector, particularly in providing diagnostic laboratory services. Restriction on hospital expenditure has deterred hospitals from expanding their outpatient laboratory services. At the same time, the provision of a fee-for-test remuneration for commercial laboratories had led to their rapid proliferation and expansion. The payment to commercial laboratories increased from $20·7m in 1972 to an estimated $80m in 1975 in Ontario. The profit made by private laboratories partly reflects a fee schedule that is unrelated to the cost or volume of tests performed, despite the availability in hospitals of highly cost-effective automated equipment capable of performing many tests at an incremental cost, which is a fraction of the set fees. The proliferation of commercial laboratories has had some unfortunate and unforeseen consequences.

Much of the stimulus to investigate the cost-effectiveness of laboratory services has come from the Hamilton District Programme in Laboratory Medicine.[1] The advent of the McMaster University Medical School encouraged the Hamilton District Health Council to develop a regional laboratory programme in which the resources of the five hospital laboratories were so organised as to avoid duplicating specialised diagnostic services. The needs of physicians in the community have been met, in competition with commercial laboratories, by providing seven outpatient specimen-collecting stations and a car service to obtain specimens from patients ill at home. A dedicated transport service between the hospitals has enabled one or other of the laboratories to provide specialised high-cost diagnostic services and has facilitated the handling of specimens referred for laboratory tests from hospitals and commercial laboratories further afield. A consolidation of the hospital laboratory budgets and the collection of data and allocation of costs to the main disciplines of laboratory medicine have enabled the programme to account accurately for the cost of the entire range of its activities.

In March 1974, at a seminar held at McMaster University, the first few years' experience of the laboratory programme were described, and data were presented that suggested that the true costs of laboratory tests bore little relation to the fees received by commercial laboratories. The publicity these statements

Department of Medicine, McMaster University, Hamilton, Ontario, Canada L8S 4J9
MICHAEL C BRAIN, DM, FRCP, professor in medicine

Br Med J: first published as 10.1136/bmj.2.6033.464 on 21 August 1976. Downloaded from http://www.bmj.com/ on 20 April 2024 by guest. Protected by copyright.

received led the commercial laboratories to request the Minister of Health to review the claims as to the cost-effectiveness of the Hamilton District Laboratory Programme. This study, carried out by the Woods, Gordon, and Company accounting firm, took two years to complete and is one of the most comprehensive and complex cost analyses of laboratory services provided by a group of hospitals. The study included the analysis of all laboratory requests received, both on inpatients and outpatients, by five hospital laboratories in a week in May 1975 and related this to all the tests performed. The three sequential reports recently released by the Ministry of Health of Ontario concluded that, had it operated as a private laboratory, the Hamilton District Laboratory Programme would indeed have made a profit, albeit a small one.

The release of this report coincided with newspaper publicity of alleged corrupt practices by certain commercial laboratories. The allegations included gifts and commissions to doctors referring patients and billing for tests that had not been performed. Although commercial laboratories are licensed by the province, the only requirement laid down for their supervision is that of a registered medical practitioner. There has been considerable publicity of the Provincial Laboratory Proficiency Testing Programme finding that about 10% of the laboratories fell below acceptable standards.

These disclosures on the quality and cost-effectiveness of laboratories have coincided with the announcement by the Minister of Health of the closure of 1000 hospital beds, meaning that 5000 health-related professionals will be losing their jobs. A public inquiry into public and commercial laboratories has been called for but at the time of writing no action has been taken.

Financial circumstances, a minority Conservative government, and a highly articulate and courageous Minister of Health, Mr Frank Miller, who has recently had a heart attack, have led to decisions which will undoubtedly affect the future patterns of health care delivery in Ontario. The need to reduce the costs of health and the difficulties in implementing these decisions make it appear that the opposition parties are unwilling to defeat the Government. An appropriate analogy might be the national sport of ice hockey—a fast, rough game in which it is impossible not to become partisan whether watching one's son or daughter play or the professionals. The first period is over, the tempers are running high, and now that the provincial legislature has reassembled one expects at any moment the gloves and sticks to be dropped and the fights to start. Whether the benches will empty and so enable the public to give their verdict at the polls is yet to be seen. Meanwhile, the political scene in Ontario as it relates to health, like the hockey match, has one on the edge of one's seat.

Reference

[1] Brain, M C, *et al*, *Canadian Medical Association Journal*, 1976, **114**, 8, 721.

Contemporary Themes

Cost of management of patients with haemophilia

FELICITY CARTER, C D FORBES, J D MACFARLANE, C R M PRENTICE

British Medical Journal, 1976, **2**, 465-467

Summary

The cost of managing 114 adult haemophiliacs in the west of Scotland was assessed for the period 1 March 1971 to 28 February 1974. Altogether 23 of them (20%) accounted for 80% of the resources used. The cost of hospital treatment of these patients during the period was compared with the predicted cost of home treatment, given the availability of freeze-dried factor VIII concentrate in sufficient amounts. We calculate that adequate on-demand home treatment would cost only 16% more than the present treatment, which is substantially less efficient.

Health Services Operational Research Unit, University of Strathclyde, Glasgow G4 0NG
FELICITY CARTER, MSC, research fellow
J D MACFARLANE, BSC, director

University Department of Medicine, Royal Infirmary, Glasgow G4 0SF
C D FORBES, MD, FRCP GLAS, senior lecturer
C R M PRENTICE, MD, MRCP, senior lecturer

Introduction

In the past few years the availability of potent concentrates of plasma clotting factors has produced important changes in the management of patients with bleeding disorders. This, in turn, has led to a decline in mortality with a resultant increase in numbers of patients and a demand for facilities for self-administration of plasma concentrates at home.

Although the number of patients with haemophilia A is small, their consumption of medical resources is high. In the west of Scotland the mean prevalence of such patients is 1·12 per 10 000 of the male population. The prevalence of patients by age is shown in fig 1. There are apparently fewer haemophiliacs in the younger age groups because mild haemophilia is not always diagnosed until the teenage years or later, while the declining prevalence with age is probably due to the shorter life expectancy of haemophiliacs before effective treatment with factor VIII concentrates became widely available. If the prevalence in the group aged 19 to 23 years in 1974 (2·03/10 000 male population)

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