The Canada UK Colloquia

Health Care Systems in Canada and the United Kingdom

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List of participants

Mr Duane Adams
Deputy Minister
Department of Health
Government of Saskatchewan

Mr David Angell
UK and h-eland Desk Officer
Department of External Affairs, Ottawa

Mr and Mrs Serge April
Deputy High Commissioner
Canadian High Commission
London

Mr Geoffrey Bacon
Executive Director,
Canada-UK Chamber of Commerce

His Excellency Sir Nicholas Bayne
British High Commissioner, Ottawa

The Honourable M Benoit Bouchard
Canadian Ambassador to France

Dr Carol Clemenhagen
President
Canadian Hospital Association (CHA)

Dr Phyllis Colvinand (husband) Dr MichaelJenkin
Director of Health Policy Division
Health Canada

Mr John Cooke
Industry Affairs Manager
Glaxo Pharmaceuticals UK Limited

Ms Gaffney Devon Cross
President
Donner Canadian Foundation

Mr Gerald Dafoe
Canadian Public Health Association

Mr Alan Davis
Vice-President
SmithKline Beecham Pharma of Canada Inc.

Dr Maureen Dixon
Director of IHMS Consultants Ltd, London

Mr Peter Dobell
Founder Director
Parliamentary Centre for Foreign Affairs and Foreign Trade
Secretary/Treasurer of the Institute of Research on Public Policy

His Excellency Mr Fredriks Eaton and Mrs Eaton
High Commissioner for Canada
Canadian High Commission
London

The Honourable Judy Erola
President
Pharmaceutical Manufacturers Association of Canada

Dr Norbert Gilmore
Professor
Department of Medicine at the McGill Centre

Mr Graham Hart CB
Permanent Secretary of State
Department of Health, London

Mr Strachan Heppell
Deputy Secretary
Department of Health, London

Mr and Mrs Allan Hird
Executive Secretary
British Committee
Canada-United Kingdom Colloquia

Dr Ullrich Hoffmeyer
National Economic Research Associates, London

Miss Vivien Hughes
Canadian High Commission
London

Mr Ken Jarrold
Chief Executive
Wessex Regional Health Authority

Dr John Keown
Fellow, Queens College, Cambridge
Lecturer in Law and Ethics of Medicine, University of Cambridge

Professor Richard I Kitney
Professor, Biomedical Systems Engineering, Imperial College
Director of the Centre for Biological and Medical Systems (CBAMS)
Colloquium "Chairman"

Dr Leo-Paul Landry
Secretary-General
Canadian Medical Association

Professor Kenneth Lee
Director of Centre for Health Planning and Management
Keele University, Colloquium "Rapporteur"

Dr Peter Lyon
Institute of Commonwealth Studies
London University; and,
Chairman, British Committee
Canada-United Kingdom Colloquia

Mr Frank Mayuard
Deputy Minister
Department of Health
Government of Manitoba

Mrs Julia Montgomery
Canadian High Commission
London

Ms Heather Morrison
The Patients Association
London

Mr John Peet
The Economist

Dr Errol Pickering
Director General of the Inter-national Hospital Federation
London

Dr Tom Rathwell
Nuffield Institute for Health
University of Leeds

Rev Martin Smyth MP
Ulster Unionist member for Belfast South

Mr and Mrs Greg Traversy
Executive Vice-President
Canadian Life and Health Insurance Association

Mr Mark Turner
Canada *Desk Officer*
Foreign and Commonwealth Office
London

Dr Morton Warner
Executive Director
Welsh Health Planning Forum
NHS in Wales

Dr Roger Williams CBE
Vice President of the Royal College of Physicians

Mr A A Willis
European and International Affairs Manager
Association of the British Pharmaceutical Industry

Health care systems and health care reform

Kenneth Lee

INTRODUCTION

The serious student of comparative health care systems faces a daunting task. Not only is there a major challenge of seeking to understand and interpret the differences between (and, not uncommonly, within) countries in respect of their methods of resource mobilisation, resource allocation and resource management; but, also, the significant differences between countries in their cultures, social structures, politics, values and behaviour make comparisons often difficult if not heroic.

Yet, a belief exists – and rightly so – that no one country has a monopoly of wisdom in deciding upon the great issues of our time, and the health and welfare of populations can be considered to be one of the great issues. The 1990s heralds a decade of probably unparalleled inquiry into the concept of *health gain*; and, into the role and importance of health care services, both public and private, as major contributors to the pursuit of improving the health and well-being of individuals and populations.

It might reasonably be expected that countries at similar levels of economic development, with similar traditions of political democracy, and similar espousal of the rights of individuals to health care, and a shared recognition of the role of government in ensuring that these rights are respected, might be worth comparing and contrasting – in terms of their policies, plans, aspirations and achievements. That the literature is burgeoning is self-evident; that much remains to be done is also clear from the paucity of evidence and documentation to date.

The agenda for *health sector reform* may now accelerate the momentum in favour of looking across countries for lessons and insights; rather than relying, perhaps in too insular a fashion, upon one's own country experiences and prejudices. Transplantation is always a hazardous business; in comparative health care it can be fatal. The necessary conditionalities for success in one country setting may be imperfectly understood; or, worse still, not detected. In consequence, the organ of change may be rejected without sufficient care and attention to cross matching!

Nevertheless, when one is approached as Head of an International Centre for Health Planning and Management, and Editor of an

International Journal on the same theme, all the caveats and caution count for little. One convinces oneself, not without a degree to rationality, that both Canada and the UK do have some very important similarities and that it is not too heroic to consider simultaneously whether their two health care systems can deliver. In shorn I accepted the role of rapporteur to the proceedings, an invitation extended by the organisers: the British Committee for Canada-United Kingdom Colloquia, London, and the Institute for Research on Public Policy, Montreal; and to produce an edited text that would accompany the papers presented and a flavour of the lively debate that ensued throughout. This publication is the result of all our individual and collective endeavours.

I guess that, at the time, I accepted the invitation to be Rapporteur and Editor with a mixture of pleasure and foreboding: pleasure (and, maybe, indulgence) in that it would allow me to revisit some of the similarities and contrasts in health care systems between Canada and the United Kingdom; and, unashamedly, to renew friendships and make new ones. That was, however, coupled with a fair degree of foreboding: one that the role of rapporteur is forever an imprecise one; that it is probably, in unequal parts, an art rather than a science; and, that abstracts received and papers despatched become points of departure once presented. Well, all of that has come to pass; but, not in equal measure I am delighted to say, and the astute reader may detect an element of personal indulgence on my part from cover to cover.

The Colloquium took place in early November, over three days at Wiston House in Sussex, and was attended by some forty delegates from Canada and the UK, often with detailed knowledge of both country settings. Organisers of an International Colloquium are rarely blessed with perfect foresight, especially over the timing of their events, and so it proved this time. The event coincided with the immediate aftermath of the Canadian Federal Elections, when the results were largely known but barely digested, and the pressure of UK parliamentary sessions which demanded the time (and presence, in some cases) of parliamentarians, civil servants and others.

Notwithstanding, a distinguished gathering assembled, and were duly rewarded by a series of Autumnal mists which characterised the three days. Inside the splendid House, the level and quality of debate turned out to be far from misty, although the occasional agricultural turn of phrase e.g. reference to the Grim Reaper and the budget famine, did envelop the room from time to time. The language was a common one, though the terminology at times might be viewed as less than transparent, to the reader. We certainly identified asymmetry (moral hazard); we measured transaction costs; employed the Gini Coefficient; exposed cream skimming and Glasnost; defined proxy consumers, produced paradigms, functional justice; and, analysed concealed risk selection, centripetal effects and

downsizing. Indeed, while these and others appear in this text, hopefully their precise interpretation is made clear and such terms will not prove too testing on all our mind sets!

HEALTH CARE SYSTEMS

The idea of the Canada-United Kingdom Colloquium is to serve as a process of discussion between persons sharing a common political, social, economic and cultural heritage from two different countries, who share similar but not identical problems. In a sense, therefore, it was likely that our opening paper by Tom Rathwell, would be a litmus test for that idea (now appearing as Chapter Two). He necessarily invited the delegates, and was invited to do so himself, to paint on a wide canvas, and to examine health care systems from a comparative perspective. Disarmingly, he suggested he would explore some questions, but not put forward any answers. (In parenthesis, one can leave it as an open question as to whether he was thereby leaving sufficient material for subsequent speakers so that they would have the luxury of something positive to say; or, was he implicitly admitting that all the answers were not yet in?) However, whichever interpretation you take, Rathwell's chapter explores three themes: the first is the health care system itself; and, in a sense, that had challenges throughout the Colloquium – on the meaning of *health*, *care*, and *system*, as to what is ***health care*** and what is a ***health care system.*** A lively debate followed which bordered on saying that we were not in the business of producing health, and we were not in the business of providing care. Indeed, we might have aborted the whole proceedings if we had addressed the question of whether our respective countries could justifiably claim to possess health care ***systems!***

Fortuitously, and maybe because it was the first evening, we retreated from that kind of self-destruct strategy and moved on to Rathwell's second theme. This turned out to be the expectations one has of a health care system. Rathwell reviewed a number of ***attributes e.g.*** accessibility, efficiency, and so on, which turned out to be key points of discussion throughout the Colloquium as to their meaning and policy translation. At the time, discussion did not focus on whether there were trade-offs between the attributes, whether we could prioritise them, and whether or not they were mutually compatible. What we did look at were a number of performance indicators: for example, of expenditure on disability, on mortality, and on lifestyle issues.

The third of Rathwell's themes, referred to as the *policy puzzles*, included: universality versus personal choice, effectiveness versus efficiency, comprehensiveness versus selectivity, centralisation versus decentralisation. What in a sense these puzzles highlighted at the outset was that the

canons of health care contained in the Canadian Health Act (1984) and in the founding principles of the British National Health Service (1948) were, indeed, remarkably similar; universality, comprehensiveness, accessibility, public administration; portability. In short, they certainly walked across the Atlantic; the question remained, however, as to how we were going to interpret them in policy terms and in implementation. That, Rathwell concluded, was the *real* challenge facing politicians, providers and purchasers; and, one might say, the public itself.

PRESENT NEEDS AND FUTURE CONTEXT

Morton Warner's thesis (see Chapter Three) is to chart both the European and global health movement, and the adaptations that have taken, and are taking place; and, then, to offer some glimpses of the future i.e. how do we get where we want to be. On the first step, Warner revisited some of the important works produced on an international scale: on economic competitiveness; on substitution possibilities; and, on health care as a means to an end rather than as an end in itself. On the second step, he addressed the clear ***vision*** required if we are going to proceed and succeed i.e. looking forward rather than simply driving through the rear view mirror. To do so, Warner advanced, required attention to years ***to*** *life* and *life* ***to*** *years*, attention to people as individuals and to staff and customers, to intersectoral co-operation, and to efficiency and effectiveness (i.e. the health gain rhomboid). He introduced the concept of the demise of the District General Hospital, the rise of the closer to home movement, and the move from hierarchical to circumferential modalities. That the future could be significantly different from the present, not least in service delivery terms, was a theme echoed through the Colloquium. The steady state was not a realistic option.

Frank Maynard's thesis, in turn, is grounded in what is now known and provides us with an impressive dataset (see Chapter Four), The premise is that, given finite resources and increasing demand for seeming non-market services in terms of health education, income support, it is vital that we address the question of what business should we be in. From his perspective, one needed to be in the ***production of*** *health* business, and adopt a much more holisitic approach than at present, which went beyond the immediate boundaries of medical care and health care. Socio-economic determinants proved particularly challenging, as Maynard demonstrated the relationship between unemployment and health, socio-economic groupings and educational achievements, and so on. Indeed, he went on to offer a health warning, to the effect that one cannot expect institutional systems to rectify inequities rooted in early life and in society generally. A healthy ***social environment*** was likely, therefore, to be a key issue.

Both chapters and their authors recognise the inevitably of finite resources; it was not surprising, therefore, that discussion in the Colloquium focused heavily on rationing. While convenient phrases, such as priority setting or right-sizing might be employed in the political debate, nobody had any illusions that what we had to address under the heading of health care was: who does it, how, over what timescale, and to whom.

MANAGEMENT AND MONEY

Clearly, once strategic direction is assured and needs articulated, the issue of following through on that strategic direction and of harnessing the resources to do so, becomes all important. The next two Chapters, while with their own titles, are essentially complementary: employing the currency of ***management*** on the one hand, and the currency of money and *resources*, on the other. Maureen Dixon (Chapter Five) started her presentation by documenting some of the similarities – organisationally and managerially – between the two systems; clearly, clinical freedom, social contract, horizontal integration, severe financial pressures were included within the list. Strategic aims are clearly important, therefore, as is the importance of ensuring implementation. There is a gap commonly between strategy and implementation in many societies. Two pointers that Dixon wished to raise for wider debate were: firstly, whether or not in fact the social welfare function, is or could be, eroded by market forces; and, secondly, whether policy and strategic issues are capable of being separated from, or could be separated from, management5 right to manage.

Phyllis Colvin's presentation (Chapter Six) was ostensibly on Canadian health financing; ostensibly, because while it did provide a pretty clean sweep of relevant financial issues and portray the sources of finance, patterns of expenditure and benefits, its real messages were all to do with the scope for adjustment, improvement and control. Once again, the parallels with the UK were striking: with the reality of the single payer architecture, the degree of monopsony power that provides, and the immediate benefits of cost containment. Colvin's strategic reform package might look something like this: a shift from the institutional to the community, adjustments in hospital capacity, regionalisation, and adjustments to clinical practice and technical assessment. Most if not all of these were mirrored in Dixon's own list of strategic aims and objectives also.

The open forum that followed from those two presentations highlighted and debated a number of key issues including: strategy and its implementation; the responsibility of government; the responsibility of the individual; remunerating health care professionals; the scope and avenues for public participation; inter-sectoral initiatives to the promotion of health; the interface between management and the health care

professions; and, the corporate and individual responsibilities of the health care professions and of management. A number of suggested routes to follow were proposed; and, a corresponding number of cm-de-sacs identified ***not*** to go down.

The next speaker was Ullrich Hoffmeyer (and his paper appears as Chapter Seven, co-authored with Adam Lloyd). He presented a thesis that challenged and, indeed, sought to challenge the reliance of both the Canadian and UK systems on what may be termed their largely social welfare forms of financing health care systems; whethefunded, in whole or in part, from national and regional or indeed provincial tax monies. The alternatives to be considered, in terms of health care financing, included *sickness fund* models, and the *private* market. The main assumption of Hoffmeyer and Lloyd is that health care reform is necessary; it is merely a matter of how best we tackle it. Their concern, hence, was to review the options and to address the issue on empirical grounds and not on a ***priori*** grounds. The choice was a simple one, Hoffmeyer posited: either of a paternalistic system of planning, with some competition between providers; or, an alternative of competing social insurance funds subject to regulation, and relying more explicitly on competition on the demand side as well as on the supply side. Not surprising, perhaps, not all the delegates thought this to be quite unexceptional;, and attention focused on a number of themes, including: how much of the health care budget in Canada and the UK could be handled justifiably through a purely atomistic competitive environment; can competition between producers/purchasers for funds rest easily, and be compatible, within an overall health strategy; and, will competition amongst purchasers and/or insurers lead to the kinds of niche marketing commonly exhibited by private insurance. Ultimately, these questions summarise to one two-part question: whether or not there is a structural defect in single payer systems such as Canada and the UK in ensuring that there is no close correspondence between the payer and the patient; or, whether the benefits of consumer sovereignty outweigh the benefits of guided paternalism.

ETHICS AND THE LAW

To respond to that key question can be attempted on several plains of analysis, not least in terms of ethics and the law. The proposition offered by Nobby Gilmore (paper not reproduced in this volume) was a simple one; namely, that it is not unreasonable to assume that governments, either as providers and/or asfunders, want to be ethical and that ethical considerations should be addressed and analysed at all levels. i.e. macro, missal, micro. But, what does it mean to be ethical? Gilmore responded to his own question by inviting a systematic study of values, such as justice, respect, acceptability, professional discretion, and so on. No consensus

is guaranteed, of course, not even among a group of ethicists. The central problem for ethical consideration was how do we respond to infinite needs in a finite resourced world. While some may label the problem as (simply) an economic or a political one, it is most certainly an ethical one; indeed, many could, and would, label all dilemmas and problems in health care as having an ethical dimension.

John Keown (see Chapter Eight) agreed readily on the importance of ethics across a wide spectrum of issues, and yet chose to illuminate the issue specifically in respect of *euthanasia* and ***assisted suicide.*** By his own admission, his presentation and the chapter on which it is now based, is somewhat of a hop, skip and a jump through the literature, the reviews and the legal judgements. But, we are being encouraged to focus attention on ***liberty,*** and on the *security* of the person, and on the principle of *fundamental* ***justice.*** Unanimity of judgement is not assured by any group in society, including the legal profession; nine lawyers proceeding to four answers in the Sue Rodriguez case. (In parenthesis, that does seem to be a remarkable improvement on nine health economists and ten judgements). The issues drawn up by Keown are four-fold: one is the judicial role as arbiter compared and contrasted with that of the legislature; the divergent views expressed on the meaning and scope of rights; the perceived dangers of abuse as an incomplete and perhaps inadequate explanation for case laws; and, the appropriateness, or otherwise, of the principle of the sanctity of life.

This last issue, in particular, became the touchstone for an important debate among delegates about the imperatives of resource allocation, whereby the populations of Canada and the United Kingdom are divided by our respective health care systems into three categories: those who receive; those who are kept waiting; and, those who are denied. As delegates made clear, however, one simply (or, not so simply) had to make choices about the marginal dollar whether expressed in terms of health gain or other units: when deciding to favour chiropody at the expense of renal dialysis; to discriminate against those who knowingly or willingly hazard their own health e.g. smokers being denied cancer treatment; or issues of brain death. These illustrations confirmed that there is as yet no uniform system of ethics; that it is, indeed, a minefield; and, that it is not entirely clear from whom and how a system of *shared values* can be derived to influence resource allocation at both micro and macro levels.

THE FUTURE AND LONG RANGE PLANNING

Chapters Eleven and Twelve share the same title, but from the perspective of the UK and Canada respectively are provided by Strachan Heppell and Duane Adams, Not for the first time in this book, and in the Colloquium itself, are the themes remarkably similar. Heppell identifies

a number of ***a priori*** considerations in terms of the main elements of a planning framework, and seven features are chosen: access to health care, a reliable financial framework, strategy, priority setting, decision making, user voices, and monitoring and evaluation. He then proceeds to indicate how well the UK are doing as perceived at the central level. Looking ahead, so far as the UK is concerned, there is and always will be a tension between the centre and the periphery, and perhaps between competition and population-based approaches to planning. The issue, hence, is whether that is constructive or destructive. Clearly its also an issue about whose futurology, and how far we can indeed shape the future in such terms as the role of hospitals in long-term care and in such areas as the re-profiling of the labour force.

Duane Adams (Chapter Twelve) started from a not dissimilar standpoint; in fact, with the five key principles enshrined in the Canadian Health Act (1984), and went on to address some of the implicit and explicit shortcomings of the Canadian health care system. For instance, Adams considers the extent to which Canadian health care is provider driven, and to the extent to which it is acute oriented, pharmacological driven and illness focused. The start point for Adams must be: first, the articulation of goals; second, the definition of services to be included; and, third, the substantial inertia against seeking appropriate services. Not surprisingly, perhaps, debate in the Colloquium focused less on the founding principles of health care in Canada and the UK and more on their interpretation and relative importance. The debate, in short, was about realism, empowerment, the dispossessed, accountability and not about simply 'shoving clouds around'.

HEALTH GAIN

Chapters Thirteen and Fourteen are by Ken Jarrold and Carol Clemenhagen respectively, and are undoubtedly not about 'shoving the clouds around'; they are about health policy and the management agenda to effect health gain. What we want to have in place in purchasing, in the UK that is, is addressed by Jarrold's seven main stepping stones: of strategy, effective contracting, a knowledge base, local voices, mature relationships with providers, local alliances, and organisational capacity. How these requirements are coming together in the UK and what management action is still required were important themes. Undoubtedly, policy *formulation* is one thing, *implementation* is another. Many of the issues are still to be taken forward, Jarrold considers, including: integrated purchasing, the budget clash, accountability, consumer empowerment, the role of the professions. What is identified in the chapter are those factors at the heart of purchasing and health system decision making, namely: values;

evidence; opinion; and, self interest. And, it is clearly the interplay of these same factors that will weigh heavily in terms of a strategy for health, and its implementation.

Carol Clemenhagen's chapter expresses a concern that health education and health promotion could be marginalised in a health care system that is increasingly financially constrained. Clearly, there are concerns in both Canadian and UK settings about employment, about the demographic time bomb, about income capacity, about protecting children, about cardiovascular disease, and about the diseases of affluence and socio-economic status. What should be done requires a careful examination of the determinants of health, the priority attached to them, and to seeing health both as an investment and as a consumption good. The challenge is to try and destroy the false antithesis, namely that you can have one or the other – but, they are not substitutes they are complements, one is not a replacement of the other. It does mean, of course, that health education and health promotion is everyone's business, but that does not make it easier to delineate the precise roles and responsibilities of the individual and society in the production, and maintenance, of health.

SUMMARY AND CONCLUSION

So that brings one back full circle to the question posed of the Colloquium. Can our respective health care systems deliver? From the debate of the three days, there was no school of thought advanced that a cataclysmic event was imminent; rather, health sector reform was seen to be inevitable and likely to be significant; yet, evolution rather than revolution was the most likely scenario. Why? The authors of Chapter Nine and Ten may have provided the necessary clues. Graham Hart, Permanent Secretary of State in the Department of Health, England, and The Honourable M Benoit Bouchard, former Canadian Minister of Health, from their own vantaged positions emphasise the importance, and commonality, of the founding principles of the two health care systems now, and in the future.

Both speakers emphasised, and rightly so, the strength and importance of the principles that underpin the two systems; and, in any reform process, perhaps it does need to be emphasised that history and continuity do have their part to play. At the same time, there was, throughout the Colloquium, a shared willingness to revisit the mission, to look in some cases at significant changes were appropriate, to identify and eradicate the wrong things, to address the issue of whether or not our Health Care Systems do have too narrow a focus, and the burgeoning issue of significant public involvement. Indeed, what was refreshing about the Colloquium was the absence of complacency, the presence of self analysis, and the search for solutions. Nobody is in any doubt that our health care systems cannot,

of themselves, deliver health; but, they are not bit players either, as frequent testimony of their respective publics makes clear. Health is everyone's business; governments in both Canada and the UK have a particular responsibility, nonetheless, as do all those who work in such largely 'single payer' health care systems.

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It would not be appropriate to sign off on this volume without a few words of sincere thanks. In the first place, I thank Peter Lyon, as Chairman of the British Committee of the Canada–United Kingdom Colloquia, for the initial invitation to be both the Rapporteur and Editor, and to Allan Hird, its Executive Secretary, for the constant advice and guidance before, during and after the Colloquium itself. To Peter Dobell, of the co-organisers, the Institute for Research on Public Policy, Montreal, for his kind counsel during the Colloquium also. Colloquia do not materialise without a great deal of effort, thought and organisation; neither do the finished products in book form. My sincere thanks, therefore, to all the contributors to the volume, for revisiting their texts for publication; and, finally, and far from least, to Mrs Val Watts who has, single handedly and in the shortest time imaginable, produced the final proof copy for the printers.