

## **TWO TIER OR MULTI- LAYERED: A CRUCIAL DIFFERENCE**

The Ontario College of Family Physicians is committed to the maintenance and further development of a universal, accessible, and effective and publicly funded health care system (**Bringing The Pieces Together, March, 1995**). In recent times there has been considerable debate on what the components of such a system should be and what society can afford in the face of increased fiscal pressures on the health care system. The following perspective is meant to stimulate discussion, develop clarification and explore possible alternatives to effectively achieve the maintenance objectives of the system.

### **BACKGROUND**

Over the past few years there has been a great deal of discussion about Canada moving to a two tier health care system. William Thorsel (March 7th, 1998 [Globe and Mail](#)) strongly advocated that Canada move to a two tier system. The Fraser Institute has been telling Canadians for years that all the problems of the current health care system would be addressed if we moved to a two tier system. The problem with these discussions is the definition of a two tier system.

In the United States, a two tier system refers to the public and private systems. The reality of American health care is that there are many different tiers to the system. There is an estimated 40 million persons who have no health care coverage and thus must pay cash for all health care needs. If these individuals require hospitalization, they will only be allowed to enter public hospitals where they have no choice of physician and where conditions can be best described as third world.

A lack of health care coverage results in perinatal-natal mortality rates that are worse than Cuba and many other so called "developing nations". The largest group of Americans are described as under-insured. This means that their health insurance has many restrictions that limit them to certain hospitals, tests and procedures and usually exclude coverage of long term or chronic conditions like diabetes, heart disease or arthritis. Furthermore, if you are unfortunate enough to become ill with a chronic disease and need to change your health insurance coverage for some reason (i.e., changing jobs, company changes insurance carrier) then you will not get coverage at all with another company because of your illness. This problem is so pervasive that President Clinton referred to outlawing the practice in this year's State of the Union address in January.

For Americans that have full insurance coverage with executive insurance coverage (fewer than 10%) there are still restrictions on what physicians, hospitals and services may be used. Insurance companies, even at the high end of coverage, will restrict the number of tests, visits or coverage of hospitalization permitted for each year. Only those who can pay directly hundreds of thousands or even millions of dollars directly for health care have unrestricted access to the entire health care system.

In Great Britain, a "two tier system" has a different meaning. The primary health care system gives everyone in Britain access to a general practitioner (family doctor). Almost everyone in the UK is rostered to a GP meaning that they are registered in a specific practice where they first go for all their health care needs other than acute life threatening emergencies. If they require specialists, hospital admission or surgery, then the two tier system clicks in. Those who have private health insurance or are willing to pay the doctors fees get to choose which doctor and which hospital they wish to use. They will have their own physician, who works in both the public and private system, as their physician and will have a very short waiting time (even though the facilities are the same as the public system and are publicly paid for).

The remaining 80% of the British population who do not have private insurance, have no choice in hospital or doctor and go on a public waiting list which can be as long as 5 years for some procedures.

## DRAFT FOR DISCUSSION ONLY

One of the problems with this system is that specialists work in both public and private systems using the same facilities but paid very much less for work in the public system. This situation gives the specialist an incentive to have as long a wait as possible in the public system so that anyone who could pay private fees will have an increased incentive to do so, thus increasing the physician's private billings.

In Canada, we have yet another version of a so called two tier system. As much as 27% of all health care spending in Canada is through private health insurance. In our two tier system all "core services", including all physician services, all hospitalization, some home care service and some drugs, are covered by the publicly funded system.

Private insurance is for extra services that extend beyond the core, such as private rooms in hospital, drug costs, extra physiotherapy, dental care, eye care and a myriad of other services that vary from one company to another. Although not thought of as a two tier system, the Canadian health care system does have two tiers which are growing as the governments are reducing the number of services provided through the publicly funded system. Although detractors say we cannot afford our present system, the costs of our health care system are better controlled than the American system (which is at least 30% more costly per capita than our system) and our overall costs are falling in relation to other industrialized countries.

### DISCUSSION

Why would any Canadian be arguing for an American style, or even British style, two tier system when the promoters of the idea almost never specify what they are arguing for? The only people likely to experience a financial gain if we moved to any other style of two tier system would be insurance companies and some medical specialists who traditionally are able to demand very high fees for their services (i.e., ophthalmologists for cataract surgery and orthopedic surgeons for joint replacement surgery). With all hospitals in Canada publicly owned, the standards in our public hospitals are remarkably high, often exceeding American and British private facilities, and dramatically superior to any American public hospital in resources, facilities and standards of care. The Canadian publicly funded system has implemented an extensive infrastructure that guarantees high standards in laboratories, X-ray and all types of medical procedures, something that does not exist at uniform level in the US or other developed countries.

One could argue that a move to a US or British style system would take the 20 or 30% of the taxpayers who demand high standards in our system out of the current system and cause a widening gap between a public and private system. This is a phenomena seen in every other developed and developing country in the world. Although William Throttle spoke disparagingly of Canada's alongside Cuba as having a "single tier" system. By his undefined criteria, Cuba can be extremely proud of its system which, at a fraction of the cost of the American system, boasts better perinatal mortality figures than its very much wealthier neighbour.

Family Medicine needs to maintain that all essential services, both consultant and primary, be readily accessible to the general population, with no significant difference despite the availability of options in certain areas of care. For example, cardiac surgery, access to hip surgery and other fundamental medical needs should not be significantly and disproportionately available dependent on the ability to pay for the services rendered. Any move in that direction would clearly result in a deterioration in the success and effectiveness of the system that has been built upon over the past decades.

Family Medicine should also take a strong stand in any discussions on the simultaneous availability of both private and public health care at all levels of care; and that physicians only be allowed to practice in one or the other but not in both. This point is extremely important both for primary and specialty care if we are to avoid the significant deterioration that has resulted in many European countries as physicians being funded by the public purse shift their care and attention to private services to supplement their income. This shift results in significant waiting time for care and decreased appropriate services for

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those accessing services provided by the public domain. Over a period of time there is a significant deterioration that undermines the public health care system, a situation which Family Medicine should oppose.

### **DIRECTIONS FOR FAMILY MEDICINE**

Terminology which is less likely to cause the confusion that occurs within the very substantive differences of perspective on this definition of a two tier system is important. A suggestion is to promote a **Multilayered Health System**. This terminology reflects a more current and appropriate reality, i.e. that while a broad spectrum of health and medical services are available through the public domain, some options exist within the current system. For example, within medical procedures, certain surgeries such as breast augmentation or other plastic surgery interventions are excluded from OHIP coverage. Similarly, many services provided at home such as private nursing, are available to those who can afford them. Pharmaceutical care is another example, with many individuals with no coverage while others have the financial resources to access medications not currently covered by drug benefit plans. Dental care and eye glasses are further examples of public benefit exclusions.

### **THE FOUNDATION OF A MULTI-LAYERED SYSTEM**

The preservation and further development of a publicly funded, universal and accessible health care system should be a priority. Services which must remain in the public domain, and those which could be considered patient options for convenience or personal preferences must be defined. Much work has already been done in this area but needs to be documented. For example, the PCCCAR Report details the primary health care services which need to be protected within any effective publicly-funded health care services. These services include:

1. *Health Assessment*
2. *Clinical evidenced-based illness prevention and health promotion*
3. *Appropriate interventions for episodic illness and injury*
4. *Primary reproductive care*
5. *Early detection, initial and ongoing treatment of chronic illnesses*
6. *Care for the majority of illnesses (in conjunction with specialists as needed)*
7. *Education and support for self-care*
8. *Support for care in hospital, in home and in long-term care facilities*
9. *Arrangements for 24-hour/7 day a week response*
10. *Service co-ordination and referral*
11. *Maintenance of a comprehensive client health record for each rostered consumer in the primary health care agency*
12. *Advocacy*
13. *Primary mental health care including psycho-social counseling*
14. *Co-ordination and access to rehabilitation*
15. *Support for people with a terminal illness*

### **RELATED ISSUES**

#### **Rostering and Accountability**

Individuals should take some responsibility for utilizing services that are more issues of personal preferences or options. For example, these include house call services (other than palliative care or those confined to home) or seeing a secondary family physician outside of the rostered practice network. More work needs to be done to define other parameters of care which are more preference or option issues and a reflection of reasonable access to appropriate health care systems.

**Specialist Care in a Multi-Layered System**

To maintain a broad spectrum of specialty services, some issues require discussion and positions. Two issues are:

- non-family medicine referred specialist care
- patient request for repeated consultation by various doctors in the same specialty area

These represent minor components of larger issue(s) that merit further attention and exploration.

It might help the perspective become clearer if one considers these changes in light of the available province wide, publicly funded education services as an example. Both public and private services exist in this domain without decreasing the quality and nature of the public funded systems. Controls and checks are required to maintain this balance, with continuous controversies and modifications. However, the balance has been maintained and could well serve as a model for the directions that we may wish to take health care in the near future.

**CONCLUSION**

Family Medicine has a challenge in the orderly development of the health care system in the immediate future. The introduction or expansion of privately available health systems within a seriously financially stressed health system is a reality. How we can manage the orderly introduction without significant detriment to the quality, availability and accessibility of the public-funded component is the challenge that must be addressed. Failure to do so will not only compromise the singular success of the Canadian health care system, but in the long run will detract from the role and responsibility of family medicine within that system.

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