The Saskatchewan Medical Care Insurance Act

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Probably no piece of medical care legislation since the introduction of the British National Health Insurance Act in 1946 has excited as much controversy in medical circles, and as much newspaper publicity throughout the world. A crisis developed in which the normal medical care services of the Province were disrupted. At least one patient was alleged to have died as a result,** before a compromise was reached between the government and the body representing most of the doctors of the Province, the College of Physicians and Surgeons.

In the proposals and counter-proposals, charges and counter-charges, tempers rise, facts become distorted and attention is directed to the superficial symptoms of the conflict, rather than to the underlying principles involved. Both physicians and the general public may become confused as to what is really happening and why, although they may have strong feelings supporting or opposing one of the protagonists. Ulterior motives are imputed to the opponent, and an atmosphere of mutual distrust develops which destroys the co-operation between government and medical profession necessary for the provision of good health and medical care services.

With the compromise settlement, it is hoped that the bond of mutual interest in the welfare of the patient will help establish confidence between the government and the medical profession in Saskatchewan. Should the same type of program for physicians' services insurance become a major issue of public policy in another province, or in Canada as a whole—as has already happened with the Saskatchewan type of hospitalization insurance—perhaps in a different location the bonds of mutual respect and concern for the public interest will be stronger between the elected representatives of the people and the officers the doctors have selected to represent them. The public has a right to expect that differences will be negotiated on their merits in a mature and statesmanlike manner without disrupting medical services, despite election deadlines. I believe this should be the lesson in Saskatchewan for all good doctors and good citizens.

Physicians and medical students may make some small contribution to this end by trying to study the actual legislation, the issues and the technical administrative problems involved with the same scientific detachment and critical appraisal they are taught to use in making a diagnosis or prescribing therapy. It is true that most of us lack any special professional competence in economics, political science, administration or law, but in these matters we are usually at least as well informed as the average citizen. We do have a handicap in our special interest in the economics of the existing pattern of medical services, but perhaps this is offset by our special technical knowledge of medical diagnosis and treatment, and our day-to-day experience with those receiving medical services.

Physicians are too busy to read all the current legislation relating to medical services. Along with summary descriptions of such legislation that we may read in our professional journals or in trade journals, we sometimes encounter a bias, a special interpretation or a selection of facts that is inevitable in any such summary. One difficulty is that this bias tends always to be in the same direction, and we are therefore at times surprised to discover that large numbers of the general public are so wrong-headed as to support a government that advances an opposing viewpoint. We

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must encourage our own professional journal editors to follow the principles of good journalism and to present important legislation, minority views and government proposals verbatim, without comment or interpretation, and then to present as separately as possible, opposing viewpoints and comments:

*"Let (truth) and falsehood grapple; who ever knew truth put to the worse in a free and open encounter."** With the modern Madison Avenue approach we tend to get a public relations man's slant instead of the free and open encounter. Of course, the physician cannot live in an ivory tower, separated completely from political bias by such an aseptic editorial technique. He must learn to exercise his own discretion and pick fact from opinion or hearsay, the way he does in taking a medical history.

PRINCIPLES AT ISSUE IN THE DISPUTE

Before applying such good advice to the author's necessarily biased summary of part of the legislation, let us get some impression of the feelings and views of able men who took opposing views of the matter. The party politician tends to be more wordy, but no less convinced. Can we discern some of the principles these men feel are at stake, and the points at which their interpretations of the facts are at variance?

First, Dr. H. B. Atlee, 1960:[1]

Socialized medicine . . . is already with us in Saskatchewan. What are we going to do about any scheme that either stabilizes our income at a mediocre level, or puts that income at the mercy of inflation, or—by placing us too firmly under the heel of a bureaucracy—will restrict our present freedom to expand and explore . . .

We have already accepted the philosophy of medical insurance in Maritime Medical Care, which is a degree of socialization. If government took over medical insurance we would simply be exchanging the bureaucracy of Martime Medical Care for that of the Department of Health.

. . . the whole system of bureaucracy inherent in government control works to restrict our freedom, and to hamper us with rules and regulations . . . governments squander your money and mine to maintain their pork barrel . . . those working under a bureaucracy can be fobbed off with a gew gaw when what they need is a raise in pay . . .

We should say to governments . . . 'We will accept government medical insurance, if you will tie . . . fees . . . to the cost of living . . . But if you encroach further than that on our rights as free men we will fight to the bitter end with every legitimate weapon at our disposal, including the strike.' . . .

* Milton, John, "Areopagitica."

Next, the Premier of Saskatchewan, in May, 1962:[2]

A comprehensive, universal care program should not come as a surprise . . . The people of Saskatchewan for many years have clearly expressed their concern for the provision of adequate health services . . . (They) have had the satisfaction of the cancer program, the medical care program of the Swift Current Health Region, the hospitalization plan and other public programs. A principle which serves well when applied to the treatment of cancer should also apply equally well in treatment of measles or broken arms . . . These are simply social services which, with the co-operation of your profession, governments and public agencies developed in response to public need and demand . . .

. . . suggestions that governments do not have such a responsibility and . . . are not to be trusted when they attempt to discharge it (are) disconcerting. Attacks on the integrity of government as an institution can undermine the foundations of the very liberties we prize . . . Medical care is not an optional commodity—it is a necessity . . . When a commodity or service is essential, our society has long since accepted that consumers have a legitimate right to a voice in making the essential governing decisions . . . That voice has been . . . embodied in the Saskatchewan Medical Care Insurance Act . . . passed by a properly elected Legislature of the Province . . .

Under an insurance service which is universal there will be an increase in the volume of necessary services rendered . . . the public . . . are willing to provide the necessary resources because their contributions are related to their capacity to pay on a regular predictable basis . . . There has been no real demonstration that the public of Saskatchewan were unwilling or unable to support a hospital insurance service in which costs have increased from 7½ million dollars . . . to thirty-six . . . even in times (of) economic difficulty . . . It is . . . unreasonable . . . to suggest we cannot afford a medical care insurance program on a universal comprehensive basis if we can afford necessary medical services at all.

. . . You must have the freedom to choose your patients and the location of your practice . . . The patient must have the right to his choice of doctor . . . Doctors will be free to exercise . . . 'their profession to the best of their abilities for the good, safety and welfare of all persons . . . committed to their care' . . . The government declared its willingness to refashion sections of the Act to . . . remove concern . . . about the possible interference with professional standards and professional independence . . .

. . . To deal with the amendments to the Saskatchewan Medical Care Insurance Act . . . into one section there has been read intentions and interpretations by no means intended . . . This section makes explicit the right and responsibility of the Commission to be the agent of a beneficiary . . . only with regard 'to payment for insured service' . . . This is a long standing provision in any insurance arrangement . . . (to) protect the right of a citizen who has prepaid the cost of medical services. It transfers to the Commission only the power which the individual has always had to protect himself . . . in the discussion we had with the members of the Council of your College it became apparent we were not going to arrive at any agreed contractual relationship . . . respecting the payment of medical bills. In the absence of such a relationship the government felt there was no other way to guard citizens against . . . being unnecessarily harassed . . .

This section . . . permits anyone to declare he does not wish the Commission to act as his agent in . . . payment of a medical account . . . still . . . the Commission will pay for his medical care . . . If he wishes the Commission neither to act as his agent nor to pay his bill, he has that right also—no one is compelled to accept the benefits of the medical care plan . . . the patient can make any arrangement . . . satisfactory to him and his doctor . . .

A mechanism for settling disputes . . . with respect to the rates of payment . . . was incorporated as a demonstration that the Government in no way desired to dictate to the physicians the amounts that they could receive . . . The Commission . . . recommended . . . a mediation board.

There has been a great deal of discussion recently over . . . the rights of individuals . . . the rights of professions . . . The people of Saskatchewan . . . as consumers of medical services and as taxpayers, have a right to say how we pay our medical bills . . . (and) to construct an administrative agency, responsible to us, to arrange for such payment.

Last, from the summary presented to the General Council of the Canadian Medical Association, in June, 1962, prepared by B. E. Freamo, Secretary for Medical Economics:[3]

The Saskatchewan Medical Care Insurance Act . . . represents . . . an ingenious method of controlling doctors and the practice of medicine in a political, economic and legislative sense . . .

A Commission . . . appointed by government . . . will be a political commission. Unless it is given broad powers independent of Cabinet control it must reflect the current thinking of the government which appointed it . . .

Economic control is present whenever any agency, government or private, becomes the sole buyer and seller of medical services . . .

Doctors in Saskatchewan are not primarily concerned about their personal incomes because for the first few years at least their incomes would increase above present levels . . . Under the Act . . . the dollars to pay for medical services must be in constant competition with dollars needed to . . . support other . . . services. Inevitably, costs rise and economic controls must be instituted as a result of . . . a limited budget . . .

In theory the doctors . . . could negotiate with the government on points of difference . . . In practice, however, you can only negotiate in a true sense if you are a body which has an equal status in law. The profession cannot effectively negotiate with a government which has power to legislate its own point of view . . .

Restrictive amendments which may be unprecedented in Anglo-Saxon law . . . effectively prevent any attempt to continue private practice . . . This of course would not apply if the patient 'contracted out' for the service; . . . the (contracting out) method is cumbersome . . . and . . . would only apply to those patients who could afford to pay twice for their medical care.

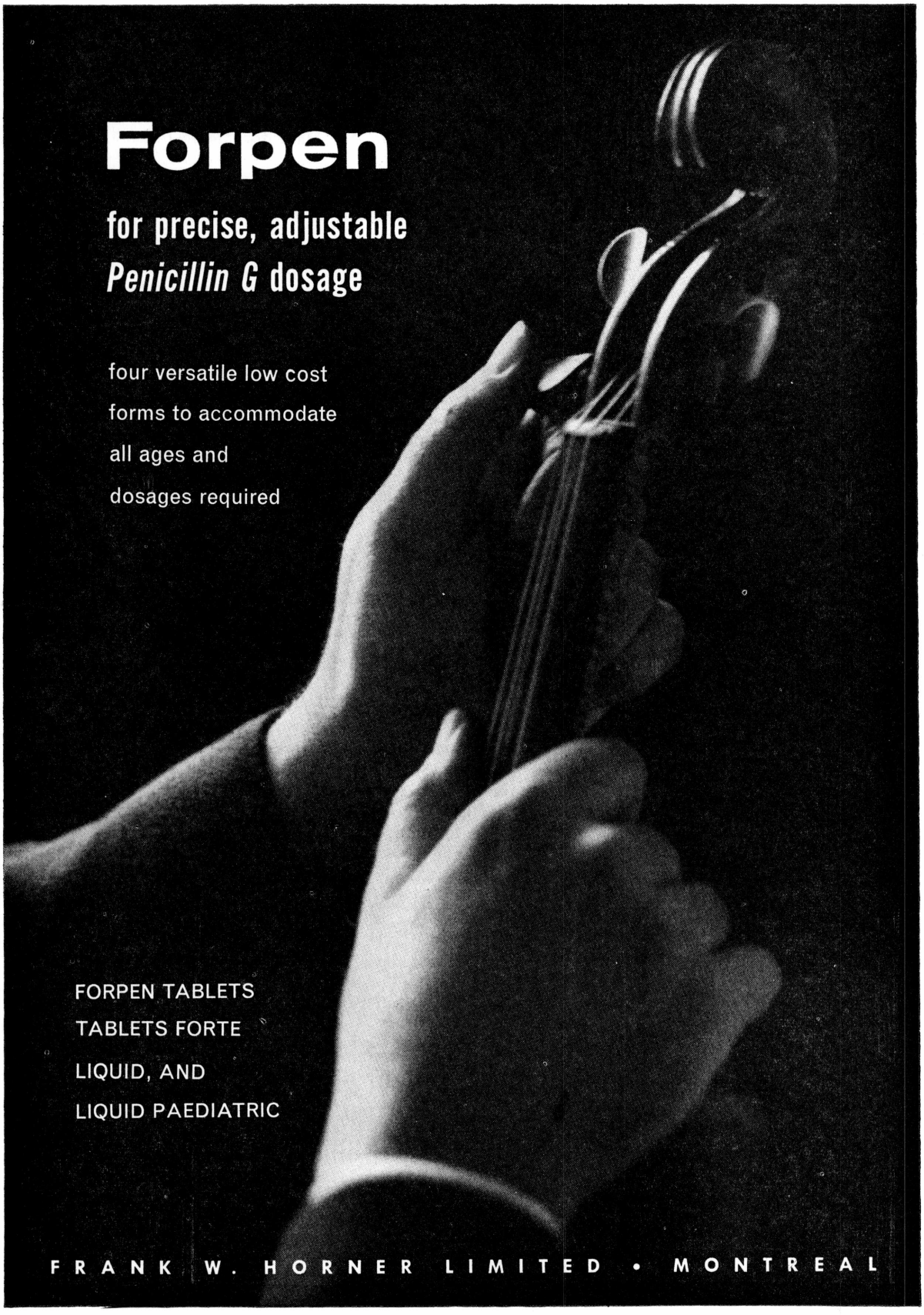
The doctors of Saskatchewan . . . have decided they must withdraw their services. The great majority of doctors' offices in Saskatchewan will be closed . . . Emergency services will be provided . . . Resumption of normal practice will occur when the profession is assured that government legislation will be withdrawn . . .

SOME PROVISIONS OF THE ACT[4]

The title is "An Act to Provide for Payment for Services Rendered to Certain Persons by Physicians and Certain other Persons". In the definitions a physician is a "person registered under The Medical Profession Act, and not under suspension". A specialist is "a physician whose name is on a list of specialists established under regulations" under this Act. The Act is to be administered by the Saskatchewan Medical Care Insurance Commission. This originally was to consist of six to eight members appointed for staggered three-year terms, including at least three physicians, one of whom is to be the Deputy Minister of Health without vote.

In the amendment to the Act following the compromise agreement between the profession and the government, the definitions of physician and specialist contained in the original regulations, naming the Saskatchewan College of Physicians and Surgeons, were transferred to the Act itself. In the amendment, three additional physicians are to be appointed to the Commission and nominated by the College. The total membership of the Commission may be increased to eleven.

The original legislation provided that a specialist who saw a patient referred to him by another physician would be paid in full for his services by the Commission,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but that a specialist who saw a non-referred patient would only be paid by the Commission for a portion of his fee, and might charge the patient an additional amount to be specified in the regulations. The amendment following the compromise agreement specifies that the specialists seeing a non-referred patient may collect from the patient the full amount of the difference between the non-referred fee paid by the Commission and the referred patient fee paid by the Commission.

In the original legislation the Commission was empowered to take action for "the improvement of the quality of the insured services provided" under the plan. The original Act also made provision for an Advisory Council of up to twenty-five persons, broadly representative of the professions and other organizations interested in medical care insurance for the residents of Saskatchewan. The Advisory Council might propose improvements and changes in the medical care insurance plan. The Commission was required to consult the Advisory Council on any matter substantially affecting the operation of the plan, other than a measure for its financing. The Council was to have the power to submit an annual report which would be public, and to review in some detail and report on the operations of the plan every five years.

In addition, in the original Act there was provision for a Medical Advisory Committee consisting of physicians whose appointments were approved by the Council of the College of Physicians and Surgeons of Saskatchewan. It had powers to appoint technical and scientific committees, and the Commission had the power to appoint other scientific committees to advise it "with respect to matters of a technical or scientific nature".

The amendments following the compromise eliminated the reference to quality of the insured services, the Advisory Council, the Medical Advisory and other scientific committees.

One of the most controversial features of the legislation was whether private practice was possible outside of the Act, in the sense in which it is now possible in England. The Act made provision, as indicated above, for specialists under certain circumstances to receive direct payment from patients, and in addition made provision for physicians to collect such deterrent charges as might be specified by the Commission to limit excessive demand, or to provide additional sources of revenue. Such deterrent charges are one of the major modifications made in the original compulsory government insurance program for physicians' services in the Swift Current region, which has been in operation for nearly fifteen years. The controversy on this point is further complicated by the more restrictive amendments introduced by the government in April, 1962, after they failed to reach agreement with physicians regarding the original Act.

The wording of the original Act certainly attempted to protect the patient against extra charges beyond an agreed fee schedule and possible deterrent charges. The restrictive amendments in April made specific the right of the Commission to deal directly with physicians, as the agent of the patient in respect of payment or recovery of fees, or in law suits arising out of attempts to collect fees for insured services. The quotations at the beginning of this article by Mr. Freamo and Mr. Lloyd present divergent views of the method described in these amendments, whereby the patient could arrange to pay a private physician directly for some medical services, and could receive other medical services under the Act and have them paid for by the Commission. The right of a physician to charge a patient who is not a beneficiary under the Act was specified in the original Act.

Free choice of physician by patient and of patient by physician, and guarantees of preservation of professional confidence were written into the original Act. This

last is pretty inclusive, and might interfere with research. It specifies "no person employed in connection with the administration of the Act shall publicly or privately, orally or in writing, directly or indirectly, state or intimate the identity of a beneficiary receiving insured services, nor the nature of the illness, disability or injury for which a specified beneficiary is receiving insured services," etc., except under specified circumstances, such as the consent of the patient, for payment of accounts, and other matters relating directly to the program.

In the April amendments the government had provided a procedure for settling differences with physicians over rates of payment, mentioning mediation as one alternative. The amendments following the compromise agreement specifically named the Council of the College of Physicians and Surgeons as the bargaining agent for the physicians, and required that arrangements regarding rates of pay be settled by negotiation or by mediation. The wording in several other sections was modified in line with the feeling of physicians that it was unduly restrictive or punitive. For example, the statute of limitations after which the government could not prosecute a physician for violation of the Act, such as falsification of an account, was reduced from six years to one year for any violation other than failure to pay the premium. (The fine is a small one in any event). The specific authority for the Commission to pay bills, recover money for charges that should not have been made, or take legal action on behalf of a patient unless directed not to by the patient, was rescinded.

We have left to the last what was probably the major concession made by government in the compromise agreement. This was the acceptance of non-profit voluntary health insurance plans, notably the two sponsored by physicians, one in Regina and the other in Saskatoon, as carriers or contractors for payment of physicians for basic services under the Act. It would probably have been possible for these plans to con-

tinue to provide supplementary benefits under the original Act, in the same way as Blue Cross supplements government hospital insurance coverage, but the basic coverage for most physicians' services would have been administered by a single health insurance Commission. In this respect, the compromise arrangement is not unlike the administrative situation in which "approved societies" operated under the old British National Health Insurance Act between 1912 and 1948.

With these amendments it appears that a variety of arrangements, as set forth in the agreement between the physicians and the government, is open to physicians for collection of payment for services. These include several kinds of contract directly with the Commission, with the voluntary agencies acting for the Commission, under the Act outside these plans with the patient seeking reimbursement from the government of fees paid to the physician, or entirely outside the Act with the patient unable to claim reimbursement.

COMMENTS

No one really knows how well the final arrangement will work. Pessimists maintain that the original legislation put the doctors in a straight jacket, that the compromise agreement is an administrative nightmare, and that neither plan is workable. But if the power struggle between the College and the government has been transferred from the party caucus, the election platform and the strike committee to debates within the Commission and to economic competition between government and voluntary insurance carriers, much has been gained by all. Doctors serve the public better as expert technical advisors than as politicians issuing propaganda statements.

One may legitimately ask how the compromise program squares with the principles laid down by each side in advance. Is the compromise program really a

universal comprehensive medical care insurance plan, in which every citizen can prepay his physician's bills and not have unpredictable extra medical costs? Does the compromise plan really guarantee the physician, in economic practice as well as in the letter of the law, freedom from bureaucratic regulation, whether by government or by an administrative agency that was originally voluntary and under his direct control, but which may become less so the more it serves a public interest? Are there perhaps some fundamental issues regarding medical care that have been overlooked in the dispute? How well are medical practice and our system of institutions organized to deal with long-term illness? If an agency paying for most medical services does not consciously accept a responsibility to improve the quality of care, is it not likely to have the opposite effect?

It is our personal opinion that the government and medical profession in Saskatchewan can either make the present program work, or modify it so that it will work, if only the politicians—both party politicians and medical politicians—will let them alone to get on with the job.

REFERENCES:

1. Atlee, H.B., "Our Deadliest Menace", Nova Scotia Medical Bulletin, Vol. XXXIX. p. 394-400, December 1960.
2. Lloyd, W. S., "Address to Saskatchewan College of Physicians and Surgeons", Queens Printer, Regina Saskatchewan, 1962.
3. Freamo, B. E., Secretary for Medical Economics, Canadian Medical Association. "The Saskatchewan Situation", Summary of Background and Current Position of the Medical Profession in Saskatchewan, presented to the General Council, C.M.A., June, 1962.
4. Province of Saskatchewan, "The Saskatchewan Medical Care Insurance Act, 1961". Being Chapter 1 of the statutes of Saskatchewan 1961 (Second Session) as amended by Chapter 68 of the statutes of 1962 and Chapter 1 of the statutes of 1962 (Second Session). Queens Printer, Regina, Saskatchewan.