

HEALTH CARE IN CRISIS: DOES CANADA HAVE THE ANSWER?

by *CONSUMER REPORTS*

More than 30 years ago Canada enacted a program to bring health care within reach of all its citizens. By 1971, Canada's provincial governments were paying the medical bills for everyone in Canada, and few people outside Canada were paying much attention.

As the U.S. health-care system began to creak and groan under the weight of its runaway costs – and as its inability to serve every citizen became increasingly apparent – Americans started to look seriously at Canada's health-care system as a model for reform. At the same time, Canada's system started to come under concerted attack from those special-interest groups – health-insurance companies, medical associations, and hospitals – that profit most from the present nonsystem of health care. This report examines the strengths and weaknesses of the Canadian system and evaluates the criticisms leveled against it.

HOW THE SYSTEM WORKS

Contrary to what some in the U.S. health-care industry would have you believe, Canada does not have "socialized medicine." Medicare, as Canada's health-care system is called, is simply a social insurance plan, much like Social Security and Medicare for older people in the U.S. Canada's doctors do not work on salary for the government.

Canadians pay for health care through a variety of federal and provincial taxes, just as Americans pay for Social Security and Medicare through payroll taxes. The government of each province pays the medical bills for its citizens. Because the government is the primary payer of medical bills, Canada's healthcare system is referred to as a "single-payer" arrangement. Benefits vary somewhat among the provinces, but most cover, in addition to medical and hospital care, long-term care, mental-health services, and prescription drugs for people over 65. Private insurance exists only for those services the provincial plans don't cover.

Although each province runs its own insurance program as it sees fit, all are guided by the five principles of the Canada Health Act:

- 1. Universality. Everyone in the nation is covered.**
- 2. Portability. People can move from province to province and from job to job (or onto the unemployment rolls) and still retain their health coverage.**
- 3. Accessibility. Everyone has access to the system's health-care providers.**

4. Comprehensiveness. Provincial plans cover all medically necessary treatment.

5. Public administration. The system is publicly run and publicly accountable.

WHERE DOCTORS FIT IN

The role of doctors in the Canadian system is little understood in the U.S. and frequently distorted by the foes of a single-payer system. For example, in announcing his plan for health reform last winter, President Bush declared: "We don't need to put Government between patients and their doctors and create another wasteful federal bureaucracy." Nor should the Government tell doctors how to practice medicine, other opponents of Canadian-style health care often add.

Canada's health-care system does neither. "in the U.S. there's a myth that Canadians have an awful government bureaucracy that tells doctors how to practice medicine," says Dr. Michael Rachlis, a Toronto physician and health-policy consultant. "There's much more interference from third parties [such as insurance companies and utilization-review firms] in the U.S. than from the government in Canada."

Canada's physicians practice in their own offices and work for themselves, just as most U.S. doctors do. The main difference: Canadian doctors may not charge whatever they wish. Their fees are set according to a schedule negotiated by the ministry of health in each province and the provincial medical association. Canadian doctors cannot engage in the common American practice of "balance billing" – billing the patient the difference between what an insurer will pay and what the doctor wishes to charge.

The negotiation process has managed to keep fee inflation in Canada at least modestly in check. Fees tend to be much lower than those commanded by American doctors for the same service. In British Columbia, for example, doctors receive about \$349 to remove a gallbladder, in Manitoba, \$354; and in Ontario, \$348. But in New York City, the customary fee paid by insurance carriers averages about \$2700: in Buffalo, N.Y., \$945. (All figures are in U.S. dollars.)

Despite the lower fees, physicians in Canada, like those in the U.S., enjoy high incomes. In British Columbia, the average payment (before overhead) made by the health ministry to cardiologists last year was \$290,500; to ophthalmologists, \$240,500; to dermatologists, \$200,500; and to general practitioners, \$128,000.

WHERE PATIENTS FIT IN

Canadians, like U.S. citizens, can select any doctor they like. Those doctors bill the provincial insurance plans directly and are usually paid within two to four weeks. For patients, there are no bills, claim forms, out-of-pocket costs, or waits for reimbursement from insurance carriers, all common complaints in the U.S.

Roughly half of all Canadian physicians are family practitioners (compared with 13 percent in the U.S.), and Canadians go to them for treatment that Americans might seek from costlier specialists. Most Canadians, for instance, take their children to family practitioners instead of to pediatricians for common childhood illnesses. Most children see pediatricians only for serious problems.

The provinces encourage people who need a specialist's care to obtain a referral from a family doctor, much the way HMOs and other managed-care plans do in the U.S. If a specialist sees a patient who has not obtained a referral, that specialist can bill the Government only the fee that would ordinarily have been paid to a general practitioner.

Those rules, aimed at controlling costs by preventing the overuse of high-priced specialists, do not always have their intended effect. If a patient shows up at a specialist's office without a referral, the specialist need only call the family practitioner, obtain a referral number, and bill the Government the higher fee. Many family doctors are only too glad to send any complicated or time-consuming case to a specialist so they can see more patients and earn more fees. The increased use of medical services is a major reason costs are escalating there as they are here.

NOT ENOUGH HOSPITAL BEDS?

Canada's rising health-care costs are a favorite target of U.S. critics, who have also made much of the fact that Canadian hospitals have reduced their number of beds in recent months. The implication is that the Canadian health-care system is collapsing and that Canadians now suffer from insufficient hospital facilities. Actually, Canada has too many hospital beds, which is also the case in the US. Hospitals proliferated in both countries during the last two decades. Money flowed freely, building new hospitals was good politics, and the public as well as the government came to believe that another hospital bed meant better health.

As health-care costs in Canada rise, the provinces are being forced to rethink how best to spend their health dollars. Most bed closings stem from deliberate government strategies to eliminate waste and duplication of services. In Toronto, for example, where a total of 2200 beds have been permanently closed, the city's 45 hospitals still have 1000 beds empty on any given day.

Provincial governments can implement such cost-cutting measures because they control how much money a hospital receives. Every year they negotiate a "global budget" with each hospital in the province. That budget includes money to cover operating costs, increases for inflation and

greater utilization, and any special services the ministry wants the hospital to offer. The global budgets set by the provincial governments comprise about 95 percent of a hospital's total funds. Any other money must come from fund-raising and investment earnings. Within the global budgets, hospitals are free to move money around. If, say, a hospital finds the costs of running the emergency room are lower than expected, it can redirect some of the money to increase the number of cataract surgeries, if it chooses to. Canadian hospitals, however, are not allowed to run deficits.

LONG WAITS FOR CARE?

Perhaps the most frequently heard charge against the Canadian system is that it rations care, and people don't get the treatment they need. The *New York Times* told readers of its editorial page last November that as a result of "rationing," Canadian "women must wait months for a simple Pap smear."

In reality, women in Canada routinely have Pap smears done by their family doctors, who perform them the same way U.S. doctors do. Canada's ambassador to the U.S. traced the tale of Pap smear waits to a brief delay in laboratory processing in Newfoundland some years ago – a problem long since corrected.

Canadian men and women routinely have general surgery, diagnostic ultrasound, X-rays, thyroid tests, amniocentesis, EKGs, and hundreds of other procedures and treatments without delay. But Canadians may not have immediate access to the latest technological innovations, such as lithotripters (machines that crush kidney stones with sound waves) and magnetic resonance imagers (MRIs), or to such surgical procedures as a coronary-artery bypass or hip replacement. Someone who pulls a knee muscle playing soccer isn't likely to get an MRI scan the day after the accident. And those who want bypass surgery to relieve angina symptoms won't be wheeled into the operating room right away. However, anyone requiring emergency care gets it immediately.

Because provincial governments control hospital budgets, they also control the introduction and use of technology. In some cases, they have kept a tight lid on that technology to restrain the high costs associated with overuse, inappropriate use, or duplication. Hospitals denied some piece of equipment by the provincial health ministry are free to buy it with money raised from private contributions, but they can't look to the ministry for funds to operate it.

In Winnipeg, Manitoba, for example, Seven Oaks Hospital purchased a CT scanner with its own funds and is already operating it. The Ministry of Health maintains that the province doesn't need another CT scanner, that the six scanners available at other provincial hospitals are enough to serve the province's needs. The ministry has hinted that it may not cover the \$1-million operating and depreciation expenses for the machine.

The ministry has taken a hard line on MRIs as well. The province has just one, and the hospital operating it must follow strict guidelines in deciding when it should be used. The province probably could use another MRI machine, says Dr. Cam Mustard, an assistant professor of

community health sciences at the University of Manitoba. But, he adds, "it's not such a scarce resource that people are coming to harm because they can't get on it. Doctors are very satisfied with the quality of service, and the waiting times are not seen as obstructing their ability to care for patients."

"The alternative [to having such waiting times]," says Dr. Charles Wright, a vice president for medicine at Vancouver General Hospital, "is to have a grossly overbuilt system as in the U.S. If you build for the peaks, you have a hell of a lot of wasted resources."

The published figures on the number of Canadians on waiting lists probably exaggerate the actual delays in receiving care. For the most part, doctors manage the lists, putting people on one or more of them as they deem appropriate. Sometimes doctors put a patient on a list to give him or her hope when a condition is actually hopeless. Sometimes they put patients on just in case their condition worsens and a procedure not now necessary becomes necessary. Queues shift constantly as those needing care immediately move ahead of those whose conditions are less serious. Sometimes queues develop and then disappear. At Wellesley Hospital in Toronto, for example, kidney patients once faced a three-month wait for lithotripsy. Now there's virtually no wait, and the machine doesn't always run at capacity.

When St. Boniface Hospital in Winnipeg investigated its waiting list of 143 people for cardiac angiography, a radiological examination of the arteries surrounding the heart, it found that only 56 people were really candidates for the procedure. Some didn't need it, some didn't want it, and some had already had the procedure done at another hospital. One doctor was accused of packing the list for his own political reasons.

In 1991, a British Columbia Royal Commission on health care investigated all the well-publicized cases of people who claimed to have been harmed by delays in the queue for heart surgery. "When we tracked them down, almost all of the cases crumbled," says Appeals Court Justice Peter Seaton, who chaired the commission.

That finding hasn't stopped opponents of Canadian-style health care from citing waiting lists in British Columbia as evidence that the system is grinding to a halt. "A waiting list of 700 to 800 people for heart surgery is not uncommon," a vice president of the National Center for Public Policy Research, a conservative think tank, wrote in a 1992 *New York Times* column.

A waiting list of that length did exist, but only for a short time. When researchers looked into it, they found that two-thirds of the people on the list were waiting not for the procedure, but for three particular surgeons.

When waiting lists have grown too long, provincial governments have in some instances offered patients the option of going to the U.S. for treatment. The British Columbia Ministry of Health, for example, contracted with hospitals in Seattle to provide 200 heart surgeries. It took more than a year before Canadians filled all 200 slots, raising the question of whether the delays were indeed life-threatening.

Critics like to portray the availability of treatment in the U.S. as a safety valve for Canadians. However, that says as much about the overcapacity of the American system as it does about poor planning on the part of Canada. The British Columbia Health Ministry received many calls from U.S. hospitals eagerly soliciting its heart-surgery business.

UNAVAILABLE OPERATIONS?

When he was running for the Democratic presidential nomination, Paul Tsongas said that if he had lived in Canada, he would be dead by now. The procedure that arrested his cancer, Tsongas said, was not available there. In fact, the procedure that saved Tsongas' life, autologous bone-marrow transplantation, was indeed available in Canada in 1986 when Tsongas had his operation. In fact, the pioneering research that led to bone-marrow transplants took place at a Toronto hospital 30 years ago.

In making his charge, Tsongas joined the long list of critics of the Canadian health-care system who contend that it denies its citizens appropriate care. The National Center for Public Policy Research, for example, has asserted that "Canadians do not have enough surgery, at least not enough of the surgery they need the most." and Newt Gingrich, the Republican whip in the House of Representatives, has contended that "it is illegal in Canada to get a whole series of operations."

If anything, Canadians are probably getting too much care, just as Americans are. A report prepared for the Conference of Deputy Ministers of Health last year found that a "nontrivial" amount of the medical services Canadians receive are ineffective and inappropriate. The report blamed fee-for-service reimbursements to doctors for much of the problem. The same criticism applies to the U.S. . . .

Surgery rates for some procedures are actually higher in Canada than elsewhere. Canada is a world leader in the number of gallbladder surgeries and is second only to the U.S. in heart bypass operations. Each year, the French perform 15 to 20 bypass surgeries per 100,000 people; the British, 20 to 30; the Canadians, 50; and the Americans, about 100.

NEEDLESS DEATHS?

In its health-care reform proposals put forward earlier this year, the Bush Administration asserted that "post-operative mortality is 44 percent higher in Canada than in the U.S. for high-risk procedures, including heart surgery." Dr. Leslie Roos, a professor of community health sciences at the University of Manitoba and one of the authors of the study to which the Administration referred, told CU that the statement "seriously distorts our overall findings."

For one thing, the study compared only Manitoba and New England, not the U.S. and Canada. For another, it compared a number of low-risk and moderately risky procedures and only two

that were high-risk-repair of hip fracture and concurrent valve replacement with bypass (one kind of heart surgery). The study showed that for the low- and moderate-risk procedures, the number of people who died shortly after surgery was similar in the two regions. The mortality rates for hip-fracture repair in New England were lower than in Manitoba, primarily because many Manitoba patients had to be transported long distances from remote, northern parts of the province.

Roos told CU that later research is showing Manitoba's heart-surgery results "to be fully comparable with those of the leading American centers." He added that three-year survival rates for cardiovascular surgery are better in Manitoba than they are in the U.S.

HOW COSTS COMPARE

Opponents of a single-payer system also like to claim that health-care costs are rising faster in Canada than in the U.S. A study by the Health Insurance Association of America (HIAA), the insurance companies' trade organization, reported that per capita spending in the U.S. rose, on average, 4.38 percent per year from 1967 to 1987, compared with 4.58 percent in Canada. But Canada's single-payer system wasn't even completely in place until 1977. Although other researchers have refuted the HIAA's findings, the numbers live on in propaganda against the Canadian system. . . .

Health-care costs are lower in Canada than in the U.S., whether measured by per capita spending or as a percentage of gross national product. In 1989, the U.S. spent \$2450 per person on health care, while the Canadians spent \$1800. In 1990, the U.S. spent 12.2 percent of its GNP on health care; Canada spent 9.5 percent.

Before Canada fully implemented its Medicare system in 1971, both it and the U.S. were spending comparable amounts of their respective GNPs on health care. But as Canada's system of universal coverage took hold in all the provinces, spending by the two countries sharply diverged.

Canadian researchers believe that 25 to 35 percent of the difference may be due to Canada's controls on hospitals. One study found that in the early 1980s, for instance, the U.S. spent as much as 50 percent more per person on hospital services, even though Canadians stayed in the hospital longer, on average.

But perhaps the most striking differences are in administrative costs. In 1987, researchers have estimated, the U.S. spent between 19 and 24 percent of its health-care dollars on administrative expenses; the Canadians spent between 8 and 11 percent.

PLAYING POLITICS

Much of the ammunition fired at the Canadian system has inadvertently been supplied by the Canadians themselves. When it comes time to negotiate fees or new budgets, doctors and other providers there often assert that the Canadian system is underfunded.

Providers don't hesitate to make waiting lists a political issue or to put their case before the public by writing letters and running advertisements that take their health-care system to task. This spring, a Manitoba Medical Association newsletter featured an open letter to the minister of health headlined "Rationing eye surgery impairs patients' quality of life, MMA President tells Minister." The publication also ran letters from a doctor and a patient's relative pleading for more money for hip-replacement surgery. The British Columbia Medical Association ran newspaper ads warning of the harm that could come from placing a cap on the fees earned by its highest-paid members, such as ophthalmologists, dermatologists, and cardiologists – a strategy the ministry was pursuing to reduce health-care expenditures.

Conflicts between Canada's health-care providers and the government, however, are often overblown in the U.S. Not long ago, Dr. Gur S. Singh, then president of the British Columbia Medical Association, sent a letter to provincial newspapers arguing that Americans should keep their system basically unchanged. Singh said he wanted the U.S. to "continue to provide the necessary safety valve to an overly restrictive Canadian system which will only get worse as further bureaucratic controls are adopted." Health Insurance Association of America president Carl Schramm quoted from Singh's letter in testimony to the U.S. Senate.

At the end of his letter, however, Singh said the Canadian system was "one of the best, and perhaps it still is the best health-care system in the world." That point didn't make it into Schramm's testimony.

An astute Canadian observer would have known that Singh's letter was simply a "piece of negotiating rhetoric intended to bat the minister [of health] over the head," says Dr. Healy Fry, Singh's predecessor at the medical group. "That letter was for public consumption in B.C."

WHAT AILS THE SYSTEM?

The Canadian health-care system, like every health-care system in the world, has problems, though they're not of the scary sort usually cited by U.S. critics. There is a more-than-adequate supply of doctors in Canada, but there is a shortage of physicians in the remote, northern areas of the country, where few want to practice. The U.S. has the same problem, of course; few doctors care to practice in rural or poverty-stricken areas.

Even though Canada has a greater proportion of family doctors than the U.S., medical-school incentives have steered doctors-in-training to specialties that command higher fees and result in

higher costs to the system. . . . A report presented to Canada's deputy ministers of health last year blamed at least part of this trend on the bad example of the U.S., where 87 percent of all physicians are specialists.

A more fundamental flaw is that through the years, provincial governments have acted more like check-writers than health-care managers. As in the U.S., hospitals and doctors often received generous increases simply by asking for them. In Ontario, for instance, hospital spending has increased 10 percent or more each year for the last 10 years. But that is changing. This year Ontario hospitals are getting just a 1 percent increase in their global budgets, and the ministry is redirecting money to other types of health care.

Canadian patients also may have stayed in hospitals longer than was necessary. In 1989, the average length of stay was 10.5 days, compared to 7.2 days in the U.S. In Canada, patients are still entering hospitals a day or two before their surgeries for preoperative workups, a practice that utilization firms in the U.S. are rapidly putting an end to.

Since 1984, health-care spending by the provinces has increased 80 percent, to about \$44-billion. At the same time, the economy that funds that spending has grown less than 20 percent. The Canadian federal government, which once provided about 50 percent of the funding for the provincial health budgets, now supplies only about 35 percent. Eventually it may leave the funding solely to the provinces.

Pushed by rising costs and by pressures on funding, the provinces are redirecting money and starting programs to make better use of their dollars. "We're afraid we're going to lose our system if we don't change it," says Lin Grist, a special assistant to Ontario's minister of health. "It's really quite precious to us."

The U.S. faces similar problems, but Canada is in a better position to solve them. For one thing, it long ago answered the question of whether everyone in the country should be entitled to health care – a question the U.S. seems incapable of resolving. For another, Canada's single-payer system is better suited to the task of redeploying resources as needed. It can decide where to spend its budget for the good of all citizens.

In the U.S., the rhetoric of the day is to contain costs. But few, if any, doctors or other providers embrace limits on their own incomes. And there's no single payer with enough influence to impose the controls necessary to squeeze the billions of dollars of waste out of the system.

One option Canadians are not considering is a move back to a system like the one in the U.S. Of the 1503 people who testified before the British Columbia Royal Commission in its hearings on health reform, only one favored adopting the American way of paying for health care.

Canadians like their health-care system and expect their government to fix its current problems. But a government that tried to tinker with the basic principles of the Canada Health Act would be a government out of power very soon.