31. HEALTH CARE FOR ALL: DOES CANADA HAVE THE ANSWER?

by CONSUMER REPORTS

Nearly 50 years ago Canada enacted a program to bring health care within reach of all its citizens. Since then, Canada's provincial governments have been paying the medical bills for everyone in Canada. Every other high-income Western and modern country has some form of national health care system covering all adults and children. Except the U.S. Instead, the U.S. health-care system continues to suffer under the weight of its runaway costs and as its inability to serve every citizen.

Now, more than ever, Americans have begun looking looking seriously at Canada's health-care system as a model for reform. This is called a single-payer system. Sometimes this is called medicare for all.

At the same time, such universal health care systems have come under concerted attack in the U.S. from those special-interest groups that profit most from the present non-system of health care. This classic 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, 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 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, often a third to a tenth of what some U.S. doctor's charge.

Despite the lower fees, physicians in Canada, like those in the U.S., enjoy high incomes, many hundreds of thousands of dollars a year.

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. 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, after eliminating many hospital beds, 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.

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. 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, just like U.S. hospitals do.

For the most part, doctors in Canada manage their own waiting 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 th 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.

A Commission in the province of British Columbia 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. It turns out that a waiting list 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 elsewhere for treatment. The British Columbia Ministry of Health, for example, contracted with hospitals in nearby 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.

UNAVAILABLE OPERATIONS?

When he was running for the Democratic presidential nomination years ago, 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 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.

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, 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." Roos reported that that in fact 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. In fact, 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 general, all health care costs in Canada are third to a half of those in the U.S. (and that is true in other single-payer systems in Europe and elsewhere).

Before Canada fully implemented its Medicare system, 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 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. Researchers have estimated, the U.S. has spent between 19 and 24 percent of its health-care dollars on administrative expenses; the Canadians spent between 8 and 11 percent.

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 saw this in part as 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 and the ministry is redirecting money to other types of health care.

Canadian patients also may have stayed in hospitals longer than was necessary. One study found that the average length of stay was 10.5 days in Canada, 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.

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.
