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The Top 10 Things People Believe About Canadian Health Care, But Shouldn't

By Brian Lee Crowley

According to Statistics Canada, the federal government, provinces and territories will spend a combined $121 billion on health care for Canadians this year, an increase of 28 percent since 2005.

As health care reform continues to dominate the political landscape in the United States, it is time to update my 2003 essay of the same title.

No. 1: Canada has the best health care system in the world.

Not even close. The Frontier Centre for Public Policy in Winnipeg and the Brussels-based Health Consumer Powerhouse recently jointly published a comparison of how the Canadian system stacks up against European health care systems.[1]

The 2009 Euro-Canada Health Consumer Index (ECHCI) report states:

- Canadians suffer from a health care system officially based on equity and solidarity — but in reality it is a sub-standard one that denies Canadian health care consumers many of the services taken for granted in Europe;
- Patient rights, access to information, and choice and services without delay are under-developed in Canada and deliver low value for the money spent;
- The positive part of the comparison is that the quality of treatment — when delivered — puts Canada on par with most European countries.

ABOUT THE AUTHOR

Brian Lee Crowley is the founding President of the Atlantic Institute for Market Studies, www.aims.ca, located in Halifax, Nova Scotia. Crowley is co-author of two Sir Antony Fisher Award-winning projects on the Canadian health care system. In recognition of his health care work, he was named to the the most influential provincial health care inquiry in Canada, the Mazankowski Committee.

The ECHCI rates Canada in the lower third of the index, competing with countries like Slovakia, Lithuania and Poland, all ex-planned economies in formerly Soviet-occupied areas. The authors of this annual study would like to include the United States in the ranking, but that will be a more complicated affair given the great differences that distinguish the American from European and Canadian systems and the difficulties of gathering comparable data. I will return to the U.S. comparison with Canada in a moment. For now, let's stick with the European comparison.

According to Health Consumer Powerhouse President Johan Hjertqvist:

> Canada keeps up in only one of the five Index segments, i.e. outcomes. That seems to reflect the Canadian approach: if the treatment outcomes are decent you can stand long waiting, limited choice and lack of information. The ECHCI, by contrast, takes a more holistic stand, where many characteristics together form the quality of care. When all these factors are taken together, Canada does quite poorly; if we focus on medical outcomes alone the picture is more favourable.

In other words, if you can get the Canadian health care system to take you and your health problems seriously, and if you can navigate the many obstacles to timely and effective care, the care you actually get stacks up reasonably well. But those "ifs" are not minor quibbles — they are major problems with the system, as we shall see in a moment.

With respect to direct comparisons between Canadian and American health care, the reliable data are few and far between. One exception worthy of note is a 2004 study carried out jointly by the two countries' respective statistical agencies, Statistics Canada and the National Center for Health Statistics. The most useful finding of the study is the extent to which Canada has a single

national system, while the United States clearly has access strongly differentiated by income, although Americans express more satisfaction with the health care services they receive:

- *Overall*, more Americans reported that they had experienced an unmet health care need in the previous year compared with Canadians (13 percent versus 11 percent). There was no difference in the proportion who reported unmet health care needs between Canadians and *insured* Americans. (*Emphasis added*)
- The top reasons for unmet health care needs differed between the two countries; waiting time was most often reported in Canada, and cost was most often reported in the U.S.
- Americans were more likely to be "very satisfied" with their health care services (both all services and doctor services), while Canadians were more likely to be "somewhat satisfied" (for all services), even when compared with insured Americans.[2]

Finally let me offer a comparison that will shake some the complacent assumptions that many Americans seem to have about the equity and effectiveness of the Canadian health care system compared to their own. They figure that the market-driven system of health care in the United States is harder on low-income families and minorities. Let's talk about infant mortality for African-American babies, which are more likely to be born to low-income families than American babies on the whole. Infant mortality risk is a function of birth-weight, with the risk of death rising as the birth weight falls. Over the full range of low birth-weights (i.e. any birth-weight below 2,500 grams), African-American babies fare better than Canadian babies except at the very top end of the range, where they are essentially equal. In short, among low birth-weight babies, you are better to be born to an African-American family than you are to be born to the average Canadian family. In fact, those who believe that the Canadian system of "free" access (at point of consumption) to health care breaks the link between income and health status will be disappointed to know that the "health-income gradient," or the rate at which health improves in tandem with income, is slightly steeper in Canada than in the United States. In other words, having a higher income improves your health status in Canada more than it does in the United States.[3]

No. 2: The Canadian public loves medicare

We have to be careful here. The public loves some features of the system it refers to as medicare (with a small "m"). In particular, there is huge support for the principle that no one should be denied access to needed medical care on the basis of ability to pay. Ideologues in the health care system have tried to stretch the public's support for that basic principle in all kinds of distorted directions.

For example, there is a view afoot in health policy circles that because Canadians support this basic principle, they support the current health care monopoly; that Canadians disapprove of private, for-profit business in the health care sector; and that only the state should deliver health care services.

But Canadians have actually shown themselves to be a deeply practical and non-ideological people. Unfortunately, most of the serious polling on these issues is now several years old, but there is little evidence that these attitudes have changed.

According to a poll several years ago titled "The National Pulse on Health Strategy," 80 percent of Canadians want major reforms to the health care system:

> Two-thirds of Canadians (66 percent) tend to be supportive, more or less, of a host of new models of financing in order to reduce stress on the system — for example, where everyone (except those with low incomes) pays a small amount for health care services out of their own pocket. They also tend to support strategies such as using nurses or other health practitioners rather than physicians to provide certain services. Just under half (45 percent) tend to be supportive of market-oriented reforms — greater efficiency, accountability and customer service, including private sector companies delivering health care services.[4]

The National Post reported that the same Environics poll found that fewer than half of respondents would support increasing taxes to pay for health reforms. But notably, only 10 percent of Canadians would accept a health care system that excluded those who could not afford to pay for services.

These results need not be seen as a contradiction. As Jane Armstrong, senior vice president of Environics Research Group said at the time, "Canadians, ever-constant champions of fair play and equity, are devoted to maintaining a system that ensures access to quality health care for all. … They're willing to make changes, even if this includes new and varied ways of financing the system as well as a greater dependence on market forces such as private companies delivering certain health services."[5]

Another poll, by Decima Research (Oct. 25, 2002), found that more than half (55 percent) of Canadians were opposed to paying higher personal income taxes, even if these funds were designated to pay for health care. An even

larger majority of respondents (67 percent) also believed that they would have to rely on their own personal savings to pay for their use of health services in the future.

Similarly, a 2006 poll by Leger Marketing of Montreal for the Montreal Economic Institute found:

> Overall, nearly half of Canadians (48%) would agree if the government allowed faster access to healthcare for those who wish to pay for this healthcare in the private sector, while maintaining the current free and universal system. An equal proportion of respondents (48%) disagree with this proposal.[6]

The poll went on to probe the attitudes of Quebeckers, who represent roughly one-quarter of the Canadian population, and found:

> Two-thirds of Quebeckers (66 percent) say they are in favor of access to private health care insurance for all medically required care. Conversely, nearly one-third of them (31 percent) are against this type of initiative by the government of Québec.[7]

These public opinion polls appear to indicate that Canadians want a system of health care that provides high-quality medical services and is financially sustainable over the long term at an acceptable economic price, without excluding poorer people from access to medically necessary services. And in a typically pragmatic way, Canadians are not worried whether it is the private sector or the public sector that achieves this; they just want results. In fact, when Canadians do express a preference for either private or public approaches to health reform, the majority are willing to fund their future medical needs themselves rather than pay higher taxes to expand the medicare model of health care.

No. 3: Canadian medicare is sustainable

On the contrary, medicare is not sustainable on its present course. A modest slowdown in the rate of spending increases in the 1990s was bought chiefly through reductions in services, closure of facilities, fewer health professionals, dissatisfaction among those who remained, increased waiting times and forgoing innovative — but expensive — new technologies. Since then, we have returned to the rapid escalations in health care spending.

Medicare *as we know it* can only be "sustainable" if Canadians are willing to accept less service or more taxes. Polls, as I've already mentioned, indicate that neither is acceptable. And given increasing consumer expectations for expensive health technologies, drugs and procedures, and the expected health demands from an aging population, medicare's problems are only going to grow. In fact, a paper by Bill Robson, president of the C.D. Howe Institute in Toronto, has argued that the unfunded liability of medicare (promises to pay for services for which normal increases in the revenue from the existing tax load will not cover), is in the $500 billion to $1.2 trillion range.[8] Canada's entire federal government debt, by comparison, is currently about $480 billion[9] (but rising this year and next because of recession-induced deficit spending).

In the early years of this decade, there were a number of major public inquiries into the future of our health care system. Most of them, including the Kirby Report (by a committee of the Senate of Canada), the Mazankowski Report (by the Alberta Premier's Advisory Council on Health, of which I was a member) and the Fyke Report for the Government of Saskatchewan, identified sustainability of the health care system as *the* challenge we face.

Apologists for the current system deny that there's a problem. They point out that we Canadians are spending the same share of gross domestic product today on public health care as 30 years ago. If a little more than 7 percent of GDP was sustainable in 1972, why is that same percentage unsustainable today?

That's the wrong question. It's not how much we're spending, but how we're paying for it and what we're getting in return. For years, we borrowed and spent on health care (and other services), so we got more than we were willing to pay for. Today, as the only G8 country that was consistently in budgetary surplus for the decade prior to the current downturn, we pay the full cost of today's services, *plus* the interest on money we borrowed for health care and other things in the past. So while the *spending* has remained constant as a share of GDP, we can no longer supplement the tax-financed spending with borrowed dollars. We have to pay for everything we consume today, plus pay off the bill from past borrowing. There is little appetite to increase taxes, and in fact, the trend is the other way. The pressure of health care spending has been the chief culprit behind deficit financing by a number of provincial governments (as distinct from the federal government). And much of the deficit spending in provincial health care systems is in fact not reflected in the budgets of the provinces, because it takes the form of hidden deficits in provincial hospital budgets, reduced access to care, crumbling infrastructure (the average hospital in Ontario is now more than 50 years old), and so forth.

The irresistible force of demand for "free" services is running headlong into the immovable object of unavoidably limited health budgets. To date, the pressure has been relieved by crumbling health infrastructure, loss of access to the latest medical innovations, declining numbers of medical

professionals and lengthening queues. By and large, people have access to ordinary, relatively low-cost services like general practitioner office visits, but find it increasingly difficult to get vital services such as sophisticated diagnostics, or many types of surgery and cancer care, where the waits can be measured in months if not years.

This is the exact reverse of what the rational person would want. We should use the public sector to pool everyone's risk of expensive interventions, ensuring that they are available when needed, but leaving ordinary interventions, whose cost can easily be borne by the average person, to individuals, supplemented by private insurance and subsidies for those on low-incomes. Hardly anyone can afford cancer care, bypass surgery, gene therapy or a serious chronic illness on their own. These are the things that, without insurance, destroy people's finances.

But as much as 30 percent of the services consumed under medicare are unnecessary, not medically beneficial or even harmful. No one would be financially ruined by having to pay for an ordinary doctor's office visit if we ensured that people on low-incomes were subsidized and there was a reasonable maximum anyone would be called on to pay. No one would be harmed by an incentive not to go to the emergency room when a visit to the family clinic would do just as well. The biggest health care study in the world, the RAND experiment, found that people who had to pay something toward the cost of their care consumed less of it, but that their health was, with very slight qualifications,* every bit as good as those who got totally free care.[10]

Our experience has been that the extra infusions of taxes merely put off the day when we realize that we must concentrate scarce public health care dollars where they'll do the most good, and give users of the system incentives to be prudent about how they spend them. We spend vast sums on procedures of little or no value, while we place patients whose condition endangers their life in lengthening queues.

No. 4: Single payer, Canadian-style, keeps costs under control

A mythology has grown up about the superiority of our system to control costs. The friends of the Canadian system point out that, until the introduction of medicare in the late 1960s, our health care costs tracked those of America's. After the introduction of medicare, however, our growth in costs, and especially physician costs, dropped significantly after the predictable short-term rise. Health care economist Brian Ferguson examined these numbers more carefully, and a wholly different picture emerged.[11]

We see the spike in expenditure associated with the introduction of medicare, and the drop off in expenditure growth as the adjustment to universal coverage works itself through. But by the late 1970s, the two countries' expenditure growth series are back in sync — in fact they are more closely aligned in that period than they are in any previous period. They diverge again only in the mid to late 1980s, when, arguably, Canadian governments became really serious about controlling spending.

While we can identify transitional effects surrounding the introduction of medicare, it is not possible to identify a lasting effect of the introduction of medicare on expenditures. Basically, the introduction of medicare had no effect on the growth rate of expenditures, and the reason the Canadian GDP share figure fell below the U.S. figure was not because of differences in the rate of growth of expenditure, but rather because Canada happened to have the good fortune to bring medicare in during a period in which the Canadian economy outdid the U.S. economy in terms of real growth.

Had our economic growth been as weak as U.S. economy's growth was through the 1970s and '80s, and had our health spending nonetheless remained unchanged, for two decades our share of GDP devoted to health care would have been higher than the actual U.S. GDP share. Canada, in other words, would have had the most expensive health care system in the world, a situation that would have changed only in the 1990s.

Why, given Canada's apparent success at controlling health care costs through the '70s and '80s, at least as judged by the GDP share evidence, were recent efforts at cost control not handled with less disruption?

The answer now seems to be not that we were poor performers this time around, but rather that our earlier "success" at cost control was illusory. Simply put, the introduction of medicare did not introduce a period of, or efficient mechanism for, health care cost control. When it came to the question of how much of our national income we were spending on health, we weren't particularly good, we were just lucky.

No. 5: More cash is the solution to medicare's problems

Canada spent just over 10 percent of GDP on health care in 2007 (vs. 16 percent in the U.S.).[12] Of that amount,

* The qualifications are that for a small number of chronic conditions, such as hypertension and vision care, poor patients in these conditions under-spent on care. Part of the advantage of the RAND experiment is in helping us to identify areas, such as these, where poor patients' health can be improved by targeted subsidies.

roughly 70 percent was spent by governments on publicly funded health care (the other 30 percent or so was spent on private health care, including drugs, dentistry, chiropractic, etc.). Interesting fact to note: That means that Canada and the U.S. spend almost identical shares of national income on tax-financed public health care — roughly 7 percent of GDP.[13]

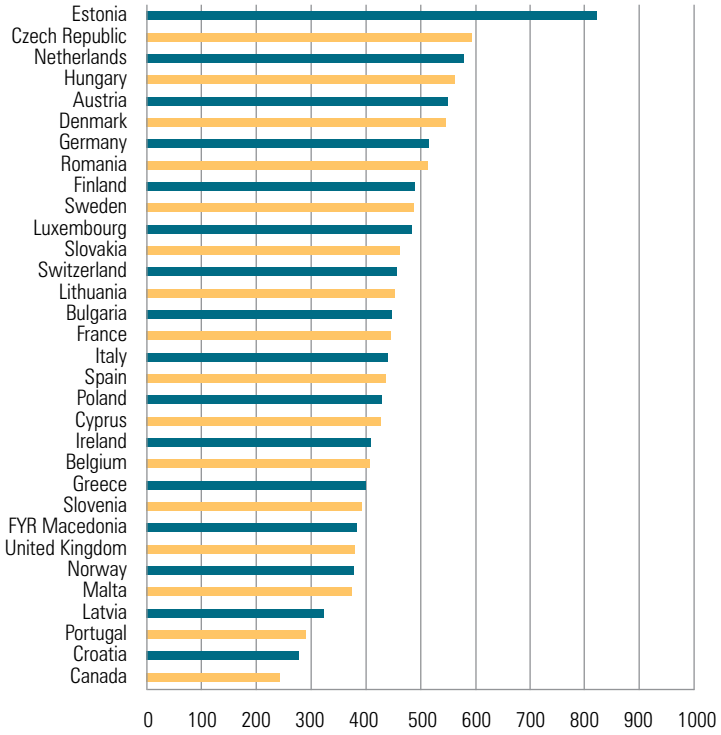
After our last round of national angst over the state of health care in the mid 1990s, a new $6.5 billion per year was made available by the Canadian federal government. But just under ordinary cost pressures within our system, costs rise in real terms by 5 percent to 6 percent per year, and there are a number of new pressures that are likely to accelerate that trend. So you do the math. Add an annual tax-financed contribution of $6.5 billion to a tax-financed health care budget of $75 billion (the base in the early years of this decade) rising at 5 percent per year, and the ordinary and totally foreseeable costs of the existing system rapidly ate up every penny of that new funding. Again, that did nothing to address the chronic "deficits" within the system hidden within hospital deficits, ageing buildings, inadequate diagnostics, etc.

Indeed, the health care system in Canada staggers from crisis to crisis, with new funding promised each time by the federal government. Prior to the new $6.5 billion, the federal government put about $20 billion into medicare, and nobody knows what value we got for that money. After every cash infusion, the queues lengthen, or at best remain the same, the shortage of diagnostic equipment gets worse and people are less able to find a family physician. This helps to explain Johan Hjertqvist's observation that, "Year by year injecting more money into the system evidently is not the answer. Rather what is needed is to reform the incentives and the assessment mechanisms within the Canadian health care system." In fact, we have had a lot of experience in Canada with new injections of cash into the system, supposedly to "buy change." Normally, the powerful interests within the system — doctors, nurses, support staff, etc. — organize to capture a share of that money. Costs rise, but productivity does not and services are not better or timelier. The Canadian medicare system is a black hole into which we can pour seemingly infinite amounts of money. These facts put lie to the claim I often hear from proponents of the Canadian system in the United States to the effect that if only Canada spent a little more per person, we could solve all of the system's problems. I see little evidence to think that this is the case, because the problem is not that the system is underfunded, but that it is systemically incapable of responding to consumer demands and, like all monopolies, it distributes "rents" to producers within the system rather than providing better quality service to patients. No amount of new funding will change this, and any such new funding will be captured by groups within the system.

This may help us to understand why the Frontier Centre for Public Policy's Euro-Canada Health Consumer Index finds that Canada gets notably poor "bang for its buck" on health care spending compared to the other countries ranked in the index.[14] The ECHCI attempts to assess and compare health care systems in 32 countries, where spending varies widely. To account for this, the annual health care spending is adjusted to reflect purchasing power parity between these various nations. When so adjusted, and stated in U.S. dollars, spending varies from less than $500 in Macedonia to more than $4,000 in Norway, Switzerland and Luxembourg. Continental Western Europe and the Nordic countries generally fall between $2,700 and $3,500, while Canada spends close to $3,700. Because total spending tells us little about the benefits obtained for the spending, the ECHCI includes a value-for-money adjusted score: the Bang-For-the-Buck adjusted score.

It is remarkable that Canada, which spends at the very top end of the index, finds itself at the absolute bottom on this value-for-money measure. According to Hjertqvist, "This is a clear signal of the need for radical change to improve output and user-friendliness."

Bang for the Buck Adjusted Scores, ECHCI 2009



No. 6: Under medicare, people get the health care services they need

A whole host of things need to be said here, and I don't have time for them all. Let me start by saying that while the language of medicare is that Canadians get "medically necessary services" paid for by the state, this is not at all so. Among the services that are not covered are prescriptions (increasingly important as many forms of surgery are now being supplanted by drugs regulating the body's functions), dentistry, home care, chiropractic (in most provinces) and a number of other services. And there is a wide range of new diagnostic and other services, such as gene therapy, that it is not yet clear whether medicare will cover. In fact, one of the "brilliant" research papers for one of our endless series of public inquiries into the future of health care argued that in fact technology need not be a cost driver for the health care system because it is only a cost driver if we actually use these technologies.

Let's talk about a few other aspects of whether we get the care that we need in Canada.

Queuing

Queuing is a controversial measurement, not least because there may be many explanations for the queuing, many of them medically justifiable, so that aggregate queuing figures may conflate those who suffer no health or other risk while waiting with those who may be impaired or may suffer pain while waiting.

That being said, in a system in which health services are free at the point of consumption, queuing is the most common form of rationing scarce medical resources. And since patient satisfaction plays no part in determining incomes or other economic rewards for health care providers and administrators in the public system, patients' time is treated as if it has no value. There are no penalties in the system for making people wait.

It is thus not surprising that the measures of queuing now available, including the Fraser Institute's annual report card titled "Waiting Your Turn: Hospital Waiting Lists in Canada,"[15] indicate at best a stabilizing of the queues for a great many medical services, including access to some specialists, diagnostic testing and surgery. This stabilization has been achieved at the cost of a huge amount of effort designed to "shorten" waiting times.

According to the Fraser Institute's 18th annual waiting-time survey, "Canada-wide waiting times for surgical and other therapeutic treatments decreased in 2008. Total waiting time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, fell from 18.3 weeks in 2007 to 17.3 weeks in 2008."[16] So the national average is that patients have to wait somewhere around four and a half months to get needed medical treatment after seeing a doctor. The average is considerably worse in many provinces. It can take a year and a half to get a hip replacement in Saskatchewan. A friend of mine was recently told that heart surgery he needs might take over a year.

It must also be noted that those administering the system must rely on external studies, not having implemented modern information systems to monitor waiting periods and identify those who have had an excessive wait. Incredibly, while we talk a lot about queuing in the Canadian health care system, and while we talk as if we know how many people are waiting and how long they wait, we do not know these things at all, aside from rudimentary attempts to fill the gap, typically covering only a few types of surgery. There is little quality control over data collected, making comparisons between institutions, let alone provinces, highly problematic. Moreover, the data collected can, by definition, only include those people who have made their way officially into the system and have been properly diagnosed. According to David Zitner, director of medical informatics at Dalhousie University in Halifax, health policy fellow at my institute and one of Canada's leading experts in the use of information technology in the Canadian health care system: "The waiting time systems are not rigorous. They would not be acceptable in industries that needed useful information for commercial success. The few waiting time systems are prone to game-playing."

Ironically, for the largest single expenditure of tax dollars in Canada, we know astonishingly little about what we get for our money. Again according to Dr. Zitner, no health care institution in Canada can tell you how many people got better, how many people got worse, or how many people's condition was left unchanged by their contact with their institution. None of them can give you an answer. No one knows how many people died while waiting for needed surgery. No one knows how many people are queuing for any particular procedure, or how many people cannot find a family doctor. Mostly we have guesswork, anecdotes and subjective measures, not objective ones (such as the Fraser Institute reports mentioned earlier). We don't even know how long someone has to wait before they've waited "too long," because the health care system does not establish official standards for timely care. The best we have are politically negotiated "benchmark wait times"[17] — i.e., standards that suit politicians, not ones that have been established according to rigorous medical standards. And politicians have been anxious to make clear that these benchmarks

are nothing more than desirable outcomes. They are certainly not prepared to use them as official goals of the system, lest their failure to attain them be used as a measure of their failure to provide timely care.

Some of you may think that a reference to people dying in the queue is regrettable hyperbole. If only that were true. We had a court case on this very point in Canada a couple of years ago, in which physician Dr. Jacques Chaoulli and a patient alleged that the way that the health care system was run in the province of Quebec (which is representative of the country as a whole) jeopardized Quebeckers' right to security of the person as guaranteed under both the Quebec and the Canadian Charters of Rights. The Supreme Court of Canada ruled that the health care system violates Quebeckers' rights under their provincial Charter of Rights because it collects taxes and promises health care in return, forbids competing suppliers, and then often doesn't deliver the care. As the justices said, a place in a queue is not health care. The Supreme Court did not rule on whether the health care system also violated the Canadian Charter, because once they found that Quebeckers' rights were violated under their provincial Charter, the justices did not find it necessary to rule on the applicability of the federal Charter as well. As a result, the Supreme Court's decision, while made by the highest court in the land, applies only to the health care system in Quebec. Other cases are being brought forward in other provinces, however, in an effort to broaden the scope of the original decision. Since the Quebec Charter's language closely follows that of the federal Charter, the chances of success of these supplementary challenges seem good.

Access to doctors and medical technology

Aggregate numbers of doctors per 1,000 people do not give a good picture of access to physicians in, say, cities versus rural areas within countries, nor of proportions between scarce specialists and plentiful general practitioners, nor of the quality of medical training. On the other hand, it is a crude measure of the overall state of access to qualified practitioners. On this measure, Canada performs badly. In 1996, it had 2.1 practicing physicians per 1,000 people, while of the comparison group, only two — Japan and the UK — had a lower ratio: Australia had 2.5; France, 3.0; Germany, 3.4; Japan, 1.8; Sweden, 3.1; Switzerland, 3.2; the UK, 1.7; and America, 2.6. Thus, even in countries with lower per-capita spending than Canada, there is greater access to physician services.

Not only is there unacceptable queuing for procedures, but there is considerable difficulty getting in to see a family physician. The doctor shortage is now so severe that Statistics Canada reports that roughly 4 million Canadians do not have a family doctor,[18] and family doctors are now engaging in lotteries to cull their patient lists.[19] The coming wave of baby-boomer-driven retirements of physicians will only exacerbate what is already a critical situation. Yes, it is true that in many communities, people can queue in local clinics and eventually get to see a physician. But seeing an anonymous physician who knows nothing of your family background or health history and may only have five minutes to meet you and assess your condition is not the high-quality system that Canadians were promised, nor are such clinics available to everyone.

With respect to medical technology, Canada's performance is also unimpressive. In a Fraser Institute study comparing Canadians' access to four specific medical technologies — computed tomography scanners, radiation equipment, lithotriptors and magnetic resonance imagers — with access by citizens of other OECD countries, Canadians' access was significantly poorer in three of the four. Despite spending a full 1.6 percent of GDP more than the OECD average on health care, Canadians were well down the league tables in access to CT scanners (21st of 28), lithotriptors (19th out of 22) and MRIs (19th out of 27). [20] Moreover, access to several of these technologies worsened relative to access in other countries over the last decade.

A somewhat more recent study drawing on 2005 data came to a similar conclusion: "Canada has fewer MRI machines per million inhabitants, fewer CT-Scanners per million inhabitants, and fewer lithotriptor machines per million inhabitants than the OECD average."[21]

Canada's public health care system is undersupplied with the latest diagnostic and other technologies[22] because they are expensive and their use leads to more consumption of health care services. The logical prescription: Keep your health care system primitive and your costs will be kept low.

All of this is due, as I argued in a major paper I co-authored,[23] to the conflict of interest at the heart of medicare, in which the people who are the ultimate providers of health care services in Canada are also the people charged with regulating the system and quality assurance. Since no one is a competent judge of their own performance, and no one likes to be held accountable for their work, the result is that the health care system simply doesn't set tough standards or collect the information that would allow us to hold the system's administrators accountable. The people who would collect the information are also the people whose performance would be assessed if useful information were

made available. There appears to be no legal obligation on governments to supply the services they have promised to the population as their monopoly supplier of health insurance. This is an appalling double-standard, as no responsible regulator would permit a private supplier of insurance to behave in this way.[24] And the Supreme Court of Canada, in the Chaoulli case referred to above, agrees.

Finally, the comparison with America is always instructive. In this regard, I often like to quote from a wonderful letter I saw from Susan Weathers, a hospital physician in Houston, Texas. She wrote to The Wall Street Journal after reading an article there about how the Canadian health system actually works. She wrote that the article describes a health care system that:

> "... resembles the country hospital where I work. Our patients pay little or nothing. They wait three months for an elective MRI scan and a couple of months to get into a subspecialty clinic. Our cancer patients fare better than the Canadians, getting radiotherapy within one to three weeks. The difference is that our patients are said to have no insurance (a term used interchangeably with no health care), whereas Canadians have "universal coverage."

In other words, the question we must always ask when we talk about universal coverage in Canada is, What does it mean to be "insured" when services are not available? Prices were also attractively low in the GUM department store in Moscow; unfortunately, the goods to which those prices referred were rarely on the shelves.

No. 7: "Free" health care empowers the poor

Everything I want to say about this is summed up in a story that happened to Shelley, my business partner. Shelley and I own a restaurant, although she actually runs it. She was given an appointment at the hospital for a procedure, and she duly showed up at the appointed time. Two hours later, she was still sitting there waiting to be called. She was only able to get a two-hour parking meter, and so she approached the desk and asked if she could go and put money in the meter. She was curtly told that she was free to go and put the money in, but that if her name was called while she was away, her name would fall back to the bottom of the queue. She decided that she would take the parking ticket as part of the price of getting the medical service she needed. Another two hours passed, and still she was not called, so she again approached the counter and very patiently and politely explained that she actually had a small business to run, that she was there at the scheduled time for her appointment, that she had waited four hours, which is far longer than she had been led to expect the whole thing would take, that she had other commitments because of the business and could they possibly at least give her some idea of how much longer she might have to wait?

The woman behind the counter glared at Shelley and said, "You're talking as if you're some kind of customer!"

That is the essence of the problem. When the government supplies you with "free" health care, you are not a powerful customer who must be satisfied. They are doing you a favor, and you owe the state gratitude and servility in return for this awesome generosity. They can give you the worst service in the world, but because it's free, you are totally disempowered.

The articulate and the middle class don't let little things like that get them down. Even though they don't pay, they still get in the face of the people providing service and make their wishes known. But often, the vulnerable, the poor, the ill-educated and the inarticulate are the ones who suffer the most because no one's well-being within the health care system depends on patient/consumers being well-looked-after. By depriving them of the power of payment within the health care system, medicare disenfranchises them.

In a Compas poll for The National Post, fully 41 percent of Canadians were of the view that individuals should be able to choose private health insurance over medicare, allowing them to obtain better, or at least faster, care than at present. Interestingly, for a society preoccupied with the inequities implied in "two-tier health care," more of those earning less than $25,000 a year (47 percent) were interested in this option than those earning over $75,000 (39 percent). Those most satisfied with their health care were not the least educated, but the best educated — those with postgraduate degrees.

Canada's system in fact does create multi-tiered health care where health care services are distributed on the basis of middle-class networks and ability to communicate one's needs aggressively to professional caregivers. It is the poor, the vulnerable — including most obviously, the sick — and the inarticulate who receive the worst care, because they cannot circumvent the system the way the middle class and its advocates can.

No. 8: Canadian medicare is fairer because no one gets better care than anyone else

The apologists for the current system want to ensure that "two-tier" health care, a higher or faster level of care for those willing to pay, continues to be forbidden in Canada.

Too late.

There are a number of groups that are exempt from the requirements to use the single-payer system. Examples include members of the armed forces, the Royal Canadian Mounted Police, people who work for a company that employs physicians and other medical personnel, people who use a private hospital or one of the country's private abortion clinics, people who are on workers' compensation, people who pay for various services in the numerous private clinics now emerging across the country, and, finally, people who cross the border and pay for access to private care in the United States or other countries.

What is often ill-understood in the United States is the extent to which the American medical system is the private-sector alternative to Canada's public single-payer system. About 80 percent of Canadians live within 100 miles of the American border, so geography is no barrier, although cost is clearly a consideration. There is, for example, a CT/MRI clinic right across the border from Manitoba in Grafton, N.D., intentionally put there to attract Canadians from nearby Winnipeg.[25] Despite the fact that Manitoba is always one of the highest per-capita spenders on health care of all the provinces, the unsatisfied demand for diagnostic and other services is high enough that American investors find it worthwhile to pay for expensive diagnostic machines and put them at the border to cater to underserviced Canadians. We now have several companies that specialize in what is increasingly known as medical tourism — people who are in need of care that they cannot get in a timely way in Canada are using these services to arrange for care abroad.

Note, by the way, that it is not only individuals within Canada who rely on the United States and other foreign sources for health care. Provinces (which deliver the health care services in Canada) have also been known to use the U.S. system as marginal swing capacity. For example, several years ago, the province of Ontario contracted with a number of clinics in New York state to provide cancer care that Ontario was not in a position to provide.

Moreover, technology is allowing the remote delivery of ever more health services, so the ability of governments to frustrate patients' desire to get better and faster treatment is declining, and that decline will accelerate. The debate, therefore, is really about how many tiers and under what conditions they will exist. And many of these tiers are beyond government control.

Virtually any kind of pharmaceutical product can now be purchased over the Internet from foreign providers who can evade governmental controls. You can even get involved in online auctions for the drugs you want. Your X-rays or MRI scans can be read just as easily by a radiologist in Boston or Bombay as in Toronto or Truro.

More powerfully, the brain repair team at Dalhousie University some time ago operated on a patient in Saint John, New Brunswick. The surgeons never left Halifax. Using video cameras and computer controls, they operated robotic arms that actually did the surgery hundreds of miles away. When you can go to a surgical booth in Canada and be operated on by the best surgeon in the world, who may be at his office in London or Houston or Minneapolis, the notion of a closed national health system in which people must take what public authorities decide they should have simply cannot survive.

Multiple tiers is a slippery concept. For some, if certain people can get a service by paying for it, while others who cannot pay do not get access, that is multiple tiers.

On the other hand, there are people who oppose tiers because of an ideology of egalitarianism. They would object if two people with similar conditions both got treated, but one more quickly through private payment and the other more slowly, but within appropriate norms for their condition, by medicare.

Remember, we are not talking about people being denied care based on ability to pay, because anyone willing to wait will eventually get care (although again we possess no figures on how many die while queuing for public health care). The complaint is rather that someone got care more quickly. It's a very different objection that no one should be able to get faster treatment than in the public system, even where such faster access does not affect the quality or timeliness of the care obtained by people who continue to use the public system.

This peculiar brand of egalitarianism suggests that people should *not* be denied service because of their own inability to pay, but *should* be denied access because of *their* neighbor's inability or unwillingness to pay (through taxes) for the care an individual decides he or she needs.

Canada is almost alone in the Western world in outlawing people paying privately for services that are also publicly insured. One consequence of this is that there are many services, such as drugs or home care, which we cannot afford to cover publicly, whereas they are often publicly insured elsewhere.

This might be a defensible trade-off if our system were superior to others, and indeed we frequently hear it said that we have the best health care system in the world.

But the evidence presented here underlines the extent to which the Canadian system is costly and produces, on the whole, mediocre results.

In sum, many of the concerns expressed by the Canadian health care establishment about any kind of serious reform are ideological, and have little to do with the quality of care delivered within the public system. The politicians and administrators cling to a system that outlaws private spending on publicly insured services, in the mistaken belief that parallel systems rob the public system of resources, while both objective and subjective international rankings show that multiple tiers of access are fully compatible with quality public systems, high levels of care overall, high levels of patient satisfaction and public health outcomes as good or better than Canada's.

No. 9: Medicare-type spending is the best way to improve health

Again, a lot of people seem to believe this, but it just isn't so. In fact there are many forms of spending that are far more likely to improve health outcomes than health care spending. Consider, for example, that there is a very close link between health and wealth. The wealthier you are, the more likely it is that your health is good. This implies that spending that is likely to improve the wealth-creating capacity of society is also an investment in health. That means things like education, economic infrastructure and a reasonable tax burden are all key determinants of health. So are public health measures like sanitation, water quality, environmental protection and preventative measures.

The irony is that as the health care budget expands in Canada, it is crowding out many of these other forms of public spending. For example, the provinces, which have responsibility in Canada for the delivery of most services, such as health care, education, roads, environmental protection and water provision, have seen health rise from around 30 percent of spending to nearly 50 percent. It is expected to exceed 50 percent in all provinces within a decade. And Canada's tax burden is higher than the U.S. tax burden, although the difference is rapidly disappearing because of our superior management of public finances (a Canadian policy Americans *should* want to copy).

No. 10: Medicare is an economic competitive advantage for business

As the price of health care increases in the United States, so do insurance premiums since all insurance payments ultimately come from the pool of premiums collected from the insured. Since people usually obtain this type of insurance through their place of employment, it is often thought that the rising cost of insurance constitutes an increased cost to employers. This view is especially widespread with regard to health insurance in the United States, where it is often said that health insurance premiums make up a larger part of the cost of building a car than steel does. Canadian politicians are prone to argue that since, under medicare, Canadian companies do not have to bear this extra cost, they have a competitive advantage in world markets. As with so many statements concerning medicare, this too is wrong.[26]

Economic theory predicts, and empirical evidence confirms, that the full cost of the insurance premiums is passed back to workers in the form of lower take-home pay. Canadian workers pay the costs of medicare through income taxes; U.S. workers pay the cost of their health coverage through the pass-back of premiums. Even the part nominally paid by the employer actually comes out of the pool of funds available for paying labour and therefore comes out of the workers' pockets — in that case, before it even reaches them.[27]

In conclusion, let me just summarize again the top 10 things many people believe about Canadian medicare but shouldn't:

- No. 1: Canada has the best health care system in the world
- No. 2: The Canadian public love medicare
- No. 3: Canadian medicare is sustainable
- No. 4: Single payer, Canadian-style, keeps costs under control
- No. 5: More cash is the solution to medicare's problems
- No. 6: Under medicare, people get the health care services that they need
- No. 7: "Free" health care empowers the poor
- No. 8: Canadian medicare is fairer because no one gets better care than anyone else
- No. 9: Medicare-type spending is the best way to improve health
- No. 10: Medicare is an economic competitive advantage for business.

As I said in my original 2003 essay for the Mackinac Center, I, like most Canadians, believe that our system is superior in many respects to the U.S. system, but it is a system that staggers under the burden of serious design flaws.

I remain just as worried in 2009 about the long-term sustainability of the Canadian health care system as I was in 2003, and think that we have much to learn from countries that get much better rankings than either Canada or the United States in comparative studies. These countries demonstrate that many of the fears that Canadians have about significant reform to medicare — introducing payment for health care, allowing people to pay directly for health care outside the government monopoly, and even breaking up the monopoly provision to allow competition and a greater role for the private sector — can be addressed within a public policy framework that continues to be preoccupied by equity considerations, and that gives Canadians better value for the tens of billions of dollars they so patiently and lovingly devote to public health care spending in a repeated triumph of hope over experience.

As for my American audience, the only advice I can offer as you struggle with plans to reform your own health care system, is that the evidence indicates that a Canadian-style system would offer only modest improvements in some forms of equity and would come at a considerable cost, including freedom of choice, competition and consumer empowerment, for the vast majority of Americans who express higher levels of satisfaction with their current health care coverage than Canadians do. Incremental changes aimed at solving specific problems within the American health care system, rather than its wholesale replacement by a government bureaucracy such as Canada now has, would seem a far more promising route to take.

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