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PERCEPTION VS. REALITY: TAKING A SECOND LOOK AT CANADIAN HEALTH CARE

INTRODUCTION

In the continuing debate over how to reform America's ailing health care system, one solution often proposed – especially in the press – is for the United States simply to adopt a government-run system similar to that of Canada. Proponents of this view contend that the Canadian system provides access to health care for all its citizens at a lower cost than in the U.S. and with the same or better quality. Furthermore, they claim, a U.S. version of Canada's system could retain the freedom of choice currently enjoyed and valued by Americans, while hospitals and physicians would be free to practice medicine with less interference or oversight from government regulators than many providers face today. The reason this is possible, proponents of the Canadian system maintain, is that while government controls the overall financing of the health care in Canada, it does not directly control the health care delivery system.

Inaccurate Assertions. Presented in this way, it is perhaps no surprise that the Canadian system looks very attractive to many U.S. policy makers and individual Americans. Indeed, it registers considerable support in U.S. public opinion polls, far exceeding support for the existing system.[1] Recent research, however, reveals

1 Robert J. Blendon, "Three Systems: A Comparative Survey," *Health Management Quarterly*, First Quarter 1989, pp. 2-10. The article reports the widely cited results of a survey of citizens of Britain, Canada, and the United States that asked respondents to rate their satisfaction with various aspects of their own health care system and their preference for the systems of the other two countries. The Canadian system was viewed as most appealing for all three groups.

that many of the assertions made about the Canadian system by its enthusiasts are not accurate. Studies of Canada show:

- Canada's track record in controlling health care costs is no better than that of the U.S. Example: Between 1967 and 1987, inflation adjusted per capita health care spending increased at an average annual rate of 4.58 percent in Canada, versus 4.38 percent in the U.S.
- The Canadian system is suffering significant and growing problems in providing access to care and assuring quality. Example: In the Canadian province of British Columbia the average wait for heart surgery is five months.
- There would be enormous costs associated with U.S. adoption of a Canadian-style system. Recent studies estimate that adopting a national health system in the U.S. would require new government spending of between $189 billion and $339 billion a year, depending on how the system would be structured.

This new research should prompt U.S. policy makers to take a second, much harder look at the reality of the Canadian system before attempting to institute such a system in the U.S. The picture of the Canadian system painted by its proponents has seemed too good to be true. It is.

THE STRUCTURE OF THE CANADIAN HEALTH SYSTEM

The Canadian "national" health care system is actually a collection of separate, though very similar, provincial systems. Each of Canada's ten provinces and two territories administers its own universal health plan and pays for most of its costs. Historically, the role of the Canadian federal government primarily has been to provide partial financing of the provincial health systems and to establish broad structural guidelines to which the provincial plans must adhere if they are to receive federal financial support.

These national guidelines were developed over several decades, leading to the establishment of similar systems in all provinces by 1971. In 1984, the federal guidelines were revised and consolidated in the Canada Health Act, which forms the basis of the current system.[2] Under this act, provincial health plans are eligible for partial federal funding if they meet the following requirements:

2 This description of the structure and financing of the Canadian health care system is taken from Edward Neuschler, "Canadian Health Care: the Implications of Public Health Insurance" (Washington, D.C., The Health Insurance Association of America, June 1990), pp. 9-18; and Michael Walker, "Why Canada's Health Care System is No Cure for America's Ills," Heritage Foundation *International Briefing* No. 19, November 13, 1989.

Universality. The plan must cover all residents of the province under uniform terms and conditions. For new residents, the waiting period prior to entitlement must not exceed three months.

Portability. The plan must provide continuous coverage for residents who are temporarily absent from the province and for individuals who move to another province until they qualify for that province's plan.

Comprehensiveness. The plan must cover all hospital and physician services deemed "medically necessary" by the federal government. Other items can be covered at the discretion of the provincial plan under terms set by the provincial government. Such discretionary items include: out-patient services provided by health care practitioners other than physicians (such as basic dental and eye care, prescription drugs, and physical therapy), and non-medically necessary services or amenities (such as cosmetic surgery or private hospital rooms).

Accessibility. The plan must provide all residents with reasonable access to care without financial barriers (including out-of-pocket costs) and provide reasonable levels of compensation to physicians.

Public Administration. The plan must be operated and administered by a non-profit, public authority accountable to the provincial government.

Prior to the 1984 Act, provincial plans could charge patients user fees for services, although these were generally quite low and did not cover actual costs. Moreover, doctors were permitted to charge patients more than the fixed reimbursements provided by the provincial plans, a practice known as "extra billing." The Act effectively ended these practices, however, by stipulating that the federal payment to provincial plans would be reduced by the total amount of any user fees and extra billing paid by patients for the federally-required basic services. Since 1987, all provinces have eliminated user fees, and extra billing is illegal throughout Canada for the basic services. Provincial plans, however, are still able to set user fees, or limit coverage, for any additional services they cover.

The Role of the Private Sector

By law, private insurers in Canada are prohibited from selling policies that include coverage for any basic services covered by the provincial plans. Private insurers can, and do, sell policies covering additional services. Most Canadians are covered by some form of private, supplemental insurance, often provided by employers as an employee benefit. The most recent estimate is that in 1985 about 65 percent of Canadians had private, supplemental insurance.[3]

3 Neuschler, *op. cit.*, p. 15.

Fewer than 1 percent of Canadian physicians do not participate in the government-run system. However, if a patient seeks treatment from such a physician, he or she must pay the entire cost out-of-pocket, since the provincial plans will provide no reimbursement, and reimbursement by private insurance for basic services is illegal.

THE FINANCES OF THE SYSTEM

Approximately 74 percent of Canada's total health care expenditures are financed by government, with the remaining 26 percent paid for by Canadians either out-of-pocket or through private, supplemental insurance.

Prior to 1977, the federal government provided matching funds to the provincial health plans on a 50-50 basis for basic hospital and physician services. Concerns over inflation and the lack of fiscal discipline in federal and provincial health budgets, however, led the federal government to scrap this open-ended matching formula and replace it with an indexed, per capita block grant. Since 1977, the total federal contribution to provincial health plans has declined as a result of this new formula. In 1979, the federal contribution funded 44.5 percent of total provincial health spending, but this share dropped to 38.6 percent by 1987. As part of a recent package to reduce the federal budget deficit, the federal government decided to freeze its per-capita contributions to the provinces at current levels for the next two fiscal years (1990-1991 and 1991-1992), which will have the effect of further reducing the percentage share of the federal contribution.

While the Canadian federal and provincial governments control the financing of health care, they exercise little direct control over the delivery of care. Most physicians are self-employed and paid on a fee-for-service basis according to fee schedules periodically negotiated between the provincial governments and physicians' associations.

The Hospital Sector. Most Canadian hospitals are in private hands, though virtually all of them are operated on a non-profit basis. Out of a total of 1,243 hospitals, only 61 (or less than 5 percent) are operated on a for-profit basis by private owners. These do not participate in the provincial plans, and as a result their patients must pay all costs directly out-of-pocket. Most of these hospitals are really long-term care facilities. Another 49 hospitals are owned and operated directly by the federal government to serve patients in programs such as those for veterans, defense personnel, immigrants, and prison inmates.

The remaining 1,133 hospitals are called "public," meaning that they operate on a non-profit basis, participate in their respective provincial health plans, and serve the general public. Of these, over half are privately owned (11 percent by religious orders and 46 percent by voluntary organizations), with the remainder owned by either provincial governments (14 percent), or county or municipal governments (29 percent).

Hospital Budgeting. The operating expenses of all public hospitals are financed by the provincial plans on the basis of "global budgets." This means that each hospital negotiates each year with the provincial plan for its total (global) operating budget for the coming year. The money then is disbursed to the hospital in periodic, lump-sum installments throughout the year.

Most of a hospital's capital budget, used for acquiring new equipment or facilities or upgrading existing ones, also is provided by the provincial government. This budget is kept separate from the hospital's operating budget. While hospitals may, and usually do, raise private funds for capital expansions through bonds or donations, those funds are controlled indirectly by the provincial governments as well. The reason for this is that if the authorities do not agree with a planned capital outlay, they simply will refuse to provide the additional funds in the hospital's operating budget needed to staff or operate the new facilities or equipment. Thus, in practice, the provincial plans use the operating budget to limit the ability of hospitals to expand or offer new services.

By exercising their "power of the purse" in these ways, the provincial governments are able to control total health spending. In the delivery of health care, however, the provincial governments allow considerable discretion to doctors and hospitals to run their facilities and treat their patients as they judge best.

SUPPOSED ADVANTAGES OF THE CANADIAN SYSTEM

Advocates for the Canadian system argue that it contains many key features that make it an attractive substitute for the current U.S. system. Among these:

Lower Total Cost. Measured as a percentage of gross national product (GNP), the United States spends more on health care than any other nation in the world. In 1987 U.S. health care spending was 10.8 percent of U.S. GNP. In contrast Canada's official health care spending was only 8.9 percent of its GNP.[4]

Lower Administrative Expenses. It is argued that with government functioning as a "single payer" for medical services, the Canadian provinces incur much lower administrative costs in operating their plans than do the "multiple payers" (businesses, insurers, and government programs) in the U.S. Some scholars estimate that in Canada at most only 13.7 percent of health care dollars go to administrative costs, while in the U.S. they estimate that the figure is at least 22 percent.[5]

Clinical Freedom. It is said that doctors and hospitals in Canada have wide clinical freedom to practice medicine as they see fit. By contrast, American physicians must deal with government or insurance industry bureaucrats constantly questioning or controlling their billing and treatment decisions.

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4 *Ibid.*, Appendix 2.

5 David U. Himmelstein and Steffie Woolhandler, "Cost Without Benefit: Administrative Waste in U.S. Health Care," *The New England Journal of Medicine*, February 13, 1986, pp. 441-445.

Quality. Proponents of the Canadian system note that standards of medical training and practice in Canada are as good as those in the U.S., the generally acknowledged world leader in the field. They also maintain that, in general, the Canadian system achieves standards and produces medical results as good or better than the U.S. system, as measured by such indices as life expectancy and infant mortality rates. The estimated average life expectancy for a child born in the U.S. in 1989 is 75.4 years versus 77.2 years for a child born in Canada. The 1989 U.S. and Canadian infant mortality rates (defined as the number of deaths of children under one year of age per 1,000 live births in a calendar year), were 11 and 7, respectively.[6]

Universal Access. The most important characteristic of the Canadian system claimed by proponents is that it provides universal access. Unlike the U.S., where approximately 31 million citizens are uninsured, all Canadians are covered by a provincial plan and can seek treatment from any participating doctor or hospital in the country.

In sum, it is argued by advocates of the Canadian system that were the U.S. to adopt a system like that of Canada, Americans would enjoy universal access to high quality medical care at a lower cost than the current system. But while there are statistics which on the surface seem to support this contention, closer and more precise examination of the data, as reported in several recent studies, paint a very different picture of the Canadian system.

DOES THE CANADIAN SYSTEM REALLY CONTROL COSTS?

The claim that the Canadian health system is less expensive than that of the U.S. is taken as a tribute to the system's ability to control the growth of health care spending. The claim usually is supported by comparing health care spending in the U.S. and Canada relative to each country's GNP, as seen in Figure

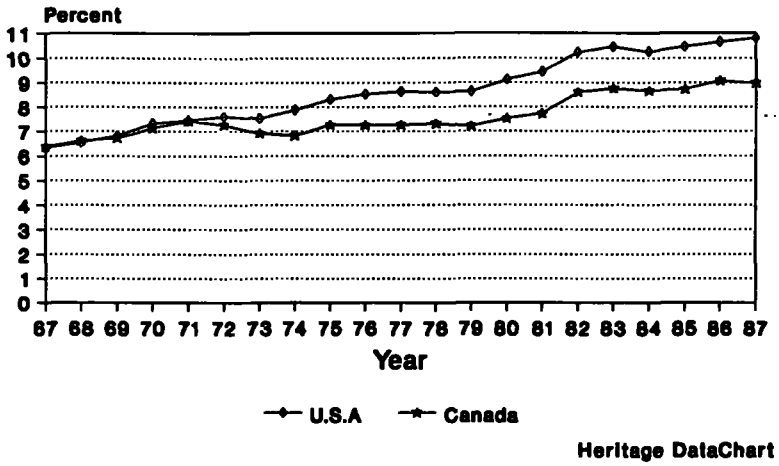
Figure 1 seems to show that in the early 1960s Canada was spending a slightly higher percentage of its GNP on health care than was the U.S. After 1971, however, when the main elements of Canada's system were introduced in all provinces, costs began to diverge significantly, with Canada spending considerably less of its GNP on health than the U.S.

The simple conclusion, drawn countless times from these data by experts and laymen alike, is that Canada significantly limited the growth of health care spending once it introduced a national system. This leads to the assertion that these

6 U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the U.S.*, 1990, Table 1440, p. 835.

Figure 1

Total National Health Expenditures as a Share of Gross National Product



Source: Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance" (Washington, D.C.: the Health Insurance Association of America, June 1990), Figure 4.7, p. 45.

lower spending rates are produced by instituting that system, and that the U.S. would achieve similar results if it adopted a Canadian-style system.

Invalid Conclusions. However, a recent study by Edward Neuschler, Director of Policy Studies at the Washington, D.C.-based Health Insurance Association of America, finds that this simplistic comparison of relative health spending as a percentage of GNP is grossly misleading, and that the popular conclusions drawn from it are invalid.[7]

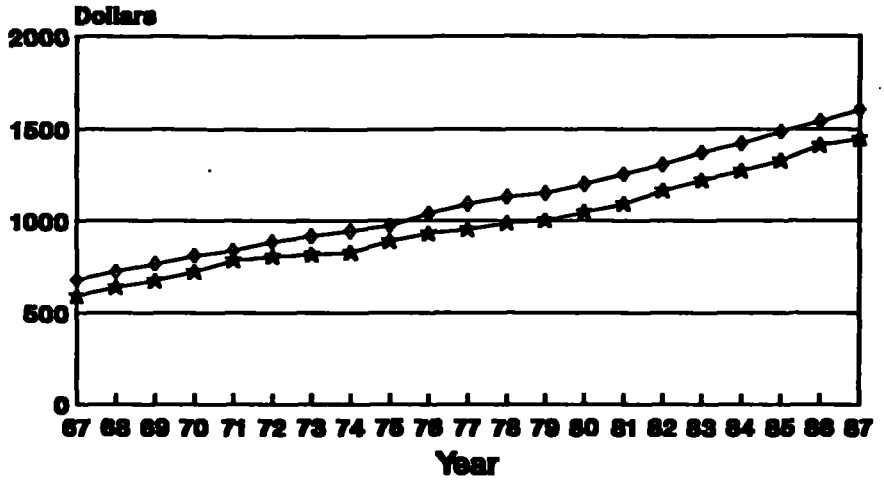
The study compares health care spending in both countries for 1967-1987 the most recent twenty-year period for which data are available. To obtain a true picture of the relative spending rates, Neuschler adjusts the figures to eliminate distortions caused by differences in economic growth rates. GNP growth was, on the average, higher in Canada then in the U.S. during the period. From 1967 to 1987 Canada's real (inflation adjusted) per capita GNP grew 74 percent, while the real growth in U.S. per capita GNP was only 38 percent.[8] This is important because higher GNP growth rates in Canada distort the Canadian figures in Figure 1

7 Neuschler, *op. cit.*, Chapter 4, pp. 37-46. Neuschler based his analysis on the most recently revised official U.S. and Canadian government estimates on national health spending. Many of the revised U.S. estimates for the years 1960-1987, which supersedes previously published data, can be found in Office of National Cost Estimates, "National Health Expenditures, 1988," *Health Care Financing Review*, Summer 1990, pp. 1-41.

8 *Ibid*, p. 45. In contrast, during the period 1960 to 1967, real per capita GNP grew 27 percent in Canada versus 24 percent in the U.S.

Figure 2

*Total Health Care Spending Per Capita**



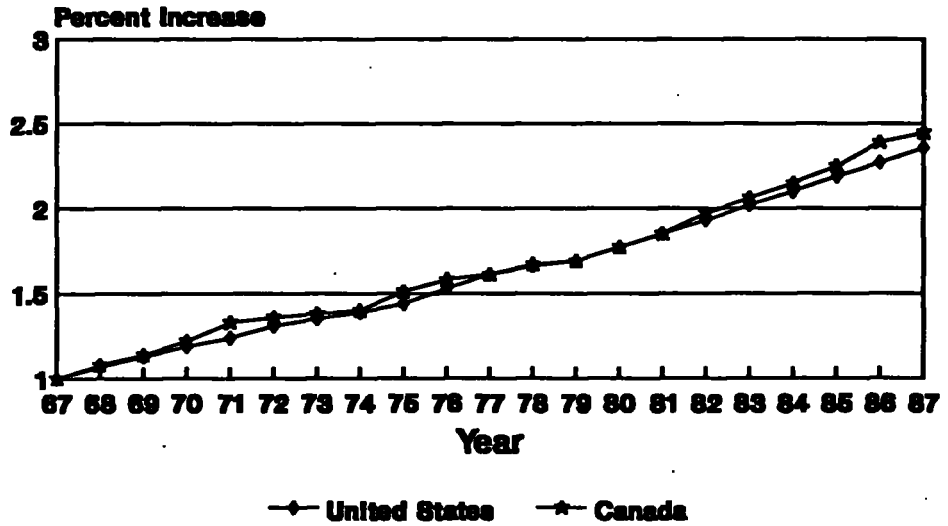
* In Constant 1981 Dollars in Each Nation's Own Currency

Heritage DataChart

Source: Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance" (Washington D.C.: the Health Insurance Association of America, June 1990), Figure 4.2, p. 39.

Figure 3

Cumulative Increase since 1967 in Real Health Care Spending Per Capita



Ratio of health spending in each year to health spending in 1967, adjusted for inflation by GNP deflator.

Source: Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance" (Washington, D.C.: the Health Insurance Association of America, June 1990), Figure 4.3, p. 30.

downward since health care expenditure growth is being compared with a more rapidly rising GNP level.

To eliminate this distortion, and to avoid introducing other distortions due to differences in inflation rates, population growth rates, and currency exchange rates, Neuschler instead calculated health care spending for both countries on a per capita basis in constant dollars in each country's own currency. The results, as seen in Figure 2 on the following page, show practically parallel rates of increase in health spending for both countries.

Almost Precise Coincidence. Next, Neuschler corrected for "baseline" differences in the spending levels in 1967, the initial year of comparison. In this way he was able to compare the growth in expenditures with the same baseline amount in each country. He did this by calculating each country's real per capita health spending as the ratio of spending in each year to spending in 1967. Thus Figure 3 shows the cumulative growth in real per capita spending for both countries over the twenty-year period. As Neuschler notes, "[W]ith the visual distortion caused by the difference in base year spending thus removed, the almost precise coincidence of the trend lines is absolutely clear."[9]

Finally, Neuschler used a standard method for currency conversion to put real per capita Canadian health care spending into U.S. dollars. He then calculated Canadian spending as a percentage of U.S. spending. The calculations show that Canada consistently has spent between 73 percent and 80 percent of what the U.S. spends on health care, both before and after the introduction of universal government funding in Canada (Figure 4).[10]

Even this remaining difference is explained in part by the findings of another study, conducted by Canadians Jacques Krasny and Ian Ferrier, who are directors of the health care consulting firm of Bogart Delafield Ferrier Inc. in Morristown, New Jersey. Krasny and Ferrier did not adjust the data for differences in inflation and GNP growth rates, but instead looked at differences in such things as health care spending patterns and demographics in each country.[11]

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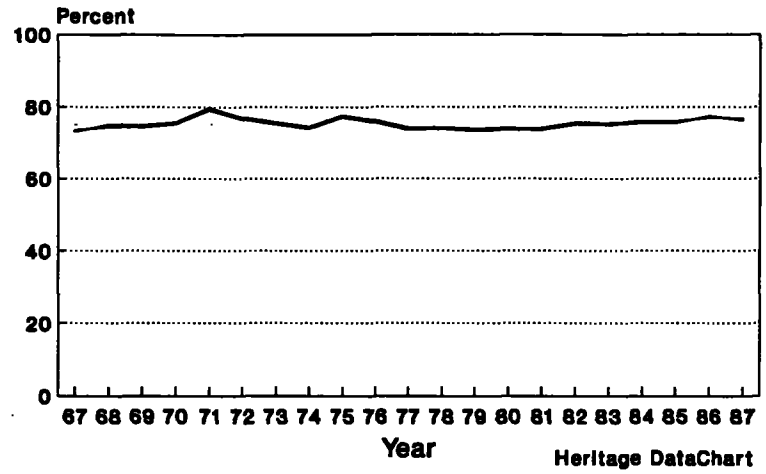
9 *Ibid.*, p. 40.

10 Neuschler provides comparative data from 1960 to 1987 (Appendix 2), though his analysis, as replicated in Figures 2, 3 and 4, is based on the period 1967-1987. What is striking is the virtually indistinguishable similarity of the results achieved when performing Neuschler's analysis using any year from 1960 to 1970 as the base year. The only way to achieve even the appearance of decreased real, per capita Canadian spending relative to the U.S. is by using 1971 as the base year, as has been argued elsewhere (Robert G. Evans, *et al.*, "Controlling Health Expenditures – The Canadian Reality," *The New England Journal of Medicine*, March 2, 1989, p. 572). Because 1971 was the first year that the present system was in effect in all ten Canadian provinces, Canada experienced a substantial (presumably, demand-driven) jump in health spending that year. Indeed, as Figure 4 shows, real, per capita Canadian health spending was at its all-time highest level in 1971 relative to the U.S. While the misleading use of 1971 as a base year thus shows an initial drop in Canadian spending, even this calculation cannot disguise the obviously parallel rates of spending growth in subsequent years. The more accurate method is to use, as Neuschler does, a pre-1971 base year.

11 Jacques Krasny and Ian R. Ferrier, *The Canadian Healthcare System in Perspective,* Bogart Delafield Ferrier Inc., July 1990.

Figure 4

Canadian Health Care Spending Per Capita as a Share of U.S Spending Per Capita



Comparison made in constant 1981 dollars using OECD purchasing power parity exchange rates.

Source: Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance" (Washington D.C.: the Health Insurance Association of America, June 1990), Figure 4.6, p. 43.

Example: Krasny and Ferrier found that while the elderly (those over 65) comprise 12.2 percent of the population in the U.S., they make up only 11 percent in Canada. Because the elderly in both countries consume considerably more health care than the non-elderly, the country with the greater share of elderly citizens would expect to have higher total health care spending. Using data on health care consumption patterns among the elderly, Krasny and Ferrier calculate that if both countries had elderly populations of proportionally the same size, Canadian health care spending would increase by 5.3 percent.

Example: Canada spends proportionally much less of its GNP on medical research and development (R&D) than does the U.S. Krasny and Ferrier calculate that if Canada spent proportionally the same on R&D as the U.S., it would face a 2.4 percent increase in total health spending. Of course, it could be argued that R&D should be accounted for separately from health care goods and services – but that simply means that total U.S. health spending would have to be adjusted downward.

Krasny and Ferrier note other differences between the two countries, which they did not attempt to adjust for but which obviously increase U.S. costs more than Canada's.

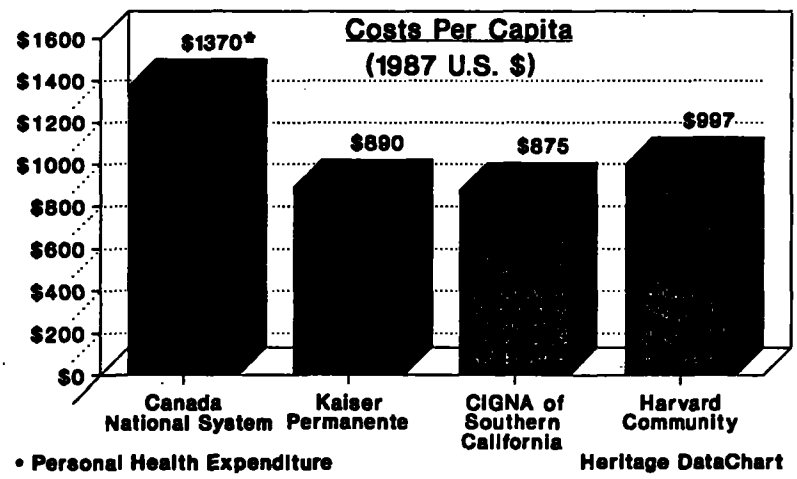
Example: Because of substantial differences in the legal systems, U.S. doctors are more likely to be sued for malpractice and face higher malpractice awards

than their counterparts in Canada. As a result, U.S. doctors pay much more in malpractice insurance premiums and are more likely to practice "defensive medicine." Defensive medicine is the practice of doctors prescribing additional tests or procedures, not because they are medically necessary, but because the doctor wishes the defense, in court, to be able to say that he did "everything possible" for the patient. These malpractice and defensive medicine costs are passed on to the patient in the form of comparatively higher fees.

Example: The U.S. has a substantially larger inner-city poor population experiencing such characteristics as drug abuse problems and high teenage pregnancy rates, which add disproportionately to U.S. health care costs. Krasny and Ferrier note that the teenage pregnancy rate in the U.S. is almost two and one-half times (242 percent) greater than the rate in Canada.

In spite of these factors, Krasny and Ferrier found that in some areas the U.S. health system actually does a much better job of controlling health care costs than does Canada's vaunted system. They observe that the Canadian system is analogous to a collection of large, province-wide American-style Health Management Organizations (HMOs). HMOs provide comprehensive medical care to their subscribers at fixed annual rates and seek to limit costs through various measures such as limiting patients' choice of doctors, requiring pre-approval of non-emergency hospital admissions and surgery, and paying doctors fixed salaries

Figure 5
Comparing Some Large U.S.-Managed Healthcare Plans to Canada



Source: Jacques Kransy and Ian R. Ferrier, "The Canadian Healthcare System in Perspective," Bogart Delafield Ferrier, Inc., July 1990.

instead of per procedure. They note that five of Canada's provinces have populations of one million or less and another three provinces have populations between one million and three million. In contrast, the seven largest U.S. HMOs each have enrollments of between one million and five million subscribers. When compared with Canada, some of these U.S. HMOs have a much better track record of controlling health care costs – showing per-enrollee costs that are $300 to $500 a year less than Canada (See Figure 5).

This new research shows that the perception of Canadian success in controlling health care spending is in fact a myth. The perceived lower rate of Canadian spending results from differences in the economies and demographics of the two countries, and not from differences in the efficiency of their health care financing systems. The reality is that actual health care spending in Canada is growing as fast or faster than in the U.S. Furthermore, Canada's record of cost control is no better than that of the U.S., despite a generally healthier population, lower spending on medical research and development, and significantly fewer costs imposed by its legal system.

Are Administrative Costs Lower?

Enthusiasts for the Canadian system argue that the perceived differences in health spending by the two countries can be accounted for by the greater efficiency of the Canadian system and its lower administrative costs. But as the research cited earlier indicates, the perceived Canadian "savings" vanish when more accurate data are used. Still, even if the claimed difference in spending exists, that would not itself imply that the U.S. would close the gap by adopting a Canadian-style system.

For one thing, the U.S. would still be burdened by wasteful spending attributable to defensive medicine and malpractice costs. Introducing a Canadian-style health system in the U.S. would do nothing to tackle lawyer-driven health care spending. That requires tort law reform. And for another thing, the data supporting estimates of Canada's administrative costs are tenuous at best, and generally do not account for all of Canada's true administrative costs.

In the final analysis, this administrative cost argument rests on the implied assertion that government monopolies are more efficient than competing private sector providers because they can reduce overhead through economies of scale and do not incur marketing costs. While this may be true in the short term, over time all monopolies, including those in health care, become increasingly inefficient due to the lack of competitive pressure, and hence, increasingly costly as well.

IS THERE GREATER CLINICAL FREEDOM IN CANADA?

The claim of greater clinical freedom in Canada is based on the fact that government control of the system is limited largely to setting physician fees and hospital budgets. However, Canada is edging away from this "hands-off" approach to medical decisions. The reason for this is that in any fee-for-service system where

patients do not purchase care directly, or even buy their health insurance themselves, there is no financial reason for them to question physician decisions. This leaves doctors free to compensate for reduced government-set fees by increasing the volume of services they provide. Thus wasteful spending increases, and total costs continue to escalate. This situation now faces the Canadian provincial governments and is triggering more regulation of treatment decisions.[12]

Holding Down Fees. Canada has been experiencing a significant rise in the volume of treatments as it has tried to hold down fees. Neuschler observes that between 1971 and 1985 "the increase in the level of U.S. physician fees exceeded general inflation by 22.3 percent, in sharp contrast to Canadian physician fees, which fell 18 percent behind inflation." But during the same period, "per capita utilization of physician services grew much more rapidly in Canada – 67.8 percent, compared to 49.4 percent in the United States. Perhaps more significantly, utilization per physician over the same period rose a total of 25.1 percent in Canada, but only 7.0 percent in the United States."[13]

Quebec is already responding to this trend by placing limits on the amount they will pay individual doctors – strongly discouraging them from providing treatments. As Neuschler notes:

> Since the mid-1970s, Quebec has limited the incomes of physicians by setting a maximum amount payable to each individual general practitioner each calendar quarter. If this quarterly cap is exceeded, any further billings in that quarter by that physician are paid at only 25 percent of the established fee schedule. In addition, there are separate annual global caps for general practitioners and specialists. If either cap is exceeded in a given year by the profession as a whole, fees are reduced in subsequent years until the excess payments have been recouped.[14]

Restricting Clinical Freedom. Other Canadian provinces are now either considering or introducing similar changes. Some are also looking at adopting U.S.-

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12 This failure of price controls and related "expenditure/volume targets" to control increases in the volume of services provided is exactly the same situation that the U.S. government will soon confront when it fully implements the new Relative Value Scale (RVS) physician payment system Congress established last year for Medicare. Indeed, Canadian fee schedules served as the model for the new Medicare RVS system. See Robert E. Moffit and Edmund F. Haislmaier, "The Medicare Relative Value Scale: Comparable Worth for Doctors," Heritage Foundation *Backgrounder*, No. 732, October 25, 1989.

13 Neuschler, *op. cit.*, pp. 30, 32.

14 *Ibid.*, p. 33.

style utilization review and control methods. Each of these trends will curb drastically the vaunted clinical freedom of Canadian doctors.

Canadian doctors and hospitals see their clinical freedom restricted in other ways, particularly because of global budgeting for hospitals and because of government controls over hospital spending on capital improvements. Many Canadian hospitals were built in the 1950s and 1960s. But since the nationwide health system was put into place in 1971, hospitals have found it increasingly difficult to obtain the funding they need to replace obsolete or worn out equipment or facilities. In essence, Canada's hospitals have been living off their existing capital for twenty years, and more of them are gradually exhibiting the obsolescence and decay found in many British National Health Service hospitals.[15] Furthermore, to prevent physicians from increasing the volume of services they deliver, the provincial governments sharply restrict the availability of medical equipment outside of hospitals, forcing doctors to conduct most procedures in a hospital, where they can be more closely monitored and controlled.[16]

This means that while doctors may have, in theory, freedom of action to undertake procedures, restrictive hospital operating and capital budgets can mean that in practice they have neither the equipment nor the facilities needed for a procedure. Not surprisingly, hospital capital funding has become a serious and contentious issue in Canada.

DOES CANADA PROVIDE GOOD HEALTH CARE?

Advocates for the Canadian system argue that statistics show that it delivers better medicine. To be sure, many commonly-used measures of health status do suggest that Canadians are healthier than Americans. For instance, the estimated average life expectancy for a child born in the U.S. in 1989 is 75.4 years; for a child born in Canada, 77.2 years. The 1989 U.S. and Canadian infant mortality rates were 11 and 7 per 1,000 live births, respectively.

But these common health status indicators are influenced as much – or more – by social factors than they are by health systems. For example, the U.S. has a teenage pregnancy rate almost two-and-a-half times higher than Canada's. The U.S. also has higher levels of adverse maternal behavior during pregnancy such as smoking, drinking, and drug abuse. Given what is known about the relationship of

15 *Ibid.*, p. 28. See also John K. Inglehart, "Canada's Health Care System," *The New England Journal of Medicine*, July 17, 1986, p. 203.

16 As Neuschler observes (p. 18), "The dramatic shift to outpatient diagnostic testing and outpatient surgery that has taken place in the United States has not been replicated yet in Canada. For example, all Canadian computerized tomography (CT) scanners are located in hospitals and, in Ontario, this has been made a legal requirement. Keeping major medical procedures in hospitals, which are under their direct budget authority, allows provinces to better manage total costs by controlling supply." In other words, to control physician practice patterns and patient demand, Canada foregoes the potential cost savings and quality improvements these out-patient technologies could otherwise be expected to generate in a true free market.

these factors to infant mortality, it should not be surprising that the U.S. has higher infant mortality rates. It is very difficult to maintain that the differing infant mortality rates are the product of health care financing systems. Indeed, if government policies are to blame in the U.S., it is more likely the fault of America's welfare system than its health care system.

There is every reason to believe, on the other hand, that Canada's system leads to a deterioration in the quality of care. In particular, global budgeting for hospitals has even led to the denial of care. To stay within budgets hospitals have resorted to closing beds for part of the year or limiting the number of operations they perform. Yet at the same time, while Canada has only a 5.2 percent higher rate of hospital admissions than the U.S., Canadian hospitals, compared with their U.S. counterparts, have:

- 29 percent more beds per 1,000 population;
- a 27 percent higher bed occupancy rate;
- a 52 percent longer average length of stay rate; and
- 63 percent more patient days per 1,000 population.[17]

This raises the obvious question: "What are all these people doing in hospitals?" The answer is that it only seems like many Canadians are receiving care. To some extent, the lack of alternative outpatient care in Canada forces many individuals to enter hospitals for services that would be provided in a doctor's office or clinic in the U.S. But an additional reason is that hospital administrators under a global budget have a strong incentive to keep patients longer rather than serving more patients with shorter hospital stays. The reason is that longer-staying patients tend to use more of the hospital's "hotel" services and fewer of its more expensive medical services. Thus, providing fewer acute treatments and granting longer stays is a good way to stretch a fixed budget.

Administrator's Strategy. If complaints are then raised about waiting lists to enter the hospital, the administrator credibly can claim that he does not have enough funds to meet the demand. The administrator then will either receive more money from the provincial government, or he will have effectively bucked the problem up the chain of command to his political superiors. The administrator wins either way. Indeed, this practice of lengthening patients' stay to avoid breaching budget guidelines instead of treating a greater number of short-stay patients, which would make the hospital a more efficient health care institution, is so common that Canadians have dubbed such long-stay patients "bed blockers."

Ultimately, the effects of restricting providers and funding in Canada are borne by patients in the form of diminished access to treatment. So while Canadians

17 Neuschler, *op. cit.*, pp. 18-19.

TABLE 1
Waiting List Characteristics for Selected Medical Procedures in British Columbia Between November 1989 and February 1990

Treatment	Number of Patients	Range of Number of Weeks Spent Waiting	Average Wait Per Patient (Weeks)
Hand Surgery	340	5 - 24	12.4
Hysterectomy	206	2 - 32	16.3
Cataract Removal	882	4 - 30	18.2
Hernia Repair	68	3 - 52	24.6
Myringotomy/Tonsillectomy/ Adenoidectomy (Children)	522	2 - 40	14.1
Colonoscopy	33	4 - 7.5	6.2
Varicose Veins	21	24 - 52	36.1
Disc Surgery	315	8 - 20	14.1
Coronary Artery Bypass	313	15 - 30	23.7
Other Open Heart Surgery	83	15 - 30	21.4

Source: Steven Globerman with Lorna Hoye, "Waiting Your Turn: Hospital Waiting Lists in Canada" (Vancouver, British Columbia: Fraser Institute *Critical Issues Bulletin*, May 1990.

may have "universal access" to health insurance, they are in practice receiving less and less access to health care.

To date, most of the evidence of declining access and growing waiting lists has been anecdotal. However, the Fraser Institute in Vancouver, Canada, recently published the first comprehensive, scientific survey of waiting lists in the Canadian health system. The study was conducted for the Institute by Steven Globerman, a professor at Simon Fraser University, and was limited to the province of British Columbia. The Institute plans to sponsor similar studies of other provinces.[18]

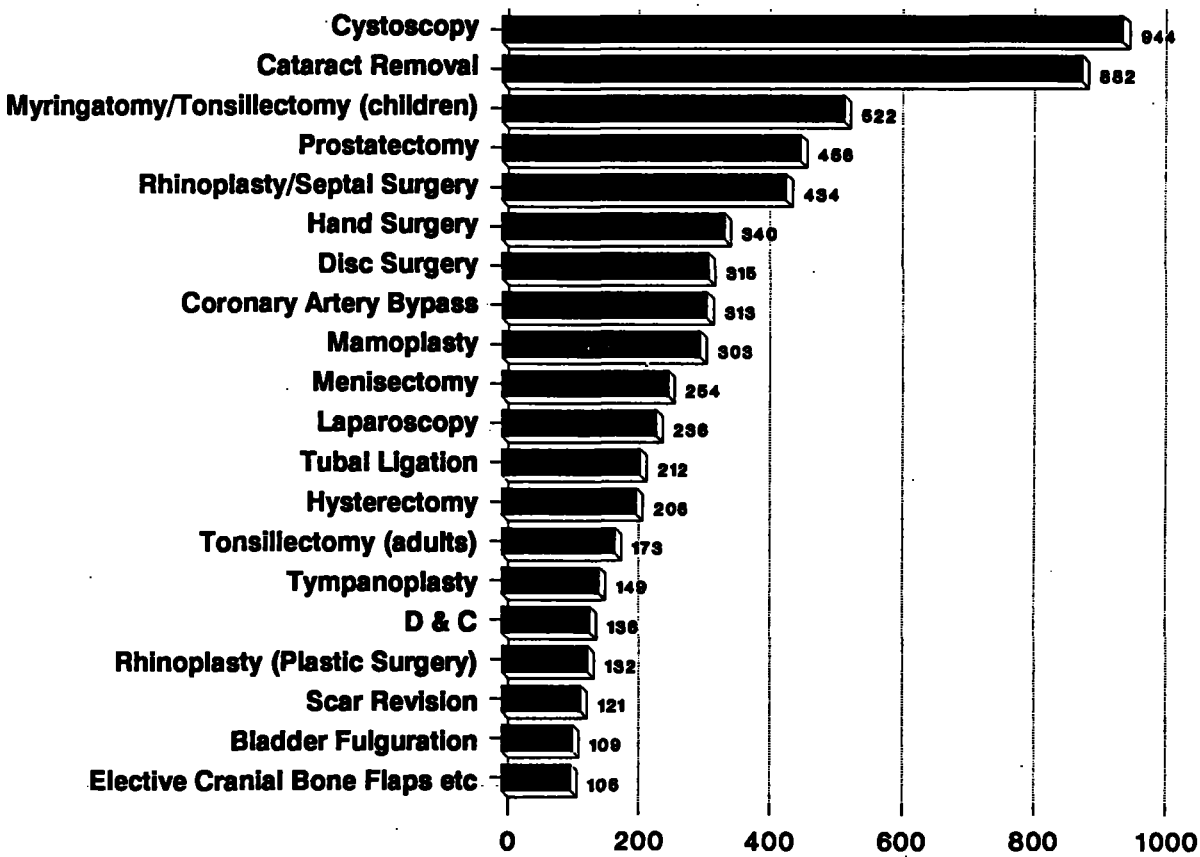
Disturbing Patterns. In general, what Globerman finds is that waiting lists are much longer and more pervasive than was previously thought to be the case. Table 1 shows the study's findings for the number of patients waiting for treat-

18 Steven Globerman with Lorna Hoye, "Waiting Your Turn: Hospital Waiting Lists in Canada" (Vancouver, British Columbia: Fraser Institute, *Critical Issues Bulletin*, May 1990).

ment, the average waiting period, and the shortest and longest waits for just 10 of the 53 procedures on which Globerman collected data. Graphs 6 and 7 show, respectively, the number of patients waiting and the average waiting times for the twenty least available procedures in British Columbia.

The disturbing pattern now emerging in Canada is eerily similar to that found in other nationalized health care systems. As governments confront the unlimited demand unleashed by "free" health care and the resulting cost escalation, they resort to capping total health spending. These caps in turn limit the ability of providers to deliver medical services, resulting in shortages and waiting lists. In the end, while all Canadians may have access to health insurance, more of them are finding it difficult to get access to medical treatments.

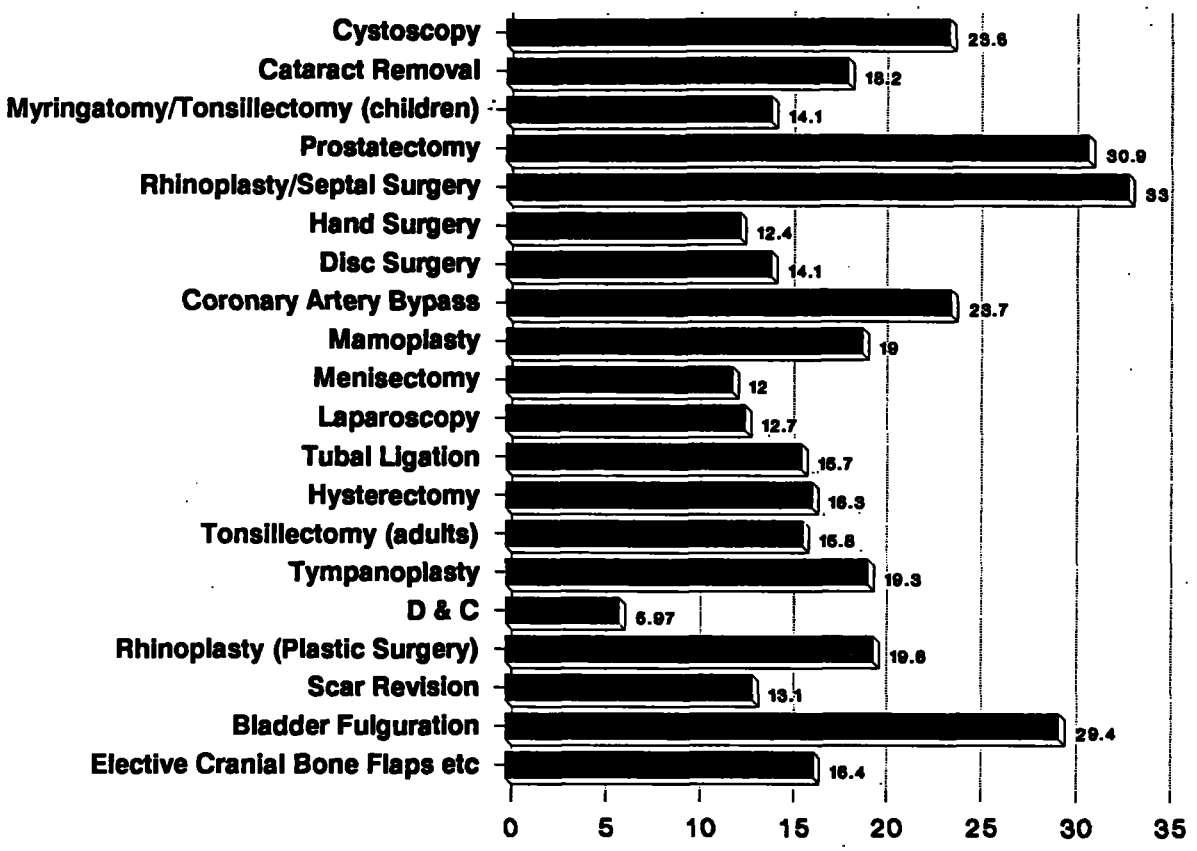
Figure 6
Number of Patients Waiting for the 20 Least Available Treatments in British Columbia



Note: Survey Data on the above chart was collected between November 1989 and February 1990.

Source: Steven Globerman with Lorna Hoye, "Waiting you Turn: Hospital Waiting Lists in Canada" (Vancouver, British Columbia: Fraser Institute Critical Issues Bulletin, May 1990, Figure 1, p. 36.

Figure 7
Average Waiting Time in Weeks for for the 20 Least Available Treatments in British Columbia



Note: Survey Data on the above chart was collected between November 1989 and February 1990.

Source:Steven Globerman with Lorna Hoye, "Waiting you Turn: Hospital Waiting Lists in Canada" (Vancouver, British Columbia: Fraser Institute Critical Issues Bulletin, May 1990, Figure 2, p. 36.

WHAT A CANADIAN-STYLE SYSTEM WOULD COST THE U.S.

If all of these findings are not enough to dissuade U.S. policy makers from instituting a Canadian-type system, the projected costs definitely should be. During the past year, two estimates of the cost of adopting a Canadian type system have been calculated. One is contained in the Neuschler study, and the other is from a study prepared for the Dallas-based National Center for Policy Analysis, by economists Aldona and Gary Robbins.[19]

19 Aldona Robbins and Gary Robbins, "What a Canadian Style Health Care System Would Cost U.S. Employers and Employees," National Center for Policy Analysis, *Policy Report* No. 145, February, 1990.

Neuschler calculates that a Canadian-style system in the U.S. would, in 1988, have required an additional $189 billion in government spending. The Robbins put the costs of national health insurance to the U.S. government at $339.3 billion in 1989. Aside from the different years used, the large discrepancy between the two estimates can be attributed to the different methods used in calculating them.

Neuschler takes as his starting point the fact that 74 percent of Canadian health spending is funded by the public sector, while only 42 percent of U.S. spending is publicly funded. After reducing U.S. administrative costs to 3 percent across the board, the claimed level for the current U.S. Medicare program, raising U.S. public sector funding to 74 percent in 1988 would have required an additional $179 billion, while expanding coverage to the uninsured would have required another $10 billion, for a total of $189 billion.[20]

The Robbins' methodology is to add the $156.9 billion spent by employers on health insurance in 1989 to the $201.8 billion paid for out-of-pocket by patients and an estimated $29.1 billion in additional costs for covering the uninsured. This gives a total of $387.8 billion. The authors then subtract the $48.5 billion in federal tax relief for private health insurance, resulting in a figure for net new spending of $339.3 billion.[21]

Since it is highly likely that, should the U.S. adopt a nationalized system, there would be strong political pressure to provide more coverage for items that are only partially covered in Canada, such as long-term, dental and vision care, it is not unreasonable to assume that the eventual cost would fall somewhere between the two estimates.[22]

Heavy New Taxes. The Robbins' study also calculates the tax rates that would be needed to fund such a system. To obtain the revenue, they point out that the government would have to introduce heavy new taxes. Among the alternative options:

- Raise the combined employer-employee payroll tax from its current rate of 15 percent to 29 percent; or
- Raise income tax rates across the board by 14 percent; or
- Impose a new national sales tax of 10 percent.

While Neuschler does not calculate tax rates, he does observe that if the U.S. adopted a "pure" Canadian system – with total health spending distributed be-

20 Neuschler, *op. cit.*, Chapter 5, pp. 55-66.

21 Robbins, pp. 1-6, Appendix A.

22 Indeed, recent proposals advocating the adoption of a Canadian-type system, either nationally or in a single state, call for much more extensive coverage than provided by the Canadian system. For example, see David U. Himmlestein, Steffie Woolhandler, *et al.*, "A National Health Program for the United States: A Physician's Proposal," *The New England Journal of Medicine*, January 12, 1989, pp. 102-108; and Robert McCarthy "Florida Debates Universal Access," *Business and Health*, January 1991, pp. 56-57.

tween the U.S. federal and state governments in the same proportions as between the Canadian federal and provincial governments – the vast majority of the new costs would be borne by the states. He estimates that combined state tax receipts to fund the system would have to increase 71 percent over their current total level.

POLITICAL PROBLEMS

The one thing that none of these studies estimates, since it is impossible to measure accurately, is the effect of the U.S. political structure on introducing a version of the Canadian national health system. Unlike other countries with nationalized systems, including Canada, the U.S. does not have a parliamentary system of government. Congressmen and state legislators more closely represent the narrower interests of their constituents, have much more power to alter legislation, and are much less subject to party discipline than are their parliamentary colleagues in other countries.

Because of these significant political differences, any national health system in the U.S. likely would quickly degenerate into pork-barrel politicking and legislative micro-management. Indeed, one does not have to look to obsolete military bases, farm subsidies, public works programs, or dubious research projects to find examples. There are already two graphic examples in the U.S. health care system of what would happen nationally with a Canadian-style system. One is the medical system run by the Department of Veterans affairs. That system labors under chronic budget problems and constant restrictions and special-interest requirements imposed by Congress. The second example is the colossal failure of the attempt to impose nationwide certificate of need regulations on hospitals during the 1970s. This later program was enacted in the 1974 National Planning and Resources Development Act and was designed, as in Canada, to restrict the ability of hospitals to overbuild their facilities or to acquire expensive and redundant equipment in order to make the system more efficient. The program so quickly degenerated into a morass of bureaucratic paperwork and pork-barrel politics that after only six years some of its original sponsors were willing to scrap it.[23]

CONCLUSION

Far from being a model to emulate, the Canadian health care system is an alluring siren whose fetching appearance masks hidden dangers. Contrary to popular perception, Canada has failed to control the growth in health care spending. At the same time the clinical freedom so desired by doctors is being steadily taken

23 Frank D. Campion, *The AMA and U.S. Health Policy Since 1940* (Chicago: Chicago Review Press, 1984), pp. 344-348.

away from Canadian physicians, while patients are forced to wait in lengthening lines for major treatments.

That Canada's system is still highly popular with its citizens is undeniable. But that popularity is derived increasingly not from any inherent virtues in the system, but from the inevitable calculus of political economics. As in other nationalized systems, the Canadian system increasingly allocates health resources on the basis of votes, not on the basis of need. For the lucky majority who are reasonably healthy, they will continue to find ready access to routine, low cost medical services. But for the unfortunate minority with serious conditions, they will increasingly be expected to take a number and wait.

In short, health care in Canada is evolving into what Canadians sought most to avoid – a two-tiered system. While all Canadians may have access to health insurance, they are receiving less and less access to quality health care.

Achieving Affordable Access. This does not mean, however, that U.S. policy makers should abandon the goal of universal access to affordable health care in this country. Rather, they should pursue that goal in a more effective manner, by unleashing market forces to control health care costs and bring efficiency to the system. At the same time, they should reform tax policies and public programs to provide the poorer and less healthy members of society with the extra purchasing power they need to obtain necessary medical care and health insurance.[24]

Pursuing such policies will result not only in better health care and a less expensive system, but also one which stands the most chance of achieving the goal that Canada has failed to reach – affordable access to health care for all citizens.

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24 For a detailed explanation of these proposals, see Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989), and Stuart M. Butler, "Using Tax Credits to Create and Affordable National Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990.