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PROBLEMS IN PARADISE: CANADIANS COMPLAIN ABOUT THEIR HEALTH CARE SYSTEM

INTRODUCTION

Health care costs are escalating out of control. Families are finding it harder to obtain needed medical care. Spending on health care is taking a huge and growing bite out of federal and local government budgets, and the recession has made those budgets tighter. The spread of AIDS, the need for better treatment of drug and alcohol addiction, a chronic shortage of doctors in rural areas, and an aging population are imposing further burdens on the nation's health system.

Calls for health care reform thus are growing. Faced with demands for more government spending on health care, but with limited or declining funds to meet those demands, a number of government commissions are busy studying the mounting health care problems. Both in and out of government, critics complain there is too much waste in the system. They say it is too bureaucratic; that doctors make too much money; that they perform to many unnecessary tests and procedures.

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A snapshot of America's health care crisis? No, it is a description of the health care debate in Canada—the very same Canada to which some American lawmakers look for a solution to America's health care problems. Just when some voices on Capitol Hill urge the United States to import Canada's universal, government-run health system, that system itself is sinking deeper into trouble and debt amid Canadian finger pointing and recriminations.

Eerie Similarity. To be sure, the Canadian health system has not yet reached the degree of crisis as in the U.S. But that day may not be far off. And while there are major differences between the U.S. and Canadian systems, there is an eerie similarity in some of the problems on both sides of the border. This similarity should induce more sober reflection by U.S. policy makers, particularly those inclined to advocate the adoption of a health system resembling Canada's.

In present day Canada unlimited demand for "free," government-funded medical care has collided headlong with limited public resources. As such:

- Canada's health system is plagued by soaring costs, with spending in recent years escalating at rates as great or greater than those of the U.S. system.
- The Canadian federal government, burdened with large budget deficits, is steadily reducing its share of funding for provincial health plans.
- Provincial health ministers are struggling to control their hemorrhaging budgets by closing hospital beds, laying off health workers, capping doctors' incomes, and limiting entry to medical schools.
- Provincial governments, including those headed by socialists, are trying to shift more health care costs to consumers by reducing or eliminating coverage for optional benefits and imposing user fees. Quebec's government is even considering adding to the taxable incomes of its citizens the value of the medical services they consume each year.
- Waiting lists are now endemic in Canada's health system, and a recent study estimates 260,000 Canadians are currently waiting for major surgery.
- In British Columbia, one of two provinces that charge citizens a monthly premium to help finance its health plan, between 2 percent and 5 percent of the population do not pay their premiums and thus technically are uninsured. These uninsured must pay doctors out of pocket for treatment or rely on charity care from physicians.
- When Robert Bourassa, the Premier of Quebec, needed cancer treatment, he crossed into the U.S. and obtained it at his own expense. Such actions by more affluent or politically well-connected Canadians raise the question of whether a "two-tiered" health system, of the kind Canadians long sought to avoid, is now emerging.

As Canadians increasingly debate the future of their health system and wonder how long it can survive in its present structure, the lesson for America should be clear. The existence of an ideal health system that offers unlimited, "free" government-funded medical care, while simultaneously limiting health spending without restricting patient choice or provider decision making, is a myth. If it ever did exist in Canada, it does not any more. Pursuing the ephemeral mirage of a government-run health care Utopia, never will lead to a high quality, low cost health system in America or anywhere else.

THE CANADIAN HEALTH SYSTEM

Known colloquially as "medicare," Canada's universal, government-funded health system actually is a collection of similar systems operated by the provinces. [1] Each of Canada's ten provinces and two territories administers its own universal health plan and pays for most of its costs. The main role of the Canadian federal government is 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.[2]

Canadians take great pride in the fact that their health system gives all citizens access to care from hospitals and physicians that is free of charge to the patient at the point of service. While Canadians pay high taxes to fund this system, it is a price which, at least until now, the vast majority of Canadians have been willing to pay. Since their country, moreover, is increasingly questioning its very existence as a single nation, many Canadians view their medicare system as a unifying institution. And many Canadians are proud that, at least in health care, their nation of 26 million is widely regarded as superior to its overbearing southern neighbor.

A growing number of Americans, including many members of Congress, look with envy at Canada's health system. Conscious of the 35 million Americans who lack health insurance, and the U.S. health system's dubious status as the world's most expensive, they see in their neighbor to the north a health system that provides universal coverage at a lower cost.

But all is not well in what some Americans view as Canada's health care paradise. While it is still all but unheard of for a Canadian to call publicly for scrapping or privatizing medicare, complaints are becoming louder and proposed reforms more sweeping in their scope. The major cause for Canada's growing health care debate: Soaring health care costs.

THE REALITY: ESCALATING HEALTH CARE COSTS

The Canadian press now routinely carries news stories and columns describing the escalating costs and funding crisis afflicting Canada's health system. The irony of this, given U.S. fascination with the Canadian system, is not lost on some Canadian com-

1 Each province administers its own universal health plan. While each of those provincial plans has its own proper, official name, Canadians often use the name "medicare" when referring to the entire, nationwide health system, and particularly when discussing federal funding or regulation of the provincial plans. This use of the name "medicare" should not be confused with the U.S. federal government's program for providing health care to elderly Americans, the proper name of which is also Medicare. Henceforth, when it appears in this study the term "medicare" will refer to its Canadian usage, unless otherwise specified.

2 For a more detailed discussion of the structure of the Canadian health care system, see: Edmund F. Haislmaier, "Perception vs. Reality: Taking a Second Look at Canadian Health Care," Heritage Foundation *Backgrounder* No. 807, January 31, 1991, and Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance" (Washington, D.C., The Health Insurance Association of America, June 1990).

mentators. In the November 22, 1991, edition of *The Vancouver Sun* (British Columbia), for example, columnist Geoffrey Stevens wrote:

> The irony is that at the very moment American politicians and health care professionals are asking whether the U.S. can afford not to adopt Canadian-style medicare, Canadians are asking whether we can afford to keep it.
>
> There isn't a province that is not desperately worried about health costs. There isn't a province that is not struggling, not to make medicare better, but to cut back.[3]

An editorial in *The Toronto Star* expressed similar sentiments last summer, noting that:

> We, the taxpayers of Canada, are not willing to pay for the level of service that we, the users of medicare want. After 25 years of congratulating ourselves on having one of the finest health-care programs in the world, we have begun to wonder whether we can afford it.[4]

Last May 18, in an article on the debate over the future direction of Canadian medicine, Paul Benedetti, a reporter for *The Burlington Spectator* (Ontario), observed:

> Not only is our health system, considered by many to be the finest in the world, teetering under enormous financial strain, but the very assumptions upon which that system was created more than 30 years ago are crumbling beneath it.[5]

Writing also last May, reporter Joan Ramsay of the Southam News syndicate complained about the soaring cost of the system:

> The weight on the shoulders of Canada's health care system is becoming unbearable. The problem, experts say, is that you can't have virtually unlimited advanced care on a limited budget...Medicare has become a black hole, sucking tax dollars indiscriminately and, too often, inefficiently.[6]

And just last month, reporting on the results of a meeting of Canadian provincial health ministers called to map a joint health care reform strategy, an article in *The Vancouver Sun* noted that, "The system has grown to be the biggest cost item in provincial budgets and future estimates clearly show the limits of health care spending are rapidly approaching."[7] In a related editorial the same day, the *Sun* comments that:

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3 Geoffrey Stevens, "Medicare Irony Mounting," *The Vancouver Sun* (British Columbia), November 22, 1991, p. A19.

4 *The Toronto Star* as quoted in, Clyde H. Farnsworth, "Recession Forcing Canada to Re-examine Health Care," *The New York Times*, November 24, 1991, p. A20.

5 Paul Benedetti, "Health Care Faces Significant Change: System Needs New Approach," May 18, 1991, *The Burlington Spectator* (Ontario), p. A1.

6 From syndicated stories by Joan Ramsey of Southam News Service which were published on May 11, 1991 under the headlines: "Costs and Demands Build a Health Care Pressure Cooker," and "Hard Choices Ahead on Medical Funding," in *The Hamilton Spectator* (Ontario).

7 "Doctors' Bill-Cuts Signal New Health Services," *The Vancouver Sun*, January 30, 1992, p. A6.

> The governments' past successes at administering health care have been dubious and are declining in number. Provincial health ministries win few fights with doctors and have failed to use billing numbers or payment methods to create rural/urban balance in health care delivery.
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> But there is, in this, one indisputable truth: if the provinces do nothing, health care costs will continue to skyrocket. The best health care system in the world will spend itself to death.[8]

Skyrocketing Costs. Indeed, if misery loves company, then Americans and Canadians can find in each other good company when it comes to skyrocketing health care costs. While it is still commonplace to argue on both sides of the border that, in comparison with America, Canada's health system delivers more care for less money, that comparison is increasingly misleading.

It is, of course, true that Canada gives almost all its citizens health insurance coverage, while an estimated 35 million Americans are uninsured for at least some period in any year. It is also true that Canada spends less than the U.S. on health care, as measured in per capita terms or as a percentage of each country's respective gross domestic product (GDP)—even though that difference has been greatly exaggerated.[9]

But broader comparisons show that the margin of difference in health spending between the U.S. and Canada offers little reason for American envy or Canadian pride. The simple fact is: America may have the most expensive health system in the world, but Canada has the world's second most expensive system.

While most Americans are ignorant of this budget fact, more and more Canadian taxpayers are grimly aware of it. Explains Dr. Martin Barkin former deputy health minister for Ontario, who argues that the current woes of Canadian health care cannot be blamed on underfunding:

> Canada is now the highest per-capita spender on health care of any country with a national health system. Amongst industrialized nations, only the United States, which doesn't have a government-run system covering all citizens, spends more—with worse results.[10]

Similarly, Diane Francis, a columnist for *Maclean's*, Canada's leading news magazine, states flatly, "Proponents of Canada's medical myth should contemplate the fact that our costs are growing exponentially and are now the second-highest per capita in the world, after the United States."[11]

Bleak Future. When health care spending trends are analyzed, the future of the Canadian health system is as bleak as that of its U.S. counterpart. In both countries, the rates of growth in health care costs are outstripping general inflation rates by wide margins. Indeed, comparative data show that, during the past two decades, the rates of

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8 "Praise and Questions for Health Ministers," *The Vancouver Sun*, January 30, 1992, p. A16.

9 Haislmaier, *op.cit.*

10 Dr. Martin Barkin, as quoted in: Charlotte Gray, "Medicare Under the Knife: Is Ottawa Quietly Destroying Our Most Precious Social Programme," *Saturday Night*, September 1991, p. 12.

11 Diane Francis, "Expensive and Dangerous Myths," *Maclean's*, September 2, 1991, p. 13.

growth in real (inflation adjusted) per capita health spending in the two countries have been virtually identical. In fact, real per capita health spending has grown faster in Canada than in the U.S. in recent years.[12]

The lesson for America should be clear. Genuine success in bringing soaring health care costs under control will require a far better solution than simply adopting a national health system modeled on Canada's experience.

RUNAWAY BUDGETS

The most visible side-effect of escalating health care costs in the U.S. has been a growing population of uninsured Americans who cannot afford to buy coverage. In Canada the most visible effect has been a growing fiscal crisis in federal and provincial government budgets. The three factors that aggravate the health care financing problems resulting from high demand in Canada for "free" health care are:

1) **The Canadian recession.** As in the U.S., this is reducing Canadian government tax receipts at federal and local levels. In Canada the recession also puts an added direct strain on the health system because 74 percent of health spending is funded out of tax revenues. In contrast, only 42 percent of the U.S. health spending is taxpayer-funded.

2) **Huge budget deficits** that Canada's federal and provincial governments have been laboring to close. Indeed, the net budget deficit for all levels of government is greater in Canada than in the U.S. when measured as a percentage of GDP.[13]

3) **Canada's on-again, off-again constitutional crisis,** which is fueled by separatist movements in Quebec. Canada is attempting to redefine the respective roles of its federal and provincial governments. The funding and future of Canada's health system are inexorably intertwined with Canada's political and constitutional structure. This is because although the health system is operated separately in each province, over one-third of its funding comes from the federal government, as do the rules dictating the basic structure of the system. Thus, any major change in Canada's political structure means a major change, in the financing or control of Canada's health system—and vice versa.

Hardest hit by the recession and budget crunch have been the Canadian provincial governments. Typically, health spending now accounts for 30 percent to 40 percent of a province's budget. Health spending not only consumes a greater share of provincial budgets than other social spending items, such as welfare and education, but is also growing at a faster rate.

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12 For more detailed discussion and analysis of the relative rates of health care spending growth in the U.S. and Canada, see: Haislmaier, *op. cit.*, pp.6-12, and Neuschler, *op. cit.*, pp. 37-46.

13 Neuschler, *op. cit.*, pp. 55-56.

Reduced Federal Funding. Compounding the problem for provincial lawmakers is the fact that the financially-strapped federal government in Ottawa is reducing steadily its share of funding for the provincial health plans. Originally, under the Medical Care Act, which created the framework for a national system in 1966, the federal government contributed matching funds to the provincial health plans on a 50-50 basis.[14] However, concerned that such generosity gave little incentive for the provinces to manage their plans efficiently, and faced with its own large budget deficits, since 1977 the federal government has steadily curbed its funding of provincial health plans. Canada's federal government now contributes an average of 38 percent of medicare funds. And under a new law passed in February 1991, the federal contribution could decline to zero by the year 2004, and sooner for some more affluent provinces. While the federal government has eased the provincial budget burden somewhat by transferring certain taxing authority to the provinces, it still imposes mandates on the provinces that dictate the basic structure of the system and levels of benefits provinces must guarantee.

Governors and state legislators in the U.S. should take a warning from their counterparts north of the border. As U.S. states grapple with budget deficits, diminished tax revenues, runaway state Medicaid budgets, new federal Medicaid mandates, and attempts by Washington to limit Medicaid payments to the states, some state lawmakers believe adoption of a Canadian-style national system would spell relief. But if the Canadian provinces' experience is any guide, the result would be more and bigger headaches for states of the kind they already face with Medicaid.

Breaking Up Is Not Hard To Do

Canadian critics charge that if Ottawa backs out of funding Canada's health system entirely, then it will lose all leverage over the provincial health plans. The eventual result, critics predict, will be the breakup of Canada's national health system. Without a federal mechanism for enforcing basic uniformity, each province could discard most or all of the unifying elements of the system.

Portability of benefits, for example, could be lost. Currently Canadians can seek medical treatment anywhere in the country, and their home province will pay the bill. But if the federal support of the provincial plans erodes, a province could refuse to pay, in whole or in part, for treatments its citizens obtain in other provinces. Conversely, a province could refuse to treat citizens from other provinces unless the patients or their provinces provided payment in advance. Nor would a province any longer be prevented by federal law from imposing user fees for medical services on its own citizens, from means testing its health plan, or from privatizing its health plan in whole or in part.

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14 Implementation of the Medical Care Act of 1966 was delayed until 1968. By 1971, all ten Canadian provinces had established plans that complied with the terms of the Act, and the two territories (Yukon and Northwest Territories) followed a year later. Thus, the present form of Canada's national health system actually dates from 1971. See: Neuschler, *op. cit.*, pp. 10-11, and Gordon H. Hatcher, Peter R. Hatcher and Eleanor C. Hatcher, "Health Services in Canada," in Marshall W. Raffel, ed., "Comparative Health Systems" (University Park, The Pennsylvania State University Press, 1984).

A number of Canadian critics are even suggesting that absent the powerful unifying force of a popular national health plan, moves toward separatism would accelerate, leading to the eventual breakup of Canada itself.

HOW CANADA IS CUTTING HEALTH SERVICES

Responding to soaring health care costs, the Canadian provincial governments have been taking or proposing measures to cut costs, limit services, or discourage or restrain patient demand. Notes Canadian columnist Geoffrey Stevens: "Everywhere in the country there is talk (and, in many places, action) of closing hospital beds. A British Columbia royal commission wants to limit doctors' incomes and restrict the number of physicians."[15]

As an example, The *New York Times* reported last year that:

> Ontario, the richest and most populous province, where more than a third of Canadians live, has lost nearly 5,000 hospital jobs and 3,500 beds over the last two years. In Toronto, the provincial capital, 2,900 of 15,000 acute-care beds have been taken out of service.
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> More than 300 beds have been closed in British Columbia this year, the Hospital Employees Union of British Columbia said, and with 30 percent of the province's hospitals saying they will be short of money next year, the pressure for cuts is likely to continue.[16]

In another example, the Canadian Press Service reported last April that in the province of Saskatchewan:

> The Wascana Rehabilitation Centre, the province's showpiece health care project, announced last month that it would close 30 beds. Regina General Hospital also announced bed closures and layoffs, and hospitals in Moose Jaw and Yorkton have closed beds.[17]

Provinces also have been looking for ways to shift costs onto patients without raising taxes. Last year Ontario's socialist New Democratic Party (NDP) government cut the payments for those residents who obtain care outside of Canada, usually in the U.S. Payments for those services had risen from $100 million[18] annually in the province's 1988-1989 budget to a staggering $225 million annually in the 1990-1991 budget, as Canadians tired of waiting in line for care simply headed for U.S. hospitals and sent the bill home to Ontario.[19] The cuts are expected to save $40 million to $60 million a year.[20]

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15 Geoffrey Stevens, "Medicare Irony Mounting," *The Vancouver Sun*, November 22, 1991, p. A19.

16 "Recession Forcing Canada to Re-examine Health Care," *The New York Times*, November 24, 1991, p. A20.

17 Chris Wattie, "Medicare Resurfaces as Major Issue Once Again," *Moose Jaw Times-Herald* (Saskatchewan), April 30, 1991.

18 These and all subsequent cost or spending figures are in Canadian dollars, not U.S. dollars.

19 Prior to last year's changes, Ontario paid 100 percent of the cost of emergency care outside Canada, 100 percent for services unavailable in Ontario, and 75 percent of the cost of elective treatment outside Canada. A common practice for Canadians waiting for treatment at home is conveniently to need "emergency" care while vacationing abroad—

Increased Premiums. Alberta and British Columbia are the only two provinces in Canada that charge premiums to their residents to help fund their health plans. Both provinces increased these premiums last year; British Columbia by 11.5 percent and Alberta by 13 percent. The annual premiums in British Columbia are now $420 for single individuals, $744 for couples, and $840 for families.[21]

While Canadian federal law prohibits the provincial plans from charging patients for basic hospital and physician services, that restriction does not apply to optional benefits. Consequently, these benefits are prime targets for health care budget cutters in the provincial governments. Some examples:

- British Columbia's socialist NDP government, last spring, increased the deductible for its prescription drug program from $50 a year to $375.[22]
- At the same time Alberta's government announced plans to reduce benefits to its senior citizens. It eliminated coverage for most non-prescription drugs, cut subsidies for eyeglasses, dentures and dental care by 20 percent, and began to charge patients needing home oxygen services 25 percent of the cost of their oxygen tanks, up to an annual maximum of $500.[23]
- Quebec's health minister last December proposed a package of changes which call for, among other things, charging for some pharmaceutical products and scrapping free dental and optometry services.[24]

Tempting Target. Not surprisingly, payments to doctors are another very tempting target for budget cutters, as they have been in the U.S. Medicaid and Medicare systems. Although all of the provincial plans set payment limits for each of the thousands of different procedures performed by physicians, payments to physicians continue to escalate. This is because when doctors in a fee-for-service payment system (like Canada's or much of the U.S. system) are hit with fee freezes or fee cuts, they simply

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usually in the U.S. Also, much of the "elective" treatments abroad are for drug and alcohol abuse—treatment services which are in chronic short supply in Canada. Some U.S. drug and alcohol abuse clinics advertise for Canadian patients and charge top rates, knowing that most of the cost will be picked up by provincial health plans. Under the new rules, Ontario will only pay for emergency and elective care abroad the amounts it pays its own doctors and hospitals. The patients must now pay the rest of the bill themselves. Also, Ontario will now pay 100 percent of the cost of treatment abroad for services not available in "a timely fashion" in Ontario, but only if the patient obtains prior approval from the health ministry and is treated by one of the "preferred providers" designated by the ministry. See: Betsy Powell, Canadian Press Service, "Ontario to Curb Out-of-Province Payments," in the *London Free Press* (Ontario), May 3, 1991.

20 *Ibid.*, and Yvonne Bendo, "Local Health Officials Cautious Regarding Laughren's Budget," *The Daily News* (Chatham, Ontario), May 7, 1991.

21 Ian Austin, "Higher Health Premiums Help Cure Debt," *The Province* (Vancouver, British Columbia), May 22, 1991. Gordon Cope, "What Price Health Care," *The Calgary Herald* (Alberta), April 28, 1991.

22 Ian Austin, "Higher Health Premiums Help Cure Debt," *The Province* (Vancouver, British Columbia), May 22, 1991.

23 Tom Korski and Kevin Martin, "Seniors Face New Charge for Air Tanks," *Calgary Sun* (Alberta), April 28, 1991.

24 Tu Thanh Ha and Carolyn Adolf, "Health Care Fees Meet Resistance in Ottawa," *The Gazette* (Montreal), December 19, 1991, p. A1.

increase the volume of services they provide to recoup the lost revenues. Some examples:

- A 1991 study by the Congressional Budget Office (CBO) of the U.S. Medicare program finds that, "Growth in volume of physician services completely offset the 1984-1986 fee freeze."[25]

- *Technology Review,* a journal published by the Massachusetts Institute of Technology, in writing about the Canadian health care system, noted: "Provincial attempts to control health budgets by restricting doctors' fees have failed. From 1972 to 1984, the provinces cut fees by 18 percent in real terms, but by an amazing coincidence, doctors' total billing claims rose by 17 percent. Similarly, when Quebec froze doctors' fees in the early 1970's, and their real-dollar value dropped 9 percent from 1972 to 1976, doctors increased their billings by almost the same amount, 8.3 percent. Alberta froze medical fees in 1984, but doctors upped their gross incomes that year by more than 12 percent."[26]

Wanting Out. In response, Quebec has since the mid-1970s set limits on the total billings individual physicians can charge to its plan each calendar quarter. In addition to providing their own income, physicians must also cover their office and practice costs such as rent, staff salaries, and supplies, out of the billings they submit to the provincial plans. The province's general practitioner association now estimates that 20 percent of its members exceed the limit one or more times a year.[27] Last year the provinces of Ontario and Newfoundland adopted similar measures; other provinces now also are considering introducing such limits. The result is likely to be a future shortage of doctors. Two weeks after Ontario's government reached agreement with the Ontario Medical Association (OMA) on the new billing limits, for example, the Canadian Press Association reported:

> A U.S. company's job fair to lure Canadian doctors south drew a flood of Toronto physicians who say they can't afford to practice medicine here anymore . . . "I think there's a better future in the States than here," said ophthalmologist Dr. Sheldon Herzig. "What brought me here is the recent OMA agreement with the province. It's disastrous."[28]

Not only, moreover, can doctors respond to government cuts in fees by seeing more patients faster or by doing more procedures. Increasing the number of doctors also fails to cut costs through competition as it would in a normal market where patients pay directly. Instead, more doctors mean more services and higher costs for the govern-

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25 *Health Policy Week*, vol. 20, No. 10, March 11, 1991, p. 4.

26 Milton Terris, "Lessons from Canada's Health Program," *Technology Review*, February-March, 1990, p. 31.

27 G. Pierre Goad, "Canada Seems Satisfied With a Medical System That Covers Everyone," *The Wall Street Journal*, December 3, 1991, p. A1.

28 Canadian Press Service, "Flood of Canadian Doctors Turn Out for U.S. Job Fair," *The Evening Telegram* (St. John's, Newfoundland), May 23, 1991.

ment. Consequently, Canada's provincial health ministers are considering steps to limit the number of doctors and to stop paying doctors on a fee-for-service basis.

Expanding Control. The most recent moves to expand government control over physicians came this January 28, when nine of Canada's ten provincial health ministers signed an agreement on a unified, national strategy for curbing soaring health care costs. According to the Southam News Service report, the key changes proposed in the agreement include:

- A nationwide 10 percent reduction in medical school admissions in the 1993 academic year to bring future expansion of the medical profession in line with population growth.
- A shift toward either a salary-type compensation [rather than fee-for-service payments], an overall community clinic grant [in other words, giving each clinic a fixed budget each year], or a bulk fee for long-term treatment [paying doctors a fixed, annual amount per patient]: moving away for fee-for-service payments to doctors.
- Elimination of exclusive medical fields of practice in provincial legislation [in other words, lifting some licensing restrictions] to permit expansion of such skills as midwifery and nurse-practitioners.
- A commitment to "establish predictable medical care expenditures through a combination of global, regional and individual practitioner budgets."[29]

The clear implication of the January 28th agreement is that Canadian doctors soon will lose their independence—a feature that currently distinguishes the Canadian system from many other national health systems. Eventually, doctors in effect would become salaried employees of government, as are their colleagues in other national health systems like Britain's or Sweden's.

Probably the most controversial health reform proposals of 1991 came from Marc-Yvan Cote, the Liberal Party health minister of Quebec. After a lengthy and heated debate, he gained passage last August of a bill authorizing the provincial plan to charge "user fees" for "unnecessary" visits to hospital emergency rooms. The amount discussed was $5, although this was not actually specified in the law.

Violation of Principle. Such a fee violates one of the basic federal principles in the Canadian system: that patients not be charged anything for their care at the point of service. When the province of Alberta imposed user fees in 1982, the federal government withheld its payments to Alberta until the fees were dropped. Immediately following last year's approval of the user fee by Quebec's legislature, the federal health minister threatened that if Quebec actually imposed the fees, federal payments to Quebec would be cut by the amount the province collected in fees.

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29 Patrick Nagle, Southam News Service, " Health Ministers Agree to Curtail the Number of Graduating Doctors," *The Gazette* (Montreal), January 29, 1992, p. B1.

Polls, however, find that a majority of Canadians support user fees to deter wasteful or unnecessary use of health services. An April 1991 poll, for instance, found 71 percent support for the idea nationwide, with 80 percent support in Quebec and 75 percent support in Alberta. Several months after Quebec enacted its user fee measure, a poll still found 56 percent support nationwide, with the highest level of support (69 percent) in Quebec.[30]

Quebec's government clearly has popular support for its proposed action, but numerous critics have decried user fees as the thin edge of the wedge undermining the fundamentally egalitarian structure of Canada's health system. They predicted that once the practice of charging user fees becomes accepted, however small the fees might be, the inevitable result would be creation of a health system based on ability to pay.

While Quebec's Cote has yet to impose the fees, he already has confirmed the critics' fears by announcing even more sweeping reform proposals. Last December 18, he called for imposing user fees on all visits to doctors, requiring patients to pay for their hospital room and board, and adding to people's taxable income the cost of the health services they used during the year.[31] In an editorial two days later, *The Gazette* (Montreal) characterized the plan as a continuation of "the minister's almost obsessive determination to make the sick pay for part of the costs of being sick." The editorial also noted, "'Rooms, meals and management of files do not in themselves constitute medical services,' says the document, an astonishing view of hospital care."[32]

ACCESS TO WHAT AND FOR WHOM?

While all Canadians have access to government health insurance, the growing question is how much access to medical care—and of what kind—does that health insurance provide.

The *Wall Street Journal* last December reported that at Montreal's Royal Victoria Hospital tight budgets mean that the wait for a cataract/lens replacement is about three months, and for a coronary bypass it is between three and six months. In addition:

> Tight budgets put extra strain on patients and staff. The hospital saves $660,000 a year by using an older type of injectable dye for X-rays that is less comfortable for patients than a newer dye. It bought new beds with manual cranks instead of electric motors. That means that the Royal Vic's 1,000 nurses must work a little harder every time they have to raise or lower a bed and patients can't just push a button to do it for themselves, On the maternity floor, it is strictly BYOD—bring your own diapers. The hospital stopped handing out free ones eight years ago.

30 Angus Reid Poll for the Southam News Service, Bill Walker, "We 'Love' Medicare, But Favor User Fees," *The Ottawa Citizen*, May 11, 1991; CBC-Globe and Mail Poll, Kate Dunn, "User Fee Threatens Medicare," *The Gazette* (Montreal) November 8, 1991, p. A5.

31 Tu Thanh Ha and Carolyn Adolf, "Health Care Fees Meet Resistance in Ottawa," *The Gazette* (Montreal), December 19, 1991, p. A1.

32 Editorial, "Renewed Attack on Medicare: Quebec Should Drop its Plan for User Fees," *The Gazette* (Montreal), December 20, 1991, p. B2.

> A weekend here [in the emergency room] shows what happens when all the problems of Canadian health care converge. The ophthalmoscope and otoscope next to each bed that doctors use to examine patients' eyes and ears don't always work. Sometimes it takes hours to get a specialist to come down from a ward for a consultation, complains Francois Giumond, an emergency room doctor.[33]

According to *The Christian Science Monitor*, last November at Toronto's Sunnybrook Health Science Centre:

> A heart-disease patient categorized as an emergency case gets an operation within 48 hours. The wait lasts up to a week for urgent patients, up to six weeks for semi-urgent patients, and up to four months for elective patients.
>
> Hospital officials are quick to point our that the system does accommodate patients who suddenly become emergency cases. In a few cases, though, the delay has proved fatal. To avoid the wait, some Canadians cross the border and have the operation in a U.S. hospital, where no such waiting lines exist.[34]

In an April 28, 1991, article entitled, "What Price Health Care?" the *Calgary Herald* (Alberta) led with the story of Al Hingley, a 53-year-old resident of suburban Edmonton:

> One of the arteries to his heart is completely blocked and the other three are 99 percent obstructed...If you think Hingley's condition is serious enough to warrant immediate surgery, you're wrong: he has been waiting for triple bypass surgery for the last 14 months. "I started out as 57th on the list and worked down to sixth, but now there's a second list of emergency and urgent cases, and I'm back to 55th," he says with a sigh. "It's very frustrating."

Then the article added:

> While costs rise, facilities shrink. Seventy-five beds were closed and 165 staff eliminated at the Colonel Belcher Hospital for veterans. Three hundred nursing and support staff were laid off at the Calgary General Hospital. Patients may wait more than a year for surgery, and expensive operations are given yearly quotas.
>
> And there are more black clouds on the horizon. Hospital buildings are deteriorating, the average age of the population is rising and advanced medical treatments for cancer and other diseases are becoming more expensive and complex. At the present rate of increase in costs, Alberta's health care expenses will almost equal the provinces entire 1991-92 budget of $12.5 billion by the middle of the next decade.[35]

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33 Goad, *op.cit.*

34 Laurent Belsie, "Reform Pressure in U.S. Puts Spotlight on Canada," *The Christian Science Monitor*, November 25, 1991, p. 9.

35 Gordon Cope, "What Price Health Care?" *The Calgary Herald* (Alberta), April 28, 1991.

A Canadian Press Service story reported last April that some senior citizens in the province of Manitoba have been waiting up to four years for knee or hip replacement operations.[36]

Too Many Babies. Last July, *The Washington Post* reported on the case of an obstetrician in suburban Montreal who was suspended by his hospital for exceeding his quota of 107 deliveries per year. Too many Canadians apparently were having babies. After other physicians protested, the doctor "was reinstated by the hospital administration, which had imposed and annual ceiling of 4,200 deliveries in its obstetrics ward last year in an effort to reduce overcrowding and a chronic budget deficit."[37]

Most of the evidence of declining access and long waiting lists is anecdotal. However, preliminary findings of a privately sponsored survey of waiting lists in five provinces last year reveal that an estimated 260,000 Canadians were waiting for major surgery.[38] The equivalent in the U.S. would be 2.4 million Americans waiting for major surgery.[39]

What should perhaps be most disturbing to Canadians is evidence that their health system is separating into "two-tiers." The widespread and strongly felt desire to avoid a two-tiered health system was the principal reason why Canadians turned to universal government financing of health care in the first place. This now seems to be changing. Thus when Quebec Premier Robert Bourassa in August 1990 learned that he needed an operation for melanoma, a potentially fatal skin cancer, he chartered a plane at his own expense and flew to Washington, D.C., for a consultation at the National Cancer Institute in Bethesda, Maryland. In November, he returned to Bethesda for the operation, which was a success. Such treatment options are not generally available to less wealthy or politically well-connected Canadians —or for that matter, to Americans.[40]

Uninsured Canadians

What might come as the biggest surprise to Americans is the existence of uninsured Canadian citizens. In the two provinces that charge health care premiums, Alberta and British Columbia, citizens who fail to pay technically are uninsured. While Alberta actually reimburses hospitals and doctors anyway for treating uninsured patients, as do many U.S. states, in British Columbia only the hospitals get reimbursed. This is because, as in all Canadian provinces, the government gives each hospital a fixed, annual (or "global"), budget, regardless of whom it treats. But the uninsured must pay for physician care out-of-pocket, or the doctors treating them must absorb the loss.

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36 Canadian Press Service, "Health Care Games Played, Doctor Says," *The Standard* (St. Catharines, Ontario), April 29, 1991.

37 William Claiborne, "No Quick Fix," *The Washington Post*, July 23, 1991.

38 Michael Walker, "Cold Reality: How They Don't Do It In Canada," *Reason* Magazine, March 1992, p. 37. The survey was conducted in the provinces of British Columbia, Manitoba, Newfoundland, Nova Scotia and New Brunswick. It was sponsored by the Fraser Institute in Vancouver, British Columbia. Walker is the institute's executive director.

39 The 1990 estimates for the Canadian and U.S. populations were 26.5 million and 250.4 million respectively. U.S. Department of Commerce, *Statistical Abstract of the United States 1991*, Table 1434, pp.830, 832.

40 Nancy Wood, "Missing But Not Forgotten," *Mclean's*, December 10, 1990, p. 14.

Various estimates put the uninsured population of British Columbia at between 2 percent and 5 percent, or 50,000 to 100,000 individuals. Were this figure applied to all of Canada, some 530,000 to 1.3 million people would be uninsured. And were this figure then transposed to the U.S., some 5 million to 12.5 million Americans would be uninsured—this is still a significant one-sixth to one-third of the present U.S. uninsured population. The British Columbia Medical Association estimates that each year its member doctors provide $15 million to $50 million in uncompensated care to the uninsured.[41]

CANADA AT THE CROSSROADS

The picture emerging from Canada is of a health system at the crossroads. Escalating costs and deteriorating access soon may force Canada to make a fundamental choice about the future of its health system.

One option is to introduce market-based reforms. The likely path would be a series of gradual steps such as the imposition of user fees and premiums, removal of restrictions on doctors and hospitals billing patients directly for all or part of their treatment, and the reintroduction of private insurance. Eventually, the government program could be means-tested—serving only the poor—with possibly some tax relief for private care and insurance purchased by the middle class.

Robert Evans, a Canadian health economist, points out that such a development essentially would mean the end of Canada's national health insurance experiment, and a return to where Canada was thirty years ago. This, says Evans, is where "the Americans have been all the way through."[42]

The other scenario is to introduce ever tighter controls, restrictions, and rationing throughout the system, making doctors salaried employees of the government and drastically limiting Canadians' freedom of choice in medical care. Such a scenario would mean that Canada effectively would nationalize not only the financing of health care, but its delivery as well. The resulting system would resemble the heavily bureaucratic, centralized, and unresponsive national health systems found in Britain and Sweden. This path is the one Canada is more likely to follow in coming years, if the provincial health ministers' joint reform plan of January 28 is any guide.

CONCLUSION

The lessons for America in Canada's health care crisis should be clear. Ultimately, a government-run health system does not hold the hope of both restraining health care costs and expanding access to health care. While such systems may provide universal access to health insurance, and may initially bring some savings, inevitably, over time they prove that they can only control costs by denying access to medical care.

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41 See: Ian Mulgrew, "B.C. Health Premium Hike Called Threat to Universality," *The Toronto Star*, May 26, 1991, "Doctors Promised Aid on Uninsured Patients," *The Vancouver Sun*, July 8, 1991, editorial, "Make Medical Premiums an Election Issue," *The Vancouver Sun*, July 16, 1991.

42 Joan Ramsay, Southam News Service, "Medicare: Canada's Black Hole," *The Windsor Star* (Ontario), May 11, 1991.

In the final analysis, access to health insurance is meaningless if it does not also give access to medical care. Contrary to the fond hopes of many Americans, including some members of Congress, Canada's national health system is finding that it is no exception to this rule.

Consumer Choice. If Americans are to achieve an affordable, universal, high quality health system, they cannot follow the Canadian path. The way to genuine reform of America's health system lies in consumer choice and true market competition, coupled with more effective government assistance for the needy and disadvantaged.

In theory, every health system in the world exists to serve patients and consumers. But the only way to make that theory a reality is by giving consumers direct control over the finances of the system. Only when individual consumers pay the piper, will health care providers and health insurers dance to the tune of consumer demand. And only then will the providers and insurers offer the combination of low prices and high quality every health care consumer desires. It turns out that the Canadian health care paradise of unlimited, high quality, "free" government-funded medical care, combined with limited, controlled health care spending, is a mirage. Such a system does not and cannot exist.

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