

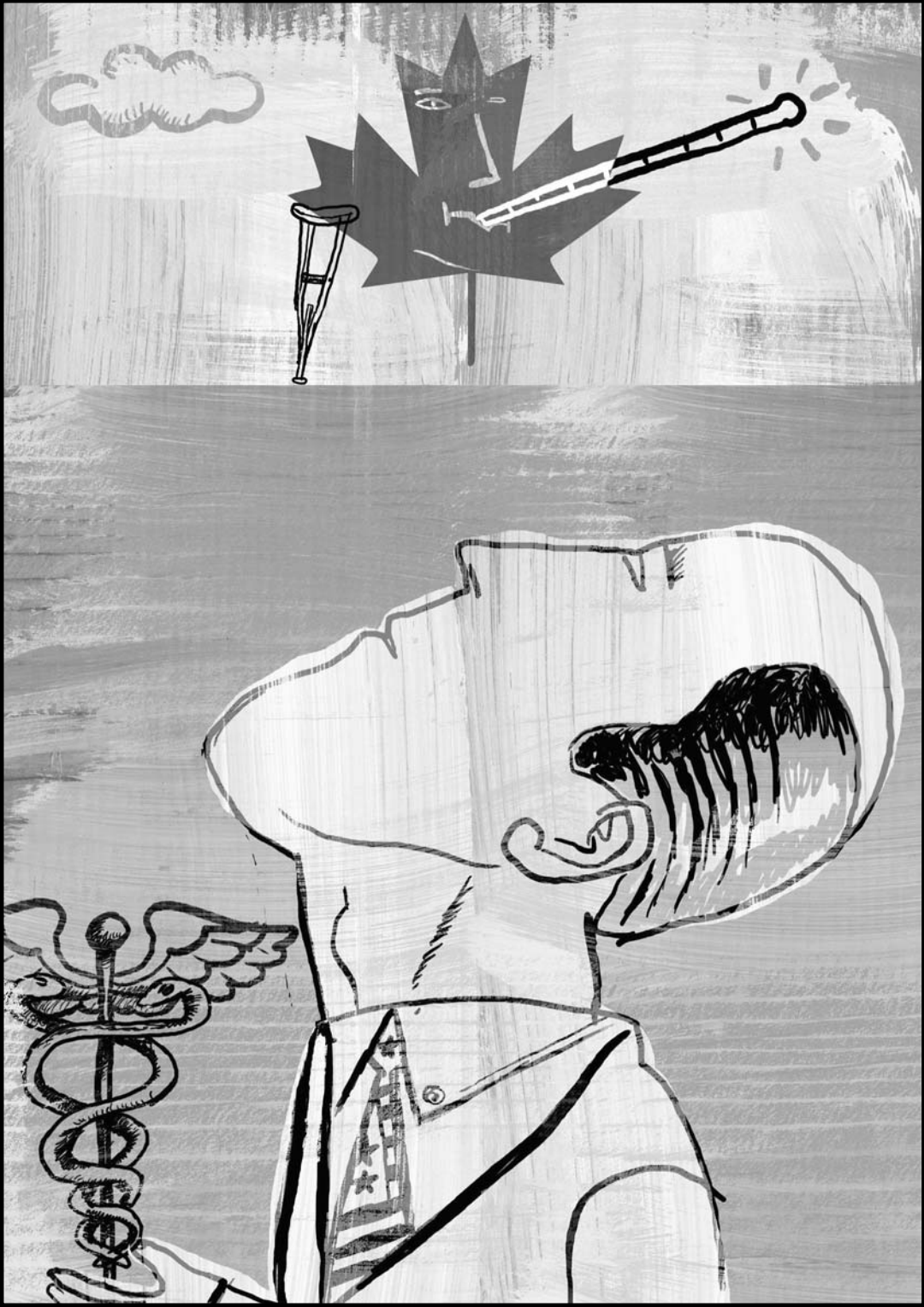
Looking North FOR Inspiration

What Americans Can Learn From Canada's Health Care System

*By
Nadeem Esmail
and
Michael Walker*

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Universal health care insurance has been on the table in the United States for more than half a century. And though the Bush administration has made no secret of its distaste for sweeping changes in the way health care is delivered and paid for, the undertow of public discontent with health-care-as-usual virtually guarantees that the issue will reappear in the next presidential election. Indeed, several states are not waiting for that election; their legislatures have already begun to grope with the challenges of introducing universal coverage on their own. Hence, the importance of understanding the strengths and weaknesses of universal health care in Canada, the country whose economy and culture are closest to those of the United States.

To its defenders, Canada's version of "single-payer" (that is, government-payer) universal medical coverage is a realistic way to provide adequate, affordable health care for everyone. To its critics, it is a system that undermines incentives to provide health care efficiently and unnecessarily infringes on individual freedom, to boot. Here, we offer an arms-length analysis of a system that many love and many others love to hate.



CANADA'S HEALTH CARE

JUST HOW GOOD IS CANADIAN HEALTH CARE?

For Canadians, the most relevant comparison of performance is with other health care systems that guarantee universal access. And to this end, the Fraser Institute, a free-market-oriented (but independent and nonpartisan) think tank in Vancouver, has been making comparisons of cost, access and quality for health care systems in developed countries for some years.

Canada spends almost 11 percent of its GDP on health care, fully three percentage points more than the average of developed countries offering universal access. Indeed, only Iceland and Switzerland spend a higher percentage. There is nothing inherently wrong with high health expenditures. Spending a lot of money on health care is, in essence, not all that different from spending a lot of money on a house or a car. But, implicit in consumer choice is the idea that buyers are getting the most bang for a buck – that an expensive system delivers top-quality service. Sadly, the reality is quite different.

Consider that, in 2005, a Canadian could expect to wait 17.7 weeks from the time his or her general practitioner determined the need for specialized care to the time a specialist delivered the treatment. That waiting time broke down into an 8.3 week wait to get an appointment with a specialist and another 9.4 weeks to receive treatment. According to a 2005 survey completed by the New York-based nonpartisan Commonwealth Fund, just 15 percent of sicker adult Canadians got elective surgery in less than a month compared to 48 percent of Australians, 59 percent of Ger-

mans, 32 percent of New Zealanders and 25 percent of residents of the United Kingdom. Note, too, that universal access does not always come at the price of long waits for service. At least seven nations with universal coverage – Austria, Belgium, France, Germany, Japan, Luxembourg and Switzerland – deliver health care without any systemic delays.

Canada's performance is equally problematic in terms of the number of physicians and high-tech medical devices available. Adjusting for the age of the population (the elderly require more care), Canada ranked 24th of 27 nations in physicians, 13th of 22 nations in the availability of MRI machines, 17th of 21 in the availability of CT scanners, 7th of 12 in the availability of mammographs, and last among 16 nations in the availability of lithotrippers – which are used for breaking up kidney stones without surgery.

Canada does better in comparisons of health care results. It ranks 4th among 18 developed nations in preventing avoidable deaths through appropriate medical intervention and 2nd among 28 in preventing colorectal cancer mortality. But the record is still quite mixed. For example, it ranks just 20th among 28 countries in preventing infant mortality.

TESTING PATIENTS' PATIENCE

We believe that virtually all of the shortcomings stem from the distorted incentives built into the system. To understand what we mean, consider Canadian health care from the perspective of a patient with a newly discovered ailment.

The patient's journey ought to begin at the office of a family practitioner who knows both the patient and his or her medical history. But thanks to rules that prohibit direct charges to patients, fix the fees doctors earn for individual services and cap physicians' total annual billings, there is a considerable

NADEEM ESMail is director of the Fraser Institute's Health System Performance Studies. MICHAEL WALKER is the president of the Fraser Institute Foundation.

shortage in primary-care doctors. Indeed, in 2003 roughly 1.2 million Canadians were unable to find a regular physician and were thus left to the anonymous care of clinics.

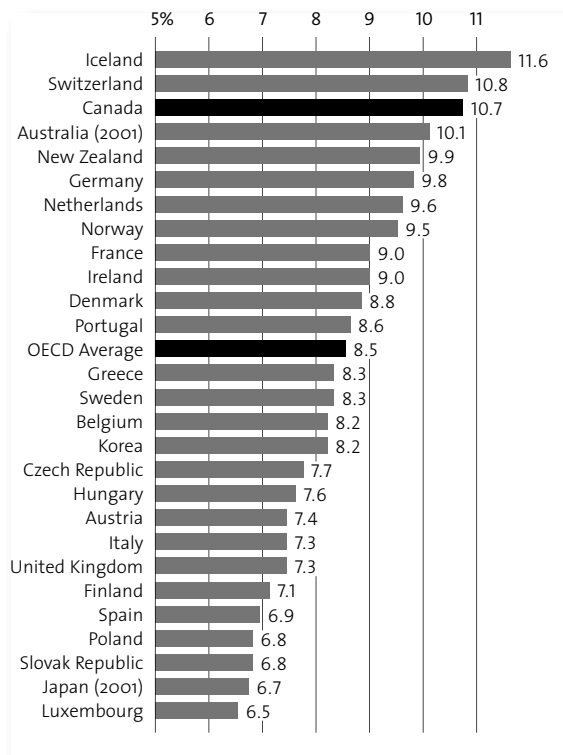
The issue of user fees is particularly nettlesome. When individuals are not asked to make co-payments for insured health services, they have no incentive to think twice before seeing a physician. So, while Canadian patients pay nothing for most care, access to the doctor is rationed by waiting time.

If a general practitioner determines that a patient needs a high-tech noninvasive diagnostic procedure, but that the need is not urgent, the patient will be subjected to a true trial by endurance. For example, he or she can expect to wait 12.3 weeks for an MRI, 5.5 weeks for a CT scan, and 3.4 weeks for an ultrasound.

In part, these delays are the direct consequence of scarcity: to save money, the government licenses the operation of far fewer diagnostic machines per person than are available in the United States. But they are also the result of a tangle of regulations and perverse budgetary allocations in the top-down government-run system. It is common to hear of MRI machines available only during bankers' hours because their operators are not compensated for scanning services during evenings, weekends and holidays. Affluent Canadians can use a safety valve in the rules that permits them to purchase scans from private suppliers, and thus avoid the delay. That is surely better than not having the option to pay, but it is hardly testament to the success of a universal health care system.

With the scan and analysis complete, the patient can once again return to his or her general practitioner (or, all too often, a clinic) for a referral to a specialist. The need to get a referral before seeing a specialist serves to limit demand for expensive physician ser-

AGE-ADJUSTED HEALTH SPENDING (% GDP) IN OECD COUNTRIES WITH UNIVERSAL ACCESS, 2002



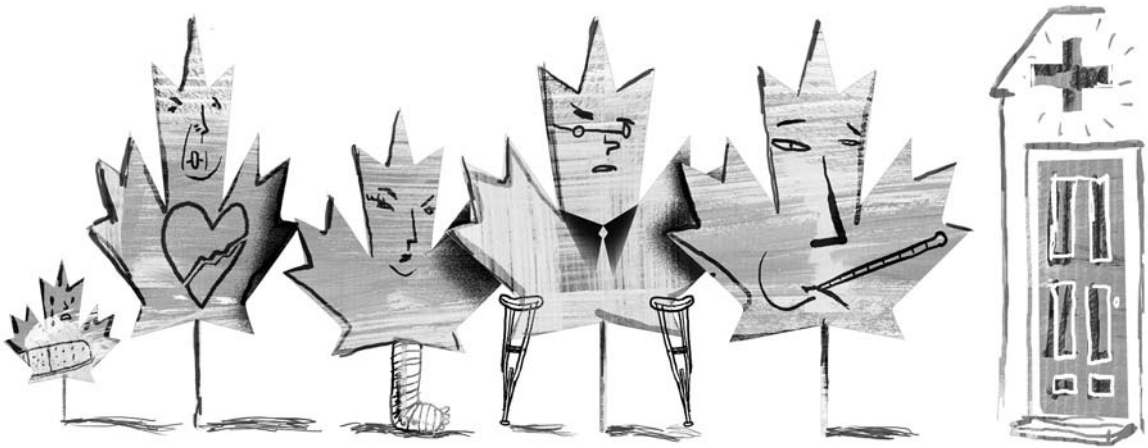
SOURCE: The authors

vices but it also adds another layer of bureaucracy and waiting time to the system.

Moreover, obtaining a referral to a specialist doesn't mean the appointment will be timely. Patients with referrals in hand still wait (on average) anywhere from 1.6 weeks to see a radiation oncologist to 15.4 weeks for a plastic surgeon.

Actually, the gauntlet is yet longer. Canadian hospitals generally operate on fixed annual budgets, and are not paid for the amount of services delivered. So they have little incentive to maximize the use of their facilities. What's more, the block-grant approach disconnects financing from the quality of services, leaving hospital administrators with little incentive to insist on better than least-

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common-denominator care. Nor is there really much creditable pressure to minimize the cost of services delivered; the government generally covers budgetary shortfalls at the end of the year, in order to keep hospitals open.

On the other hand, hospital administrators do have an incentive to discharge patients quickly, to avoid the admission of patients in need of very costly services and to shift patients to other institutions. By the same token, they have an incentive to tie up beds with long-stay patients in order to prevent the admission of patients who would be more costly to treat. And the consequences of these perverse incentives are compounded by the lack of competition from private hospitals that could set benchmarks for both quality and efficiency. For while most of Canada's hospitals are nominally private, they depend on the government for capital allocations, are compelled to employ union workers at state-determined wages, and are overseen by regulators with the power to merge or close them.

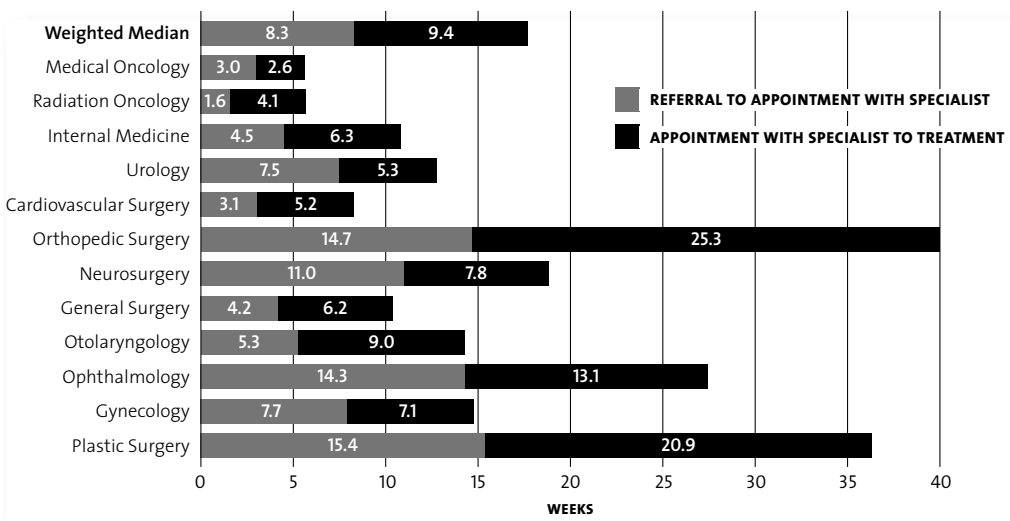
From the perspective of an individual patient, the most pertinent issue is that block-grant financing turns every additional operation into a drain on the hospital budget.

Thus, it should not be surprising that Canadian operating rooms are often closed during the weekends, evenings and holidays to all but emergency cases. As a result, physicians sometimes limit the number of patients they see for consultations in order to manage their waits for treatment. The result is a line at each gate: one to see the specialist and one to be treated by him or her.

Thus far, our hypothetical Canadian has waited to see a family physician, then waited for diagnostic tests, then to consult with a specialist. Now, he or she will endure another 9.4 week wait (on average) for treatment. This waiting time varies based on the specialty (between 1.1 weeks for critical cardiovascular surgery and 25.3 weeks for orthopedic surgery) and on the perceived urgency (waiting times of more than a year are common for some expensive elective operations like joint replacements).

Just as troubling as the length of the wait is the reality that those waiting are not organized according to actual medical need. There is evidence that preferential access to surgery because of factors like personal prominence or political connections is common. Equally

**MEDIAN NUMBER OF WEEKS WAITED
FROM REFERRAL TO TREATMENT IN CANADA (2005)**



SOURCE: The authors

revealing, the actual waiting time for treatment in Canada (averaged across all medical specialties) is nearly twice as long as what Canada’s physicians consider to be clinically reasonable, implying that the long waits are, in fact, doing harm.

This latter point has not been lost on Canada’s Supreme Court. In June 2005, the court decided that the prohibition on the purchase of private health insurance for services defined as “medically necessary” imposed by the provincial government of Quebec “infringes the right to personal inviolability and that it is not justified by a proper regard for democratic values, public order and the general well-being of the citizens of Quebec.” The court also ruled that “in the face of delays in treatment that cause psychological and physical suffering, the prohibition on private insurance jeopardizes the right to life, liberty and security of the person of Canadians in an arbitrary manner, and is therefore not in accordance with the principles of fundamental justice.”

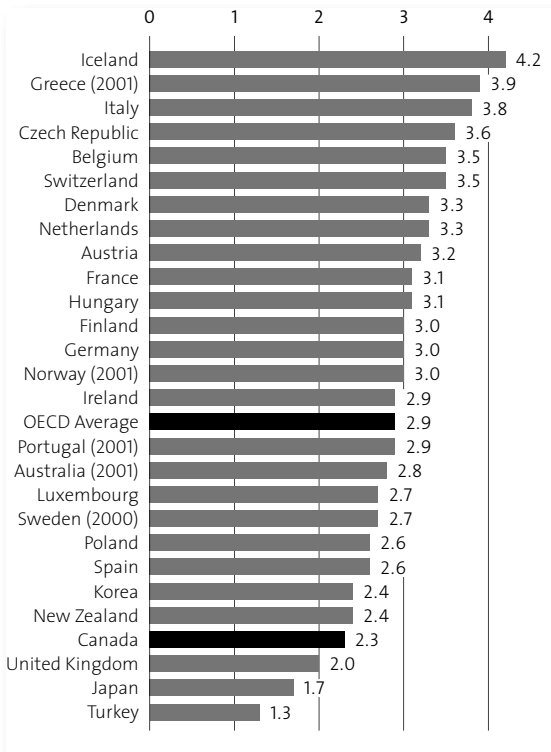
In any event, it is important to keep in

mind that rationing services by imposing longer waits is inherently inefficient. The very existence of chronic delays in delivering services implies that the system is failing to use prices to equate supply and demand.

Finally, apart from the option to buy imaging services on the private market, our hypothetical patient had little choice in all that has happened over the weeks, months or even years it has taken to be treated. Private options for treatment are generally outlawed in Canada in order to keep the best medical personnel from opting out of the public system. The notable exceptions are in British Columbia where, thanks to a loophole in legislation, private treatment is currently available to those willing to pay, and in Quebec, where private treatment for some conditions has been available for some time and where the recent Supreme Court ruling has opened the door to private insurers.

What happened to all the money that should be providing world-class treatment to the masses? Some of it is wasted on patients

**DOCTORS PER 1,000 POPULATION
(AGE-ADJUSTED) IN OECD COUNTRIES
WITH UNIVERSAL ACCESS, 2002**



SOURCE: The authors

NOTE: Figures for Turkey were not age-adjusted due to remarkably low dependency ratios that were not conducive to meaningful adjustment

who demand unnecessary services because those services cost them nothing. Some of it is lost in monopoly hospitals that have little incentive to maximize either the quality or quantity of services. Some of it goes to bloated administrative budgets and excessive compensation for hospital personnel, whose salaries are determined by public-sector bargaining, rather than by market forces.

COMPARING CANADA TO THE USA

To Americans, the important question is not whether Canadians get adequate treatment. Rather, they need to know whether a Canadian-style approach would outperform the

existing American hybrid system.

Canada certainly does not do well when judged by waiting times for diagnosis and treatment. According to the Commonwealth Fund, U.S. residents urgently in need of treatment are less likely to wait than their Canadian counterparts. Specifically, 20 percent of sicker adults see a specialist within a week compared with just 10 percent in Canada. Meanwhile, fully 57 percent of sicker Canadians waited more than four weeks for a specialist, compared with 23 percent of their American counterparts. On the treatment side, 15 percent of sicker Canadians waited less than a month for elective surgery while 33 percent waited four months or more, compared with 53 percent and 8 percent of sicker adult Americans, respectively.

The picture is murkier, though, when treatment quality is measured by medical results. Canada can, indeed, boast of lower infant mortality rates and longer life expectancy than the United States. But these measures don't entirely reflect the performance of the health care system – other factors, including drug use, nutrition, crime and public sanitation also affect public health.

Measures that are more closely related to the actual performance of the health care program show that Canada's system outperforms the U.S. system in some cases, and underperforms it in others. For example, a 1998 study by Ellen Nolte and Martin McKee of the London School of Hygiene and Tropical Medicine found that Canada did better than the United States in terms of deaths that could have been avoided through appropriate medical intervention. On the other hand, our own comparison of the incidence of mortality from breast cancer and colorectal cancer (based on work published by the World Health Organization's International National Agency for Research in Cancer) put

the United States ahead of Canada. Finally, a 2004 comparison of the quality of care in five developed countries, led by Peter Hussey of Johns Hopkins, showed that the United States outperformed Canada in some categories and underperformed in others. Neither nation consistently outperformed the other.

CANADA AS A MODEL

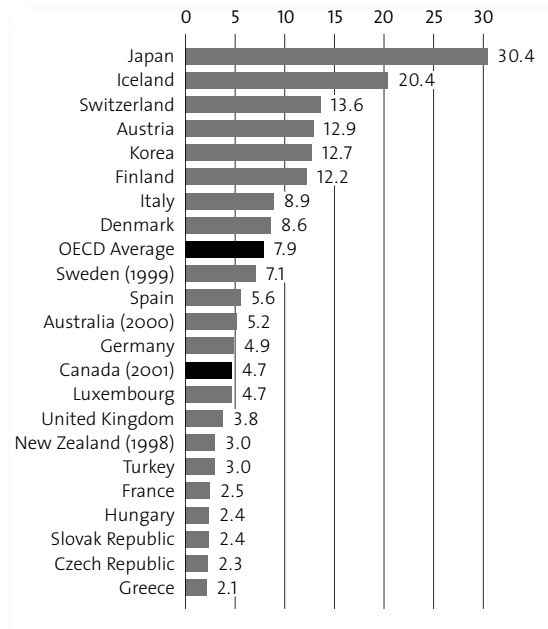
As must be clear by now, the disadvantage of the Canadian health care system compared with the American is the length of time it takes to get treatment. The results, as measured by preventable deaths, are more or less the same. But Canadians are more likely to be frustrated by delays than their insured American counterparts.

The advantage of the Canadian system is that nobody is denied treatment for lack of money. Nor are there limits on the amount of services paid by health insurers. What's more, since Canada's system is financed from government revenues, Canadians in lower tax brackets can expect to pay less for comprehensive health care insurance (through their taxes) than would their American counterparts – as little as C\$880 for someone with an income of C\$20,700. Conversely, Canadians in the highest tax brackets pay substantially more for the health insurance than their American counterparts—as much as C\$26,600 for someone with an income of C\$200,700.

The right question here, though, is not whether Canada's health care system is better than the American system, but whether there are better models for universal coverage to be found in the developed world. And the answer is an emphatic “yes.”

Take, for example, Switzerland's system. It is expensive, costing even more than the Canadian system when measured as a percentage of GDP. But it offers both minimal waiting times for treatment and exceptionally

MRI MACHINES PER MILLION POPULATION (AGE-ADJUSTED) IN OECD COUNTRIES WITH UNIVERSAL ACCESS, 2005



SOURCE: The authors

good medical results in return. The Swiss approach is based on the mandatory purchase of health insurance in a competitive marketplace (involving private insurers), while services are delivered competitively by both public and private caregivers. Swiss patients are also required to share in the cost of their care, and are permitted to seek care privately, on their own terms, whenever they feel the need to do so.

The Canadian health care experience, then, should be as much a cautionary tale as an inspiration for Americans unsatisfied with the status quo. Canada's single-payer system delivers on the promise of universal access, but at a price that reflects its failure to use market-based incentives to ration services and to maximize the efficiency of their delivery. It's hard to imagine that planners who started afresh couldn't do better. **M**