Myth REALITY

Myths and Realities of Canadian Medicare

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> Public health insurance is a key expression of the principle of solidarity.
>
> *— Bob Rae,*
> *Premier of Ontario, 1990-95*

> Healthcare systems are the product of specific historical and socio-economic circumstances; they evolve, rooted in each country's political culture, in its value system. In that sense, healthcare systems are not easily exportable.
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> *— Monique Bégin,*
> *Federal Minister of Health and Welfare, 1977-84*

I recently returned from six months in Canada, where I held appointments as visiting professor and Fulbright Scholar in the Department of Epidemiology and Community Medicine and the Institute of Population Health at the University of Ottawa. The main focus of my research was on the Canadian approach to population health. Although many Americans are familiar with the Canadian healthcare system, far fewer have heard of the Canadian population health model. Briefly, for some years, Canadian scholars and policy makers have adopted the view that healthcare is obviously an important contributor to health, but it is only one component of a much broader set of determinants of health. As a visiting scholar in Ottawa, I had numerous opportunities to talk with Canadian legislators, academics, practitioners, medical association officials, journalists, and common citizens about the myths and realities of their healthcare system.

I was fortunate to be in Ottawa during the recent federal election, when healthcare emerged as a dominant campaign theme among the three major party candidates despite the warning by Jeffrey Simpson, the *Toronto Globe & Mail* columnist, that healthcare is the "third rail" of Canadian politics (touch it and you are dead). Politicians of all ideological stripes proposed to reform the healthcare system. During the refreshingly short month-long political campaign, all three major candidates (Liberal, New Conservative, and New Democratic) called for reducing the waiting lists for crucial procedures and expanding pharmacare (outpatient drug insurance coverage). Paul Martin, the incumbent and Liberal party leader, promised to inject $9 billion (CAD) and possibly $16 billion, depending upon the negotiations with the provinces, to implement the proposed healthcare reforms. He also vowed to halt the proliferation of private clinics and to discourage the practice of private companies delivering publicly funded services ("creeping privatization") (Picard, 2004). Even Stephen Harper, leader of the "New" Conservatives (a right-of-center political party, formed by the merger of the Reform Conservative Alliance and the Progressive Conservative Party), called for the infusion of more cash into the system and vowed to protect Canadians from crippling drug costs.

Medicare: A Pan-Canadian Enterprise

Medicare, the name given to the national health insurance program, is a "pan-Canadian" enterprise (Banting & Boadway, 2004). To most Canadians, this term means that all citizens should have access to good-quality healthcare services on comparable terms and conditions, regardless of their place of residence. More specifically, the bedrock is the conviction that a sick child in British Columbia is entitled to health services that are broadly comparable with those of a sick child in Atlantic Canada. The reality of Medicare is that Canadians enjoy comparable—but not identical—health insurance coverage across the country.

Hertzman compared infant mortality for all Canadians with that for white Americans between 1970 and 1998. The white US infant mortality rate was roughly six deaths per 1,000 babies, compared to slightly more than five for Canadians.

The Medicare program started as an innovative provincial program that became national through federal support. The roots of Medicare can be traced back to Saskatchewan. Tommy Douglas, a Baptist minister, socialist, and premier of Saskatchewan (1944-1961), considered by many to be the "father of Medicare" established the first universal public healthcare pro-

gram over 50 years ago. In 1947, the province inaugurated its hospital insurance plan—the first universal health insurance program in North America. As told by Rachlis in his book *Prescription for Excellence* (2004), Tommy Douglas's burning desire for Medicare was fueled by his childhood experience with osteomyelitis. The Winnipeg doctors told Douglas that he had to have his leg amputated, but, at the last moment, Dr. Robert Smith, a prominent Winnipeg surgeon, volunteered his expert services if Tommy agreed to be a teaching patient. These events left Douglas with the view that if he had not been considered an "interesting case," he would have lost his leg. He vowed that no Canadian family should ever have to choose between healthcare and impoverishment.

Douglas's Co-operative Commonwealth Federation, the predecessor of the New Democratic Party, came to power in 1944, when Saskatchewan was struggling out of the Great Depression. Douglas took on the health portfolio himself, and on January 1, 1947, the province inaugurated the first universal health insurance program in North America. By 1957, some other provinces began to experiment with their own programs, and in 1957 the federal government passed the Hospital Insurance and Diagnostic Act. The act laid down the template for future federal health programs. By 1967, Prime Minister Lester Pearson and the other provinces agreed to the creation of a national Medicare program.

The Canada Health Act

The Canada Health Act was passed unanimously by Parliament in 1984 "in response to the growing prevalence in a number of provinces of extra-billing by physicians and the introduction of hospital fees, both of which the federal government opposed as inhibiting equal access to care" (Banting & Broadway, 2004, p.10). The purpose of the federal legislation was to establish criteria and conditions (see side bar) that provinces must fulfill to receive their share of federal funds (of note here is that the federal contribution to provincial health expenditures dropped precipitously from about 44 percent in 1980 to about 29 percent in 2000). The Canada Health Act sets the conditions that the provinces and territories must accept in exchange for a full federal cash contribution under the terms of the 1995 Canada Health and Social Transfer Act. Although the federal government cannot regulate healthcare issues per se, it can dictate what provinces do through its "spending power." This power is effectively the basis for a national healthcare standard in Canada.

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Publicly Financed and Privately Delivered

Today, federal contributions to provinces and territories are tied to population and other factors and conditional to compliance with the Canada Health Act. Under the terms of the act, the provinces provide all residents with health insurance cards, which entitle the bearers to receive free medical care for almost all procedures. Patients are free to choose their own physicians, hospitals, and so forth. Healthcare facilities are either private and not for profit (such as university hospitals) or government run, and physicians in private practice are entrepreneurs who bill the Medicare system for their services (Evans, 2000).

How does Canada's Medicare system work? First, Medicare is a subsidy and transfer program. Through taxation, healthcare is funded by a progressive transfer of money from one segment of society to another providing services for all on the basis of need. Second, the program is simple—managed by five succinct Canada Health Act principles as opposed to the 50 volumes of the *US Federal Register;* see Brown, 2003. The single-public payment mechanism keeps administrative and transaction cost to a minimum (in 1999, health administration costs were $307 per capita in Canada compared to $1,059 in the United States, according to Woolhandler, Campbell, & Brown, 2003), eliminates overhead for sales and competition, and provides a national standard of public coverage for most medically necessary needs. Third, it controls costs through the bargaining power of a single payer. Cost-control measures include mandatory global budgets for hospital/health regions, negotiated fee schedules for healthcare providers, formularies for public drug plans, and limits on the diffusion of technology (Sullivan & Baranek, 2002).

Provinces vary in the range of services that are considered medically necessary (Banting &

The 5 Principles of the Canada Health Act

The five principles of the Canada Health Act are the cornerstone of the healthcare system, and have iconic status for Canadians. According to Health Canada (www.hc-sc.gc.ca/Medicare/home.htm), the five specific criteria of the Canada Health Act are these:

1. **Public administration:** the administration of the healthcare insurance plan of a province or territory must be carried out on a non-profit basis by a public authority;
2. **Comprehensiveness:** all medically necessary services provided by hospitals and doctors must be insured;
3. **Universality:** all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;
4. **Portability:** coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and
5. **Accessibility:** reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

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Boadway, 2004, p. 42). There are also provincial differences in the availability of physicians, nurses, and hospital beds. It is worth noting, however, that decisions on these services reflect different provincial decisions about the delivery of healthcare services, rather than differences in the strength of provincial economies. According to governmental data on provincial per capita expenditures, the Maritime Provinces and Quebec tend to spend less than the national average, and the rest of the provinces tend to spend more. Although there is considerable variation in the availability of physicians, registered nurses, and acute-care hospital beds across the country, the differences are not rooted primarily in provincial income levels (Maioni, 2002).

Much more substantial regional differences are evident in services that fall outside the scope of the Canada Health Act, including prescription drugs provided outside hospitals and home care (Banting & Boadway, 2004). Drug insurance coverage, in particular, differs widely across the country. Provincial programs tend to cover low-income older adults and social assistance recipients in all regions, but coverage of other citizens varies considerably. In fact, only a handful of provinces (namely, Quebec, Ontario, Manitoba, Saskatchewan, and British Columbia—*approximately 82% of the population —Ed.*) have drug programs that provide a minimum level of coverage for all residents.

Home care also varies substantially across Canada (Banting & Boadway, 2004). Although each province and territory offers some form of home care, there are major differences in eligibility, the percentage of those needing care who are covered, the range of services provided, and

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the level of user fees. All provinces offer services, such as assessment, nursing care, and home support for those they deem eligible. However, only some provincial programs provide physiotherapy, speech therapy, and respiratory therapy.

Although care from a physician or hospital is covered by the state to a greater degree than in any other country in the world, Canada has one of the most limited public healthcare systems. For example, dental care is still almost entirely private, prescription drugs are only partially covered, and optometry is only partially covered and only in certain provinces. In fact, the proportion of healthcare expenditures coming from public sources puts Canada among the least publicly financed in the industrialized world (Deber, 2003). According to OECD data, government revenues funded 71 percent of health spending in Canada in 2001, slightly below the average of 72 percent in OECD countries (OECD, 2003).

A Medicare Report Card

Canadians are proud of Medicare (Deber, 2003), even when they worry about its future as they do right now (Bégin, 2003, p. 179). Polling data have consistently shown that Medicare is the most important political issue for the Canadian electorate.

However, the apparent inefficiencies have become a source of controversy in Canadian politics, mostly because of the common perception that the quality of care that is provided has been steadily decreasing, particularly throughout the past two decades. Commonly cited problems include limited access to diagnostic equipment (e.g., MRIs), lengthy waiting times for elective and non-emergency surgeries, and a severe shortage of primary-care physicians (partly because the proportion of students who choose family medicine as a residency specialty has been falling steadily across Canada). In some provinces, the waiting time to acquire a general practitioner has been quoted as several years. In response to the waiting-list problem, conservative politicians (e.g., Alberta Premier Ralph Klein), think tanks (e.g., Fraser Institute), and print media (e.g., *National Post*) have called for the expansion of for-profit care—a development that would open the door to a two-tier healthcare system (Sullivan & Baranek, 2002).

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While complaints of a steadily worsening system are common, statistical evidence for these is hard to find. Despite growing waiting lists and some funding cuts, there has been no sign of any decrease in the overall health of Canadians, and Canadians still rate their experience with the healthcare system as highly as anywhere else in the world. Indeed, Canada has maintained a high level of healthcare standards relative to other developed nations. Let's quickly look at the evidence. The *Boston Globe* (Forman, 2004, p. C2) compiled an impressive array of comparative data showing that Canadians live longer and healthier than their American counterparts. Here are some examples:

- "By all measures, Canadians' health is better," said Barbara Starfield of the Johns Hopkins School of Hygiene and Public Health. Canadians "do better on a whole variety of health outcomes," she said, "including life expectancy at various ages—1, 15, 20, 45, 65, 80, you name it." According to a World Health Organization report published last year, life expectancy at birth in Canada is 79.8 years versus 77.3 in the United States (Japan's is 81.9). Canada now ranks fifth in life expectancy at birth (after Japan, Sweden, Hong Kong and Iceland), while the United States ranks 26th, according to the United Nations Human Development Report.
- Infant-mortality rates also show striking differences between the United States and Canada, according to Clyde Hertzman, associate director of the Centre for Health Services and Policy Research at the University of British Columbia in Vancouver. Hertzman compared infant mortality for all Canadians with that for white Americans between 1970 and 1998. The white US infant mortality rate was roughly six deaths per 1,000 babies, compared to slightly more than five for Canadians.
- Maternal mortality shows a substantial gap as well.

According to data published last year by the OECD, there were 3.4 maternal deaths for every 100,000 births among Canadians compared to a 9.8 among all Americans.

Detractors on both sides of the border claim that Canadian patients flee their country in droves to get private health care (so-called Medicare refugees) and that Canadian-trained physicians and nurses leave for "greener pastures" down south, where private hospitals can pay much higher wages and income tax rates are lower. Let me examine the validity of these assertions. First, Steven Katz and his colleagues from the University of British Columbia (2002) found little cross-border traffic for healthcare. Based on their analysis of the 1996/97 Canadian National Population Health Survey, a large population-based survey, only 0.5 percent of respondents indicated that they had received healthcare in the US in the prior year and only 0.11 percent (i.e., 20 of 18,000 respondents) said that they had gone there for the purpose of obtaining any type of healthcare, whether or not covered by the public plans. Apparently, most Canadians who use US health facilities do so for emergency or urgent reasons while visiting the United States. As for the question of whether Canadian physicians are leaving Canada for the United States in large numbers, the Canadian Institute for Health Information (CIHI) reported that the proportion of departing physicians has fallen (see Canadian Health Services Research Foundation, 2001). The data show two peaks when physicians left Canada: one in the late 1970s, and the other about 1996, when 731 physicians left. But since then, CIHI has estimated that fewer physicians have left Canada: 659 in 1997, 569 in 1998, and 585 in 1999 (the most recent year available).

In just over three decades, Medicare has become deeply embedded in the Canadian national identity and civic culture. The Canadian philosopher John Ralston Saul put it this way (quoted in Evans, 2003, p. 21)," Medicare becomes an evocation of the soul of the country." Canadians, unlike their US counterparts, regard healthcare as a basic right and are proud of their universal health system, since it exemplifies many of their core values, such as shared community, equality and justice, respect for diversity, mutual responsibility, accountability, and engaged democracy (MacKinnon, 2004).

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