

THE POLITICS OF CANADA'S HEALTH CARE SYSTEM

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Introduction

A widely used tactic in the current debate on health care reform in the U.S. has been to compare health care delivery in the U.S. with Canada's national health care system. For U.S. supporters of a national, universal, single payer health care system, the Canadian experience offers a working alternative which has been in operation for over 20 years. While Americans are generally loathe to look at foreign institutions as models for domestic reform, the close geographic proximity of Canada and the similarities in values, institutions and outlook between the two countries makes Canada seem less foreign to Americans. Opponents of significant health care reform, are quick to warn of the evils of socialized medicine, even in Canada, arguing that the adoption of such a system will mean long waiting lists for surgery, increased government interference in the relationship between patients and doctors, tax increases, and general inferior medicine with less choice for patients.

With so much of the U.S. health care debate now pivoting on the "Canadian model," we think it is valuable to take a closer look at the origins of this system. In this article, we will look at the Canadian health care system with six questions in mind: why Canada? What exactly is the Canadian model? How was it achieved politically? What are some of the common myths about the Canadian model and what is the current status of the system? Finally, what can Americans learn from the Canadian model?

Why Canada?

Thirty years ago, there was no significant difference in the provision of health care in Canada and the U.S. Since 1971, however, the two countries have gone in dramatically different directions with dramatically different results.

To highlight some of the more important differences, in the U.S. today, over 37 million people are without health insurance and a further 53 million are underinsured, which means that they are inadequately insured in the event of a serious illness.¹ Canada, by contrast, not only offers all of its residence comprehensive health care, but it does so at a far lower cost than in the U.S. While Canadians spend 8.7% of their Gross National Product on health care, or the equivalent of \$ 1,483 (U.S.) per person, the U.S. spends 11.8% of the GNP, or \$ 2,051 per person for a health care system that doesn't provide health care for all.²

For Americans, health care coverage depends primarily on whether health insurance is provided by their employer or through two major public programs, Medicaid for the poor and Medicare for the elderly. For both public and private employees, health care benefits and cost vary

tremendously. By making workers dependent upon their employer for health care, there is an extra burden on workers who are forced to change or lose their jobs in the U.S. Also, a growing number of people with a history of health problems, or with what insurance companies deem to be "pre-existing conditions," find themselves "uninsurable." With rising health care costs, many employers in the private sector do not provide any health care benefits at all. Most employers, whether private or public, are attempting to shift the cost of health care programs onto workers. Medicare, for example, now covers only about 40% of the health care costs of the aged.³

All Canadians, rich and poor, regardless of the state of their health, age, or employment status, are covered by the same comprehensive system. Canadians go to the doctor of their choice and receive hospital care for free. There are essentially no financial barriers to health care in Canada, and there is an ample supply of physicians. Private insurance that duplicates the comprehensive services covered by the provincial plans are prohibited. Co-payments, deductibles, and direct patient payments to providers for covered services are also not permitted.

What is Canada's Health Care System?

The Canadian system is a carefully crafted hybrid reflecting the many political compromises entailed in adopting a major social program in face of a powerful opposition. The system can be described as a publicly-funded, privately-provided, universal, comprehensive, affordable, single-payer, provincially administered national health care system. To explain each of these components in turn, publicly-funded means that its operating revenues come out of government general revenues -- taxes.

A provincially administered national program sounds contradictory, but in Canada, as in the U.S., there is a division of power between the Federal and Provincial levels of government, with health care designated a provincial responsibility. Federal legislation, the Canada Health Act, set out the basic guidelines for the system. The federal government encouraged provincial government cooperation by agreeing to pay 50% of the costs of provincially-administered systems which followed the national standards.

The health care system is administered in each province through a single public agency -- the single payer -- accountable to the provincial legislature. All provincial health care plans are required to be fully portable within Canada which means there is reciprocal recognition of coverage between provinces. Universal access is defined to mean that no less than 95% of the eligible recipients in any province must be covered by the program.

Health care itself is privately provided, with the vast majority of doctors in private practice charging for care on a fee-for-service basis. Doctors' organizations annually negotiate the fee schedule with each provincial health care agency. The overwhelming majority of hospitals in Canada are private, non-profit. They receive global operating budgets from the provincial government. New capital expenditures are allocated separately.

To many Americans, the Canadian health care system could be a working model for an equivalent American system. In a recent national survey in the U.S., two-thirds of the respondents

said that they would prefer the Canadian system to the one in the U.S.⁴ While identifying an appropriate model is useful, devising a political strategy to implement such a program is a far more challenging problem. Again, the Canadian example can provide some insight.

How did they get it?

The general principles of the national health care system were established in 1959 in the prairie province of Saskatchewan by Canada's social democratic party and predecessor to the New Democratic Party (NDP), the Cooperative Commonwealth Federation (CCF)⁵. Long committed to health care for all, the CCF was first elected provincial government in Saskatchewan in 1944. During their first term in office in 1947, they introduced a province-wide public hospital insurance plan. Within a few years, this program was sufficiently popular that the other provinces adopted similar schemes.

In 1958, the provincial and federal governments worked out an arrangement to share the costs of the provincial hospital insurance programs. In Saskatchewan, this meant that provincial funds were now freed up to undertake further health care reform. In the 1960 provincial election, the CCF/NDP promised to introduce a comprehensive provincial health care system. Voters were told that a system of comprehensive medical service coverage for all, with affordable premiums subsidized by general revenues, was now possible. This system would emphasize prevention and early diagnosis and treatment, and was to be co-ordinated with other existing health programs, such as hospital insurance. It was to promote medical research and education and to emphasize the value of human life. Finally, reflecting the concerns of a rural province, the program was to seek ways of encouraging the best distribution of doctors throughout the province.⁶

The CCF won the 1960 election, in spite of a well-funded campaign by doctors in opposition to the health program. As the government proceeded to put its program into legislation through the Saskatchewan Medical Care Insurance Act (1961), the doctors continued their campaign against what they termed "socialized medicine." Accusing the government of "communism" and "compulsory state medicine," the doctors warned that the province was interfering with their right as professionals to practice medicine and was attempting to make them "salaried government employees." They warned that doctors would leave the province rather than work under such a system. Finally, in a last-ditch effort to force the government to back down on its health care reform, the doctors went on strike on July 1, 1961, the first day the new legislation came into effect.

The doctors' strike in Saskatchewan lasted 23 days and gained worldwide attention. While the doctors agreed to maintain emergency services and the provincial hospitals remained open with reduced staff, most private practitioners closed their offices. Ironically, the mortality rate in the province declined during the strike, primarily because of the decline in surgery.

While much of the national and international media condemned the doctors action, the local media supported the doctors and demanded that the government back down on its program. In spite of the local media's support, as the strike wore on public opinion in Saskatchewan turned against the doctors. As communities started to recruit doctors willing to work under the health plan from other

parts of Canada, the local doctors' resolve rapidly dwindled. The strike ended with the new health program still intact. The provincial government negotiated a face-saving agreement with the doctors which permitted them to opt entirely out of the plan and bill patients privately. With over 900 doctors in the province at the time, none chose this option. The agreement also permitted doctors to maintain their own medical insurance companies as clearinghouses for the Medical Care Commission, though these were eventually eliminated by the doctors themselves as needless duplication.

In spite of the controversial start to the Saskatchewan program, it quickly proved to be a success. Within a few years, the Saskatchewan model became the prototype for other provinces. Similar to what had happened with the ground breaking initiative on hospital insurance, once the Saskatchewan model was in place the federal government passed legislation in 1966 which established the guidelines for a national health care system. The speed of the spread of the new system is impressive. By 1971, less than ten years after the introduction of the Saskatchewan system, every province in Canada had established a single payer, universal, comprehensive health care plan.

Common Myths about the Canadian System

Adopting a system similar to the Canadian system means challenging powerful groups in U.S. society, specifically the insurance companies and the doctors. Both groups have lobbied politicians and commissioned studies to try and show that a U.S. national health insurance scheme modeled on the Canadian system would not work. They seek to convince Americans that they will get inferior health care coverage and fewer choices with a Canadian-type system.

An old charge which is rapidly declining in its effectiveness but which is still sometimes heard, is that the Canadian system is "socialized medicine." The doctors in Saskatchewan made this charge at the time of its introduction. However, under a system of socialized medicine, doctors are salaried public employees rather than private practitioners. This clearly is not the case with the Canadian system, where 95% of the doctors are private and bill on a fee-for-service basis.

It may be worth noting, however, that from a socialist perspective, this is a problem with the Canadian system. While there is greater cost containment through the provincial health care agency negotiating the fee schedule, doctors in Canada -- as in the U.S. -- are still the gatekeepers in the system. And the fee-for-service system in both countries rewards doctors who perform more procedures and encourages doctors to perform unnecessary services to drive up their income.⁷

Doctors in Canada have fared quite well under the national program. One important difference, though, which has led to considerable cost savings is that while only 75% of U.S. doctors are specialists, in Canada only 50% are specialist and the remainder general practitioners. In both countries specialists charge significantly more than general practitioners and have higher earnings. Nevertheless, in Canada, in the five years preceding the introduction of the national health care system, physicians' incomes averaged 33.94% above the average for other professionals. For the five years following, their incomes surged to 47.02% above other professionals.⁸ Doctors still remain the highest paid professionals in Canada today.

The fear that a national health care program may mean further "big government," administrative "red tape" and bureaucratic interference in the doctor/patient relationship is probably the most legitimate concern over "socialized medicine." Existing government-run health care programs in the U.S., which many people find inhibitingly complex, are hardly appealing models for a national system. One recent study revealed that 1 million medicare enrollees a year find the claim process so complicated or time consuming that they do not seek reimbursement, losing about \$ 100 million in benefits to which they are entitled.⁹

On the charge of "big government," one of the major advantages of the Canadian single-payer system is its administrative efficiency and savings. Less than 3% of the expenditures in the Canadian system go to administrative costs. In the U.S., administrative costs consume over 15% of health care costs.¹⁰ The "free market" in health care in the U.S. with over 1,500 insurance providers with different fee schedules, wide variations in eligibility, co-payments, and deductibles, is an expensive and wasteful administrative maze, especially when compared to the simple, efficient Canadian system. Also, recent cost containment measures in American health care programs such as "managed care," "preferred provider organizations" and "health maintenance organizations," have increasingly encroached upon patients' choices, of doctors, treatment and services. Ironically, there is more choice in the Canadian publicly-run system, where patients may go to the physician of their choice and the physician need not worry about the patient's ability to pay for treatment.

But what about quality of care? In Canada, we are warned, there is a lack of new technology and long waiting lists for care. Yet according to a recent report by the General Accounting Office of Congress on Canada's health insurance, "patients with immediate or life-threatening needs rarely wait for services, but waiting lists for elective surgery and diagnostic procedures may be several months long."¹¹ Every country, including even the U.S., rations health care to some degree. The real issue is on what basis should this be done: ability to pay, or severity of need? Most Canadians who are sick or injured are cared for in a timely manner. Overall, rates of hospital use per capita are considerably higher in Canada than in the U.S.¹² There are waiting lists for a few specialized operations in major Canadian cities. This is similar to the U.S., where some surgeons have long waiting lists for "elective" operations.

While Canada has a full range of high technology facilities, they are not as abundant as in the U.S. Access to expensive, high-technology medical equipment, such as magnetic resonance imaging and lithotripters (which generate shock waves to crush kidney stones) is more limited in Canada. This is because the provincial governments seek to control rising health costs by allocating the use of technology among hospitals in any given region. In the U.S., such decisions about the purchase of new technology are made by individual hospitals seeking a competitive advantage in the marketplace. This often leads to a proliferation of high-cost technology which is, arguably, unnecessary.¹³

Measuring the overall quality of a service is somewhat difficult. One rather crude method used is to look at long term indicators, such as death from heart disease, life expectancy, and infant mortality. Here again, Canada fares better than the U.S. Infant mortality deaths per 1,000 live births is 10.4 in the U.S., compared to 7.9 in Canada. Deaths from heart disease per 100,000 is 434 in the U.S. compared to 348 in Canada. Overall life expectancy in years is 75.3 in the U.S. and 77.1 in

Canada.¹⁴

A System under Attack?

While the Canadian health care system may stack up well in comparison to the U.S., it is not without problems. First, it is fundamentally illness-care, rather than a system which promotes good health and wellness. Unfortunately, equality in access to health care does not assure equality in health. This should not be construed as an argument about the futility of health care reform. Rather, it is simply a reminder of the limitations of any health care program. In Canada today, as in the U.S., the single most important determinant of health is standard of living. The wealthiest fifth of Canadians live 4.5 years longer than the poorest fifth and avoid disability eleven years longer.¹⁵

Second, while global budgets for hospitals can be an effective overall cost containment tool, it can and has lead to shortages. Shortages and waiting lists are not widespread, but with increasing financial pressure on the health care system they are becoming more frequent. Fee-for-service remuneration of doctors has not been effective at controlling cost when there are no limits on the services that doctors can provide. From 1972 to 1984, for example, Canadian provinces cut fees by 18% in real terms, but doctors' total billing claims rose by 17%.¹⁶

Third, there are small but growing differences among provinces over what services should be included within the term "comprehensive." For example, although all provincial plans pay for psychotherapy, only Saskatchewan, Newfoundland, Ontario and the Yukon cover treatment by a classical Freudian psychoanalyst. Eight provinces cover sterilization by means of a vasectomy or tubal ligation, while only four cover the reverse process for patients who later change their minds.¹⁷

Finally, while the Canadian system has been much more successful than the U.S. at cost containment, it is nevertheless still experiencing tremendous cost pressures. The federal government has undermined the financial base of the system by phasing out its share in the provincial program. This is no accident. The Conservative federal government of Brian Mulroney dares not directly attack this cherished social program. As a recent national survey found, Canadians ranked health care "first out of 15 items that made Canada superior to the United States."¹⁸ But, a careful undermining of the system through dismantling the financing and extolling the virtues of market discipline may eventually take its toll.

Canadians constantly look to the U.S. as a reference point to measure the quality of their society. Most recognize that under the increasing integration and harmonization of our economies in the wake of the Canada/U.S. Free Trade Agreement, Canadian social programs, which are significantly out of step with U.S. programs, will be threatened. For this reason, Canadians also have a stake in the U.S. health care debate.

What we can learn from the Canadian system?

The single most important component of the Canadian system is its universality. Canadian progressives have attempted to build universality into all social programs because politically it is a

unifying strategy. In the U.S., social programs tend to be targeted to specific groups and end up causing resentment among working people who feel that they must pay for these programs but cannot receive any benefits from them. This explains at least part of the "tax revolt" phenomenon in the U.S. Also, the target group receiving the benefit is usually relatively powerless and not able to mount a campaign to maintain the quality of the service they are receiving.

Universal programs are better able to assure quality for all by extending the service to socially powerful groupings. The poor and disadvantaged are included in the system with no social stigma of "special programs" attached to their rightful entitlement. Working people pay for the service with their taxes, but they also garner the benefits personally and directly. Canadians are adamantly opposed to a two-tier system, with a private system paralleling the public one, because it would allow the wealthy and powerful to buy superior care and reduce the pressure to maintain quality for all. Universality is a useful political strategy that builds social solidarity.

There has been much debate in the U.S. as to whether the states or the federal government should take the lead in initiating health care reform. The Canadian experience shows that while ultimately a national system is needed, a single state could lead the way with an exemplary model. In Canada, the CCF/NDP model in Saskatchewan set out the principles for the national system.

The Canadian experience also shows how quickly things can move once things get started. In less than 10 years after the introduction of the Saskatchewan system, Canada had a national health care program. One suspects that Americans will be equally as anxious to universally adopt a comprehensive system once one state takes the initiative.

This does not mean that attempts at a national system should be abandoned. Rather, pressure for a quality, universal, comprehensive, single payer system must be placed at both the national as well as the state level. If success comes first at the state level, then that model could be used to demand comparable systems everywhere.

Ultimately, health care reform is about building a political constituency which demands quality health care as a right. Having a model of what we want, even if no one state has introduced such a system, is important. In the current discussion about health care reform, too much attention has been paid to trying to figure out "what Congress will go for." Surely past practice shows that Congress will go for the lowest possible common denominator that it thinks it can get away with. Politically, this means we need to build a campaign -- not around a minimal care package but around what we know ordinary Americans want. If enough pressure can be built demanding such a system, congress will come around. If Canadians started with what they believed the Tory federal government would accept, the campaign would have been lost before it started.

Models such as the Canadian model of national health care are useful because they show us concretely that change is possible, and that there are alternatives to the current system which few and fewer Americans can afford. They remind us that we need not be victims of "the way things are" but, in fact, can develop a system of health care for all. The conservative agenda in the U.S. is aimed at lowering expectations, convincing us that change is not possible and demonstrating that there is no

role for government in providing social services. What is exciting about the current debate on health care reform is that on this essential social service, millions of Americans are prepared to challenge the rule of the market and health care for profit. They are rejecting conservative arguments and coming to the conclusion that health care is a right, a privilege available only to those who can afford it.

It is highly unlikely that a national health care system in the U.S. would precisely replicate the Canadian system. Ideally, an American national health care system would take advantage of the Canadian experience but also incorporate some of the existing positive features of the U.S. health care system. Such features could include, the rationalization of administration and services through health-maintenance organizations, the use of nurse practitioners, and an extensive network of community-based clinics.

While the Canadian model is valuable as a working example of a system of health care for all, it must be examined in its political context. The history of the campaign for a universal health care program in Canada can provide some useful lessons for Americans on the politics of how to achieve such a massive social reform.

ENDNOTES

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3. Milton Terris, "Lessons from Canada's Health Program," *Technology Review*, February/March 1990, p. 27.
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