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The Top Ten Things People Believe About Canadian Health Care, But Shouldn't

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Of the many ways that are available to tackle the question of what we all need to learn from Canada's 30-year love affair with the government monopoly, single-payer health care system that we in Canada call " Medicare," I think the model of that great health care analyst and public policy guru, David Letterman, serves our purposes best. I am therefore going to entitle my talk today, "The Top Ten Things People Believe About Canadian Health Care, But Shouldn't."

Number One: Canada Has the Best Health Care System in the World

Not even close. According to the World Health Organization, Canada ranks 30th in the world, with the U.S. ranking 38th.[1] The ranking criteria were: bang for the buck, preventive measures, and access for vulnerable populations

Thus, while Canada and the U.S. are both only middling performers, we both have a great deal to learn from other places that manage to combine costs that are no higher than Canada's (and frequently are lower) and population health outcomes (e.g. longevity, infant mortality, etc.), that are as good or better.

Let me offer a comparison that will shake some of the complacent assumptions that many Americans seem to have about the equity and effectiveness of the Canadian health care system. Let's talk about infant mortality for African-American babies vs. Canadian babies. Infant mortality risk is a function of birth weight, with the risk of death rising as birth weight falls. Now, over the full range of low birth weights (i.e.,

Talking Points

- There exist many indefensible myths about the Canadian single-payer health care system.
- Among these myths are: that Canada has the best health care system in the world; that the Canadian public loves its Medicare system; that Canadian Medicare is sustainable; and that the single-payer, Canadian-style coverage keeps costs under control.
- Additionally, it is untrue that more cash is the solution to Canadian Medicare's problems; that "free" health care empowers the poor; no one gets better care than anyone else; or that Canadian Medicare-type spending is the best way to improve health.

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any birth weight below 2500 grams), African-American babies fare better than Canadian babies, except at the very top end of the range, where they are essentially equal. In short, among low birth-weight babies, you are better to be born to an African-American family than you are to be born to the average Canadian family.

Number Two: The Canadian Public Loves Medicare

We have to be careful here. The public loves some features of the system. In particular, there is huge support for the principle that no one should be denied access to needed medical care on the basis of ability to pay. Ideologues in the health care system have tried to stretch the public's support for that basic principle in all kinds of distorted directions.

For example, there is a view afoot in health policy circles that because Canadians support this basic principle, they support a health care monopoly on the current model; that Canadians disapprove of private, for-profit business in the health care sector; that only the state should deliver health care services, etc. In fact, the recent report of the Royal Commission on the Future of Health Care[2] took as its starting point a picture it painted of Canadians' values, arguing that those values supported the status quo—only more so (i.e., an expansion of the system into home care and pharmacare and a major injection of taxpayer dollars).

But Canadians have actually shown themselves to be a deeply practical and non-ideological people. Commissioner Roy J. Romanow has made the case that the debate over the future of Medicare is all about Canadians' values. But the way that Canadians express those values, unfiltered by the work of the Commission, is much different from what Mr. Romanow implies Canadians want.

According to a recent poll entitled *The National Pulse on Health Strategy*, 80 percent of Canadians want major reforms to the health care system:

> Two-thirds of Canadians (66 per cent) tend to be supportive, more or less, of a host of new models of financing in order to reduce stress on the system – for example, where everyone (except those with low incomes) pays a small amount for health care services out of their own pocket. They also tend to support strategies such as using nurses or other health practitioners rather than physicians to provide certain services. Just under half (45 per cent) tend to be supportive of market-oriented reforms—greater efficiency, accountability and customer service, including private sector companies delivering health care services.[3]

The National Post reported that the same poll found that fewer than half of respondents would support increasing taxes to pay for health reforms. But notably, only 10 percent of Canadians would accept a health care system that excluded those who could not afford to pay for services

These results need not be seen as a contradiction. As Jane Armstrong, Senior Vice President of Environics Research Group, says, "Canadians, ever-constant champions of fair play and equity, are devoted to maintaining a system that ensures access to quality health care for all. . . .They're willing to make changes, even if this includes new and varied ways of financing the system as well as a greater dependence on market forces such as private companies delivering certain health services."[4]

1. The report of the WHO was released in June 2000. See Associated Press, "U.S. Spends Most on Health; France No. 1 in Treatment," June 20, 2000, at *lists.isb.sdnpk.org/pipermail/health-list/2000-June/000010.html* (August 11, 2004).
2. This Royal Commission was a group appointed by the Canadian federal government to conduct a major inquiry into the future of Canada's health care system. It was chaired by former Saskatchewan Premier Roy Romanow, and released its report at the end of November 2002. Throughout this talk, when I refer to the Romanow Report, it is to this document that I am referring. See Commission on the Future of Health Care in Canada, "Building on Values: The Future of Health Care in Canada," Powerpoint presentation, March 28, 2003, at *www.uregina.ca/admin/marchildon/lectures/march282003.ppt* (August 11, 2004).
3. Environics Research Group, "New Survey: Canadians Want Health System to Change," Press release, October 17, 2002, at *erg.environics.net/news/default.asp?aID=501*(August 11, 2004).

Another recent poll, by Decima Research,[5] found that more than half (55 percent) of Canadians were opposed to paying higher personal income taxes—even if these funds were designated to pay for health care. An even larger majority of respondents (67 percent) also believed that they would have to rely on their own personal savings to pay for their use of health services in the future.

These public opinion polls appear to indicate that Canadians want a system of health care that provides high-quality medical services and is financially sustainable over the long term at an acceptable economic price, without excluding poorer people from access to medically necessary services. And in a typically pragmatic way, Canadians are not worried whether it is the private sector or the public sector that achieves this—they just want results. In fact, when Canadians do express a preference for either private or public approaches to health reform, the majority are willing to fund their future medical needs themselves rather than pay higher taxes to expand the Medicare model of health care.

That is why, in the context of the Romanow Report, I like to say that not since the days of Edgar Bergen and Charlie McCarthy has ventriloquism enjoyed such vogue. But at least Edgar and Charlie were good at it, and it was purely for entertainment.

The stakes riding on today's high profile ventriloquism act are far higher—the future of Canada's $100-billion public health care system. What does ventriloquism have to do with Roy Romanow's Royal Commission report on Medicare? Everything.

From the very first Mr. Romanow made it clear that the foundation on which all of his work would be built would be the values of Canadians. That is powerful: Not many politicians want to be seen as ignoring Canadians' deeply held views on a topic as important as health care. Thus, the title of Mr. Romanow's report, "Building on Values."

He invoked the values of Canadians up front in an attempt to make his recommendations invulnerable to criticism and caviling by politicians and interest groups. But for this gambit to succeed, the methods the commissioner used for arriving at a picture of Canadians' values on health care must be beyond reproach. Yet his methods were flawed and unprofessional. The report is a thinly disguised attempt to make Mr. Romanow's own values—and those of his narrow little coterie of experts and bureaucrats—pass for the values of Canadians generally. Canadians are the dummy, and Mr. Romanow is the ventriloquist.

If this analogy seems extreme, consider what Mr. Romanow and his colleagues did. They organized focus groups across the country to find out what people were thinking about where they would like to see health care go in Canada.

What they heard from these focus groups was pretty much what Canadians have been telling pollsters for the last several years and that I have sketched out for you here. Canadians are a down-to-earth, non-ideological, practical people. They are interested in what works and they are interested in real solutions to the growing evidence of the accelerating decline of the health care system.

So, in response to questions from the commission's people, they indicated that they were open to a wide range of options that needed to be tried if they might improve things. They were open minded about things like user fees, allowing more private sector involvement in health care provision, and allowing people to buy health care in circumstances in which they are not permitted to do so today.

But that did not square with the views of Mr. Romanow and his merry band. So they marched their focus groups into a room, and presented them with "expert opinion" to show these poor benighted citizens why the things they were willing to try were bad ideas that wouldn't work, that would harm people's health, and be hard on

4. *Ibid.*
5. See Decima Research Group, "Decima Express National Telephone Survey," conducted October 2002, at *www.investorsgroup.com/english/about_us/news_releases/PDFs/Decima_results_Oct2002_Eng.pdf* (August 11, 2004).

the poor. They presented these views as established facts, rather than the highly contested arguments of an elite group of health policy makers, an elite whose ideas have been responsible for bringing our health system into its current state of disrepair.

Unsurprisingly, on being presented with what seemed to be an objective and authoritative debunking of ideas that had seemed practical and worthy of trying, the members of Mr. Romanow's focus groups timidly gave in to the views of the "experts." But the irony is that there is a lot of evidence in the academic and policy literature that the practical, common sense things that Canadians were prepared to look at actually do make a difference for the better. The only real flaw with these ideas is that they did not fit the inflexible and narrow ideology of Mr. Romanow's colleagues.

Now anyone in the university polling world can tell you how to avoid such charges of bias in determining what people think about emotional topics like health care. For instance, a reputable arm's-length polling expert would never have allowed people from Mr. Romanow's own commission to be closely involved in the testing of public opinion. The risk of influencing people to say what the client wants to hear are too great. But the commissioner's own people did work directly with the focus group organizers. And those organizers were themselves not members of an objective polling group, but representatives of a public policy group closely tied to the people guiding the work of the commission and identified with their views. This "research" would never have passed muster in a rigorous review by the best university experts.

So by using a flawed process riddled with conflicts of interest and unprofessional methods, Roy Romanow was able to make it look like Canadians were ruling out of court any experimentation with the health care status quo he and his advisors favor. But for someone who made such grand claims about basing his recommendations on hard evidence, the core of the commissioner's report is nothing more than his own prejudices transformed by the ventriloquist's art into Canadians' most cherished values. Good thing we are not the dummies he thinks we are.

Number Three: Canadian Medicare Is Sustainable

On the contrary, Medicare is not sustainable on its present course. A modest slowdown in the rate-spending increases has been bought chiefly through reductions in services, closure of facilities, fewer health professionals, dissatisfaction among those who remain, increased waiting times, and forgoing innovative (but expensive) new technologies.

Medicare *as we know it* can only be "sustainable" if Canadians are willing to accept less service or more taxes. Polls, as I have already mentioned, indicate that neither is acceptable. And given increasing consumer expectations for expensive health technologies, drugs and procedures, and the expected health demands from an aging population, Medicare's problems are only going to grow. In fact, a paper[6] by Bill Robson, the Vice President at the C.D. Howe Institute, a very prestigious think tank in Toronto, has argued that the unfunded liability of Medicare (i.e., promises to pay for services for which normal increases in the take from the existing tax load will not cover) is in the $500-billion to $1.2-trillion range. Canada's entire national debt, by comparison, is currently about $530 billion.

Yet Roy Romanow has already publicly rejected these arguments and has recommended not only retaining, but even expanding, the centrally planned, government monopoly model of health care in Canada. Those recommendations are now being acted upon by Ottawa and the provinces.

Virtually every other major inquiry into health care, including the Kirby Report (by a committee of the Senate of Canada), the Mazankowski Report (by the Alberta Premier's Advisory Council on Health, of which I was a member) and the Fyke Report for

6. Bill Robson, "Will the Baby Boomers Bust the Health Budget?: Demographic Change and Health Care Financing Reform," C.D. Howe Institute *Commentary* No. 148, (February 2001) at *www.cdhowe.org* (August 11, 2004).

the Government of Saskatchewan (where Mr. Romanow was premier), identifies sustainability of the health care system as the challenge we face. Mr. Romanow's own former Minister of Finance in Saskatchewan underlined this when she appeared to testify before his commission.

But Mr. Romanow denies there is a problem. We are spending the same share of gross domestic product (GDP) today on public health care as 30 years ago. If a little more than 7 percent of GDP was sustainable in 1972, why is that same percentage unsustainable today?

It is the wrong question. It is not how much we are spending, but how we are paying for it and what we are getting in return. For years we borrowed and spent on health care (and other services), so we got more than we were willing to pay for. Today, as the only G7 country consistently in budgetary surplus, we pay the full cost of today's services, plus the interest on money we borrowed for health care and other things in the past. So while the spending has remained constant as a share of GDP, the tax burden has grown and quality has declined.

The irresistible force of demand for "free" services is running headlong into the immovable object of unavoidably limited health budgets. To date, the pressure has been relieved by crumbling health infrastructure, loss of access to the latest medical innovations, declining numbers of medical professionals, and lengthening queues. By and large, people have access to ordinary, relatively low-cost services like general practitioner office visits, but find it increasingly difficult to get vital services such as sophisticated diagnostics, or many types of surgery and cancer care, where the waits can be measured in months, if not years.

This is the exact reverse of what the rational person would want. We should use the public sector to pool everyone's risk of expensive interventions, ensuring that they are available when needed, but leaving ordinary interventions (whose cost can easily be borne by the average person) to individuals, supplemented by private insurance and subsidies for those on low incomes. Hardly anyone can afford cancer care, bypass surgery, gene therapy, or a serious chronic illness on their own. These are the things that, without insurance, destroy people's finances.

But as much as 30 percent of the services consumed under Medicare are unnecessary, not medically beneficial or even harmful. No one would be financially ruined by having to pay for an ordinary doctor's office visit if we ensured that people on low incomes were subsidized and there was a reasonable maximum anyone would be called on to pay. No one would be harmed by an incentive not to go to the emergency room when a visit to the family clinic would do just as well. The biggest health care study in the world, the RAND experiment, found that people who had to pay something towards the cost of their care consumed less of it, but that their health was, with very slight qualifications,[7] every bit as good as those who got totally free care.

The extra infusion of taxes Mr. Romanow recommends will merely put off the day when we realize that we must concentrate scarce public health care dollars where they will do the most good, and give users of the system incentives to be prudent about how they spend them. We spend vast sums on procedures of little or no value, while we place patients whose conditions endanger their lives in lengthening queues.

Number Four: Single-payer, Canadian-style Keeps Costs Under Control

A mythology has grown up about the superiority of our system to control costs. Indeed, Mr. Romanow in his report repeats the argument that, until the introduction of Canadian Medicare, our health care costs tracked those of the U.S. After the introduction of Medicare, however, our growth in costs, and especially physician costs, dropped significantly after the predictable short-term rise. In a

7. The qualifications are that for a small number of chronic conditions, such as hypertension and vision care, poor patients in these conditions underspent on care. Part of the advantage of the RAND experiment is in helping us to identify areas, such as these, in which poor patients' health can be improved by targeted subsidies.

paper on the health care numbers for my Institute by health care economist Brian Ferguson, we examined these numbers more carefully, and a wholly different picture emerged for us.[8]

We see the spike in expenditure associated with the introduction of Medicare, and the drop off in expenditure growth as the adjustment to universal coverage works itself through. But by the late 1970s, the two countries' expenditure growth series are back in sync. In fact, they are more closely aligned in that period than they are in any previous period. They diverge again only in the mid- to late-1980s, when, arguably, Canadian governments became really serious about controlling spending.

While we can identify transitional effects surrounding the introduction of Medicare, it is not possible to identify a lasting effect of the introduction of Medicare on expenditure on physician services. Basically, the introduction of Medicare had no effect on the rate of growth of expenditure, and the reason the Canadian GDP share figure fell below the U.S. figure was not because of differences in the rate of growth of expenditure *but rather because Canada happened to have the good fortune to bring Medicare in during a period in which the Canadian economy outdid the U.S. economy in terms of real growth*.

Had our economic growth been as weak as U.S. growth was through the 1970s and 1980s, and had our health spending nonetheless remained unchanged, for two decades our share of GDP devoted to health care would have been higher than the actual U.S. GDP share. Canada, in other words, would have had the most expensive health care system in the world, a situation that would have changed only in the 1990s.

Why, given Canada's apparent success at controlling health care costs through the 1970s and 1980s—at least as judged by the GDP share evidence—were recent efforts at cost control not handled with less disruption?

The answer now seems to be not that we were poor performers this time around, but rather that our earlier "success" at cost control was illusory. Simply put, the introduction of Medicare did not introduce a period of, or efficient mechanism for, health care cost control. When it came to the question of how much of our national income we were spending on health, we were not particularly good; we were just lucky.

Number Five: More Cash Is the Solution to Medicare's Problems

I might point out that Canada in 2002 spent about $75 billion on publicly funded health care (and another $30 billion or so on private health care). Mr. Romanow's solution to our problems is a cash infusion of up to $6.5 billion per year, a recommendation that now has largely been accepted by Ottawa and the provinces in a recent First Ministers Conference. But the federal–provincial deputy ministers of health, in their last report, made a convincing case that health care costs are rising within the system at 5 percent to 6 percent a year, just under the current cost pressures, and that there are a number of new pressures that are likely to accelerate that trend. So you do the math. Add an annual tax-financed contribution of $6.5 billion to a health care budget of $75 billion rising at 5 percent per year, and within two years the ordinary and totally foreseeable costs of the existing system will have eaten up every penny of that new funding.

Indeed, the health care system in Canada staggers from crisis to crisis in which new funding is promised by the federal government. But the federal government put something like $20 billion into Medicare just before the 1997 federal election, and, as Mr. Romanow himself remarked in his press conference on the release of his report, everybody wants to know what we got for that money. The queues have lengthened, not shortened, the shortage of diagnostic equipment has got worse, and people are less able to find a family physician than they were five years ago. In fact, we have had a lot of experience in Canada with new injections of cash into the system, supposedly to

8. Brian S. Ferguson, "Expenditure on Medical Care in Canada: Looking at the Numbers," Atlantic Institute for Market Studies, 2002, at *www.aims.ca* (August 11, 2004). Brian Lee Crowley, Brian Ferguson, David Zitner and Brett Skinner, "Definitely Not the Romanow Report," Atlantic Institute for Market Studies, 2002, at *www.aims.ca* (August 11, 2004).

"buy change." Normally, what happens is that the powerful organized interests within the system (doctors, nurses, support staff, etc.) organize to capture a share of that money. Costs rise, but productivity does not and services are no better or more timely. The Canadian Medicare system is a black hole into which we can pour seemingly infinite amounts of money.

Ironically, in two days of talks with the provincial premiers in September 2004, Prime Minister Paul Martin squandered a decade's effort to put Canada's public finances in order in an effort to buy peace with the provinces on the health care financing front. You would think that he would at least exact a big price for this sacrifice. After all, he more than any other single individual can properly claim the credit for having defeated the deficit and put Ottawa on the path of surplus budgets and fiscal redemption. The strategy was risky, but Martin courageously won over public opinion and became the best finance minister in a generation.

Now, under heavy fire from the premiers, who had designs on Ottawa's hard-won surpluses to finance their out-of-control health spending, Paul Martin did exactly what his predecessors did to land Canada in its earlier fiscal mess. He is trying to spend his way to popularity. Tens of billions of dollars are to go to the provinces over the next few years, allegedly for health care, but with no real control over where the money goes.

The sad irony in all this is that when he moved to shore up Ottawa's finances, Paul Martin took aim squarely at transfers to the provinces for health care. In this he was continuing a struggle the feds had been engaged in with the provinces for several decades over health spending.

In the early days of Medicare, Ottawa gave the provinces the famous "50 cent dollars." For every dollar the provinces spent on health, Ottawa kicked in fifty cents. It was an open-ended federal commitment, so the provinces had every incentive to spend on health and less on many other things. After all, if you spent on health, Ottawa picked up half the tab, which was an almost irresistible lure, and caused many a province to sacrifice what it considered higher priorities on the altar of federal cash.

In the late 1970s Ottawa tried to introduce a little more discipline. Out went the 50 cent dollars. In came Established Program Financing. The provinces got block-funding with relatively few strings attached, plus some extra taxing room.

This put a cap on Ottawa's cash commitment and made the premiers angry because they had the responsibility of actually delivering health care programs, and none of them wanted to take the political heat for cutting the expansion of health care spending. Thus began the long march upward of the share of provincial spending going on health care. Thirty years ago, most provinces were spending about 30 percent of their program spending on health. By some time in the next decade, every province is expected to be spending over half of its program spending on hospitals, docs, and drugs.

But the redefinition of Ottawa's role in health care financing was not over. As the deficit problem really bit, Ottawa realized that transfers to the provinces had to be cut back again. This time, it was Paul Martin who wielded the knife. The new federal plan, called the Canada Health and Social Transfer, removed the last minor strings on federal transfers to the provinces for social programs (chiefly health, but also welfare and education) but cut the total amount transferred.

The change was a painful one, but one that helped to restore Ottawa to fiscal health. The provinces claim, of course, that this was done at their expense, but this claim is highly exaggerated. At the same time the provinces were pleading poverty, they were also cutting taxes and failing to discipline health spending. In any case, no matter what Roy Romanow says, the health care system's problem is not a lack of cash (we've never spent more on health than we do today). On the contrary, it is poor management and a lack of accountability.

Moreover, powerful producer groups rule the health care system. If you doubt this, just watch the wave of health care worker strikes that the latest infusion of cash is guaranteed to unleash as docs, nurses, administrators, and others jockey to capture their share of the new funding. It has happened over and over again: In the absence of real reform, and particularly of demanding standards

of accountability and real hard performance measures, new cash simply disappears into the system without a trace. And at the rate health spending rises, the premiers will soon be back rallying round their standard battle cry: "It's not enough."

In order to shore up his weak political position in a minority parliament, Paul Martin has largely sacrificed the fiscal maneuvering room he himself won for Ottawa in the early nineties. Yet he got no commitments for reform from the premiers, and only token nods in the direction of greater accountability for results. The Prime Minister has largely destroyed his chief legacy as finance minister and got nothing to show for it other than a year or two of peace on the health front.

A final note on this matter of whether more money will save Medicare: The Canadian Medicare system was created in the 1960s as a new layer on an existing, relatively well-funded health care system. Since then we have paid most of the day-to-day operating costs, but we have been coasting on the capital within the system and not renewing it.

The average hospital in Ontario, our wealthiest province, is 50 years old. David MacKinnon (the former head of the Ontario Hospitals Association) and I calculate that the total working capital deficit of Canada's hospitals today is roughly $4 billion. On top of that, the cost of simply the ordinary capital expenditures for the Canadian hospital system is about $2 billion per year for the next five years.

So, simply eliminating the working capital deficit in our hospitals (because working capital represents capacity for change) and paying for the ordinary capital costs in the hospital sector alone over the next five years would wipe out all the extra funding Mr. Romanow was proposing for the system as a whole. And don't forget that he not merely proposed throwing cash at the existing system. He also talked about larding it with new responsibilities whose costs are virtually guaranteed to be higher than what has been forecast — and Ottawa is preparing to act on some of those recommendations, such as its proposed universal catastrophic drug coverage and home care. Even if you think that money is the solution, what Mr. Romanow is proposing, and that Ottawa and the provinces now seem largely to have accepted, is barely enough to take the incipient crisis in Canadian health care off the boiling point for two to three years at best.

Number Six: Under Medicare, People Get the Health Care Services That They Need

A whole host of things needs to be said here, and I do not have time for them all. Let me start by saying that while the language of Medicare is that Canadians get "medically necessary services" paid for by the state, this is not at all so. Among the services that are not covered are pharmaceuticals (increasingly important, as many forms of surgery, etc. are now being supplanted by drugs regulating the body's functions), dentistry, home care, chiropractic (in most provinces), and a number of other services. And there is a wide range of new diagnostic and other services that it is not yet clear that Medicare will cover, such as gene therapy. In fact, one of the "brilliant" research papers for the Romanow Commission argued that, in fact, technology need not be a cost driver for the health care system because it was only a cost driver if we actually used these technologies.

Let's talk about a few other aspects of whether we get the care that we need in Canada.

Queuing

Queuing is a controversial measurement, not least because there may be many explanations for the queuing, many of them medically justifiable, so that aggregate queuing figures may conflate those whose waiting poses no health or other risk with those whose health may be impaired or may suffer pain while waiting.

That being said, in a system in which health services are free at the point of consumption, queuing is the most common form of rationing scarce medical resources. And since patient satisfaction plays no part in determining incomes or other economic rewards for health care providers and administrators in the public system, patients' time is treated as if it has no value. There are no penalties in the system for making people wait.

It is thus not surprising that the measures of queuing now available, including the Fraser Institute's annual report card, "Waiting Your Turn,"[9] indicate a lengthening of queues for a great many medical services, including access to some specialists, diagnostic testing, and surgery. What is surprising is that those administering the system must rely on external studies, not having implemented modern information systems to monitor waiting periods and identify those who have had an excessive wait.

I would also like to point out that while we talk a lot about queuing in the Canadian health care system, and we talk as if we know how many people are waiting and how long they wait, in fact we do not know this at all. Ironically for the largest single program expenditure of governments in Canada, we know astonishingly little about what we get for our money. As my colleague David Zitner, Director of Medical Informatics at Dalhousie University in Halifax and Health Policy Fellow at my Institute, likes to say, no health care institution in Canada can tell you how many people got better, how many people got worse, and how many people's condition was left unchanged by their contact with their institution. None of them can give you an answer. No one knows how many people died while waiting for needed surgery. No one knows how many people are queuing for any particular procedure or how many people cannot find a family doctor. Mostly we have guesswork, anecdote, and subjective measures, not objective ones (such as the Fraser Institute reports mentioned earlier). We do not even know how long someone has to wait before he or she has waited "too long," because the health care system does not establish official standards for timely care—although presumably even Mr. Romanow would agree that someone who died while waiting for care may have waited a tad too long.

All of this is due, as I argued in a major paper I co-authored in 2002,[10] to the conflict of interest at the heart of Medicare, in which the people who are the ultimate providers of health care services in Canada are also the people charged with regulating the system and quality assurance. Since no one is a competent judge of his or her own performance, and no one likes to be held accountable for his or her work, the result is that the health care system simply does not set tough standards or collect the information that would allow us to hold the system's administrators accountable for their stewardship of our health care and the billions of dollars that they spend. The people who would collect the information are also the people whose performance would be assessed if useful information were made available. There appears to be no legal obligation on governments actually to supply the services they have promised to the population as their monopoly supplier of health insurance. This is an appalling double standard, as no responsible regulator would permit a private supplier of insurance to behave in this way, as a recent background paper for my Institute makes clear.[11]

Access to Doctors and Medical Technology

Aggregate numbers of doctors per 1000 population do not give a good picture of access to physicians in, say, cities versus rural areas within countries, nor of proportions between scarce specialists and plentiful general practitioners, nor of the quality of medical training. On the other hand, it is a crude measure of the overall state of access to qualified practitioners.

On this measure, Canada performs badly. In 1996, this country had 2.1 practicing physicians per 1000 population, while of the comparison group only two (Japan and the UK) had a lower ratio: Australia (2.5), France (3.0), Germany (3.4), Japan (1.8), Sweden (3.1), Switzerland (3.2), UK (1.7) and

9. Michael Walker and Martin Zelder, "Waiting Your Turn: Hospital Waiting Lists in Canada," Fraser Institute, *Critical Issues Bulletin*, 2002.
10. Brian Lee Crowley and David Zitner, "Public Health, State Secret," Atlantic Institute for Market Studies, 2002, at *www.aims.ca* (August 11, 2004).
11. David Zitner, "Canadian Health Insurance: An Unregulated Monopoly," Atlantic Institute for Market Studies, 2002.

U.S. (2.6). Thus, even in countries with lower per capita spending than Canada, there is greater access to physician services.

With respect to medical technology, Canada's performance is also unimpressive. In a study[12] comparing Canadians' access to four specific medical technologies (computed tomography [CT] scanners, radiation equipment, lithotriptors, and magnetic resonance imagers [MRI]), with access by citizens of other Organization for Economic Co-operation and Development (OECD) countries, Canadians' access was significantly poorer in three of the four. Despite spending a full 1.6 percent of GDP more on health care than the OECD average, Canadians were well down the league tables in access to CT scanners (21st of 28), lithotriptors (19th out of 22), and MRIs (19th out of 27). Moreover, access to several of these technologies worsened relative to access in other countries over the last decade.

Number Seven: "Free" Health Care Empowers the Poor

Everything I want to say about this is summed up in a story that happened to my partner Shelley. Shelley and I are partners in a restaurant, and she actually runs it. She was given an appointment at the hospital for a procedure, and she duly showed up at the appointed time. Two hours later she was still sitting there waiting to be called. Now she was only able to get a two-hour parking meter, and so she approached the desk and asked if she could go and put money in the meter. She was curtly told that she was free to go and put the money in, but that if her name were called while she was away, that her name would fall back to the bottom of the queue. So she just decided that she would take the parking ticket as part of the price of getting the medical service she needed. Another two hours passed, and still she was not called, so she again approached the counter, and very patiently and politely explained (as only Shelley can, because she is the soul of graciousness) that she actually had a small business to run; that she was there at the appointed time for her appointment; that she had waited four hours, which is far longer than she had been led to expect the whole thing would take; that she had other commitments because of the business; and could they possibly at least give her some idea of how much longer she might have to wait?

Well, the woman behind the counter got on her dignity, drew herself up to her full height, glared at Shelley and said, "You're talking as if you're some kind of customer!"

There you have it, ladies and gentlemen, the essence of the problem: When the government supplies you with "free" health care, you are not a powerful customer who must be satisfied. They are doing you a favor and you owe the state gratitude and servility in return for this awesome generosity. They can give you the worst service in the world, but because it is free, you are totally disempowered. One of the most important lessons I have learned from my contact with the Canadian Medicare system is that *payment makes you powerful*. And its absence makes you risible if not invisible.

Now the articulate and the middle class do not let little things like that get them down. Even though they do not pay, they still get in the faces of the people providing service and make their wishes known. But often the vulnerable, the poor, the ill-educated, and the inarticulate are the ones who suffer the most because no one's well-being within the health care system depends on patients/consumers being well looked after. And by depriving them of the power of payment within the health care system, Medicare disempowers them. And the poor see this, because while they may be poor, they are not stupid.

In a Compass poll for *The National Post*, fully 41 percent of Canadians were of the view that individuals should be able to choose private health insurance for Medicare if they so chose—allowing them to obtain better, or at least faster care than at present. Interestingly, for a society preoccupied with the inequities implied in "two-tier health care," more of those earning less than $25,000 per

12. David Harriman, William McArthur and Martin Zelder, "The Availability of Medical Technology in Canada: An International Comparative Study," Fraser Institute *Public Policy Sources* No. 28 (1999).

year (47 percent) were interested in this option than those earning over $75,000 per year (39 percent). Those most satisfied with their health care were not the least educated, but the best educated—those with postgraduate degrees.

These findings are consistent with my view that Canada's system does, in fact, create multi-tiered health care where health care services are distributed on the basis of middle-class networks and ability to communicate one's needs aggressively to professional caregivers. It is the poor, the vulnerable (including, most obviously, the sick) and the inarticulate who receive the worst care, because they cannot circumvent the system the way the middle class and its advocates can.

Number Eight: Canadian Medicare Is Fairer Because No One Gets Better Care Than Anyone Else

Roy Romanow has made it clear that he wants to ensure that "two-tier" health care continues to be forbidden in Canada and this was a major theme of the 2004 federal election. Too late. If you are on worker's compensation; are in the Royal Canadian Mounted Police or the military; if your company has its own salaried physicians; if you use a private hospital like Shouldice (which specializes in hernia surgery) in Toronto or one of the country's private abortion clinics; if you are a member of the medical professions or know someone who is; or are just articulate and determined or famous and connected; if you travel to the U.S. or any one of a number of other places, you can get better, faster, or more satisfactory care than someone who just lets the wheels of Medicare grind on.

Moreover, technology is allowing the remote delivery of ever more health services, so the ability of governments to frustrate patients' desire to get better and faster treatment is declining, and that decline will accelerate. The debate, therefore, is really about how many tiers and under what conditions they will exist. And many of these tiers are beyond government control.

Virtually any kind of pharmaceutical product can now be purchased over the Internet from foreign providers who can evade our government's controls. You can even get involved in online auctions for the drugs you want. Your x-rays or MRI scans can be read just as easily by a radiologist in Boston or Bombay as in Toronto or Truro.

More powerfully, the brain repair team at Dalhousie University recently operated on a patient in Saint John, New Brunswick. The surgeons never left Halifax. Using video cameras and computer controls, they operated robotic arms that actually did the surgery hundreds of kilometers away. When you can go to a surgical booth in Canada and be operated on by the best surgeon in the world, who may be at his office in London or Houston or Minneapolis, the notion of a closed national health system in which people must take what public authorities decide they should have simply cannot survive.

"Multiple tiers" is a slippery concept. For some, if some people can get a service by paying for it, while others who cannot pay do not get access, that constitutes multiple tiers. On the other hand, there are people who oppose tiers because of an ideology of egalitarianism. Thus, two people with similar conditions may both get treated, one more quickly through private payment, the other more slowly (but within appropriate norms for their condition) by Medicare.

We are not talking about people being denied care based on ability to pay, because anyone willing to wait will eventually get care (although we possess no figures on how many die while queuing for public health care). The complaint is rather that someone got care more quickly. That is a very different objection: No one should be able to get faster treatment than in the public system, even where such faster access does not affect the quality or timeliness of the care obtained by people who continue to use the public system.

This peculiar brand of egalitarianism suggests that people should not be denied service because of their own inability to pay, but should be denied access because of their neighbor's inability or unwillingness to pay (through taxes) for the care an individual decides he or she needs.

Canada is almost alone in the Western world in outlawing people paying privately for services that are also publicly insured. One consequence of this is that there are many services, such as drugs or

home care, that we cannot afford to cover publicly, whereas they are often publicly insured elsewhere.

Thus, by forbidding people who wish to do so the ability to pay, we satisfy our ideological craving for egalitarianism, but at the cost of an inability to make room in the public budget for a wider range of services that low-income people might truly need.

Now this might be a defensible trade off if our system were superior to others—and indeed we frequently hear it said that we have the best health care system in the world. But neither the World Health Organization (in its ranking of world health systems) nor the citizens of Canada, nor the poor and the elderly in Canada (based on polling data), agree.

In sum, many of Mr. Romanow's concerns, and those of the Canadian health care establishment whose views he now repeats, are ideological and have little to do with the quality of care delivered within the public system. He clings to a system that outlaws private spending on publicly insured services in the mistaken belief that parallel systems rob the public system of resources, while both objective and subjective international rankings show that multiple tiers of access are fully compatible with high quality public systems, high levels of care overall, high levels of patient satisfaction, and public health outcomes as good (or better than) Canada's.

Number Nine: Medicare-type Spending Is the Best Way to Improve Health

Again, a lot of people seem to believe this, but it just is not so. In fact, there are many forms of spending that are far more likely to improve health outcomes than health care spending. Consider, for example, that there is a very close link between health and wealth. The wealthier you are, the more likely your health is to be good. This implies that spending that is likely to improve the wealth-creating capacity of society is also an investment in health. That means things like education, economic infrastructure, and a reasonable tax burden are all key determinants of health. So too are public health measures like sanitation, water quality, environmental protection, and preventive measures such as pap smears, etc.

The irony is that as the health care budget expands in Canada, it is crowding out many of these other forms of public spending. For example, the provinces, who have responsibility in Canada for the delivery of most services (such as health care; primary, secondary and post-secondary education; roads; environmental protection; water provision, etc.) have seen health rise from around 30 percent of provincial program spending to nearly 50 percent. In all provinces it is expected to exceed 50 percent within a decade. And Canada's tax burden is about 8 to 10 percentage points of GDP higher than in the U.S., so that our tax burden is uncompetitive with you, our major market and major competitor, while the health care budget is cannibalizing scarce public dollars that could be going toward things much more likely to produce superior population health outcomes. But the politics of health spending are powerful and have proven nearly irresistible to date.

Number Ten: Medicare Is an Economic Competitive Advantage for Business

In the United States, in the ordinary course of things, as the price of health care increases, so, too, do insurance premiums since, ultimately, all insurance payments come from the pool of premiums collected from the insured. Since people usually obtain this type of insurance through their place of employment, it is often thought that the rising cost of insurance constitutes an increased cost to employers. This view is especially widespread with regard to health insurance in the United States, where it is often said that health insurance premiums make up a larger part of the cost of building a car than steel does. Canadian politicians are prone to argue that since, under Medicare, Canadian companies do not have to bear this extra cost, they have a competitive advantage in world markets. As with so many statements concerning Medicare, this, too, is wrong.[13]

Economic theory predicts, and empirical evidence confirms, that the full cost of the insurance

13. Crowley *et al.*, "Definitely Not the Romanow Report."

premiums is passed back to workers in the form of lower take-home pay. Canadian workers pay the costs of Medicare through income taxes; U.S. workers pay the cost of their health coverage through the pass-back of premiums. Even the part nominally paid by the employer actually comes out of the pool of funds available for paying labor, and therefore comes out of the workers' pockets, in that case before it even reaches them.[14]

Conclusion

So, in conclusion, let me just summarize again the top ten things many people believe about Canadian Medicare, but shouldn't:

- Number One: Canada has the best health care system in the world.
- Number Two: The Canadian public love Medicare.
- Number Three: Canadian Medicare is sustainable.
- Number Four: Single-payer, Canadian-style coverage, keeps costs under control.
- Number Five: More cash is the solution to Medicare's problems.
- Number Six: Under Medicare, people get the health care services that they need.
- Number Seven: "Free" health care empowers the poor.
- Number Eight: Canadian Medicare is fairer because no one gets better care than anyone else
- Number Nine: Medicare-type spending is the best way to improve health.
- Number Ten: Medicare is an economic competitive advantage for business.

Now, like most Canadians, I believe that our system is superior in many respects to the U.S. system, but it is a system that staggers under the burden of serious design flaws. Far from sharing Mr. Romanow's complacency, I am deeply worried about the long-term sustainability of our health care system, and I think that we have much to learn from countries that ranked much higher than either Canada or the U.S. in the World Health Organization rankings.

These countries demonstrate that many of the fears that Canadians have about significant reform to Medicare (to introduce payment for health care, to allow people to pay directly for health care outside the government monopoly, and even breaking up the provision monopoly to allow competition and a greater role for the private sector) are all reforms that can be carried out within a public policy framework that continues to be preoccupied by equity considerations. That gives Canadians better value for the tens of billions of dollars they so patiently and lovingly devote to public health care spending in a repeated triumph of hope over experience.

—Brian Lee Crowley is the President of the Atlantic Institute of Market Studies located in Halifax, Nova Scotia, Canada. Mr. Crowley kindly updated his remarks for this publication.

14. *Ibid.*