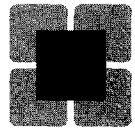

The Canadian health care system: Is our present your future?

Address to the Certificate Ceremony for Graduating Residents and Fellows, 1990
The Cleveland Clinic Educational Foundation

ALTHOUGH NO country can or should adopt another system that has evolved differently, Canadian and US health care systems share some similar successes and problems. We may benefit by taking some of the same paths.

The traditions and origins of both countries derive from our roots as European colonies. English is our common language. We share the longest undefended border in the world. We are each other's biggest trading partners and have recognized this by a free-trade agreement. We have many of the same religious and cultural institutions. We enjoy and share the same sports and entertainment celebrities. Our education programs and medical schools are so similar that in many disciplines and professions there is reciprocity of credentials. New York and Toronto, Dallas and Calgary, and San Francisco and Vancouver have more in common than any of those cities and London, Paris, or Hong Kong. But there are important differences that explain why it is unlikely that the United States will adopt Canada's health care system. Your independence was born of revolution, ours by evolution. Your values are rooted in the clearly articulated principles of your Declaration of Independence.

Your representative democracy divides its powers between the President, the legislature, and the judiciary. Our representative democracy is parliamentary. Parliament is supreme, but is accountable to the people.

You pride yourselves on individualism, self-reliance, and the entrepreneurial spirit. We are more collective, with a vast array of not only medical but also social and educational programs.

The preamble of your constitution reflects your highest values: "life, liberty, and the pursuit of happiness"; ours, "peace, order, and good government." Canadians not only trust government more than you, they look to government for many of their needs.

Yours is the richest country in the world. It has some of the most internationally respected and honored medical centers and medical research establishments. Indeed, the Cleveland Clinic is one of those. Americans have won more Nobel Prizes in medicine than any other country. Yet a recent Harris survey of the United States, Canada, and Great Britain found that 89% of Americans were dissatisfied with their health care system, and that 61% would prefer a system like Canada's. This finding was a surprise to many, because few Americans understand very much about the Canadian system other than that it reportedly covers all health needs of all citizens, and costs less.

WHY THE DISSATISFACTION?

The rise in US health care costs continues to accelerate. Between 1979 and 1989, costs increased more than 75% *after* adjustment for inflation. Projections are that costs will be $661 billion, or 11.8% of the GNP, in 1990, and $1.5 trillion, or 15% of the GNP, by the year 2000. Business is reluctant to increase or extend medical insurance for employees and families, arguing that the cost of these plans makes American products noncompetitive in world markets.

When George Bush was sworn in as President, health care ranked 16th or 17th on the list of priorities of his

presidency. Health care now ranks third, and some believe that health care may be a major factor in the next presidential campaign. During the past 7 years the portion of health expenditures borne by business has decreased from 29.3% to 27.9% and by the federal government from 17% to 16.2%; however, neither is prepared to pay more until each is convinced that the money being spent, particularly for physician-directed services, is for "medically necessary" services.

The greatest portion of the cost is borne by individuals, and this portion is increasing. Individuals paid 37% of health care costs in 1982 and 41.5% by 1989. Stu Altman of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Massachusetts, puts it cogently: "The American people are frightened. They are concerned that they will no longer be able to afford the health care they need—never mind want."[1]

Physicians themselves are increasingly concerned. In the last 5 years, a variety of Medicare Act amendments have increased the intervention in physician reimbursement and created agencies and policies that restrict activities of physicians or demand accountability as never before.

It is therefore *not* unreasonable and *not* surprising that Americans should be looking to other systems to see if others' experience might be relevant and if something can be learned.

HOW THE CANADIAN SYSTEM DEVELOPED

Canada and the United States came away from World War II with the same unstructured health care delivery systems. The health care theme that evolved in the Canadian social conscience (which was strongly supported by Canadian physicians) was that there should be reasonable access to quality health care for all Canadians, independent of personal financial means. Federal-provincial negotiations led to the Hospital Insurance and Diagnostic Services Act of 1957. By 1959 a universal and government-operated hospital insurance system was in place.

The federal government restricted its involvement to providing funds on a 50/50 cost-sharing basis with the provinces and established eligibility standards for those funds. Delivery of health care remained within provincial jurisdiction. Private insurance was available to supplement basic hospital costs and pay some or most physician fees.

Publicly administered insurance for physician services began in the 1960s. Alarmed that government was intruding on the right of doctors to negotiate mutually agreeable contracts with patients for their services, the doctors of Saskatchewan went on strike in 1962. It was a bitter dispute. At that time, there was strong public support for the concerns of physicians, who enjoyed great popularity both individually and collectively as a profession. The legislation was modified, and a plan of conjoint public and private insurance was worked out.

In 1964, as a consequence of the first doctors' strike, a Royal Commission chaired by Chief Justice Emmett Hall was formed. The premise of his report was that "Medicare must be operated on a cooperative basis by government, hospitals, doctors, and other health care providers for the benefit of the Canadian public." His recommendation for publicly funded insurance for *all* hospital and physician services led to the Medical Care Act of 1966. Its principles were: (1) public administration, (2) universality, (3) comprehensiveness, (4) portability, and (5) accessibility.

Public administration

The Canadian health care system is government-controlled, nonprofit, and supported by personal, corporate, gasoline, some property and sin (tobacco and alcohol) taxes, and government-administered insurance. The cost of public administration is 0.1% of the health care bill in Canada, compared to 0.6% in the United States. It has been estimated that the administrative efficiencies of a Canadian-like system in the United States would save $50 billion in non-health care costs annually.

With one payor, collection is easy for hospitals and physicians. It is at least one element of Canadian Medicare that is appreciated by physicians. Payment is guaranteed and is realized with minimal paperwork.

Universality

Everyone who is a Canadian resident is covered for first and last dollar for all insured services, which include all doctor fees and necessary hospital services.

Comprehensiveness

The program covers all medically necessary services, including hospital and diagnostic services. In both our countries, the meaning of "medically necessary" is debated more and more. Those who pay for services (governments, industry, insurers, and individuals) are challenging institutions and physicians about the indications and appropriateness of diagnostic tests and treatment and their outcomes and prices. *Fortune* mag-

azine states the opinion that "half of what the medical profession does is of unverified effectiveness."

Do we perform too many cesarean sections? Coronary bypass operations? Why the variation in rates and prices? To be recognized as part of the solution to these and other questions, rather than the cause of real or perceived problems, we physicians must learn the language of "quality assurance," "impact analysis," and "utilization management." We must take the lead to establish realistic priorities in health care, always keeping in mind our privileged position as advocates for our patients and for quality care.

Portability

All citizens are covered for medical services wherever they might be. For example, should I become ill here today, the province of Ontario would reimburse all usual and customary charges if I were not sufficiently well to return to Ontario for my care. This coverage applies to emergency care, or care not available in the province of residence.

Accessibility

All citizens are guaranteed reasonable access to necessary medical services. In my country as well as yours, debate about the meaning of "reasonable" accessibility is increasingly intense. In your entrepreneurial, pluralistic society, the explosion of technology and services may not be utilized effectively. Your former Secretary of Health, Joseph Califano, says that there is now so much accessibility in your system that perhaps too much—even as much as one quarter too much—is being done. Yet some 37 million Americans are uninsured and another 50 million are inadequately insured.

While many CT scanners and MRI units in the United States are *not* used to capacity, in the controlled, government-funded system of Canada, introduction of new technology has often lagged behind real needs for better and ultimately more cost- and quality-effective diagnostic and treatment services.

For those of us in academic centers, there has been increasing concern about research funding. I share with a growing number of Canadian health care leaders the concern that there is an accelerating erosion of our centers of excellence.

While there have been instances of "rationing by queue," all Canadians have enjoyed relatively good access to services when needed, and Parliament does eventually respond to public pressure. The issue is not open-ended accessibility, but getting the right patient to the right service at the right time. When I was at your stage, in the 1960s, the question was, "Can we do it?" In 1990, we can. The question is, "Should we? Can society afford it?"

What evolved in Canada over the past 30 years is a complex and ever-changing system mandated and partially funded by our federal government but administered and delivered through ten provincial and two territorial jurisdictions. It has been and still is a comparatively good system. Most Canadian citizens, politicians, and, until recently, health providers—including physicians—have been happy with the capacity and the quality of our health care system. Indeed, universal access to health care has come to be regarded by Canadian residents as a fundamental right.

HEALTH CARE IN TODAY'S ECONOMY

In the past, when the Canadian government talked about "free health care," it meant no charges at the time of service. However, any such system is expensive. Provinces are now spending 24% to 34% of their total budgets on health care alone, exclusive of social services, education, industry, transportation, and environmental programs—all of which affect health status.

Much has been said in both the United States and Canada about the statistic that Canada has contained its health care spending at 8.6% of the GNP for the past 3 years, while the United States spends an ever greater proportion of its GNP. But the economy of Canada has outperformed that of the United States, and the economy of Ontario has outperformed that of Canada, the United States, West Germany, and even Japan during the past decade. So while it is true that per capita annual spending is greater in the United States ($2,200) than in Canada ($1,800), and that the proportion paid for physician services is also greater (22% US, 18% Canada), the differences become minimal when economic performance is taken into account.

Differences in national policy also affect medical economics in the two countries: Canada spends far less on defense, relying on your willingness to defend "fortress North America." The United States spends 20 cents of every federal tax dollar to service the national debt; Canada spends 37 cents.

Accordingly, the Canadian government has diminished its share of health funding from 50% to 33%, and has frozen its share for the next 3 years, thereby raising the cost to individual provinces or territories, some of which do *not* have robust economies. Even in a rich province like Ontario, 14 cents of each tax dollar services the provincial debt.

How physicians have fared

What has happened to physicians during the evolution of Medicare in Canada? By the end of the 1960s, private insurance for hospital and physician services had been eliminated. Doctors were still free to negotiate fees with their patients, who were responsible for paying the balance between the fee negotiated with the physician and that paid by government insurance. Hospitals were free to charge user fees to supplement revenues from government rates.

In 1970, Quebec imposed exclusive public rates for both hospitals and physicians, as well as caps on physician income and proration of fees depending upon urban or rural practice settings. When the doctors went on strike, they were legislated back to work. This time, there was little public support for physicians.

In 1984, the federal government, with the support of all political parties but vigorously opposed by all provinces and the national and provincial hospital and medical associations, passed legislation creating penalties in the federal transfer of payments to provinces should they continue to allow hospital user charges or balance billing by physicians—by now labelled pejoratively, *extra* or *over* billing. The original principle—that there should be reasonable access to quality health care for all Canadians independent of financial means—had been expanded to include the more collective principle that all of the costs generated by the few who were ill should be borne by the many who were well.

In 1986, the Ontario government introduced legislation to comply with the federal regulation, even though hospital user charges were minimal and less than 5% of charges for physician services were greater than the government-negotiated tariff. An angry and disillusioned profession again went on strike. The response from the globally funded hospital association was muted. A frightened public supported a popular government. The legislation passed.

Physicians fought openly with each other. The strike ended, but the image of physicians suffered badly. Organized medicine was portrayed as more interested in the bottom line than the health of the public.

GREAT EXPECTATIONS

Forty years ago, in his presidential address to the prestigious American Surgical Society, Dr. Edward Churchill of Harvard stated, "In times of change there is a need for wisdom both in external social order and within professions. Spokesmen who loudly proclaim measures based on self-interest will not be tolerated." Another famous Churchill, whose first name was Winston, once observed, "If we quarrel about the past and the present, the future is lost." These statements are perhaps more true today than when they were first made.

Without doubt, the biggest issue facing medicine in both our countries in the next decade is to maintain quality of care while being conscious of and working to control costs. Last year, Dr. John O'Brien-Bell, reflecting the views of the Canadian Medical Association, a voluntary professional association representing 85% of the 49,000 doctors of Canada, stated in a Presidential address: "Our health care system can no longer afford the almost continual, cyclical confrontation between provincial governments and the medical profession since Medicare was introduced. Governments, physicians, and other health care providers must find a way to break the cycle—to develop a way to cooperatively manage the system in an effective and cost-efficient way."

In Canada, the relationship between government and the medical profession is slowly changing. Increasingly, physician leaders are invited to the decision-making tables as equal partners with recognized medical expertise. The frustrations are many, but the future of the health care of our patients and the integrity of our profession is at stake. I am encouraged and optimistic.

HUGH E. SCULLY, MD, FRCS(C), FACS, FACC
Senior Surgeon and Chairman, Medical Education
Toronto General Hospital (Canada)
Chairman, Council on Health Policy and Economics
Canadian Medical Association

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