

Canadian Health Care System

Speaking Notes

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History

- Before 1971 medical care similar.
- Hospital care same before 1961.
- GDP shares similar.
- Experiment underway for 20-30 years.

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- GDP shares were originally the same; gap has widened dramatically

	1971	1981	1988	1991
Canada	7.4	7.7	8.5	9.0
US	7.6	9.2	11.2	12.0

Hospital and Insurance and Diagnostic Act of 1957 - triggered public insurance plans for hospital services, cost-shared 50-50 between federal and provincial governments.

Medical Care Act of 1966, expanded to doctors, with all regions in by 1972. Costs shared 50-50.

Canada Health Act of 1984 (penalties to eliminate extra billing)

Principles

1. Universality
2. Accessibility
3. Comprehensiveness - all health services provided by doctors & hospitals
4. Portability - anywhere in Canada, prior permission for elective surgery
5. Public administration

Similarities

- **Free to choose among physicians**
- **Physicians paid on a fee-for-service basis**
- **Most hospitals are private, non-profit**
- **Modern medical practices**
- **Mistakes still happen**

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Differences

Canada

- **Universal coverage**
- **Single payer**
- **No change in coverage when status changes**
- **Central health system planning in each province**
- **Governments responsible, politically and financially, for health system**

United States

- **Multi-tier system**
- **Multi-payer, including individuals**
- **Coverage may be tied to job**
- **No health system planning**
- **No one responsible for system**

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Funding

- Provincial General Revenues
- Federal transfers to provinces under EPF
- Some "fund-raising", but small
- Private insurance restricted to private room, drugs, dental, eyeglasses

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Allocation of spending on health

provincial -	23.9 billion	44.2%	27.1	44%
fed tax trfr	6.6	12.2	14.9	24%
fed cash	8.2	15.1	"	
municipal	0.6	1.1	0.75	1.2%
private	14.8	27.4	17	27.5%
total	54.1			

WCB			0.4	0.7
Federal Direct			1.6	2.6

By Type of Expenditure

Hospitals	38%	Other Institutions	11%
Doctors	15%	Dentists, et al	7%
Drugs	13%		
Capital spending		4%	
Other	12%	(public health, eyeglasses, private admin	

Economic Dimensions

- **Using general revenue reduces unit labour costs, although some provinces use a payroll tax.**
- **With universal access, not linked to employment, labour mobility is enhanced.**
- **Saving 3% of GDP offers other options.**

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Consequences

- **Canada spends 9% of GDP, US - 12%**
- **100% coverage versus 85% In US**
- **On per capita basis:**
 - **Administrative costs = 20% of US levels**
 - **Physician costs = 66%**
 - **Hospitals = 82%**

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- In one survey 12.5% in US not able to receive care (7.5% - financial, 5% - other) compared to 4% in Canada (1% - financial, 3% - other).
- For doctors, malpractice insurance in Canada is about 10% of US rates. This reflects a difference in tort systems, not relative quality or frequency of errors.

US "Advantages"

- **More medical research**
- **Bigger country, larger private endowments**
- **More rapid adoption of new technology**
- **Health Maintenance Organizations (HMO)**
- **Better health information systems**
- **Higher income for physicians**
- **More specialists in US**

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Income in 1987 - Canada - \$82,740, Ontario - \$96,450, and US - \$132,300.

GPs in Canada - 53%, US - 13% and 34% including obgy and pediatricians.

Malpractice insurance - Canada - \$1,470, US - \$15,000.

Information systems - Distinguish between accounting systems and information systems. Increasingly, provincial databases are being used for research purposes - Saskatchewan drug database and Manitoba hospital systems. Less fragmented system helps. Smart card is coming and may help as well.

HMOs in Canada, but little yet to evaluate benefits and costs.

Paul Tsongas (March 92) " If I had been in Canada when I got cancer, I might not be here today. Because the research that was being done, very experimental, was here."

FACTS: Dr. Ernest McCulloch and Dr. Jim Till at princess Margaret Hospital's Ontario Cancer Institute in early 1970s provided key research inputs to bone marrow transplants. The first operation was done in 1986 at Toronto General Hospital, the same year as Tsongas. Tsongas operation was billed at \$75,000.

"Negatives" of Canadian System

- **Less consumer sovereignty**
- **Limited markets**
- **Lack of high-tech instrumentation**
- **More centralized system**
 - **Unionized**
 - **Monopsony**
- **"Americans would rather sue than queue"**

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Some treatments are not available, queues for elective surgery form. Option remains to go to US for surgery, with part of fee paid. Few do. Choice is still part of system, just not as broad as in US.

High-tech. Does it work? More a time lag of about five years? Similar lags within regions in US?

In US, private insurers, employers, lawyers, and govts are peering over doctors' shoulders.

The vulnerability of a centralized system is felt when labour negotiations threaten to close down hospitals. But program is popular, and it is politically dangerous to mess too much with the system. Cost control is much easier with a single payer system.

And I don't understand the standard US retort of preferring to sue rather than queue.

Summary

- **The system works.**
- **Consumer choice is preserved.**
- **The resources required to deliver health care services are less, and their growth is controlled.**
- **A universal system has much appeal, particularly for those now outside the system.**
- **Opposition in US will come from those who collect the rents from the current system.**
- **From an international competitiveness perspective (Canada's view), perhaps you should stick with your own high-cost system.**

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Doctors and hospitals in US collect the rents.

Look at performance measures (HDR, Table 21, 1995):

Infant mortality: Canada - 5 deaths per 100,000 live births

USA - 8 deaths per 100,000 live births

Life expectancy at birth: Canada - 77.4 years, US - 76.0 years

US Effects of PHI

- **Utilization up, particularly for poor**
- **Administrative costs down**
- **GDP share down**
- **Long-term savings if better management of costs**

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Future Trends

- User fees for trivial uses.
- More "healthiness" emphasis.
- Less payment for foreign services.
- Federal-provincial struggle goes on.
- Stronger price regulation on drugs.

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Where is the Canadian Health System Going?

Some user fees to reduce trivial use.

More emphasis on healthiness versus health care in public programs.

Tobacco taxes

participation

Alcohol prices

Mandatory seat belts

Reduced willingness to pay for foreign operations and long-term vacations (e.g., snow birds)

Fed-prov struggle goes on on funding.

Stronger price regulation on drugs.

Other Factors

Income and health status are **positively correlated**. Causation runs from income to health.

Health care and age are positively correlated. This is a challenge for the baby boom generation, or those who must pay for their health care.