

Canada's Broken Health Care System

U.S. should not emulate its northern neighbor



By Pierre Lemieux

In the *New England Journal of Medicine* of August 21, 2003, Steffie Woolhandler et al. wrote, "A large sum might be saved in the United States if administrative costs could be trimmed by implementing a Canadian-style health care system." However, in the same issue, an editorial by Henry J. Aaron criticized the Woolhandler estimates, and pointed to "the virtual impossibility (during normal times in a democracy whose Constitution potentiates the power of dissenting minorities) of radically restructuring the nation's largest industry."

The Canadian public health insurance system is not only universal and "free," but it is also a government monopoly. Privately insuring publicly insured services (which include most medical and hospital care) is illegal, as are out-of-pocket payments to doctors who participate in the public regime. Virtually all hospitals are run by government. Since physicians who choose not to participate in the public health insurance scheme cannot practice in hospitals, where doctors cannot be paid by their patients, nearly all physicians are regimented.

As hinted by Mr. Aaron, there is some doubt that Americans would accept a Canadian-style public health care system.

Because it is a government monopoly, Canadian public health insurance is the worst model of socialized medicine. Among developed countries, it is only in Canada that no private parallel system exists. The main reason why health care costs more in the United States than in Canada is that Americans are not forbidden by law to pay more for more, or better, services.

Total health care consumes 14.6 percent of GDP in the United States, compared to 9.6 percent in Canada. But there is not much difference in the public portion of health care expenditures, which makes up 6.7 percent of GDP in Canada and 6.6 percent in the United States. Public health expenditures in the United States mostly cover Medicare and Medicaid, as well as some of the uninsured. Although the situation of the latter is no

doubt difficult, they rely on county hospitals, the so-called safety net providers.

Dr. Susan W. Walters, a Houston physician, wrote in the April 30, 2004 editions of *The Wall Street Journal* about the Canadian health care system. "[It] resembles the county hospital where I work," she explained. "Our patients pay little or nothing. They wait three months for an elective MRI scan and a couple of months to get into a subspecialty clinic. Our cancer patients fare better than the Canadians, getting radiotherapy within one to three weeks. The difference is that our patients are said to have no insurance (a term used interchangeably with no health care) whereas Canadians have 'universal coverage.'"

Thus, there is a form of public health insurance in the United States, although it is only for the poor and does not bear the name. It consumes about 6.6 percent of GDP to cover roughly a third of Americans. In Canada, 6.7 percent of GDP is used to cover the whole population. Guess which public system suffers the worst shortage of resources.

To public health expenditures, Americans add the equivalent of 8.1 percent of GDP (14.6 percent minus 6.6 percent, neglecting the rounding error) in private (insurance and out-of-pocket) expenditures. Canadians add only 2.9 percent of GDP (9.6 percent minus 6.7 percent), simply because they are forbidden to spend more. In Canada, private expenditures can cover only supplementary insurance and out-of-pocket payments for non-assured services like dental care, or single-bed hospital rooms, etc.

With a universal public system that creates entitlements and encourages overconsumption, and a public monopoly to run the delivery of medical services, the Canadian system combines the inefficiencies of government-run enterprises with the failures of monopoly. The result is not surprising: waiting lines. The Fraser Institute, a free-market think tank in Vancouver, Canada, has calculated that, in 2003, the average waiting time from referral by a general practitioner to actual

treatment was more than four months. Waiting times are high even for critical diseases: the shortest median wait is 6.1 weeks for oncology treatment, excluding radiation which takes longer. Extreme cases include more than a year median wait for neuro-surgery in New Brunswick. The median wait for an MRI in Canada is three months. Since 1993, waiting times have increased by 90 percent. A class action lawsuit has been recently launched against Québec hospitals on behalf of 10,000 breast cancer patients who, since October 1997, have had to wait more than eight weeks for post-surgery radiation therapy.

Quite interestingly, Canadians are not much more satisfied with their health system than Americans. An opinion survey reported in a *Health Affairs* article said that, in 2001, more below-average-income Americans (35 percent) than Canadians in the same income class (23 percent) are deeply dissatisfied with their health system, but note the small difference; and in the above-average-income category, there was no statistically significant difference in dissatisfaction between Canada and the United States. An older (1999-2000) survey showed that 40 percent of all Americans were satisfied compared to 46 percent of all Canadians. But dissatisfaction in Canada has been growing fast recently, and opinion polls now show that a majority of Canadians would like to see a parallel private system.

The American system is far from ideal, but the reason is that it is too socialized and regulated, not because it needs more government intervention. And at least the American system leaves room for free market competition, consumer choice and evolution. Moving toward the Canadian model would be moving in the wrong direction. ☞

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