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# Importing the Canadian Healthcare System

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An analysis of any country's "Senior Care Strategy" must include both a description of the specifics of the healthcare system, as well as the population's social attitudes and economic policies relative to these strategies. Typically, the focus of any healthcare system is on 3 major issues: access, quality, and cost. With this premise in mind, this article outlines both the specifics, such as financing, and the social factors of Canada's elder care system before evaluating the feasibility of its application to the US.

## Oh Canada

In Canada, each of the 10 provinces operates its own healthcare system with financial assistance from the federal government.<sup>1</sup> Passed in 1984, the Canada Health Act outlined 5 basic principles: public administration of provincial health insurance plans; comprehensive insurance coverage of all medically necessary services; universal coverage of the population; portability of insured benefits; and reasonable access to insured hospital and physician services. It is a publicly financed and privately delivered health system.<sup>2</sup>

The recipients of this health system are approximately 29.6 million people.<sup>1</sup> Over 60% of Canadians live in urban areas, and 75% live within 100 miles of the US.<sup>1</sup> The proportion of people older than age 65 is expected to increase from the current 12% to 22% in 2031.<sup>1,3</sup>

Regardless of age, Canadians are afforded universal coverage for conventional hospital and

medical care. This program of medically necessary services is administered by the provincial governments<sup>4</sup> and is funded primarily through taxation (provincial, federal, personal, and corporate). Private insurers may not sell supplemental coverage for publicly insured services.<sup>4</sup> Physicians cannot charge more than allowed by the government's fee schedule, similar to how US physicians cannot charge more than allowed by Medicare. Some health services, including pharmaceuticals, dental care, and vision care, are considered supplementary and are outside of the national health insurance framework.<sup>5</sup> Most provinces provide some public coverage for these supplementary services; however, these services are financed primarily through the private sector.

Both the funding for and organization of community health care are not as comprehensive as that afforded to the basic and universal services of the national health sys-

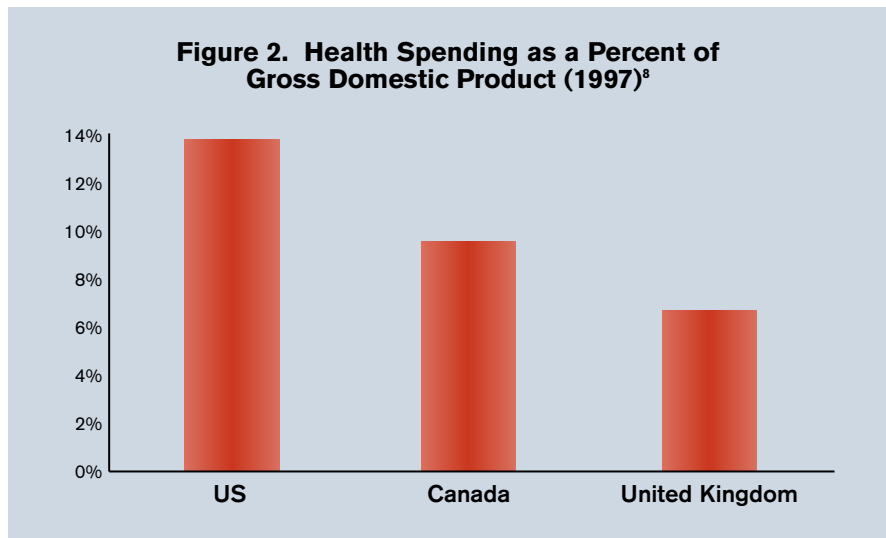
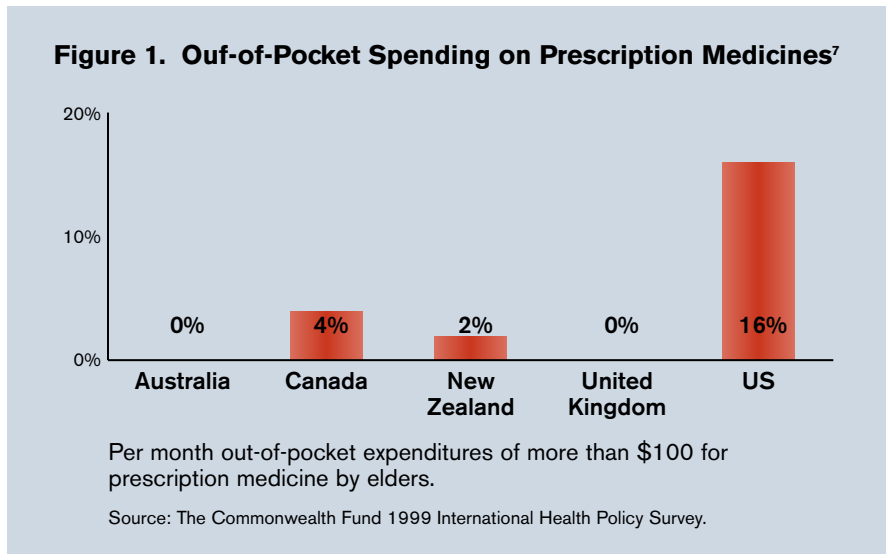
tem and vary between and within provinces.<sup>6</sup> Community care services are comprised of both institutional- and home-based care. Institutional care includes residential care facilities with limited healthcare services to chronic care facilities with extensive medical services. The majority of patients in these facilities are elderly. Institutional medical-based services are funded through the federal and provincial governments. Room and board in these facilities, however, are the responsibility of the individual and are paid out of pocket or through private insurance. Access to these institutions is available either through the healthcare system or by individuals directly. Access to chronic care through the healthcare system is usually obtained after acute care has been provided.

There is an increasing need for elder Canadians, as for older populations in other countries, to obtain community health services outside of institutions. Historically, the responsibility for delivering in-home services to the elderly patients in Canada laid with many agencies, jurisdictions, professionals, and volunteer agencies. Home care services provided by these various organizations include physician visits, nursing care, homemaker services, and adult day care. Currently, most provinces have begun to organize these services around one entry

point, with case management provided for both institutional and in-home community care. One such an example is the Local Centers for Community Services in the province of Quebec. Some provinces, such as British Columbia, also have implemented quick-response teams to redirect elderly patients out of acute institutions and into community home care programs.<sup>2</sup> The 2-fold advantage to these teams is containment of institutional costs and respecting elders' desires for in-home care. In recent years, as the demand for home healthcare services for elders has increased, budgets for these services have doubled, now representing 4.3% of total provincial expenditures.

Seniors account for the largest purchasing segment of prescription drugs of any country's population. Outpatient pharmaceuticals are not included in Canada's national healthcare system. The pharmaceutical sector is funded both privately and publicly, with private expenditures representing 68% of the total costs.<sup>1</sup> Despite the lack of federal legislation and federal cost-sharing, provincial governments have independently developed a variety of public drug plans that generously afford coverage to all seniors. These provincial prescription programs are universal in that they use a formulary system, employ copayments and deductibles, and promote the dispensing of generic drugs. Increasingly, eligibility requirements and user charges are diminishing the universality and generosity of prescription coverage to elder Canadians (Figure 1).<sup>7</sup>

Another salient concept in the Canadian strategy toward elderly



patients is an increased commitment to finding effective ways of improving the health of seniors and, at the same time, containing the demands for services. The creation of the Canadian Institutes of Health Research (CIHR) and its Institute of Aging (IA) are just 2 means by which this nation is bringing research into line with the health priorities of its seniors and ultimately developing better programs, services, and policies for this population (see "Better Access, Better Health Care"). This strategy recognizes that research is the best way to find new solutions for improving the health of elderly patients.

### Importation

Portions of the Canadian system and the underlying philosophy behind its elder care can work well in the US. However, the American political framework precludes the successful implementation of the Canadian strategy here. In Canada, health care for everyone, including seniors, is considered a public social right. In the US, health care is considered an economic enterprise (Figure 2).<sup>8</sup> Because of these different approaches—Canada's belief in the right for every citizen to have health care versus the US's free-market approach—it is presumed that the Canadian system cannot

## Better Access, Better Health Care

Despite spending nearly twice as much per capita on health care as Canadians do, US residents are less healthy than Canadians, experience more problems getting care, and have more unmet health needs according to a study by Harvard Medical School researchers.

The study, published in the July 2006 issue of the *American Journal of Public Health*, analyzes the Joint Canada–US Survey of Health, the first-ever cross-national health survey carried out by the official statistics agency in each country. The authors found that US residents had higher rates of nearly every serious chronic disease examined in the survey including diabetes, arthritis, and chronic lung disease. More US residents had high blood pressure (18% of Americans versus 14% of Canadians), and more reported obesity and a sedentary lifestyle (21% of Americans versus 15% of Canadians). However, Americans were slightly less likely to smoke.<sup>1</sup>

Canadians had better access to most types of medical care (with the single exception of Pap smears). Canadians were 7% more likely to have a regular doctor and 19% less likely to have an unmet health need. American respondents were almost twice as likely to go without needed medicine because of cost (9.9% of Americans couldn't afford medicine versus 5.1% in Canada). After taking into account income, age, sex, race, and immigrant status, Canadians were 33% more likely to have a regular doctor and 27% less likely to have an unmet health need. For each of these measures, the average Canadian did about as well as insured Americans.<sup>1</sup>

Race and income disparities, although present in both countries, were larger in the US. Nonwhites were more likely than whites to have an unmet health need in the US (18.6% versus 11.1%); while in Canada they were not (10.8% versus 10.2%). Notably, both white and nonwhite Canadians had fewer unmet health needs than white Americans. After taking into account income, age, sex, race and immigrant status, poor Americans (making less than \$20,000 per year) were 2.6 times less likely to have a regular doctor than the affluent (those making \$70,000 or more). In Canada, the poor were only 1.7 times less likely.<sup>1</sup>

In the US, cost was the largest barrier to care. More than seven times as many Americans reported going without needed care because of cost as did Canadians (7.0% of Americans versus 0.8% of Canadians). Uninsured Americans were particularly vulnerable; 30.4% reported having an unmet health need because of cost.<sup>1</sup>

Lead author Dr. Karen Lasser, primary care doctor at Cambridge Health Alliance and Instructor of Medicine at Harvard University commented, "Most of what we hear about the Canadian healthcare system is negative; in particular, the long waiting times for medical procedures. But we found that waiting times affect few patients, only 3.5% of Canadians versus 0.7% of people in the US. No one ever talks about the fact that low-income and minority patients fare better in Canada. Based on our findings, if I had to choose between the two systems for my patients, I would choose the Canadian system hands down."<sup>2</sup>

According to Dr. David Himmelstein, Associate Professor of Medicine at Harvard and a study coauthor, "These findings raise serious questions about what we're getting for the \$2.1 trillion we're spending on health care this year. We pay almost twice what Canada does for care, more than \$6000 for every American, yet Canadians are healthier, and live 2 to 3 years longer."<sup>2</sup>

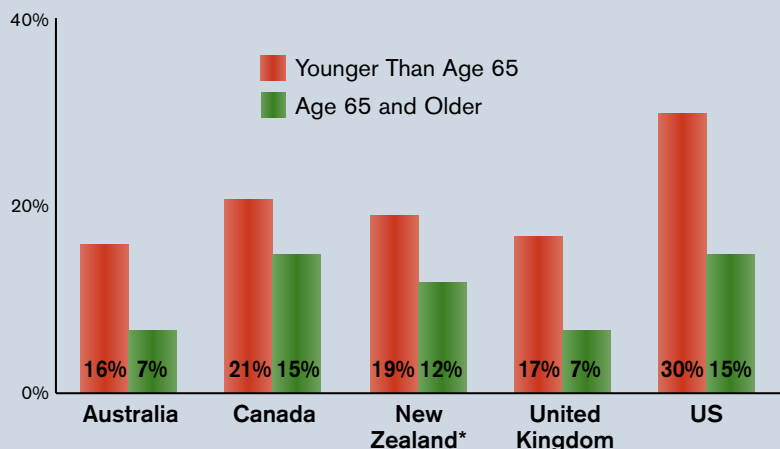
Further comments came from Dr. Steffie Woolhandler, Associate Professor of Medicine at Harvard and study coauthor: "Our study, together with a recent study showing that people in England are far healthier than Americans is a terrible indictment of the US healthcare system. Universal coverage under a national health insurance system is key to improving health. It's striking that both whites and nonwhites do better in Canada. A single-payer national health insurance system would avoid thousands of needless deaths and hundreds of thousands of medical bankruptcies each year. In 1971, Congress almost passed national health insurance. Since then, at least 630,000 Americans have died because they failed to act. How much longer must we wait?"<sup>2</sup>

Study data were from the Joint Canada-US survey of Health (JCUSH), conducted jointly by Statistics Canada (the Canadian counterpart to the US Census Bureau) and the US National Center for Health Statistics. Between November 2002 and March 2003, data were collected from 3505 Canadians and 5183 Americans to gauge health status, illness rates, behavioral risk factors, healthcare use, and access to healthcare services in the two countries.

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**Figure 3. Difficulty Getting Needed Care<sup>7</sup>**

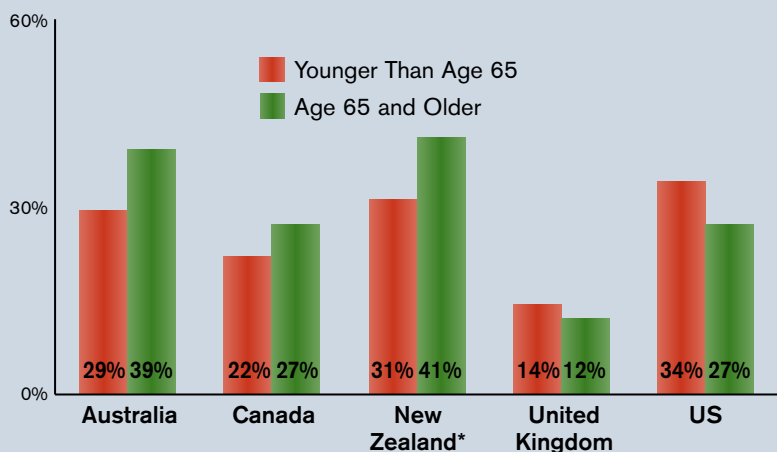


Percent who felt it was "extremely," "very," or "somewhat" difficult to get needed medical care.

\*The age break in New Zealand is "younger than age 70" and "age 70 and older."

Source: The Commonwealth Fund 1999 International Health Policy Survey.

**Figure 4. Views of the Healthcare System<sup>7</sup>**



Percent who think their healthcare system has so much wrong with it that it needs to be completely rebuilt.

\*The age break in New Zealand is "younger than age 70" and "age 70 and older."

Source: The Commonwealth Fund 1999 International Health Policy Survey.

easily be imported into the US.

Canadian citizens and American seniors do have something in common: both groups are enrolled in government health programs called *Medicare*. Canadians are enrolled at birth, and American seniors are enrolled at age 65. Medicare in the US is economically driven, with the concept of cap-

italism at the forefront. Opposition to the Canadian strategy would come from many diverse groups, all of which would consider it to be a socialistic program. In Canada, a universal health system was introduced and defined by strong labor parties, whose members demanded a guaranteed minimum social and economic rights.

In the US, the voices of communities that would most benefit from such programs—poor and elderly patients—are not as loud.<sup>9</sup>

Special interest groups with much influence on decision making would, in my opinion, vehemently oppose the Canadian system. These groups would perceive the Canadian system as more restrictive, less flexible, and more controlled by the government than US Medicare. Opposition would come from the American Medical Association (AMA), whose members would fear a reduction in earnings. The current American private payment system represents high incomes for another influential group: the insurance industry. The American Bar Association is also a powerful force that would want to maintain the current status quo. Canada, with its universal health system, is a much less litigious society. Canadian law limits malpractice awards to basic economic loss, such as future medical expenses and loss of income.

A formidable opponent to the adoption of this strategy in the US also is likely to come from the pharmaceutical industry, which plays a very prominent role in healthcare policy making. As previously mentioned, prescription drugs fall out of the realm of universal basic coverage in Canada. However, in the US, Canada's practices of setting drug prices would meet with much resistance. The US has explicit laws prohibiting Medicare from negotiating drug prices. The Canadian system promotes centralized buying by provincial governments, thereby lowering prices. Canadian laws al-

so impose medical patents less rigorously, and generic drugs are more readily available.

In addition to the previously mentioned groups, it is likely that resistance to the Canadian system of health care for seniors would arise from US private citizens. Most Americans would not tolerate a system that offers more limited access to care than US Medicare. Generally, private health insurance and paying out-of-pocket fees are illegal in Canada. In a single-payer system such as Canada's, the easiest way to control costs is to delay nonemergency services and surgeries (eg, hip replacements) that are prevalent in the older population.<sup>10</sup> The right of US seniors to choose medical care and spend their own money would take precedence over any advantages afforded to elders in a publicly funded system. Americans, and specifically its seniors, born and raised in a more individualized and free market society would not tolerate restrictions on their "freedom of choice."

## Inertia

The age-old adage, "If it's not broken, don't fix it," seems to apply to the resistance to the Canadian system of health care (Figures 3 and 4).<sup>7</sup> An international study published in *Health Affairs* found that Medicare in the US provides quality care for its elders.<sup>7</sup> The study found that Medicare goes a long way toward ensuring access to health care for the older population. "Elder Americans fare surprisingly well compared to elders in other countries," said Karen Davies, President of the Commonwealth Fund.<sup>7</sup> If this is the case,

## PROVIDER ACTION

### Impact to You

With the growing demands being placed on the current US Medicare system by the increasing number of seniors and more sophisticated medical options, the current funding system will not be able to support this surge in expenditures. As a result, some level of change is inevitable, either on the utilization side through rationing, or on the pricing side through price controls. These changes will have a tremendous impact on all Medicare providers and how they need to operate to be successful. Looking to Canada and other countries for ways to control costs is inevitable.

### What You Need to Know

It's one thing to know that change is coming. It's quite another to know what that change is. Perhaps the best of all would be being able to affect that change. At the least, Medicare providers need to know what changes are likely to occur.

### What You Need to Do

Medicare providers need to act by staying "in the know" about the changes that are likely or unlikely to occur, so that they can then prepare their practices for continued success. In the case of the Canadian healthcare system, knowing how successful physicians operate by offering services outside of the system on a fee-for-service basis is a timely example of preparing for change in the US.

and most Americans are in agreement with this belief, then there is no reason to change the American strategy of providing health care to its seniors. Americans do not identify, as do Canadians, with a strategy that embraces the values of mutually sharing. Given that most Americans believe that the current Medicare system provides good quality health care and easy access, it is unlikely that a major change in the system would be accepted just to manage the issue of costs. Instead, more subtle adjustments are likely to occur. **MPM**

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