

Universal Health Care!

Are Canadians Stupid?

by Jack Stewart, January 2000
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IT'S YOUR MONEY!

Public spending for health in Canada consumes 6.9 percent of the economy (GDP). However, public spending for health in the United States consumes only 6.6 percent of the economy. *[1]

Before deciding that the U.S. has done a slightly better job of reining in "big government" than Canada, we should examine what each country gets for its money!

1. **Public health spending** includes costs for a **Public Health Service** in both countries.
2. In the **United States public health spending also pays for health insurance** that primarily covers individual hospital and doctor costs with three government programs; **Medicare, Medicaid, and military health benefits**. These three programs provide health care through public health spending **to about 30% of our population.** *[2]
3. As in the United States; **in Canada, public health spending also pays for health insurance** that primarily covers individual hospital and doctor costs. Canada has only one government health insurance program called **Universal Health Care**. **This program provides health care** through public health spending **to essentially 100% of the population.** *[3]

Before I respond to people who are thinking, "What's the catch?" or "You can't get something for nothing.": I want to deal with the people who didn't even understand what I just said. What I just said was, that, in **Canada** public health programs **provide Universal Health Care** using about 5 percent more economic resources than, public health programs in the **United States** use, to insure about **30 percent of our population!**

I can make a slightly simpler statement. Because Canadian Universal Health Care, unlike Medicare in the United States, has; no deductibles, no coinsurance, and only Alberta and British Columbia charge premiums, the following statement is probably accurate. *[4]

Canada, insures 100% of its population using a smaller percentage of its economic resources, than the United States uses to insure 30% of its population!

WHAT'S THE CATCH?

Some people may think that the catch is that the Canadian Universal Health Care system supplies poor service. I will try to provide some significant information dealing with the quality of the Canadian health care system in this section.

Public Opinion

I have heard that Rush Limbaugh has said that "*Many Canadians prefer our health care system to theirs.*" He apparently thought that Canadians' opinions were worth something. I think that a **Gallup poll**, published in "*The Toronto Star*" on September 13, 1993, can provide a more accurate understanding of Canadian opinion.

- 96% of Canadians prefer their own health care system.
- 2% of Canadians have no opinion.
- 2% of Canadians prefer the U.S. health care system.

While I agree that, since there are 27 million Canadians, even 2% could be considered "many" Canadians, I think the vaster numbers represented by 96% are more significant!

Life Expectancy at Birth

The vital statistic called, "life expectancy at birth," is not a prediction of the future! It is simply the average age of death, for any specific year, after adjusting for age distribution. Adjusting for age distribution simplifies comparisons between different nations, and different years within the same nation. *[5]

Please remember that age distribution is only one of many factors, in addition to health care, that influences life expectancy, such as environment, life style, public safety, and maybe genetics.

Life Expectancy at Birth	United States	Canada
1991	75.50 yrs	77.95 yrs
1995	75.79	78.56
1998	76.13	79.16

These years appear to be representative. If you want more, my source was the internet, **U.S. Bureau of the Census**, "*International Data Base*".

Safety of Surgery and Medical Care

Surgery and medical care may be safer in Canada than in the United States. According to data collected by the Organization for Economic Cooperation and Development (OECD), in 1989 the incidence of abnormal reactions and misadventures during medical care in Canada was just half that of the U.S. *[6]

Infant Mortality Rate

The Infant Mortality Rate (IMR) is just a measure of the number of infants that die within a year of birth. I was able to find comparative data for both Canada and the U.S. prior to the development of the Canadian Universal Health System. Hospital insurance was initiated in most provinces over a period of a few years, and was in place in all provinces by 1961. Medical (Doctors) insurance was started in the early 1970's and in all provinces by the late 1970's.

IMR per 1,000 births	United States	Canada
1950	29.2-	40.7-
1953	27.9-	35.9-
1964	25.2-	26.7-
1983	11.20	08.52
1988	10.00	7.60
1995	7.52	5.92
1998	6.44	5.59

Please remember that for **life expectancy** rates **high numbers are good** and for **infant mortality** rates **low numbers are good**. My source was the Internet, **U.S. Bureau of the Census**, "*International Data Base*". Data for the earlier years come from various "*Statistical Abstracts of the United States*".

Years of Disability Free Life, (Late 70's) both sexes *[7]

United States	average 60 years per person
Canada	average 66 years per person

Diseases of the Circulatory System, including those of the heart. *[8]

Years of Potential Life Lost per 100,000 people (1989)	United States	Canada
Males (under 65)	1250	1020
Females (under 65)	538	320

While the above statistics don't totally prove anything about the quality of the Canadian health care system, I would want to see some strong evidence before I considered it to be of poor quality.

IMPOSSIBLE! YOU CAN'T GET SOMETHING FOR NOTHING!

It's not impossible! I agree that you can't get something for nothing, but human effort can increase efficiency and productivity. Canadians do this by partially substituting democratic planning to replace an unregulated free-market system. Anyone, who has studied the issue, knows that unregulated markets can be very inefficient, and unproductive. The previous section of this article, called "*What's the Catch?*", explored, to some extent, the productivity, defined as the delivery of useful services, of the U.S. and Canadian systems. This section will primarily examine the efficiency of both systems.

Hospital Overhead

First: In the United States, fifteen hundred different insurance companies, along with Medicaid, Medicare, and employer-provided plans, pay hospitals, doctors, and laboratories. This multi-payer structure has spawned a complex accounting system. Each "payer"; that is - an insurance company, or government agency, has its own rules and documentation requirements, and tries to shift costs onto other payers. The result is a stifling administrative burden for American medical professionals and hospitals, and the creation of an army of accountants and administrators to sift through billing paperwork. *[9]

Detailed Medicare records for 6,400 hospitals nationwide, obtained through the Freedom of Information Act, shows that in 1990, 24.8 percent of all hospital spending in the United States went to administration. Canadian hospitals spend little on billing and internal cost tracking, and between 9 and 11 percent of their total budgets on administration, less than half of U.S. spending. *[10]

Physicians' Office Overhead

There are no precise figures for the time and expense, devoted to administration, in physicians' offices. According to one estimate, U.S. doctors averaged spending \$330 (US) per capita on billing and office expenses in 1993, or more than 2.3 times the \$142 (US) spent by Canadian doctors. *[11]

Nearly half of all people employed in U.S. doctors' offices (47 percent) are clerical and secretarial. Much of their time goes to tasks that do not exist in Canada. *[12]

Canadian doctors do not have to keep different kinds of records in their offices for different payers. Nor do they have to send separate bills to individual patients. Like the Canadian hospitals, Canadian doctors get paid for their medically necessary services by a public agency and only have that single agency to deal with for payment. They waste no administrative effort in doctors' offices chasing after patients or their insurance companies for payment. They require no prior approval when ordering or providing specific health care services. No time is wasted discussing with patients the potential costs of treatments and whether they can meet them.

In Canada in 1990 there was one practicing physician for every 448 people. This ratio differed little from that in the United States, where there was a practicing physician for every 432 people. However, the Canadian doctors saw more patients. The average number of physician contacts per person that year was 6.9, compared to 5.5 in the United States. *[13]

Competition vs. Efficiency

The market theory of supply and demand rests on the assumption of readily available choices and information. For the most part, people do not have a choice about when, if, where, or how to get sick or become disabled. After a car accident or a breast cancer diagnosis, few are in a position to shop around, and if they are, seldom have the expertise required to make the appropriate choice.

Although competition is frequently viewed as a way of increasing efficiency, it often leads to unnecessary duplication and inefficiency. Competition encourages investment in expensive, sophisticated technologies designed to attract "customers." A 1990 study has demonstrated that hospital costs are higher in areas with more competition. *[14]

As an example, Boston's Massachusetts General Hospital recently opened a new obstetrical service, despite being within three miles of five well-established maternity programs with surplus beds. *[15]

In 1990, Canada had significantly more hospital beds for their population, (6.7 per 1,000 vs. 5.0 per 1,000) than the United States. Not surprisingly, more Canadians per capita were admitted to hospitals, and they also stayed substantially longer than in the United States. Canadian hospital patients averaged three more days of care. However, the United States still pays more per person on hospital services. This is not only because of the reduced administrative costs of the Canadian system, but because it is the United States, not Canada, that has the most surplus beds! *[16]

Besides having a surplus of three hundred thousand hospital beds, the U.S. also has at least five thousand surplus mammography machines. The excess raises the cost per mammogram since most machines are used only part-time. In facilities that operate at low volumes, quality is often lower, since staff may not perform enough mammograms to maintain their competence. Uncontrolled capital spending not only raises costs, but it can also lower quality. *[17]

Gaming the System

The search for profit also has disadvantages in health care. It leads to waste and to inappropriate care. Profits can be derived both from reducing costs and from increasing sales. It is consequently in the interest of for-profit firms to sell as much expensive care as possible, rather than to focus on providing appropriate services as determined on the basis of health care needs. In *"Health Care in the United States: The Facts and the Choices,"* Stephen Ayers describes the dynamic at work when payments to hospitals are tied to diagnosis related groupings (DRG's), a classification or coding system introduced in an effort to control Medicare costs.

"Certain codes paid top dollar, so every effort was made to squeeze patients into the higher paying diagnoses. Cardiac catheterization, bypass surgery, and angioplasty paid particularly well, and the number of hospitals performing these procedures increased dramatically. However, since trauma care paid poorly and many trauma patients were uninsured, the number of trauma centers in the country decreased sharply." *[18]

In Canadian hospitals however, public administration has resulted in global budgets that significantly reduce the incentives to emphasize the most complicated and expensive types of care. Under global budgeting, each hospital receives, from the province, a fixed amount that they can then allocate on the basis of patients' needs, rather than on the basis of revenue maximization. Of course the waste produced by "gaming the system" activity can also occur in a nonprofit system based on piecework incentives. However, because physicians in Canada are paid a specific wage for their time, there is very little incentive to do so!

There are, of course, other reasons that "pure" market solutions are inefficient and unproductive. In a competitive system preventive health care may not pay off for ten years, and the benefits could accrue to another insurer. Also competition means marketing, and marketing means costs.

Private Insurers

Contrary to conventional wisdom, private insurers spend far more on bureaucracy than do government insurance programs. In 1991, more than 13 percent of every premium dollar went to overhead, such as claims processing, marketing, furnishing insurance company offices, executives' salaries, and of course, perks and profits. In contrast, Medicare spent about 2 percent, and Canada's public insurance system takes less than 1 percent of each premium dollar. *[19]

Are Canadian Stupid?

Well, basing my opinion on that Gallup Poll, published in the Toronto Star in 1993, I would say that: Yes, about 2 percent are stupid, and about 2 percent are, unlike you and me, just uneducated.

NOTE: This article was extensively re-edited by the Author, July 2002.

FURTHER READING

This article was based on only a small amount of original research. The following two books cover the majority of the points made in this article - and more!

"Universal Health Care: What the United States Can Learn From the Canadian Experience," by Pat & Hugh Armstrong, The New Press, New York, 1998

"The Rational Option for a National Health Program,"
by John Canham-Clyne, with Steffie Woolhandler, M.D., and David Himmelstein, M.D.,
The Pamphleteer's Press Inc., Stoney Creek, Connecticut, 1995

Another publication produced in June 1991 by the U.S. General Accounting Office (GAO) titled "*Canadian Health Insurance: Lessons for the United States*" states on page 6,

"[if] the United States were to shift to a system of universal coverage and a single payer, as in Canada, the savings in administration costs would be more than enough to offset the expense of universal coverage."

FOOTNOTES

UHC = "*Universal Health Care:*

What the United States Can Learn From the Canadian Experience,"
by Pat & Hugh Armstrong, The New Press, New York, 1998

RO = "*The Rational Option for a National Health Program,*"

by John Canham-Clyne, with Steffie Woolhandler, M.D., and David Himmelstein, M.D.,
The Pamphleteer's Press Inc., Stony Creek, Connecticut, 1995

*[1] (**OECD**) Organization for Economic Cooperation and Development, "*Health Data 97*",
from **UHC**, p. 104 Table 6.4 Note: The actual data is from 1995.

*[2] **U.S. Census Bureau**, "*Health Insurance Coverage, 1995*" "*Highlights*"
(Washington: U.S. Census Bureau, 1996) from, **UHC** p.105 footnote 8

*[3] **UHC** p.105

*[4] "*Medicare Deductible, Coinsurance and Premium Amounts,*" **The Federal Register** 61:214
(Nov. 1996), pp. 55002-006 from, **UHC** p.26 Table 2.1

*[5] **Life Expectancy at Birth** (for any particular year) is calculated by first, counting the total number of people who die at each year of life, such as under one year of age, and dividing that number by the total population of babies under one year of age. This will give the percentage of individuals that died at that age. As an example, in the U.S., in 1998, 6.44 children out of 1000 died under one year of age. Dividing 6.44 by 1,000 gives, 0.644 percent of children in 1998 dying before one year of age. (See: **Infant Mortality Rate** in the following paragraphs of my article.)

Next do the same calculations for under two years of age, and add that percentage to your previous percent (0.644 in the example). When the total reaches 50 percent that is the (average) **Life Expectancy at Birth**, for that population or nation in that year.

Source: "*Vital Statistics of the United States*", **Department of Health and Human Services**,
(National Center for Health Statistics), pub. 1996, section 6.

*[6] **OECD**, "*OECD Health Systems: Facts and Trends 1960 - 1991*" (Paris: OECD, 1993), table 3.2.13,
from **UHC**, p. 82

*[7] **OECD**, "*OECD Health Systems,*" table 3.1.9 from, **UHC** p. 80 footnote 26

The figures for Canada are from 1978 while those for the United States are from 1980. This is thus likely to underestimate, rather than overestimate, the differences between the two countries in disability free years.

*[8] **OECD**, "*OECD Health Systems,*" table 3.2.4. from, **UHC** p.82 footnote 35

*[9] **RO**, page 44.

*[10] **Woolhandler and Himmelstein**, "*Administrative Costs*" p. 401 from, **RO** p.44 footnote 38

- *[11] **Himmelstein and Woodhandler**, "*National Health Program Book*", from **UHC**, p. 134
- *[12] **RO**, page 45.
- *[13] **UHC**, page 36
- *[14] **Himmelstein and Woodhandler**, "*National Health Program Book*", from **UHC**, p. 126
- *[15] **RO**, page 23
- *[16] Nair, Karim, and Nyers, "*Health Care and Health Status: A Canada-United States Statistical Comparison*" **Health Reports**, 4:2 (1992), p. 176 from, **UHC** p. 35 & 36
- *[17] Brown, Kessler, and Reuter, "*Is the Supply of Mammography Machines Outstripping Need and Demand? An Economic Analysis*," **Annals of Internal Medicine** 113 (1990), 547; **Himmelstein and Woolhandler**, **Chartbook**, p. 59 from, **RO** p. 23 footnote 11
- *[18] Ayers, "*Health Care in the United States*", pp. 17-18 from, **UHC** p. 119 footnote 6
- *[19] **RO**, pages 43-44