



June 2007

## **Issue Brief:**

# **Canada's Single-Payer Health Care Model**

### **Issue**

Over the past several decades, one option that has been proposed to reform the U.S. health system is a single-payer, government-run health care system, similar to the Canadian model. It is therefore important to take a close look at how the Canadian system works to assess whether it is appropriate and desirable in the context of the U.S. Upon review, serious concerns remain about the desirability of such a single-payer approach in the U.S. context.

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### **Overview of Canada's single-payer program.**

**Establishment of system:** Canada's universal health insurance system - known as Medicare - was established incrementally throughout Canada's provinces and territories between 1968 and 1971 and, in 1984 the Canada Health Act (CHA) was passed discouraging user charges/cost sharing and extra billing by providers. The system constitutionally assigns provinces the responsibility for the administration and delivery of core health care services. Provinces meeting federal requirements embodied in the CHA and the federal government's interpretations of the CHA receive some federal funding to administer their public health insurance programs.<sup>1</sup> However, provincial governments are also required to contribute significant financial support to the program<sup>2</sup> providing universal health care coverage to all Canadians.

**How the system works:** Canada's universal health insurance program is a "single-payer" system funded through personal and corporate income taxes, and provincial sales and payroll taxes, and general revenues. Canada provides comprehensive coverage for hospital and physician services on a provincial basis, and CHA provides interprovincial portability. In addition, some provinces and territories provide supplementary health benefits including medical equipment and appliances.<sup>3</sup>

**Existence of private insurance:** Canadian provinces generally outlaw the purchase of privately funded core hospital and physician services. Quebec became an exception to this rule when a June 9, 2005 majority decision by Canada's Supreme Court struck down the province's ban on private health insurance for core services<sup>4</sup> because "waiting lists had become so long they violated patients' "liberty, safety, and security" under the Quebec charter."<sup>5</sup> The ruling was limited to Quebec and did not extend to Canada's federal requirements or the laws of the other Canadian provinces.

There is a private insurance market in Canada. Private health insurance can be purchased for services not covered by the public insurance scheme ("medically necessary" physician and hospital services). Benefits have focused on prescription drug coverage, durable medical equipment, vision and dental care, complementary and alternative medicine, and home and nursing home care.

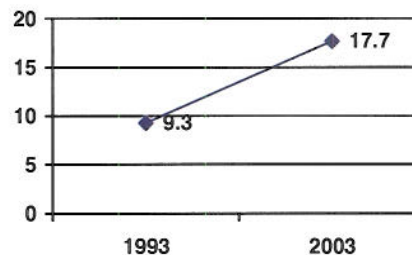
### Consumers have less access to care under single-payer health care systems.

Single-payer health care systems are designed to guarantee that every individual has guaranteed access to health coverage. However, Canada's is having increasing difficulty meeting these requirements.

- Canada's health care system is increasingly becoming a source of national anxiety. A July 2004 public opinion poll found that more than eight in 10 Ontarians are concerned about waiting for diagnostic procedures, specialists, and surgery.<sup>6</sup> In addition, a May 2004 poll found that 87% of Canada's business leaders would support seeking health care outside the government system if they had a pressing medical concern.<sup>7</sup>

- Waiting times continue to increase throughout Canada. The total number of procedures for which people were waiting in 2006 was 770,641 (an estimated 2.39% of the population). From 1993 to 2006 the total wait time from referral by a general practitioner (GP) to treatment increased by 91%, from 9.3 weeks to 17.8 weeks.<sup>8</sup> Between 1993 and 2006, GP referral to specialist consultation wait times increased by 5.1 weeks.<sup>9</sup> Furthermore, the waiting time between specialist consultation and treatment (the second stage of waiting) rose from 5.6 weeks in 1993 to 9.0 weeks in 2003.<sup>10</sup>

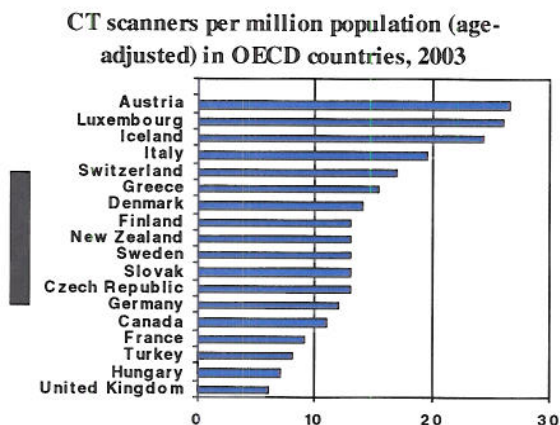
**GP Referrals to Treatment  
Wait Times (in weeks)**



- A recent survey of sicker adults in six countries found that Canadians were more likely to experience waiting times of four months or more for elective surgery and access to specialists than Americans, Australians, New Zealanders, or Germans, but less likely than patients in the U.K.<sup>11</sup>
- The median wait in 2006 for a CT scan across Canada was 4.3 weeks and the median wait for an MRI across Canada was 10.3 weeks.<sup>12</sup> According to an age-adjusted comparison using data from the Organization for Economic Cooperation and Development (OECD), in 2003, Canada ranked 13<sup>th</sup> (of 24), 17<sup>th</sup> (of 21), and 18<sup>th</sup> (of 20) (respectively) among other OECD



countries for the availability of MRIs (5.1 per million people), CT scanners (11.7 per million people), and lithotripters (0.6 per million people).<sup>13</sup>



- In order to save an estimated \$600,000, in December 2001, health care officials in Canada instructed the Queensway-Carleton Hospital in Ottawa to ration delivery of newborns. Health care officials “set the hospital quota at 2,100 newborns, and forced the hospital’s delivery doctors to sign a contract that promised they would not exceed the quota. If they served too many parents, they would lose their jobs.”<sup>14</sup>
- In Canada, 63% of X-ray equipment is out-of-date, as is much diagnostic machinery. For example, a third of the radiological equipment in the city of Victoria is more than two decades old. When a hospital tried to give one of its ultrasound machines to a local veterinarian he declined because he already had better equipment.<sup>15</sup>
- In 2003, 50% of Canada’s hospital administrators said the average waiting time for a 65-year-old man who requires a routine hip replacement was more than six months; in contrast, not one American hospital administrator reported waiting periods that long.<sup>16</sup>

- Government provision of care in Canada has not meant equal care for all. According to a Commonwealth Fund study, Canadians with below-average incomes were more likely not to visit a doctor as a result of cost concerns, and were more likely to have difficulty seeing a specialist.<sup>17</sup> The study also showed that Canadians with below-average incomes were 9% less likely than those with above-average incomes to rate care as excellent or very good, and 6% more likely to rate care as fair or poor in a survey of citizens in five countries.

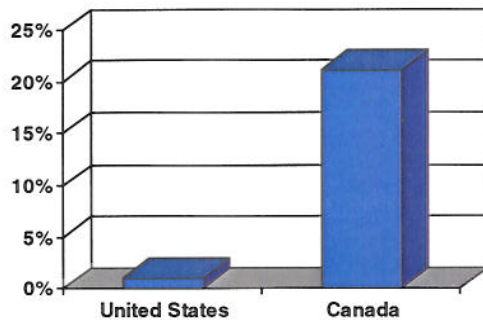
### Single-payer health systems compromise quality patient care.

Many advocates of the single-payer approach assert that such a system provides greater access to health care services and thus increases quality of care. However, evidence suggests that prolonged wait times or the use of outdated equipment not only impacts access to needed services but may lead to adverse consequences with respect to patient outcomes.

- Between 1970 and 2003, Canada’s doctors per capita rank fell from second of 20 OECD countries to 24<sup>th</sup> of 28 countries. Given that in 2003 Canada had the highest age-adjusted health spending as a percent of its Gross Domestic Product (GDP) than all other developed nations with universal access health care programs (except for Iceland), it is not unreasonable to expect Canada to have enough resources to provide for many more doctors than they now have. This, however, is not the case and the long and growing waiting lists suggest that the addition of more doctors would work to the advantage of the Canadian health care system as a whole.<sup>18</sup>
- Some 67% of Canadian specialists believe the quality of care has declined.<sup>19</sup> Twenty-

one percent of Canadian hospital administrators say their breast cancer patients face waits of more than three weeks for a biopsy. By contrast, 1% of American hospital administrators report waiting periods that long.<sup>20</sup>

**Wait times for breast cancer biopsies longer than 3 weeks**



- A December 2006 Fraser institute report employs the following seven outcome measures to rank the outcomes performance of OECD countries: healthy life expectancy versus total life expectancy, infant mortality, perinatal mortality, mortality amenable to health care, potential years of life lost to disease and the death rates from breast cancer and colorectal cancer. The data shows that health care outcomes are suffering under the Canadian health care system with the following ranking on the key indicators:

  - 16<sup>th</sup> in the percentage of total life expectancy that will be lived in full health,
  - 21<sup>st</sup> in infant mortality,
  - 14<sup>th</sup> in perinatal mortality,
  - 4<sup>th</sup> in mortality amenable to health care,
  - 9<sup>th</sup> in potential years of life lost to disease,
  - 10<sup>th</sup> in the incidence of breast cancer mortality, and
  - 2<sup>nd</sup> in the incidence of mortality from colorectal cancer.<sup>21</sup>
- Recent studies have assessed the impact of waiting times in Canada for cardiac care with respect to mortality, cardiac events (e.g., heart attacks), and heart functioning. Patients who are revascularized earlier have significantly lower preoperative mortality than those revascularized later. In addition, those treated earlier have a lower rate of subsequent cardiac events and significant improvement in heart function, unlike those receiving later treatment. Given the waiting times Canadians can experience these findings are significant. In addition, the December 2006 Fraser Institute report also found that patients with coronary artery disease who have available sophisticated, up-to-date equipment could achieve optimal therapeutic results. However, given the shortage of such appropriate technology in Canada, there are increases in patient suffering, illness, and death.<sup>22</sup>
- The Canadian Association of Radiologists' (CAR) CEO believes the radiology equipment in Canada is so bad that "without immediate action radiologists will no longer be able to guarantee the reliability and quality of examinations."<sup>23</sup> In addition, CAR reports that one in two diagnostic imaging units – ultrasound, x-ray, and CT scan machines – requires immediate replacement. One CT scanner in Montreal can't even be turned off, CAR says, because it is so outdated that replacement parts, including the power switch, are no longer available.<sup>24</sup>
- According to a June 2005 Canadian Medical Association Journal report, many Canadians are denied positron emission tomography (PET) scans which are standard in most industrialized countries and have been shown to greatly improve care. Specifically, there are only 12 PET scanners in Canada. PET scanners have proven extremely useful in detecting and diagnosing many types of cancer. Of these 12 PET scanners in



Canada, only five are available for clinical use; the others operate under research protocols for clinical trial participants.<sup>25</sup> By contrast there are more than 250 PET scanners in the U.S.<sup>26</sup>

### **Single-payer health care systems result in higher costs for consumers.**

Many view Canada's single-payer health care system as a way for the government to cover an entire population and control costs. However, a single-payer health care system translated to the United States could be an expensive undertaking and would not likely alleviate the costs to consumers.

- According to the Ohio General Assembly, an Ohio single-payer proposal initiated in 2004 would require funding so significant it could result in \$48 billion in new or increased taxes for Ohio businesses and residents. This would double the state's entire budget of approximately \$40 - 50 billion.
- A study by James Langenfeld and Richard Shin of the economic consulting firm LECG reveals that Oregon's single-payer healthcare initiative (Measure 23), defeated in 2002, could have significantly increased health care costs, increased taxes, and decreased health benefits. According to the study's conservative estimates, Measure 23 could have increased health care costs by approximately \$2.5 - \$6.5 billion in 2005 - - or approximately \$600 - \$1,800 per Oregon resident. The study showed that fully funding Measure 23 in 2005 would require additional revenues of \$14.5 - \$21.4 billion - - or approximately \$4,000 - \$5,900 per Oregon individual or \$10,000 - \$15,000 per Oregon household.<sup>27</sup>

- The Canadian experience shows that administering and sustaining a single-payer health care system requires a significant amount of resources. On an increasing basis, Canadian provinces have primary responsibility for financing the health care system. When Canada's single-payer system was first enacted, the federal government picked up about half of the physician and hospital costs. Today, the national share is less than 25%. This puts a huge burden on provinces to fund remaining health care expenses. In Saskatchewan, for example, health care comprises 40% of the province's budget. This is more than the province collects in personal income and sales tax. This experience is not exclusive to Saskatchewan. The average province spends nearly one in three budget dollars on health care.<sup>28</sup>
- Over the last several years, Canada's federal government has tried to address the critical access and quality issues facing its citizens by increasing their funding commitment to the health care system. However, this influx of money into the system has done little to improve the situation. For example, between 1993 and 2004, inflation adjusted health care spending per person increased 27%, while waiting lists nationally grew by 92%.<sup>29</sup>

### **Conclusion**

The experiences of Canada raises serious concerns as to how government approach to health care may be in achieving a balance among access, quality and cost, especially over the long term. Over the last several decades, the Canadian system appears to be severely challenged with problems on all three counts.

**Access:** As seen through Canada's system, single-payer models can lead to a shortage of

services, providers and technology which results in long-waiting times for citizens to access health care with consequent detriment to patient care.

**Quality:** Prolonged wait times have caused adverse health effects for patients in need of more immediate health care services. A substantial need for greater investment in new and better technology renders even the best physicians challenged to provide the highest quality of care to their patients. It comes as no surprise that a majority of Canadian physicians acknowledge that the quality of care has declined over the last several decades.

**Cost:** Studies suggest that single-payer health care models would be exorbitantly expensive to sustain. In addition, despite the Canadian national government's increased funding for health care over the last few years, Canadian citizens are paying more for a health care system that continues to deliver less.



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<sup>1</sup> Bridge, Kieran, "The Canada Health Act: Facts and Fallacies," 2007 and "Canada's Health Care System at a Glance", *Health Canada*, 2002.

<sup>2</sup> Veldhuis, Niels and Jason Clemens, "Clarifying the Federal Government's Contribution to Health Care," 2003 and Pipes, Sally C., "Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer", 2004

<sup>3</sup> "Canada's Health Care System at a Glance", *Health Canada*, 2002.

<sup>4</sup> Esmail, Nadeem and M. Walker, "How Good is Canadian Health Care 2005 Report", The Fraser Institute, 2005



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<sup>5</sup> PricewaterhouseCoopers, "HealthCast 2020: Creating a Sustainable Future," 2005.

<sup>6</sup> Pipes, Sally C., "Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer", 2004

<sup>7</sup> Ibid.

<sup>8</sup> The Fraser Institute, "Waiting Your Turn: Hospital Waiting Lists in Canada", 2006. .

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Esmail, Nadeem and Michael Walker, "How Good is Canadian Health Care? 2006 Report", The Fraser Institute, December 2006

<sup>14</sup> Pacific Research Institute (PRI), "The False Promise of Single-Payer Health Care", 2002.

<sup>15</sup> Gratzner, D., National Center for Policy Analysis, Brief Analysis No. 346 "Canada: A Health Care System on the Edge", February 5, 2001.

<sup>16</sup> Blendon, Robert et al., "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey", Health Affairs, May/June 2004.

<sup>17</sup> Esmail, Nadeem and Michael Walker, "How Good is Canadian Health Care? 2006 Report", The Fraser Institute, December 2006

<sup>18</sup> Esmail, Nadeem and Michael Walker, "How Good is Canadian Health Care? 2006 Report", The Fraser Institute, December 2006

<sup>19</sup> Gratzner, D., National Center for Policy Analysis, Brief Analysis No. 346 "Canada: A Health Care System on the Edge", February 5, 2001.

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<sup>23</sup> Pipes, Sally C., "Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer", 2004

<sup>24</sup> Ibid.

<sup>25</sup> Eggertson, Laura, "Radiologist, physicians push for PET scans", CMAJ, June 21, 2005; 172 (13).

<sup>26</sup> Pipes, Sally C., "Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer", 2004

<sup>27</sup> Langenfeld, James and Richard Shin, "Oregon's Measure 23 Could Increase State Health Care Expenditures By 30% in 2005," October 9, 2002

<sup>28</sup> Pipes, Sally C., "Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer", 2004

<sup>29</sup> Esmail, Nadeem, "The Black Hole that is Canada's Medicare", February 2005

