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Ten Myths about Canadian Medicare

Why the Romanow Report Missed the Opportunity to Fix Medicare

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Executive Summary

The recent release of the Romanow Report has rekindled the public discussion around creating effective healthcare policy. This backgrounder puts the spotlight on these 10 popular myths about Canada's Medicare system:

1. **Canada has the best health care system in the world.** Not even close. Canada's healthcare system placed 30th in an international ranking done by the World Health Organization in 2000.
2. **The Canadian public loves Medicare.** Various polls show that a majority of Canadians support substantial reforms to the system. By using a flawed process riddled with conflicts of interest and unprofessional methods the Romanow Commission made it look like citizens were against experimenting with major reforms.
3. **Canadian Medicare is sustainable.** The system has huge unfunded liabilities, rising costs and declining services. These are most visibly seen in crumbling infrastructure, loss of access to the latest technology, falling numbers of medical professionals and lengthening queues.
4. **The Single-payer model, Canadian-style, keeps costs under control.** The appearance of better-cost control is due more to the fact that it was introduced during a time when Canada's economy was growing faster than the American one. Canadian costs are rising at the same rate but from a lower base - which is why they appear lower.
5. **More cash is the solution to Medicare's problems.** The recommended extra infusion of taxes by the Romanow Commission would merely postpone the day of reckoning. Inflation within the system eats up the new spending in 2 years.
6. **Under Medicare, people get the health care services that they need.** Pharmaceuticals, dentistry, home care, chiropractics in most provinces and other services are not covered by Medicare. While services may be free at the point of consumption, people are required to queue in occasionally life-threatening waiting lists for access to scarce medical resources.
7. **"Free" health care empowers the poor.** With "free" healthcare, users are not powerful customers who must be satisfied. The system can provide shoddy service, but because it is free the individual is totally disempowered. The more educated, and connected middle class can use their networks to get better service than the poor. The inarticulate, the poor and the most vulnerable have much more limited ability to circumvent these systems.
8. **Canadian Medicare is fairer because no one gets better care than anyone else.** Workers compensation recipients, the RCMP and military, those with political connections, the famous, and those able to buy service at private facilities in Canada and the U.S. get better care than those lined up in the "free" public system.
9. **Medicare-type spending is the best way to improve health.** Rising health budgets are cannibalizing scarce public dollars that improve health outcomes like education, roads, environmental and water protection. Higher taxes, 8 to 10% of GDP higher than the U.S., slow economic growth and lower wealth levels which ironically correlate closely with better health.
10. **Medicare is an economic competitive advantage for business.** There is no advantage in terms of a lower production cost to manufacturers. Canadians pay for their system with higher income taxes. American workers pay for higher health premiums with lower wages and salaries.

Introduction

During Canada's 35-year love affair with the government monopoly, single-payer health care system known as Medicare, its defenders have relied on a series of beliefs about it that are not true. Herewith, the top ten things people believe about Canadian Medicare, but shouldn't:

Number One: Canada has the best health care system in the world.

This may have once been true, but now we are not even close. According to the World Health Organization, Canada ranks 30th in the world, with the United States ranking 38th. The WHO ranked countries by criteria such as:

- The effectiveness of health-care spending,
- The level of preventive measures, and
- Access for vulnerable populations.

By these measures, both Canada and the U.S. are only middling performers. We have a great deal to learn from other places that manage to combine costs that are no higher than ours, in fact frequently lower, and health outcomes, based on indicators that include longevity and infant mortality, that are as good or better.

One comparison should shake the complacent assumption that many share about the equity and effectiveness of the Canadian health care system. It benchmarks mortality rates for African-American infants against those for Canadians. The risk of infant mortality is a function of birth-weight, with the risk of death rising as the birth weight falls. Over the full range of low birth-weights (that is, any birth-weight below 2500 grams), African-American babies fare better than Canadian babies, except at the very top end of the range, where they are essentially equal. In short, among low birth-weight babies, those born to African-American families are better off than those born to the average Canadian family.

Number Two: The Canadian public loves Medicare.

The public does love some features of the system. In particular, the principle that no one should be denied access to needed medical care on the basis of ability to pay has enormous support. Ideologues in the health care debate have tried to stretch the public's support for that basic principle into all kinds of distortions.

In health policy circles, it is assumed that because Canadians support this basic principle, they also support a health care monopoly based on the current model, that they disapprove of private, for-profit businesses in the health sector and that only the state should deliver health services. In fact, the starting point of the recent Royal Commission on the future of health care painted that picture of Canadian values. It argued that those values supported the status quo, only more so, and recommended an expansion of the system into home care and pharmacare, with a major injection of additional taxpayer dollars.

But Canadians have actually shown themselves to be a deeply practical and non-ideological people. Commissioner Romanow has made the case that the debate over the future of Medicare is all about Canadians' values. But the way that Canadians express those values, unfiltered by the work of the Commission, is much different from what Romanow implies Canadians want.

According to a recent poll entitled The National Pulse on Health Strategy, 80 per cent of Canadians want major reforms to the health care system:"Two-thirds of Canadians (66 per cent) tend to be supportive, more or less, of a host of new models of financing in order to reduce stress on the system - for example, where everyone (except those with low incomes) pays a small amount for health care services out of their own pocket. They also tend to support strategies such as using nurses or other health practitioners rather than physicians to provide certain services. Just under half (45 per cent) tend to be supportive of market-oriented reforms - greater efficiency, accountability and customer service, including private sector companies delivering health care services." (Environics, October 17, 2002).

The National Post reported that the same Environics poll found that fewer than half of respondents would support increasing taxes to pay for health reforms. But, notably, only 10 per cent of Canadians would accept a health care system that excluded those who could not afford to pay for services

These results need not be seen as a contradiction. As Jane Armstrong, senior vice president of Environics Research Group, says, "Canadians, ever-constant champions of fair play and equity, are devoted to maintaining a system that ensures access to quality health care for all.... They're willing to make changes, even if this includes new and varied ways of financing the system as well as a greater dependence on market forces such as private companies delivering certain health services." (Environics, October 17, 2002)

Another recent poll, by Decima Research (October 25, 2002) found that more than half (55 per cent) of Canadians were opposed to paying higher personal income taxes, even if these funds were designated to pay for health care. An even larger majority of respondents (67 per cent) also believed that they would have to rely on their own personal savings to pay for their use of health services in the future.

These public opinion polls appear to indicate that Canadians want a system of health care that provides high-quality medical services and is financially sustainable over the long term at an acceptable economic price, without excluding poorer people from access to medically necessary services. In a typically pragmatic way, Canadians are not worried whether it is the private sector or the public sector that achieves this; they just want results. In fact, when Canadians do express a preference for either private or public approaches to health reform, the majority are willing to fund their future medical needs themselves rather than pay higher taxes to expand the Medicare model.

In the context of the Romanow Report, not since the days of Edgar Bergen and Charlie McCarthy has ventriloquism enjoyed such vogue. But at least they were good at it, and it was purely for entertainment. The stakes riding on today's high-profile ventriloquism act are far higher: the future of Canada's $70-billion public health care system.

From the very first, Romanow made it clear that the foundation on which all of his work would be built would be the values of Canadians. That's powerful: not many politicians want to be seen to be ignoring Canadians' deeply held views on a topic as important as health care. Thus the title of Romanow's report: Building on Values. He invoked these values up front in an attempt to make his recommendations invulnerable to criticism and cavilling by politicians and interest groups. For this gambit to succeed, the methods the commissioner used for arriving at a picture of Canadians' values on health care must be beyond reproach. Yet his methods were flawed and unprofessional. The report is a thinly disguised attempt to make Mr. Romanow's own values, and those of a narrow coterie of experts and bureaucrats, pass for the values of Canadians generally. Canadians are the dummy, and Mr. Romanow is the ventriloquist.

If this analogy seems extreme, consider what Mr. Romanow and his colleagues did. They organized focus groups across the country to find out what people were thinking about the direction of health care in Canada. What they heard from these focus groups was pretty much what Canadians have been telling pollsters for the last several years. They're interested in what works and they're interested in real solutions to the growing evidence of the accelerating decline of the health care system. In response to questions from the Commission's people, they indicated that they were open to a wide range of options that needed to be tried if they might improve things. They were open-minded about matters like user fees, allowing more private sector involvement in health care provision and allowing people to buy health care in circumstances where they're not permitted to do so today.

But that didn't square with the views of Mr. Romanow and his group. They marched their focus groups into a room and presented them with "expert opinion" to show these poor benighted citizens why the things they were willing to try were bad ideas that wouldn't work, that would harm people's health and be hard on the poor. They presented these views as established facts, rather than the highly contested arguments of an elite of health policy makers, an elite whose ideas have been responsible for bringing our health system into its current state of disrepair.

Unsurprisingly, when presented with what seemed to be an objective and authoritative debunking of ideas that had seemed practical and worthy of trying, the members of Mr. Romanow's focus groups timidly gave in to the views of the "experts". Ironically, a large body of evidence in the academic and policy literature shows that the practical, common-sense reforms that Canadians were prepared to look at actually do make a difference for the better. The only real flaw with these ideas is that they didn't fit the inflexible and narrow ideology of Mr. Romanow's colleagues.

Anyone in the polling business can describe how to avoid such charges of bias in determining what people think about emotional topics like health care. A reputable arm's-length polling expert would never have allowed people from Mr. Romanow's own commission to be closely involved in the testing of public opinion. The risk of influencing people to say what the client wants to hear are too great. But the commissioner's own people did work directly with the focus group organizers. Those organizers were themselves not members of an objective polling group, but representatives of a public policy group closely tied to the people guiding the work of the Commission and identified with their views. This "research" would never have passed muster in a rigorous review by the best polling experts.

By using a flawed process riddled with conflicts of interest and unprofessional methods, Roy Romanow made it look like Canadians were ruling out of court any experimentation with the health care status quo he and his advisors favour. But for someone who made such grand claims about basing his recommendations on hard evidence, the core of the commissioner's report is nothing more than his own prejudices transformed by the ventriloquist's art into Canadians' most cherished values.

Number Three: Canadian Medicare is sustainable.

On the contrary, Medicare is not sustainable on its present course. A modest slowdown in the rate spending increases has been bought chiefly through reductions in services, closure of facilities, fewer health professionals, dissatisfaction among those who remain, increased waiting times and the forgoing of innovative, but expensive, new technologies.

Medicare as we know it can only be "sustainable" if Canadians are willing to accept less service or more taxes. Polls indicate that neither is acceptable. Given increasing consumer expectations for expensive technologies, drugs and procedures, and the expected health demands from an aging population, Medicare's problems are only going to grow. In fact, a paper by Bill Robson, the Vice-President at the C.D. Howe Institute, has argued that the unfunded liability of Medicare -promises to pay for services for which normal increases in the take from the existing tax load will not cover - is in the range of $500 billion to $1.2 trillion. Canada's entire national debt, by comparison, is currently about $530-billion.

Roy Romanow has already publicly rejected these arguments and has recommended not only retaining but even expanding the centrally planned, government monopoly model of health care. Virtually every other major inquiry into health care, including the Senate's Kirby Report, Alberta's Mazankowski Report and Saskatchewan's Fyke Report identifies sustainability of the health care system as the challenge we face. Romanow's own former Minister of Finance in Saskatchewan underlined this when she appeared to testify before his commission.

Mr. Romanow denies there's a problem. We're spending the same share of GDP today on public health care as 30 years ago. If a little more than 7 percent of GDP was sustainable in 1972, why is that same percentage unsustainable today?

It's the wrong question. It's not how much we're spending, but how we're paying for it and what we're getting in return. For years we borrowed and spent on health care and other services, so we got more than we were willing to pay for. Today, as the only G7 country consistently in budgetary surplus, we pay the full cost of today's services, plus the interest on money we borrowed for health care and other things in the past. While the spending has remained constant as a share of GDP, the tax burden has grown and quality has declined.

The irresistible force of demand for "free" services is running headlong into the immovable object of unavoidably limited health budgets. To date, the pressure has been relieved by crumbling health infrastructure, loss of access to the latest medical innovations, declining numbers of medical professionals and lengthening queues. By and large, people have access to ordinary, relatively low-cost services like GP office visits, but find it increasingly difficult to get vital services such as sophisticated diagnostics, or many types of surgery and cancer care, where the waits can be measured in months if not years.

This is the exact reverse of what the rational person would seek. It makes sense to use the public sector to pool the risk of expensive interventions and ensure that they are available when needed. But ordinary interventions whose cost can easily be borne by the average person, should be left to individuals, supplemented by private insurance and subsidies for those on low incomes. Hardly anyone can afford cancer care, bypass surgery, gene therapy or a serious chronic illness on their own. These are the things that, without insurance, destroy people's finances.

But as much as 30 per cent of the services consumed under Medicare are unnecessary, not medically beneficial or even harmful. No one would be financially ruined by having to pay for an ordinary doctor's office visit if we ensured that people on low-incomes were subsidized and there was a reasonable maximum anyone would be called on to pay. No one would be harmed by an incentive not to go to the emergency room when a visit to the family clinic would do just as well. The biggest health care study in the world, the RAND experiment, found that people who had to pay something towards the cost of their care consumed less of it, but that their health was, with very slight qualifications, every bit as good as those who received totally free care.

The extra infusion of taxes Romanow recommends will merely put off the day when we realize that we must concentrate scarce public health care dollars where they'll do the most good, and give users of the system incentives to be prudent about how they spend them. We spend vast sums on procedures of little or no value, while we place patients whose condition endangers their life, in lengthening queues.

Number Four: The Single-payer model, Canadian-style, keeps costs under control.

A mythology has grown up about the superior ability of our system to control costs. In his report, Romanow repeats the argument that, until the introduction of Medicare, our health care costs tracked those of the U.S. After the introduction of Medicare, however, our growth in costs, and especially physician costs, dropped significantly after a predictable short-term rise. In a paper on the health care statistics, University of Guelph economist Brian Ferguson examined these numbers more carefully, and a wholly different picture emerged.

It shows the spike in expenditures associated with the introduction of Medicare, and the drop-off in expenditure growth as the adjustment to universal coverage worked itself through. But by the late 1970s, the two countries' expenditure growth series are back in sync - in fact they are more closely aligned in that period than they are in any previous period. They diverge again only in the mid to late 1980s, when, arguably, Canadian governments became really serious about controlling spending.

While we can identify transitional effects surrounding the introduction of Medicare, it is not possible to identify a lasting effect of the introduction of Medicare on expenditures for MD services. Basically, the introduction of Medicare had no effect on the rate of growth of expenditure, and the reason the Canadian GDP share figure fell below the US figure was not because of differences in the rate of growth of expenditure but rather because Canada happened to have the good fortune to bring Medicare in during a period in which the Canadian economy outdid the U.S. economy in terms of real growth.

Had our economic growth been as weak as U.S. growth through the 1970s and 80s, and had our health spending nonetheless remained unchanged, for two decades our share of GDP devoted to health care would have been higher than the actual US proportion. Canada, in other words, would have had the most expensive health care system in the world, a situation which would have changed only in the 1990s.

Why, given Canada's apparent success at controlling health care costs through the 70s and 80s, at least as judged by the GDP evidence, were recent efforts at cost control not handled with less disruption? The answer seems to be not that we were poor performers this time around, but rather that our earlier "success" at cost control was illusory. The introduction of Medicare did not introduce a period of, or efficient mechanism for, health care cost control. When it came to the question of how much of our national income we were spending on health, we weren't particularly good, we were just lucky.

Number Five: More cash is the solution to Medicare's problems.

Canada spends roughly $75-billion dollars a year on publicly funded health care and another $30 billion or so on private health care. Mr. Romanow's solution to our problems is a cash infusion of up to $6.5 billion per year. But the federal-provincial deputy ministers of health, in their last report, made a convincing case that health care costs are rising within the system at 5-6% a year, just under the current cost pressures, and that there are a number of new pressures that are likely to accelerate that trend. The math is clear. Add an annual tax-financed contribution of $6.5-billion to the existing budget of $75-billion rising at 5% per year, and within two years the ordinary and totally foreseeable costs of the existing system will have eaten up every penny of that new funding.

The health care system in Canada staggers from crisis to crisis in which new funding is promised by the federal government. But the federal government put something like $20-billion into Medicare just before the last federal election, and, as Romanow himself has remarked, everybody wants to know what we got for that money. The queues have lengthened, not shortened, the shortage of diagnostic equipment has got worse, people are less able to find a family physician than they were five years ago. We have had a lot of experience in Canada with new injections of cash into the system, supposedly to "buy change". But powerful interests within the system (doctors, nurses and support staff) organize to capture a share of that money. Costs rise but productivity does not, and services are no better or more timely. Canadian Medicare is a black hole into which can be poured seemingly infinite amounts of money.

The Medicare system was created in the 1960s as a new layer on an existing, relatively well-funded health care system. Since then we have paid most of the day-to-day operating costs, but we've been coasting on the capital within the system, and not renewing it. The average hospital in Ontario, our wealthiest province, is 47 years old. David MacKinnon, the head of the Ontario Hospitals Association, calculates that the total working capital deficit of Canada's hospitals today is roughly $4-billion. On top of that, the cost of simply the ordinary capital expenditures for the Canadian hospital system is about $2 billion a year for the next five years.

Simply eliminating the working capital deficit in our hospitals (because working capital provides the capacity for change) and paying for the ordinary capital costs for hospitals alone over the next five years, would wipe out all the extra funding Romanow is proposing for the system as a whole. Yet he's not merely proposing we throw cash at the existing system , he's also talking about larding it with new responsibilities whose costs are virtually guaranteed to be higher than what has been forecast. Even

if money were the solution, what Romanow proposes is barely enough to take the incipient crisis in Canadian health care off the boiling point for two to three years at best.

Number Six: Under Medicare, people get the health care services that they need.

While the language of Medicare says that Canadians get "medically necessary services" paid for by the state, this is not at all so. Among the services that are not covered are pharmaceuticals, dentistry, home care, chiropractics in most provinces and a number of other services. It is not yet clear that Medicare will cover a wide range of new diagnostic and other services, such as gene therapy. In fact, one of the least brilliant research papers for the Romanow commission argued that new technologies would only be cost drivers if we actually used them.

Queuing is a controversial measurement, not least because there may be many explanations for the queuing. Many of them are medically justifiable, so aggregate queuing figures may conflate those whose waiting poses no health or other risk with those whose health may be impaired or may suffer pain while waiting. In a system in which health services are free at the point of consumption, queuing is the most common form of rationing for scarce medical resources. Since patient satisfaction plays no part in determining incomes or other economic rewards for health care providers and administrators, patients' time is treated as if it has no value. There are no penalties in the system for making people wait. It is therefore not surprising that the measures of queuing now available, including the Fraser Institute's annual report, Waiting Your Turn, indicate a lengthening of queues for a great many medical services, including access to some specialists, diagnostic testing and surgery. Those administering the system must rely on external studies, not having implemented modern information systems to monitor waiting periods and identify those who have had excessive waits.

While we talk a lot about queuing in the Canadian health care system, as if we know how many people are waiting and how long they wait, in fact we do not know this at all. For the largest single program expenditure of governments in Canada, we know astonishingly little about what we get for our money. As David Zitner, Director of Medical Informatics at Dalhousie University in Halifax and Health Policy Fellow at AIMS likes to say, no health care institution in Canada can tell you how many people got better, how many people got worse, and how many people's conditions were left unchanged by their contact with it. None of them can give you an answer. No one knows how many people died while waiting for needed surgery. No one knows how many people are queuing for any particular procedure or how many people cannot find a family doctor. The system relies on guesswork, anecdote and subjective measures. We don't even know how long someone has to wait before they've waited "too long", because the health care system does not establish official standards for timely care. Even Romanow would presumably agree that someone who died while waiting for care may have waited a tad too long.

This is due to the conflict of interest at the heart of Medicare, in which the people who are the ultimate providers of health care services in Canada are also the people charged with regulating the system and quality assurance. Since no one is a competent judge of his own performance, and no one likes to be held accountable for his work, the result is a health care system that simply doesn't set tough standards or collect the information that would allow us to hold the system's administrators accountable for their stewardship of our health care and the billions of dollars that they spend. The people who would collect the information are also the people whose performance would be assessed if useful information were made available. Governments appear to have no legal obligation actually to supply the services they have promised to the population as the monopoly supplier of health insurance. No responsible regulator would permit a private supplier of insurance to employ this appalling double standard.

Another problematic indicator concerns access to doctors and medical technology. Aggregate numbers of doctors per 1,000 population do not reflect the differences in access to physicians in cities versus rural areas, nor of proportions between scarce specialists and plentiful GPs, nor of the quality of medical training. On the other hand, it is a crude measure of the overall state of access to qualified practitioners. On this measure, Canada performs badly. In 1996 it had 2.1 practicing physicians per 1000 population, while of the comparison group only two (Japan and the UK) had a lower ratio, with Australia at 2.5, France 3.0, Germany 3.4, Japan 1.8, Sweden 3.1, Switzerland 3.2, the UK 1.7 and the U.S. (2.6).Even countries with lower per capita spending than Canada provide greater access to physician services.

With respect to medical technology, Canada's performance is also unimpressive. In a study comparing Canadians' access to four specific medical technologies (computed tomography (CT) scanners, radiation equipment, lithotriptors and magnetic resonance imagers) with access by citizens of other OECD countries, Canadian access was significantly poorer in three of the four. Despite spending a full 1.6% of GDP more than the OECD average on health care, Canadians were well down the list in access to CT scanners (21st of 28), lithotriptors (19th out of 22) and MRIs (19th out of 27). Moreover, access to several of these technologies worsened relative to access in other countries over the last decade.

Number Seven: "Free" health care empowers the poor.

One anecdote sums up the reality of this myth. A Halifax businesswoman had an appointment at a hospital for a procedure duly showed up at the appointed time. Two hours later she was still waiting to be called. She was parked at a two-hour meter and she approached the desk and asked if she could go and put money in it. She was curtly told that she was free to go and put the money in, but that if her name were called while she was away, that she would fall back to the bottom of the queue. She decided that she would take the parking ticket as part of the price of getting the medical service she needed. Another two hours passed, and still she was not called. She again approached the counter, and very patiently and politely explained that she had a business to run, that she was there at the appointed time for her appointment, that she had waited four hours, which is far longer than she had been led to expect the whole thing would take, that she had other commitments. Could they possibly at least give her some idea of how much longer she might have to wait? The woman behind the counter drew herself up to her full height, glared at the businesswoman and said, "You're talking as if you're some kind of customer!"

That is the essence of the problem. When the government supplies you with "free" health care, you are not a powerful customer who must be satisfied. They are doing you a favour, and you owe the state gratitude and servility in return for this awesome generosity. They can give you the worst service in the world, but because it's free, you are totally disempowered. One of the most important lessons of Canadian Medicare is that payment makes you powerful. Its absence makes you risible, if not invisible.

Even though they don't pay, the articulate and the middle class still get in the face of the people providing service and make their wishes known. But often the vulnerable, the poor, the ill-educated and the inarticulate are the ones who suffer the most because no one's well-being within the system depends on looking after patient/consumers. By depriving them of the power of payment within the health care system, Medicare disempowers them. The poor see this. While they may be poor, they are not stupid.

In a Compass poll for the National Post, 41% of Canadians expressed the view that individuals should be able to choose private health insurance for Medicare, coverage that would allow them to obtain better, or at least faster, care than at present. In a society preoccupied with the inequities implied by "two-tier health care," more of those earning less than $25,000 a year (47%) were interested in this option than those earning over $75,000 (39%). Those most satisfied with their health care were not the least educated, but the best educated: those with postgraduate degrees.

Canada's system in fact does create multi-tiered health care, where health care services are distributed on the basis of middle-class networks and the ability to communicate one's needs aggressively to professional caregivers. It is the poor, the vulnerable including, most obviously, the sick, and the inarticulate who receive the worst care, because they cannot circumvent the system the way the middle class and its advocates can.

Number Eight: Canadian Medicare is fairer because no one gets better care than anyone else.

Roy Romanow has made it clear that he wants to ensure that "two-tier" health care continues to be forbidden in Canada. But it's too late. If you are on workers compensation, are in the RCMP or the military, if your company has its own salaried physicians, if you use a private hospital like Shouldice in Toronto, which specializes in hernia surgery, or one of the country's private abortion clinics, if you are a member of the medical professions, or know someone who is, or are just articulate and determined or famous and connected, if you travel to the U.S. or any one of a number of other places, you can get better, faster or more satisfactory care than someone who just lets the wheels of Medicare grind on.

Moreover, technology is allowing the remote delivery of ever more health services, so the ability of governments to frustrate patients' desires to get better and faster treatment is declining, and that decline will accelerate. The debate is really about how many tiers and under what conditions. Many of these tiers are beyond government control. Virtually any kind of pharmaceutical product can now be purchased over the Internet from foreign providers who can evade our government's controls. You can even get involved in on-line auctions for the drugs you want. Your x-rays or MRI scans can be read just as easily by a radiologist in Boston or Bombay as in Toronto or Truro. The brain repair team at Dalhousie University recently operated on a patient in Saint John, New Brunswick. The surgeons never left Halifax. Using video cameras and computer controls, they operated robotic arms that actually did the surgery hundreds of kilometres away. When you can go to a surgical booth in Canada and be operated on by the best surgeon in the world, who may be at his office in London or Houston or Minneapolis, the notion of a closed national health system in which people must take what public authorities decide they should have simply cannot survive.

Multiple tiers make for a slippery concept. If some people can get a service by paying for it, while others who cannot pay do not get access, many believe that multiple tiers are thereby created. On the other hand, there are people who oppose tiers because of an ideology of egalitarianism. Thus two people with similar conditions may both get treated, one more quickly through private payment, the other more slowly, but within appropriate norms for their condition, by Medicare. That doesn't mean that people are denied care based on the ability to pay, because anyone willing to wait will eventually get care (although we possess no figures on how many die while queuing for public health care). The complaint is rather that someone got care more quickly. That's a very different objection, that no one should be able to get faster treatment than in the public system, even where such faster access does not affect the quality or timeliness of the care obtained by people who continue to use the public system. This peculiar brand of egalitarianism suggests that people should not be denied service because of their own inability to pay, but should be denied access because of their neighbour's inability or unwillingness to pay (through taxes) for the care an individual decides he or she needs.

Canada is almost alone in the Western world in outlawing people paying privately for services that are also publicly insured. One consequence of this is that there are many services, such as drugs or home care, that we cannot afford to cover publicly, whereas they are often publicly insured elsewhere. By forbidding people who wish to do so the ability to pay, we satisfy our ideological craving for egalitarianism, but at the cost of an inability to make room in the public budget for a wider range of services that low income people might truly need.

This might be a defensible trade-off if our system were superior to others, and indeed we frequently hear it said that we have the best health care system in the world. But neither the World Health Organization in its ranking of world health systems nor the citizens of Canada, nor the poor and the elderly in Canada (based on polling data), agree.

Many of Romanow's concerns, and those of the Canadian health care establishment whose views he now repeats, are ideological, and have little to do with the quality of care delivered within the public system. They cling to a system that outlaws private spending on publicly insured services, in the mistaken belief that parallel systems rob the public system of resources. But both objective and subjective international rankings show that multiple tiers of access are fully compatible with high quality

public systems, high levels of care overall, high levels of patient satisfaction and public health outcomes as good or better than Canada's.

Number Nine: Medicare-type spending is the best way to improve health.

Many forms of spending are far more likely to improve health outcomes than health care spending. Consider, for example, that there is a very close link between health and wealth. The wealthier you are, the more likely that your health is to be good. This implies that spending that is likely to improve the wealth-creating capacity of society is also an investment in health. That means things like education, economic infrastructure, and a reasonable tax burden are all key determinants of health. So too are public health measures like sanitation, water quality, environmental protection and preventive measures such as pap smears.

But as the health care budget expands in Canada, it is crowding out many of these other forms of public spending. The provinces, who have responsibility for the delivery of most services, such as health care, primary, secondary and post-secondary education, roads, environmental protection and water provision have seen health rise from around 30% of program spending to nearly 50%. In all provinces it is expected to exceed 50% within a decade. Canada's tax burden is about 8-10 percentage points of GDP higher than in the US, which makes our tax burden uncompetitive with our major market and major competitor. The health care budget is cannibalizing scarce public dollars that could be going on things much more likely to produce superior population health outcomes. But the politics of health spending are powerful, and have proven nearly irresistible to date.

Number Ten: Medicare is an economic competitive advantage for business.

In the United States, in the ordinary course of things, as the price of health care increases, so too do insurance premiums since, ultimately, all insurance payments come from the pool of premiums collected from the insured. Since people usually obtain this type of insurance through their place of employment, it is often thought that the rising cost of insurance constitutes an increased cost to employers. This view is especially widespread with regard to health insurance in the United States, where it is often said that health insurance premiums make up a larger part of the cost of building a car than steel does. Canadian politicians often argue that since, under Medicare, Canadian companies do not have to bear this extra cost, they have a competitive advantage in world markets. This, too, is wrong.

Economic theory predicts, and empirical evidence confirms, that the full cost of those insurance premiums is passed back to workers in the form of lower take-home pay. Canadian workers pay the costs of Medicare through income taxes; U.S. workers pay the cost of their health coverage through the pass-back of premiums. Even the part nominally paid by the employer actually comes out of the pool of funds available for paying labour and therefore comes out of the workers' pockets, in that case before it even reaches them.

Conclusion

Most Canadians believe that our Medicare system is superior in many respects to the US system, but it is a system that staggers under the burden of serious design flaws. Far from sharing Romanow's complacency, many are deeply worried about the long term sustainability of our health care system, and think that we have much to learn from countries that ranked much higher than either Canada or the US in the WHO rankings. These countries demonstrate that many of the fears that Canadians have about significant reform to Medicare are based on myths. Introducing payment for health care, allowing people to pay directly for health care outside the government monopoly, and even breaking up the provision monopoly to allow competition and a greater role for the private sector are all reforms that can be carried out within a public policy framework that continues to be pre-occupied by considerations of equity. They would give Canadians better value for the tens of billions of dollars they so patiently and lovingly devote to public health care spending, in a repeated triumph of hope over experience.

About the Author:

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