POLICY BACKGROUNDER No. 129
For people with limited time and a need to know.

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HEALTH CARE REFORM:

What President Clinton Can Learn from Canada About Price Controls and Global Budgets

"Both the Congressional Budget Office and the New York Times warned that Clinton's plan may lower the quality of medical care."

As part of his health care plan, President Clinton has proposed price controls on health insurance premiums and "global budgets" that try to limit how much people can spend on health care each year.[1] Although the details of his plan are still sketchy, the concept is not new. It represents a major departure from Clinton's election campaign promise to rely on competition, not price controls, to hold down health care spending. As a result, the "Jackson Hole" health economists who originally developed Clinton's plan have now dissociated themselves from it.[2]

The *New York Times,* an early supporter of Clinton's proposal for "managed competition," clearly feels betrayed by the latest plan:[3]

> A system that was supposed to control cost with competition would amount to price controls. And the severe price caps would likely drive providers to skimp on treatment and erode the unrivaled excellence of American medicine. The Administration argues that there is plenty of waste in health care and that caps can squeeze it out. But caps don't target waste; they are likely to squeeze out important services.

And the Congressional Budget Office (CBO), which normally would be expected to support a Democratic president's health care proposal, offered a similar analysis. The CBO, according to the *New York Times*, says federal limits on private health insurance premiums could harm consumers by forcing a reduction in valuable medical care and restricting access to new medical technology.[4]

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"An estimated 1,379,000 Canadians are waiting for some kind of medical service."

To see how the Clinton plan might affect patients, the president might look at Canada. In general, Canadians have little trouble seeing a general practice or family practice physician. But specialist services and sophisticated equipment are increasingly rationed. Canada attempts to control health care spending by limiting expensive medical technology. Within hospitals, physicians work under severely limited budgets.

The resulting system of health care rationing is inefficient and unfair. It also threatens the quality of care Canadians receive. In general:

- Canadians do not have full access to existing modern medical technology, and there is very little research or development of new technology.
- Some patients, including a friend of one of the coauthors of this backgrounder, die while waiting for diagnosis and treatment.
- An estimated 1,379,000 Canadians are waiting for some kind of medical service.
- There are 177,000 Canadians waiting for surgical procedures, and 45 percent of them say they are "in pain" while they wait.
- Access to health care is unequal, with some Canadians having a much better chance of seeing a doctor than others.

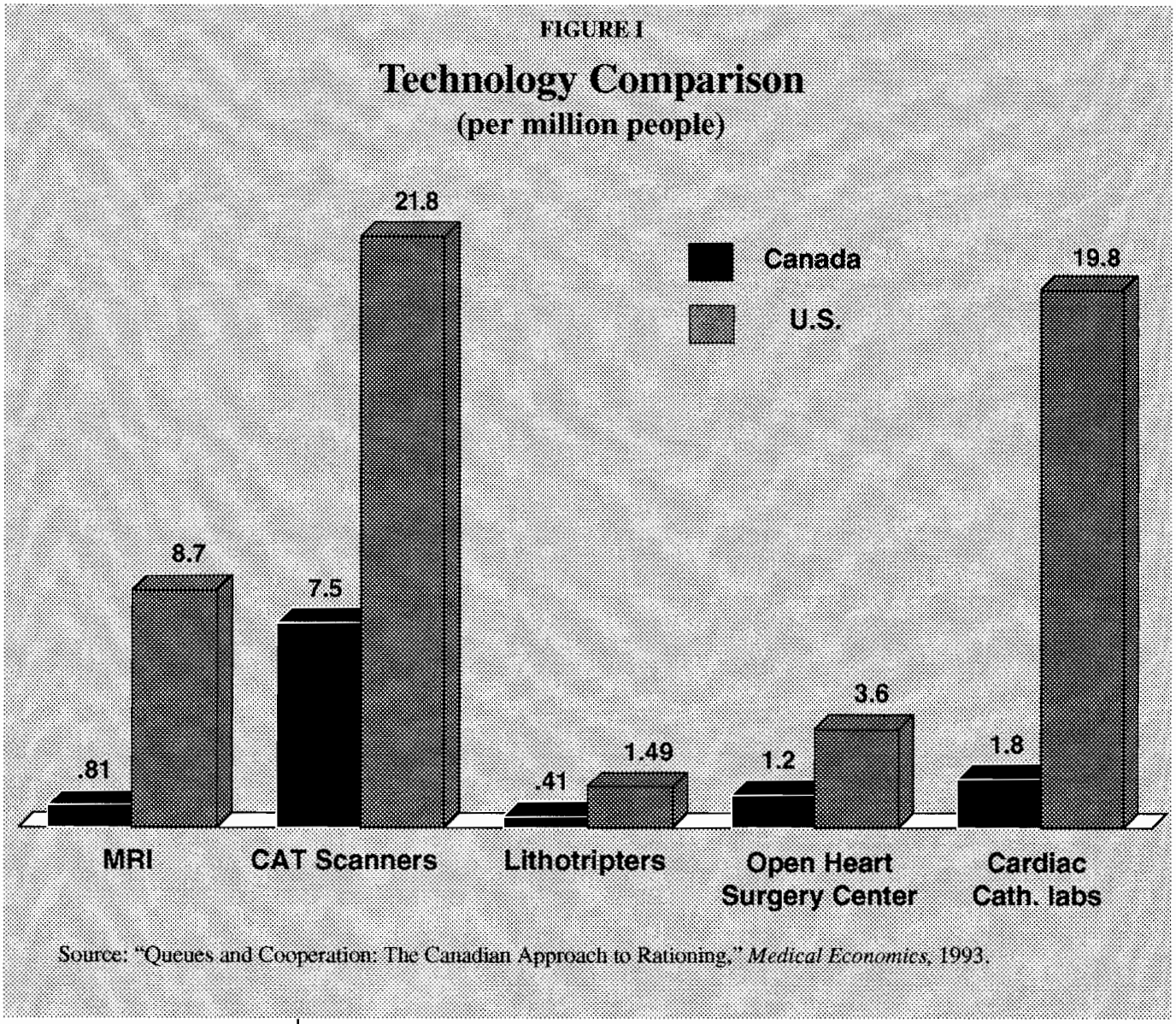
Despite these developments, Canada's per capita health care costs have been rising at roughly the same rate as those in the United States.

Lack of Access to Technology

Figure I gives the latest available statistics comparing access to modern medical technology in the United States and Canada, based on information from *Medical Economics* magazine. As the figure shows:

- On a per capita basis, the United States has 10 times as many magnetic resonance imaging (MRI) units — which use magnetism instead of x-rays — as Canada.
- The United States has three times as many computerized axial tomography (CAT) scanners per person.
- The United States also has about three times as many lithotripsy units (to destroy kidney stones and gallstones with sound waves) per person.
- And, per capita, the United States has about three times as many open-heart surgery units and eleven times as many cardiac catheterization units (for the treatment of heart disease).

FIGURE 1



Source: "Queues and Cooperation: The Canadian Approach to Rationing," *Medical Economics*, 1993.

"There are more MRI scanners in Washington state than in all of Canada."

Rationing Scarce Technology. Seattle, Washington (pop. 490,000) has more CAT scanners (used, for example, to detect brain tumors) than the entire province of British Columbia (pop. 3 million). There are more MRI scanners in Washington state (pop. 4.6 million) than in all of Canada (pop. 26 million).[5] While critics of the U.S. health care system claim that the U.S. has too much technology, all the evidence suggests that Canada has too little — as a result of the conscious decisions of government officials.

Delaying New Technology. Some argue that Canada and other countries with global budgets delay the purchase of expensive technology in order to see if it works and is cost-effective. If true, the downside of this approach is that patients are denied access to potentially lifesaving treatment while government bureaucracies evaluate it. During the 1970s, for example, lifesaving innovations were made in kidney dialysis, CAT scanning and pacemaker technology. Yet:[6]

- The rate of pacemaker implantation in the United States during the mid-1970s was almost 20 times that of Canada.
- CAT scanners were more than three times as available in the United States as in Canada.
- The treatment rate of kidney patients was more than 60 percent greater in the United States than in Canada.

Canada develops almost no new medical technology and spends very little on research and development. By contrast, research and development spending in the United States result in innovations that benefit the U.S., Canada and the rest of the world.

Rationing by Waiting

"More than 177,000 people are waiting for surgical procedures."

A recent 12,000-person survey by Canada's official statistical agency led to an estimate that 1,379,000 people (out of a total population of 26 million) are waiting for some medical service, ranging from a visit to their general practitioner to nursing home admission.[7] Of those, more than 177,000 people are waiting for surgical procedures.[8] These people must endure lengthy waits before meeting with a specialist and even longer waits before obtaining needed surgery.

The Length of Waiting. Because the demand for health care has proved insatiable, and because Canadian provincial governments severely limit hospital budgets:

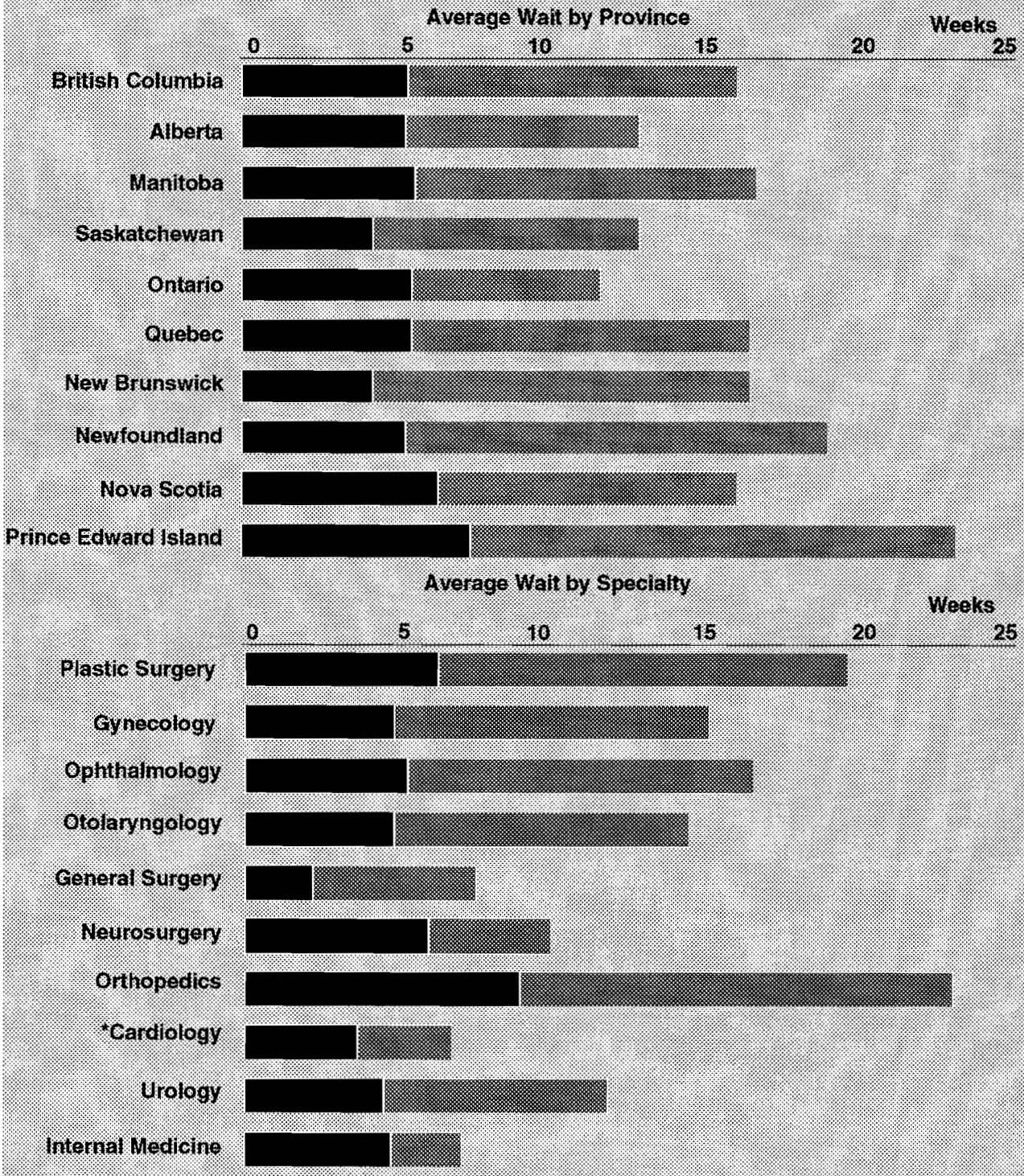
- The average wait to see an eye specialist in Prince Edward Island is six months — and it takes another six months on the average to be treated.
- On the average, it takes almost seven weeks to see a gynecologist in New Brunswick and another six months to be treated.
- To see an ear, nose and throat specialist takes a little more than two weeks in Newfoundland — but it takes another six months to be treated.

Note that these are averages for entire provinces. The wait for any particular patient can be much longer. For example:

- Patients in British Columbia wait up to a year for routine procedures such as cholecystectomies, prostatectomies, hip replacements and surgery for hemorrhoids and varicose veins.[9]
- In Ontario, patients wait up to six months for a CAT scan, up to a year for eye surgery and orthopedic surgery, up to a year and four months for an MRI scan and up to two years for lithotripsy treatment.[10]
- All over Canada, patients wait for coronary bypass surgery, while the Canadian press tells of heart patients dying on the waiting list.[11]

FIGURE II

Waiting Times in Canada



Source: Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum*, May 1993.

*Cardiology waiting time is for urgent surgery only. Elective surgery waiting times averaging as much as 48 weeks are also experienced. (Elective surgery patients are those for whom there is no immediate life threat.)

Inequalities in Waiting. On the average, it takes about five weeks to see a specialist in all 10 Canadian provinces. However, the average wait varies widely from province to province. Moreover, as shown in Figure II, the waiting time for actual treatment varies even more.

- After seeing a specialist, patients wait an additional 14.6 weeks for surgical procedures in Prince Edward Island but only 5.9 additional weeks in Ontario.
- Following a diagnosis, a high proportion of patients in the Maritime provinces wait more than six months for treatment, but 96 percent of the waits in Ontario are less than three months.

Case Study: Cardiovascular Cases. More people in Canada die of cardiovascular disease than of any other single cause. But hospital budgets for "conventional illness" and for high-cost procedures such as cardiac bypass surgery are separate. The result is lengthy waiting lists for such surgery, often as long as a year or more. Political pressures have prompted short term solutions:[12]

"45 percent of those waiting for surgery say they are in pain and some are risking their lives."

- After a report that Newfoundland's waiting list was a year long, the hospital performing open heart surgery received a special temporary grant to deal with the waiting list.
- After a public outcry over the six-month waiting list, British Columbia contracted with Washington state hospitals to perform some 200 cardiac operations in 1989.

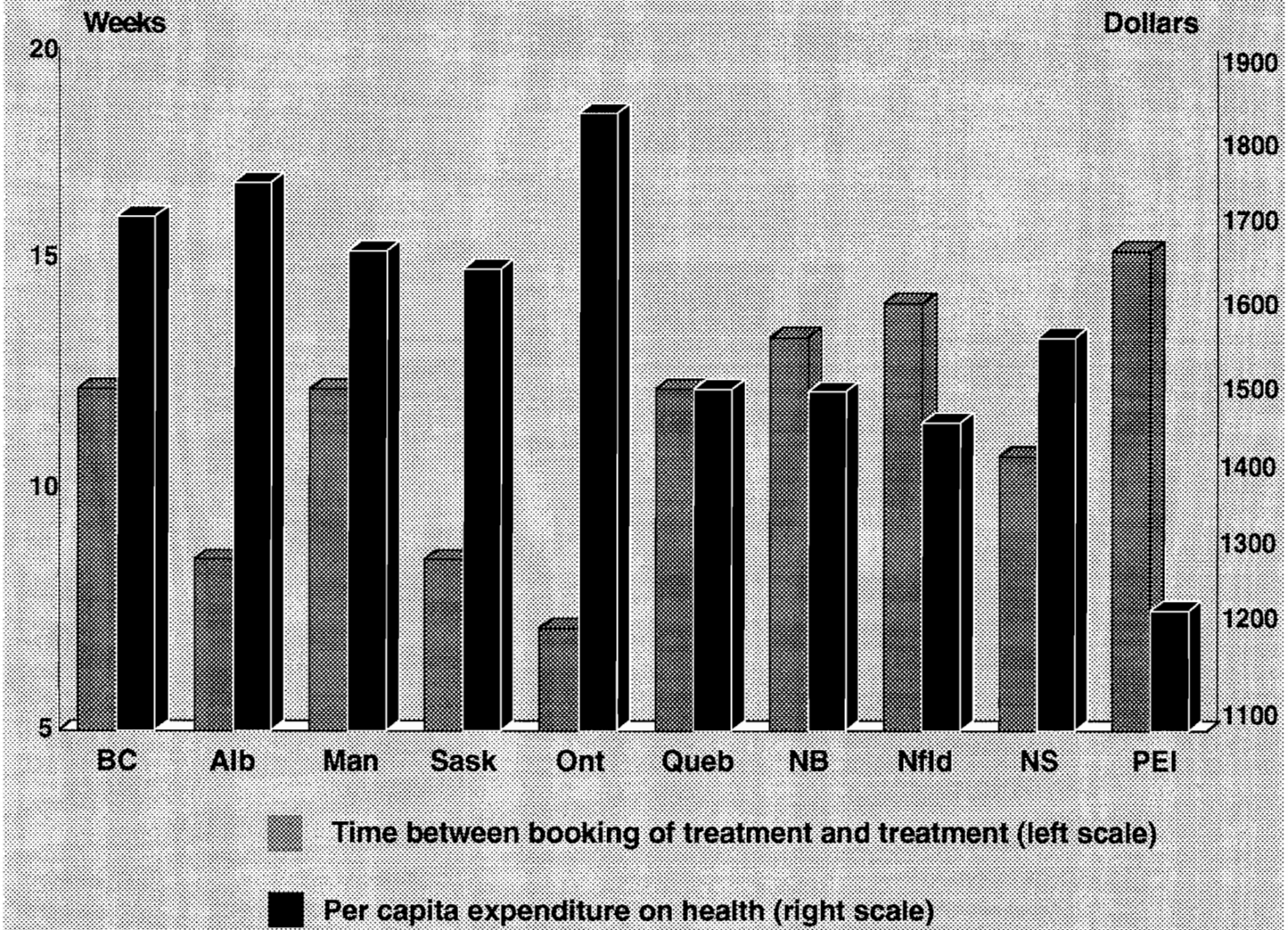
It is estimated that 5 percent of heart patients inquire about surgery outside Canada and 1.5 percent actually have their heart surgery performed outside the country.[13]

Effects on Patients' Health. The average amount of time patients wait for surgery of all kinds appears to be about the same as in 1967, the year before Canada began implementing national health insurance. However, the makeup of the waiting list is different. More people are waiting, and those waiting are sicker. Recently published data by Statistics Canada indicate that 45 percent of those waiting describe themselves as "in pain."[14] Others are risking their lives. In British Columbia, for example:[15]

- Whereas only 7 percent of the patients waiting in 1967 were classified as urgent, 24 percent were classified as urgent in 1988.
- Whereas 0.6 percent of the population was on the waiting list in 1967, 1.1 percent — almost double the fraction of the population — was on the waiting list in 1992.

FIGURE III

Per Capita Health Expenditure and Waiting



BC — British Columbia
Alb — Alberta
Man — Manitoba
Sask — Saskatchewan
Ont — Ontario
Queb — Quebec
NB — New Brunswick
Nfld — Newfoundland
NS — Nova Scotia
PEI — Prince Edward Island

Source: Per capita health care expenditure from "Public Finance Historical Data," Statistics Canada. Waiting times from "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition."

On the surface, the number of people waiting may seem small relative to the total population. However, considering that only 16 percent of the people enter a hospital each year in developed countries[16] and that only about 4 percent require most of the serious (and expensive) procedures,[17] these numbers are quite high.[18] They imply that one out of every four British Columbia residents needing expensive medical technology is unable to get it promptly.

"Americans can jump the queues at Canadian hospitals."

How Global Budgets Cause Rationing. The evidence shows that the severity of rationing is directly related to the stinginess of a province's global budget. Specifically, there is a close correlation between waiting times and the amount of money a province spends on health care. As Figure III shows:[19]

- Provinces that spend $1,500 or more per capita on health care have shorter waiting times.
- Ontario, the province with the shortest waiting times of all, spent $313.70 per capita more on health care than any other province in 1991, the latest year for which data are available.

How Americans Jump the Queue. The Canadian government has proclaimed health care to be a basic human "right." Yet the right is far from guaranteed. Not only do Canadians have no enforceable right to any particular medical service, they don't even have a right to a place in line when health care is rationed. The 100th person waiting for heart surgery is not "entitled" to the one hundredth surgery, for example. Other patients jump the queue for any number of reasons. Among the patients who jump the queue are Americans who pay out-of-pocket for care. U.S. patients add to hospital revenues, so hospital administrators value them. Since Canadians cannot legally pay for care at a national health insurance hospital, the typical Canadian patient must wait in line.[20] In this sense, Americans have a greater right to health care in Canada than do Canadians.

"Even pets can sometimes jump the queue."

How Pets Jump the Queue. In addition to Americans, animals also have been able to jump the queue in some provinces. Ordinary people, other than those designated as emergencies, cannot get a CAT scan quickly at any price because they are not allowed to pay for it. However, in an 18-month period, York Central Hospital in a Toronto suburb did more than 70 CAT scans on animals suspected of having such problems as tumors. The tests were done at night and the charge was $300 each.[21] The practice was stopped only in response to adverse publicity.

How U.S. Providers Profit from Canada's Health Care Rationing. As the waiting lines grow for virtually every type of treatment in every Canadian province, America serves as Canada's safety valve. In increasing numbers, Canadians cross the U.S. border to get care they cannot get at home. For example:

- Because of the inadequate facilities in Canada, about half of the in vitro fertilization patients at the University of Washington Medical Center are Canadians, paying $5,000 out-of-pocket for each procedure.[22]
- Enough Canadians come to the United States for heart surgery that a California heart surgery center has advertised its services in a Vancouver newspaper.[23]
- In 1990, the Ontario Health Insurance Plan paid about $214 million to U.S. doctors and hospitals — up 45 percent over the previous year.
- Of that amount, 40 percent went to Florida, 9 percent to New York, 5 percent to Michigan and Minnesota and 4 percent to California.
- In 1993, the Canada-America Health Care Corporation, based in Winnipeg, began to offer Canadians an insurance policy providing for access to care in the United States if they had to wait 45 days or longer for care in Canada.[24]

"America serves as Canada's safety valve — delivering care that Canadian patients cannot get at home."

Because of large budgetary deficits, Ontario is no longer permitting its residents to take advantage of U.S. health care services, except in special circumstances such as for procedures that simply are not done in Canada.[25]

Unequal Access to Health Care

In Canada[26] and other countries with national health insurance, there is no national waiting list to assure that the sickest people get care first. Even in the same hospital there are instances where elective patients get surgery while those in much greater need are forced to wait.[27] Who gets care and who doesn't? There is some evidence that when health care is rationed, those pushed to the rear of the waiting lines tend to be the poor, racial minorities, the elderly and people who live in rural areas. Let's take a closer look.

Global Budgets Discriminate Against the Poor. In general, low-income people in almost every country see physicians less often, spend less time with them, enter the hospital less often and spend less time there — especially when the use of medical services is weighted by the incidence of illness.

The survey that estimated the number of people waiting for some kind of medical service also collected information on the people's incomes, making it possible to determine whether those with high incomes and low incomes have an equal probability of waiting for medical services. Figure IV shows that the two highest income groups have half the probability of waiting of lower income groups. Those with annual incomes of $60,000 to $79,000 have

a 4.7 percent probability of waiting, and those with annual incomes over $80,000 have a 4 percent probability. By contrast, every other income group has a probability of 7 percent or more, and most exceed 8 percent.

"The highest income groups have a much lower probability of waiting."

Global Budgets Favor the Rich and Powerful. Most people in Canada and other countries that ration health care through global budgets believe that the wealthy, the powerful and the sophisticated move to the head of the rationing lines. As one study of the Canadian system noted:

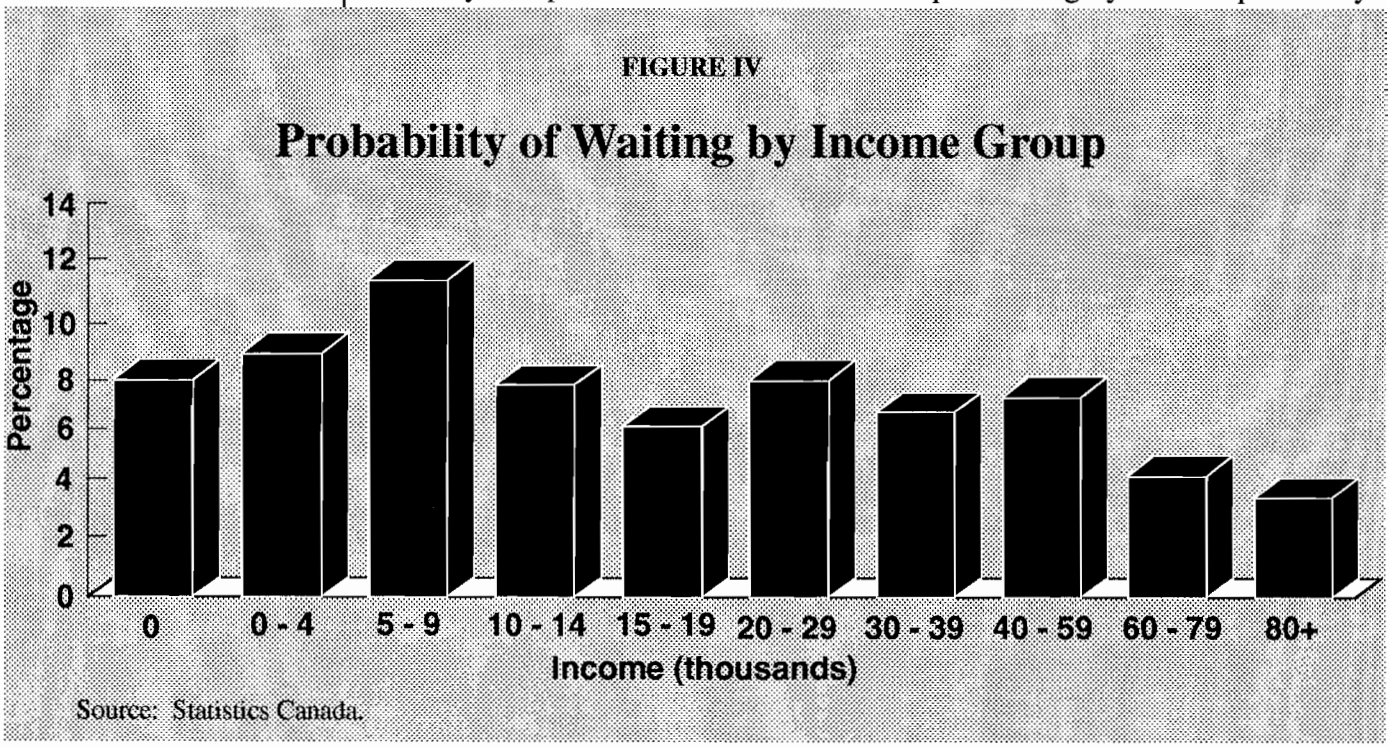
"Critics charge that those who are rich, influential, or 'connected' often 'jump the queue,' which changes Canadian health care into a two-tier system — precisely what the government wanted to avoid."[28]

Because government officials have little interest in verifying these facts, few formal studies exist. However, the evidence that does exist supports the charge. A recent analysis of surgical waiting lists in British Columbia concluded that "nearly 80 percent of queue jumping is not on the basis of emergency but on the basis of physician/surgeon preferences, requests from senior Ministry of Health officials and sometimes from members of the legislature."[29] Members of the federal Parliament and 4,364 high-ranking federal bureaucrats can avoid waiting lists because they have access to the National Defense Medical Center. In 1990, the Canadian Auditor General reported that 61 percent of the center's in-patient days were for nonmilitary patients.[30]

"Politicians jump the queue by going to a military hospital."

Canadians who can afford to pay also have other options. Since Canada does not allow private health insurance, if Canadians go to the less than 1 percent of physicians who practice privately or less than 5 percent of private hospitals that are private, they must pay the full bill out-of-pocket.[31] The only exception is a small number of outpatient surgery clinics operated by

FIGURE IV



Source: Statistics Canada.

entrepreneurial physicians, to whom government will pay the surgeon's fee but not other costs. Canadians who receive cataract surgery on an outpatient basis, for example, must pay from $900 to $1,200 out-of-pocket.[32]

As noted above, increasing numbers of Canadian citizens are coming to the United States for health care they cannot get at home. In some cases, the Canadian province pays the bill. In other cases, patients spend their own money or rely on the newly established private insurance plan for U.S. care.[33] In either event, patients must bear the costs of travel. Clearly, this alternative favors those with money.

Global Budgets Discriminate Against the Elderly. Wherever there is nonprice rationing of medical care, two pertinent features have been observed.[34] First, when resources are limited, middle-aged patients tend to get priority over older patients. Second, the more limited the resources, the worse the degree of discrimination based on age. These observations are consistent with recent evidence on access to heart surgery in Canada:[35]

"Canada's principal minority group — Indians — fares less well than American Indians."

- Per capita, the United States performs twice as many coronary artery bypass operations on elderly patients as Canada does.
- Among 75-year-olds, the difference between the two countries is four to one.

Global Budgets Discriminate Against Racial Minorities. According to the results of several studies, racial minorities do not fare as well as majorities under global budgets.[36] In a recent study of the Inuits and Crees of northern Quebec, both groups had much less access to health care than did Caucasians in southern Quebec and in other areas of Canada — despite their much greater health needs. For example:[37]

- The age-adjusted mortality rate for Inuits is almost twice the rate for Canadians as a whole.
- Infant mortality rates are three times greater among the Crees and four times greater among the Inuits than for the rest of Quebec.
- The nationwide infant mortality rate is twice as high for Indians as for non-Indians; by comparison, the Indian infant mortality rate in the United States is slightly lower than that for non-Indians.
- The life expectancy at birth for both male and female Indians is almost 10 years less than for non-Indians, compared to a difference of only about three years for both males and females in the United States.[38]

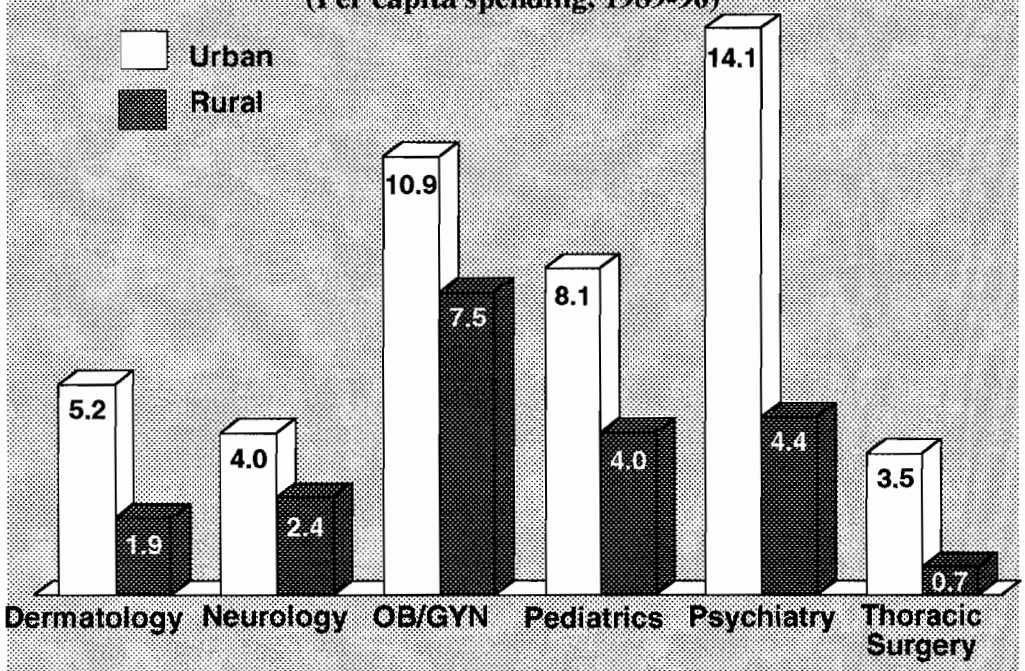
Global Budgets Discriminate Against Rural Patients. As part of the system of enforcing global budgets, Canada's health care tends to be hospital-based, with modern technology restricted to teaching hospitals and outpatient surgery discouraged. Moreover, specialists and major hospitals tend to be in

"Per capita, urban residents receive 45 percent more services from specialists than rural residents in British Columbia."

FIGURE V

Inequalities in the Use of Physician Services Among Urban and Rural Patients in British Columbia

(Per capita spending, 1989-90)



Source: Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1989-90* (Vancouver: University of British Columbia, 1992).

major cities. As a result, rural residents often travel to the larger cities for medical care. How often does that happen? A study produced at the University of British Columbia provides the answer.[39] Figure V shows some of the inequalities. The study found:

- On the average, people living in British Columbia's two largest cities (Vancouver and Victoria) receive about 27 percent more physician services per capita than those living in the 28 rural districts of the province.
- Urban residents receive 45 percent more services from specialists per capita than rural residents, and for specific specialties the discrepancies are even greater.
- On the average, urban residents are 5 times more likely to receive services from a thoracic surgeon, 3.2 times more likely to receive the services of a psychiatrist and about twice as likely to receive services from a dermatologist, anesthesiologist or plastic surgeon.

These are the broad averages. The discrepancies are worse between urban areas and British Columbia's most underserved areas. Even if we ignore the smallest districts and focus only on districts with at least 35,000 people, spending varies by a factor of almost 3 to 1 for all specialist services,

almost 4 to 1 for OB/GYN services, 8 to 1 for internists and 35 to 1 for psychiatrists. The discrepancies are greater still among people in specific age and sex classifications in the regions, again ignoring the areas with the smallest populations. Roughly speaking:[40]

- A child is 22 times more likely to see a dermatologist if the child is living in Vancouver than in the East Kootenay district (pop. 50,660).
- A baby girl is 10 times more likely to see a pediatrician for any reason if she is living in Vancouver rather than in Peace River (pop. 51,252).
- A 40-year-old woman is almost nine times as likely to have reconstructive plastic surgery if she is living in Vancouver rather than in Bulkley-Nechako (pop. 36,952).
- A 40-year-old woman with a mental disorder is 12 times more likely to see a psychiatrist if she is living in Vancouver rather than in Fraser-Fort George (pop. 88,250).

Deteriorating Quality of Care

Americans have been told that the quality of care in Canada has not suffered because of Canada's system of global budgets and health care rationing. Yet there are increasing reports by doctors and the news media of patient deaths and near-deaths, precisely because the government limits technology and causes health care rationing. Here is one doctor's report of what conditions are like in Quebec:

"There are increasing reports of patient deaths and near-deaths because of rationing."

"In my academic practice at a teaching neurologic hospital in Montreal, the wait for the treatment of a 'minor' medical problem (e.g., carpal tunnel syndrome) could be half a year or longer. What I considered essential services were unavailable. I recall losing an argument with the radiologist on call over whether a patient with a new stroke should have a CT scan at 5:05 p.m.; he judged that the situation was not an emergency serious enough to warrant performing the procedure after regular hours."[41]

Inefficiency. As an example of inefficiency in Canada's hospital sector, consider the following. The proponents of global budgets often point to the lower level of health care spending in other countries as "proof" of efficient management. Nothing could be further from the truth. By and large, countries that have slowed the growth of health care spending have done so by *denying services,* not by using resources efficiently.

How much does it cost a hospital to perform an appendectomy? Outside the United States, it is doubtful that any public hospital knows. Nor do government-run hospitals typically keep records that would allow anyone else to find out.[42] In organizational skills and managerial efficiency, Canadian

Victims of Global Budgets

Among the victims of Canada's system of health care rationing are the following well-known cases:

- Malcolm Stevens of British Columbia died of a heart attack after two months on the waiting list. Ironically, that same day his doctor bumped another patient from the surgery schedule in order to make room for Stevens.
- Charles Coleman, a 64-year-old man, died shortly after a heart operation at Toronto's St. Michael's Hospital. Coleman's operation had been postponed 11 times.
- Stella Lacroix's death started as a suicide. Moments after she swallowed a quart of cleaning fluid she raced to the nearest emergency room. Because the hospital wasn't equipped to perform the surgery she needed to stop the internal bleeding, the emergency room physician spent 3 1/2 hours contacting 14 hospitals in an effort to secure emergency surgery and an available intensive care bed. By the time she arrived at Ontario's York County Hospital, it was too late. She died that night.
- In January 1990, two-year-old Joel Bondy needed urgent heart surgery that was repeatedly postponed. Alarmed at their son's deteriorating condition, his parents contacted Heartbeat Windsor, an underground railroad for Canadian heart patients, to arrange for the surgery in Detroit. Embarrassed by media coverage of Joel's situation, Canadian officials promised Joel would be moved to the top of the waiting list. After a four-hour ambulance ride to a hospital which lacked an available bed, the family had to spend the night in a hotel. The next day Joel Bondy died.

The Canadian press has produced scores of similar stories. The following are some additional examples:

- According to one report, 24 people died in 1989 while waiting for heart surgery in British Columbia.
- At Winnipeg's Health Science Center, Manitoba's largest hospital, six heart patients died in 1988 before they reached the operating room.
- In January 1989, long waiting lists forced Toronto's highly respected Hospital for Sick Children to send home 40 children who needed heart surgery.
- At Moncton Hospital in New Brunswick, some patients were kept in hallways and even in closets, while 2,300 people were on the waiting list for surgery.
- Because of a four-month wait for mammograms at St. Clare's Hospital in Newfoundland in 1988, preventive screening became impossible and the hospital could handle only women who needed an immediate diagnosis.

Sources: House Wednesday Group, "Public Health in the Provinces," September 29, 1989; "The Crisis in Health Care: Sick to Death," *Macleans*, February 13, 1989; Michael Walker (Fraser Institute), "Why Canada's Health Care System is No Cure for America's Ills," Heritage Foundation Backgrounder, November 13, 1989; "Canadians Cross Border to Save Their Lives," *Wall Street Journal*, December 12, 1990; and Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989).

"About one-fourth of all acute-care beds are occupied by chronically ill patients using the hospitals as expensive nursing homes."

hospitals are far behind hospitals run by Hospital Corporation of America, Humana or American Medical International. In fact, Canadian hospitals in several provinces have called in management groups from the U.S. to either retrieve them from financial difficulty or to improve generally their financial performance.

While 177,000 wait for surgery in Canada, at any point in time one in five hospital beds is empty.[43] Moreover, about 25 percent of all acute-care beds are occupied by chronically ill patients who are using the hospitals as nursing homes — often at six times the cost of alternative facilities.[44]

One reason for these inefficiencies is that under global budgets hospital managers have perverse incentives. In Canada, hospitalized chronic patients are known as "bed blockers," and they are apparently blocking beds with the approval of hospital administrators. Because these patients use mostly the "hotel" services of the hospital, they are less draining to limited hospital budgets.[45]

One widely used measure of hospital efficiency is average length of stay. In general, the more efficient the hospital, the more quickly it will admit and discharge patients. By this measure, U.S. hospitals are far in front of their Canadian counterparts. The average hospital stay is 42 percent longer in Canada than in the United States.[46]

A frequent criticism of the U.S. health care system is that it is wasteful because many procedures are "unnecessary." One source of evidence for unnecessary medical care is a series of studies that show wide variations in the rate of treatment among different U.S. communities, with no apparent justification. One might suppose that in countries where health care is rationed and many medical needs are unmet, doctors would tend to provide only necessary care. That turns out not to be the case. As in the United States, treatment rates in Canada vary considerably. For example:[47]

- There is a four-to-one difference among Canadian counties in the rate of cesarean sections.
- There is a four-to-one difference in rates of tonsillectomy and hysterectomy and a two-to-one difference in the rates of mastectomy, prostatectomy and cholecystectomy.

Failure to Control Costs in Canada

Despite global budgets, rationing by waiting and other strategies, Canada has not been any more successful in controlling costs than has the United States. In 1991, the United States spent $2,868 per person on health care, whereas Canada spent only $1,915 (in U.S. dollars).[48] Some people argue that if the U.S. adopted Canada's health care system, it could cut health care spending by 25 percent. However, over the 20 years from 1967 to 1987, real increases in health care spending per capita were virtually the same in

both countries. (The increase was 4.38 percent in the United States, 4.58 percent in Canada.)

Not only has Canada been no more successful than the United States in controlling increases in spending but, as Figure VI shows, until recently it has been less successful.[49] As noted in this report, recent financial successes in Canada have been achieved largely by denying and delaying care.

Problems in Making Cost Comparisons. When comparing United States and Canadian health care spending, certain differences should be kept in mind:

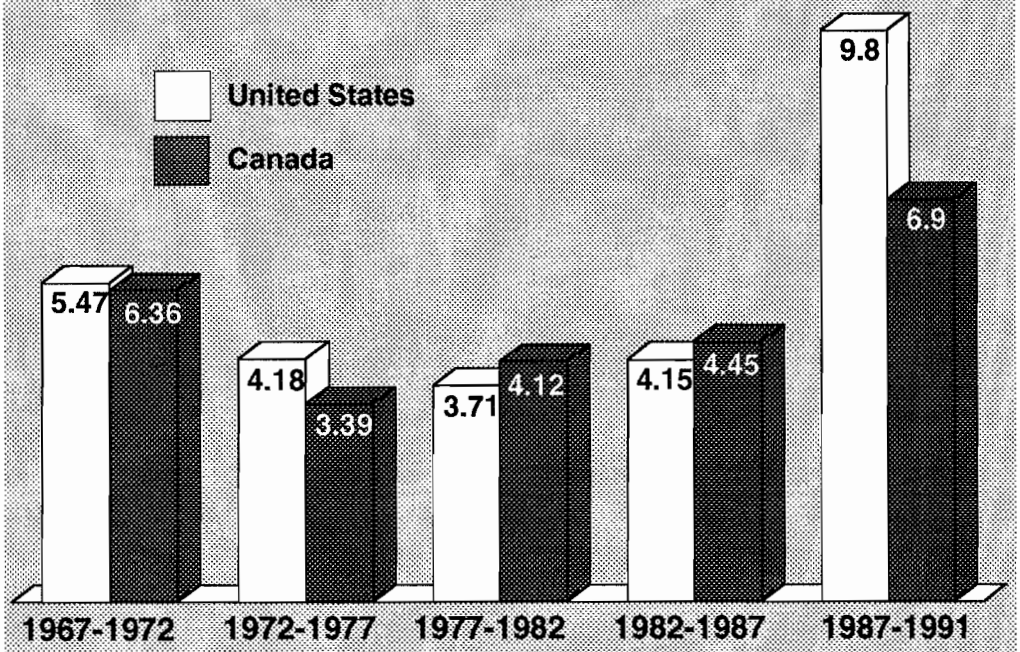
- First, the Canadian number doesn't include capital spending to the same extent as the U.S. number.
- Second, the U.S. number includes research and development costs. Canada engages in very little such spending, while U.S. spending on research and development results in technological innovations that benefit Canada as well as the rest of the world.

"In recent years, health care spending per capita in Canada has grown faster than in the United States."

FIGURE VI

Increase in Real Health Care Spending Per Capita in the United States and Canada

Annual Percentage Increase



Source: Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989), Figure 4.4, p. 41. 1987-1991 figures from Health and Welfare Canada with calculations by the Fraser Institute.

- Third, in both countries the costs of administering government health care spending are largely hidden. But since Canada's public sector is relatively larger than that of the United States, far more of Canada's costs are buried in bureaucratic budgets.

"For comparable types of spending, Canada's health costs are growing much faster than those in the United States."

More Precise Comparisons. In order to avoid these problems, one study measured international health care spending excluding costs of administration, hospital construction and research and development.[50]

- Using this more precise measure, the study found that the United States spends more of its income on health care than Canada — but the difference is smaller (10.2 percent vs. 8.4 percent.)
- During the 1980s, the real growth rate for health care spending was 85 percent higher in Canada than in the U.S.
- In per capita terms, Canada had a real growth rate that was 163 percent of the U.S. rate.

Conclusion

The characteristics described in this backgrounder are not accidental by-products of global budgets and price controls. They are the natural and inevitable consequences of government's responding to increases in the demand for health care by restricting the supply.[51]

In Canada, hospitals and doctors are given fixed budgets and are forced to ration health care, with few questions asked. Politicians create as much distance as possible between themselves and the decisions that affect the lives of patients. As a practical matter, no administration can make it a national policy that people will be denied care because the government is unwilling to allow the purchase of additional technology. Nor can any administration announce that some people must wait for surgery so that the elderly can use hospitals as nursing homes or that elderly patients must be moved so that surgery can proceed.

These decisions are so emotionally loaded that no elected official can afford to claim responsibility for them. Important decisions on who will and will not receive care and on how that care will be delivered are left to the hospital bureaucracy because no other course is politically possible.

To the extent that global budgets and rationing of care "work" in Canada, they do so because the wealthy, powerful and sophisticated — those most skilled at articulating their complaints — find ways to maneuver to the front of the rationing queues or avoid them by going to the U.S. for care. Thus those who have the power to change the system bear few of its costs.[52]

"Canadaian politicians create as much distance as possible between themselves and the rationing decisions that affect the lives of patients."

The conclusion of this backgrounder is that while the Clinton proposal has ostensibly rejected a Canadian version of nationalized health care, it has adopted the key deficiency of the Canadian system. Capping the supply of care through budget and premium limitations, as in the Canadian system, will lead to lower costs only to the extent that they lead to shortages of technology, waiting for treatment and reduced response to the health care needs of Americans.

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Notes

[1] The president outlined his health care plan on September 22, 1993, before a joint session of Congress.

[2] The "Jackson Hole Group" — named for their meeting place and including Alain Enthoven, Paul M. Ellwood and Lynn Etheredge — conceived the idea of "managed competition" based on forming regional health insurance purchasing cooperatives (HIPCs) to negotiate for health care coverage. For a description of their plan, see Ellwood, Enthoven and Etheredge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics* 1, 1992, pp. 149-68. For Ellwood's reaction to the Clinton plan, see Paul M. Ellwood, "Clinton Forgets His Health Care Allies," *Wall Street Journal*, August 10, 1993.

[3] "A Health Proposal Headed for Failure," *New York Times,* September 16, 1993.

[4] Robert Pear, "Agency Faults Plan to Control Insurer's Income," *New York Times,* September 18, 1993.

[5] Michael Walker (Fraser Institute), "Why Canada's Health Care System Is No Cure for America's Ills," Heritage Foundation Backgrounder, November 13, 1989, pp. 7-8.

[6] The treatment for patients with chronic renal failure and the use of CAT scanners continued its rise in virtually every country throughout the 1980s — an acknowledgement of the medical value of these innovations. Some have argued that the U.S. went too far in its use of pacemaker implants, however. See the discussion in John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," NCPA Policy Report No. 166, National Center for Policy Analysis, December 1991.

[7] Statistics Canada General Service Survey — Health, 1991.

[8] The discussion in this section is based on Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum*, May 1993.

[9] Steven Globerman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute, 1990.)

[10] General Accounting Office, *Canadian Health Insurance: Lessons for the United States,* June 1991, Table 4.1, p. 55.

[11] See, for example, Joan Breckenridge, "Grief, Frustration Left in Wake of Man Who Died on Waiting List," *Globe and Mail* (Ontario), January 25, 1989.

[12] Miyake and Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition."

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Hospital admissions as a percent of the total population average 16.1 percent for all OECD countries. The figures are 15.9 percent for the United Kingdom, 13 percent for New Zealand and 14.5 percent for Canada. George J. Schieber, Jean-Pierre Poullier and Leslie M. Greenwald, "Health Systems in Twenty-four Countries," *Health Affairs,* Fall 1991, Exhibit 4, p. 27.

[17] Health insurance industry officials in the United States report that about 4 percent of the population consumes about 50 percent of health care costs. See Blue Cross/Blue Shield, *Reforming the Small Group Health Insurance Market* (Chicago: BC/BS, 1991), p. 6.

[18] For example, in Ontario in 1989 the number of people waiting for open-heart surgery equaled more than 25 percent of the total surgeries performed. Because of special efforts to reduce the waiting lists, Ontario achieved a rate of one person waiting for every seven surgeries by January 1991. See C. David Naylor, "A Different View of Queues in Ontario," *Health Affairs,* Fall 1991, pp. 115-16.

[19] Ibid.

[20] Walker, "Why Canada's Health Care System Is No Cure for America's Ills," p. 9.

[21] "Humans Wait in Pain, Dogs Don't," *Daily Mercury*, Guelph, Ontario, June 14, 1991.

[22] John K. Iglehart, "Canada's Health Care System Faces Its Problems," *New England Journal of Medicine*, Vol. 322, No. 8, February 22, 1990, p. 566.

[23] Miyake and Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition."

[24] See Canada/America, Supplememtal Surgical and Diagnostic Health Plan for Canadian Individuals, Canada-America Health Care Corporation, 208-62 Hargrave Street, Winnipeg, Manitoba.

[25] Until the recent change, Ontario paid 75 percent of the standard U.S. hospital charges and the same physician's fee it would have paid had the service been provided in Ontario.

[26] General Office of Accounting, Canadian Health Insurance, pp. 53 ff.

[27] A review of the hospital records of open-heart surgery patients in Toronto found that while physicians generally assigned sensible priorities, there were "many instances of relatively short waits for elective cases while more urgent cases waited inappropriately long periods of time." See Naylor, "A Different View of Queues in Ontario," p. 121.

[28] House Wednesday Group, "Public Health in the Provinces," September 29, 1989, p. 14.

[29] D.H.A. Amoko, R.E. Modrow and J.K.H. Tan, report in the *Healthcare Management Forum*, Vol. 5, No. 4, pp. 34-39.

[30] Press release by National Citizens Coalition, September 16, 1993.

[31] Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989), pp. 17-18 and p. 20.

[32] Ibid.

[33] Rosie DiManno, "Hard Choices Facing Health Care System," *Toronto Star,* January 28, 1989.

[34] For a discussion covering several countries, see Goodman and Musgrave, "Twenty Myths About National Health Insurance."

[35] See G.M. Anderson, J.P. Newhouse and L.L. Roos, "Hospital Care for Elderly Patients with Diseases of the Circulatory System: A Comparison of Hospital Use in the United States and Canada," *New England Journal of Medicine*, Vol. 321, No. 21, November 23, 1989, pp. 1443-48; and the discussion in Naylor, "A Different View of Queues in Ontario," pp. 117-18.

[36] See Goodman and Musgrave, "Twenty Myths About National Health Insurance."

[37] Jean-Pierre Thorrez, Peter Foggin and Andre Rannou, "Correlates of Health Care Use: Inuit and Cree of Northern Quebec," *Social Science and Medicine*, Vol. 30, No. 1, pp. 25-34.

[38] Nationwide Canadian figures are from "Canadian Social Trends," Winter 1989, Statistics Canada. U.S. figures are from "Trends in Indian Health, 1991," U.S. Department of Health and Human Services. The life expectancy at birth in Canada is 62.4 years for male Indians and 71.8 years for male non-Indians, 68.9 years for female Indians and 70.7 years for female non-Indians. In the United States, the figures are 67.1 years for male Indians and 70.7 years for male non-Indians, 75.1 years for female Indians and 78.1 years for female non-Indians.

[39] Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1989-90* (Vancouver: University of British Columbia, 1992).

[40] Arminée Kazanjian et al., *Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia, 1989), pp. 121-76.

[41] David Caplan, letter to the editor of the *New England Journal of Medicine* (July 13, 1989), p. 115. Reprinted in "Public Health in the Provinces," p. 12.

[42] A Canadian observer reports that "Ontario hospitals lag at least a decade behind their U.S. counterparts in expenditure tracking and management information systems." See Naylor, "A Different View of Queues in Ontario," p. 112.

[43] The most recent statistics of the Organization for Economic Cooperation and Development (OECD) are expected to show an occupancy rate of 80.3 percent for acute care hospitals and 82.7 percent for all hospitals in Canada for 1987. See Schieber, Poullier and Greenwald, "Health Care Systems in Twenty-four Countries," Exhibits 4 and 5, pp. 27, 29.

[44] In Canada, the latest estimate is 23 percent. See Neuschler, *Canadian Health Care: The Implications of Public Health Insurance,* p. 18.

[45] See DiManno, "Hard Choices Facing Health Care System"; "Ceiling System Needs Radical Surgery," (Sunday) *Toronto Star*, March 27,1988; and Robert G. Evans et al., "Controlling Health Expenditures: The Canadian Reality," *New England Journal of Medicine*, Vol. 320, No. 9, March 2, 1989, p. 574.

[46] See the discussion in Schieber et al., "Health Care Systems in Twenty-four Countries," pp. 28-30.

[47] K. McPherson et al., "Regional Variations in the Use of Common Surgical Procedures: Within and Between England and Wales, Canada and the United States of America," *Social Science of Medical Services and Surgical Procedures: A Chartbook* (Washington, DC: National Health Policy Forum, 1985). Reprinted in Organization for Economic Cooperation and Development, *Financing and Delivering Health Care* (Paris: OECD, 1987), Chart 2, p. 18.

[48] Calculations by the Organization for Economic Cooperation and Development, reported in the *Vancouver Sun,* October 2, 1993.

[49] This analysis is based on Neuschler, *Canadian Health Care*, pp. 37-53. For a critique of this approach, see Morris L. Barer, W. Pete Welch and Laurie Antioch, "Canadian/U.S. Health Care: Reflections on the HIAA's Analysis," *Health Affairs*, Fall 1991, pp. 229-36.

[50] This section is based on Dale A. Rublee and Markus Schneider, "International Health Spending: Comparisons with the OECD," *Health Affairs,* Fall 1991, pp. 187-98. See, however, a critique of this approach in George J. Schieber and Jean-Pierre Poullier, "Advancing the Debate on International Spending Comparisons," *Health Affairs,* Fall 1991, pp. 199-201.

[51] See Goodman and Musgrave, "Twenty Myths About National Health Insurance."

[52] An exception is Robert Bourassa, the premier of Quebec, who came to the United States twice in 1990, once for consultation and once for an operation.