Canadian Health Care and Its Vulnerabilities

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HOW CANADIAN HEALTH CARE IS VIEWED IN THIS country is a reflection of the dilemmas that confront U.S. medicine. Canada's Medicare program first attracted the attention of American observers during the 1970s, when national health insurance proposals were being considered by the Congress (Marmor 1993). Following this episode, interest in Canada's system quickly subsided among all but a small coterie of health policy specialists. When health care reform regained preeminence on the American political agenda in the early 1990s, Canadian practices once again emerged as rich fodder for lessons designed to guide public policy development. As political scientist Antonia Maioni stated: "Canada's health insurance system . . . [became] a useful target and a political weapon in the reform debate, alternatively used as a model of what American health reform ought to aspire to, or as an ominous warning about the problems inherent in government in a national health insurance program" (Maioni 1994, 2–3).

Today the backdrop for American interest in Canada's health system is the controversy over managed care. U.S. health care has entered an unmistakably chaotic period, marked by rampant corporatism, a swelling wave of complaints against insurance gatekeepers, and increasing privatization of Medicaid and Medicare through large-scale public contracts

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with managed care organizations. In the context of this turbulence, the Canadian health care system appears to some as a distant beacon of comfort, order, reliability, and effectiveness. Significantly, a majority of students and faculty in American medical schools who were recently surveyed for their views on managed care rated it negatively, compared with fee-for-service, in several critical areas: access to care; handling of ethical conflicts; the doctor-patient relationship; continuity of care; and care at the end of life. When asked to choose a health system framework, 57 percent of these doctors and doctors-to-be favored the single-payer option, followed by managed care (22 percent) and a fee-for-service system (19 percent) (Simon, Pan, Sullivan, et al. 1999).

An urgent desire for rescue from our own ills, however, is probably not the best method for arriving at an understanding of the Canadian health care system. With nations, as with people, the positive cannot easily be separated from the negative; rather, the two are often different facets of the same, deeply ingrained traits. Moreover, every nation's health system is an idiosyncratic choice, reflecting a unique combination of social values, political ideology, structural interests, and institutional capabilities. As a construction of policy mechanisms, the Canadian system maximizes certain benefits and neglects others. It is also a national system that, like all others, possesses distinctive vulnerabilities. Together with the now familiar data on access, cost control, and health status indicators under Canada's single-payer system, a brief sketch of some of these vulnerabilities, plainly exposed over the past several years, can present a balanced picture of the Canadian health care solution.

The first vulnerability is an economic one. When a single payer is in charge of health care, not only is the management of the system consolidated; the impact of economic woes is intensified as well. In contrast to the United States, where health care funding is dispersed among many public and private sources, in Canada general strains in public finance reverberate through the health sector with little buffering or delay. Health care spending, which is the largest single item in Canadian provincial budgets, has been undermined by several factors during this decade: soaring deficits, declining public revenues, and the continued reduction of federal grant money for provincial health care programs (Rathwell 1994; Boase 1996; Crichton, Robertson, Gordon, et al. 1997). The fallout has been a widespread policy of retrenchment, whose impact has been strikingly severe in some locales.

Hospital bed reductions, cuts in health manpower, and physician spending caps have all been common. For example, the province of

Quebec shut down 10 hospitals in two years, and Ontario has slated 39 of its 187 hospitals for closing (Nickerson 1999; Lindgren 1999). Both Toronto and Montreal this past winter reportedly experienced extreme overcrowding and long waits for treatment in their hospital facilities. To be fair, excess hospital capacity has long been a concern in the Canadian system, and institutional downsizing is being coupled with restructuring plans that emphasize community care alternatives. However, much of the benefit of service reconfiguration has been slow to materialize, forcing policy makers to reverse some of their earlier cutbacks (Gordon 1999; Blizzard 1999).

A second vulnerability, surprisingly, is political—institutional in nature. Frustrated by the defeat of health care reform, many critics bemoan the poor performance of U.S. governmental institutions, in particular the political deadlock and influence of special interests that can result from the division of powers between our executive and legislative branches (e.g., Steinmo and Watts 1995). Canada, by contrast, has often been praised for the efficiency of its parliamentary system, which fuses executive and legislative control in a context of strong party discipline. American observers, however, tend to overlook the fact that such a policy-making apparatus is equally responsive to liberal and conservative dominance. So it is that as conservative politicians have gained power in certain parts of Canada in recent years, they have been able to undermine existing health policy commitments.

The clearest example of this phenomenon is found in Alberta, where the Tory government of Ralph Klein has held an iron grip on power since 1993. Like other provincial leaders, Klein took strong steps to control Alberta's deficit (eliminating it by 1996); in so doing, he also increased subsidies to the private sector (Taft 1997). Meanwhile, his government cut more than 10 percent from the provincial health budget over a period of just three years (Laghi 1996). Klein not only scaled back Alberta's financial commitment to health care; he has also supported changes that represent a marked departure in the character of the Medicare program, like opening private clinics for patients unwilling to tolerate public queues, instituting user fees, and "deinsuring" certain services. Although the Klein government's actions on Medicare have been moderated by federal rules and the subsequent resistance of citizens and health care professionals, there is no denying the fundamental character of his assault. As Albertan sociologists Trevor Harrison and Gordon Laxer (1995) have written, the "ultimate objective, as the government itself has proclaimed, is the replacement of a

publicly-administered, universal, and comprehensive system for the provision of medical and hospital services with a private insurance system" (p. 225).

Finally, there is the systemic vulnerability that is exposed, and experienced, by patients whose service needs are based in the Canadian medical sector while also transcending it. Consider the plight of the mentally ill (Rochefort and Portz 1993). Patients with mild or moderate mental health problems who receive their care from MD practitioners are likely to be well served by Medicare, which has few of the arbitrary treatment and payment restrictions featured in U.S. mental health insurance benefits. However, individuals with more profound disorders, like chronic mental illness, encounter many of the same barriers in Canada that such patients face in the United States when they require extensive social supports in conjunction with their medical care: resource shortages, lack of coordination, an incomplete spectrum of services, and inconsistent political support. In Vancouver, Toronto, and other major Canadian cities, the mentally ill homeless are a visible reminder of how much has been left undone in this regard (see, for example, *Toronto Star* 1998). In seeking to improve their systems of community mental health care, many provinces have actually turned to the United States, judiciously adopting (and adapting) some of our best model programs (Rochefort and Goering 1998).

Canada's record of universal access, combined with cost control, is indeed an outstanding accomplishment that perhaps should lead the United States in the direction of single-payer national health insurance. This assumes, of course, that we could overcome the major cultural, economic, and political obstacles that have blocked this path so far. Yet, Americans need to appreciate the limitations of simplified comparisons between health care in the two nations. The answer to the question of whether Canada or the United States has the better health system is largely contingent, depending on specific geographic locations, types of patients, and types of illnesses.

For both Canadians and Americans, the late 1990s have been a period for recognizing shortcomings in their societal health care arrangements. In the former instance, a governmental model has had to absorb strong financial and political shocks. In the latter, private entrepreneurship has clashed with public interest concerns. Responding to these respective challenges, each nation has diluted the purity of its own approach. In Canada, adjustments have included experimentation with innovations

like integrated delivery systems and capitation on a regional level. In the United States, we see a movement for expanded public regulation over the private health insurance industry. Resulting from this evolutionary process is an element of convergence between the Canadian and American systems. The dynamic changes in Canadian and American health care over the past decade make it very difficult to predict the futures of these systems in specific terms, but both pragmatism and social philosophy will shape the complex bargains and trade-offs that inevitably will be involved.

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