

Top Myths of the Canadian Health Care System: Implications for the United States



Sometimes we have the least insight into those who are our closest neighbors. We can slip into a comfort zone and allow proximity to foster a sense of deeper understanding than what truly exists. A pitfall of this is that we may not then invest the time and energy in thorough examination, potentially bypassing an opportunity to learn and benefit from a closer look.

Canada and the U.S. provide an interesting case study of this phenomenon, especially as it relates to their respective healthcare systems. As two contiguous nations, they share a common language and many cultural hallmarks. Both are also faced with aging populations, rising consumerism and imposing health care cost trends. Most Americans know that Canada

has comprehensive coverage via a publically financed health insurance system but, when probed, many could not say how the delivery system is structured, if Canadian citizens are responsible for any out-of-pocket costs or how physicians are compensated.

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diverse cross-section of U.S. health care including providers, payers, employers, innovators and academics. Areas of interest for the group included the alleged Canadian wait times for diagnostic and specialty services, the satisfaction levels of physicians, (especially primary care providers), and gaining a better understanding of how Canada is able to spend less than the U.S. on health care (10.4% vs. 16% of GDP) while having superior performance on some common outcomes metrics (see Table #1, page 4).

From the early framing of delegates' questions, it was clear that some had arrived with preconceived notions about Canada and its health care system that over the course of the study mission were to be addressed by our expert hosts in Vancouver. The mission included presentations by a dozen Canadian policymakers, scholars, physicians, and other stakeholders; tours of clinics and hospitals; and interactive discussions between the American delegates and the Canadian representatives.

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To facilitate U.S. health care executives' knowledge of other country's health care financing and delivery systems, the Academy for International Health Studies (AIHS) arranges study missions twice a year to a broad range of international destinations (see AIHS sidebar). In September 2010, an AIHS delegation visited Vancouver, British Columbia (BC), to learn more about the current state of health care enjoyed by our neighbors to the north. The group of forty delegates represented a

I. Structural “Myths”

Prior to World War II, Canada had a private health care system similar to that in the U.S. Its move toward a social insurance model, culminated with the federal Canada Health Act of 1984. The current program offers universal coverage for Canadians and no copays at the time of care for medically necessary services. Contrary to what many Americans might think, however, the Canadian system is not truly a public one, nor are health care expenditures 100% funded by a single payor.

The ten provinces and three territories form the backbone of the Canadian Medicare system (the U.S. and Canada share an affinity for this name). Individually and with their own unique perspectives, these provinces and territories manage the provision and financing of medical services for their citizens. Provincial governments arrange the delivery system components and

determine the definition of what is medically necessary and therefore the extent and amount of coverage of insured services. The federal role is predominantly one of funder, and it is not even the primary funder for the public program. The Canada Health Act lays out five core conditions that the provinces must abide by in order to receive any federal funds (see sidebar on next page).

British Columbia (BC), according to Steve Kenny of Canadian Advanced Medical Services International, receives only 14% of its health care budget from the federal government transfer based on an adjusted per-capita formula. BC then must come up with the additional 86% itself, a spending level that consumes 40-45% of the total provincial budget. To augment funding from its general tax revenues, BC also has a mandatory health insurance premium (one of three provinces in Canada that assesses its citizens a monthly rate) of \$54 single/\$108 family, with subsidies for low-income families. Apparently, BC uses a premium mechanism for the same reasons the U.S. favors explicit cost sharing—to sensitize consumers to the costs of health care.

Public spending from general tax revenues at both the federal and provincial levels accounts for just over 70% of the total (see Chart #1, page 5). Beyond the revelation that it is not an entirely publically funded system, a few other unexpected nuances include that the “medically necessary” covered services are not comprehensive; that there is a significant private insurance component to the system; and that Canadians actually have a higher percentage of out-of-pocket expenses vs. the U.S. (almost 15% vs. 12%; see Table 1 on page 4).

According to Dr. Robert Evans, an economist at the University of British Columbia, if you truly want to understand the Canadian system, these higher out-of-pocket costs in the face of universal public coverage are a key paradox to unravel. The out-of-pocket costs are due, in part, to the omission

Five Core Conditions of the 1984 Canada Health Act

- 1. PUBLIC ADMINISTRATION:** Provincial insurance programs must be publicly accountable for the funds they spend and the activities must be carried out by a not-for-profit authority.
- 2. ACCESSIBILITY:** Canadians must have reasonable access to insured services without charge or paying user fees.
- 3. COMPREHENSIVENESS:** Provincial health insurance programs must include all medically necessary services.
- 4. UNIVERSALITY:** Provincial health insurance programs must insure Canadians for all medically necessary hospital and physician care.
- 5. PORTABILITY:** Canadians are covered by a provincial insurance plan during short absences from that province.

of most outpatient pharmaceuticals from what is considered medically necessary services. Dental, vision, and some long-term care are also deemed outside of the public coverage arena. According to a presentation to the AIHS delegation by Bruce Cuddihy, Associate Regional Director General for Health Canada, British Columbia Region, many employers offer supplementary coverage for these areas. One key thing to note is that private insurers are prohibited from covering any benefit already included in the public program.

Some may also harbor the notion that that the Canadian health care delivery system is socialized (i.e., government-owned) and that physicians are salaried government employees. In fact, delivery of health care is split between public and private entities and the vast majority of Canadian physicians are self-employed. While the public program in BC does represent 80%+ of physicians’ incomes, 90% of all physicians are self-employed and reimbursed on a fee-for-service basis via a fee schedule negotiated between BC and the BC Medical Association (BCMA).

The public system discourages any form of balance billing or additional user fees related to medically necessary services, so any private pay income derives from uninsured patients (non-Canadians) and non-medically required services. An interesting characteristic of the BC medical community, in contrast to the American experience, is the 95% participation level among practicing physicians in the BCMA and the apparent high level of trust that physicians have in both the overall system and their medical association. This enables an environment of integration and collaboration that is a clear hallmark of the Canadian health care system and potentially the key to how they are able to “do more for less.”

II. Experiential “Myths”

It was impossible for AIHS delegates not to take note of the continually discussed cooperation and dedication to a common purpose between the stakeholders in the Canadian health system: government, health authorities, academics/researchers, physicians and, apparently, patients. This cooperation is foundational to making it all work and each group contributes by giving consent and support to the concept that health care for all at an affordable, sustainable cost level comes with some compromises. These compromises are often what the U.S. hears about in the media as they get noted and then translated through our cultural lens.

Two such areas that were brought up repeatedly during the AIHS Vancouver Mission included the experience of the primary care physician in Canada and the infamous alleged wait times for elective surgery and diagnostic procedures.

Back in the 1980s and 1990s, there was not such strong evidence of cooperation and collaboration by the physicians. Dr. Dan McCarthy of the BCMA shared that those times were characterized by a high degree of acrimony between physicians, the provincial government and the medical association.

Family practice providers in particular were very unhappy; feeling undervalued and under-compensated, a familiar song to those from the U.S. At that time, some were leaving Canada to practice in the U.S., bringing with them their tales of inefficiency, low reimbursement and frustrated patients. That story seems to have been frozen in time for some in the U.S. while the reality in Canada today is quite different and far more positive.

The next chapter of the story involved a realization in BC during the late 1990s that primary care was both the most critical area of the health services continuum (see Chart #2, page 6), and one that was failing. This stimulated a multi-pronged strategy to repair and restore family practice that aimed to move the discussion off just a fee schedule

Table 1. KEY COMPARATIVE METRICS



FINANCIAL / OPERATIONAL

| | | |
|--|---------|---------|
| % GDP Spent on Healthcare | 10.4% | 16.0% |
| Per Capita HC \$\$ | \$4,079 | \$7,538 |
| Total HC \$ = Public | 70.2% | 46.5% |
| Total HC \$ = OOP | 14.7% | 12.1% |
| Total HC \$ = Pharma | 17.2% | 11.9% |
| Acute Care ALOS | 7.5 | 5.5 |
| Gini Coefficient (measure of income disparity) | 32 | 38 |

HEALTH STATUS / OUTCOMES

| | | |
|---|-------|-------|
| Population Obese | 24.2% | 33.8% |
| Life Expectancy at Birth (yrs) | 80.7 | 77.9 |
| Life Expectancy Females at 65 | 21.3 | 19.8 |
| Infant Mortality | 5.0 | 6.7 |
| Subjective Well-Being – Positive Experience Index | 79.8 | 76.3 |

Source: OECE Reports

and to the creation of a more holistic approach.

The BCMA leadership didn't sidestep compensation; they believed that this was a necessary but not a sufficient component to enacting real change. They invested significant time, effort and money in engaging physicians to hear what their issues and needs were so that the final model also incorporated elements of fostering enduring relationships, providing needed support via training and office infrastructure and a robust focus on professional development and quality improvement in a non-threatening manner.

According to Dr. McCarthy, their efforts over the past dozen years have led to an improved culture and operations, with physician satisfaction way up and positive movement on patient satisfaction, access and several targeted utilization and morbidity measures. On the physician satisfaction front, 83% reported in a BCMA member survey that they supported or strongly supported this holistic approach that did not focus solely on compensation negotiations. Comparative data on physician compensation can be tricky to interpret but while they do not seem to be grossly underpaid, it appears that primary care physicians in Canada are on average making less than their U.S. counterparts (\$140,124 annual in Canada vs. \$186,000 in the U.S. for 2008). In their favor, however, in addition to the BC model with all its supports, their physicians also enjoy a very low burden of administration and far less expensive malpractice coverage.

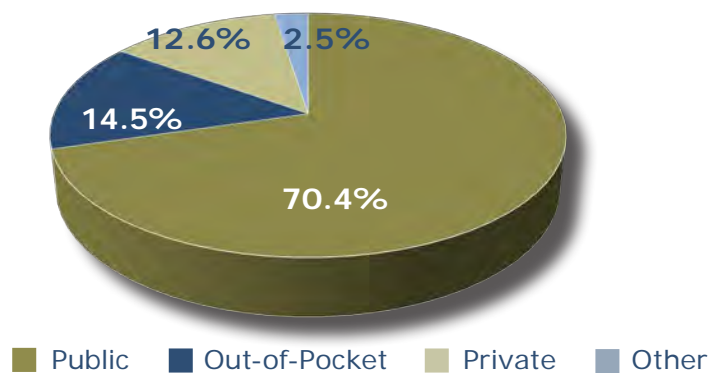
The single most controversial facet of the Canadian health care system has to be its wait times for elective surgery and diagnostic tests. Americans often point to the queues as a failing of the system and an area where the U.S. has superior performance.

It is true that there are longer wait times for specialist appointments, some surgical procedures, and access to diagnostic tests such as the MRI in Canada than in the U.S. However, this has been an

area of key focus for Canada, with some positive results. Both the federal and provincial authorities have begun to implement targeted funding to reduce specific queues and improve access for all.

It is also important to remember that wait times

Chart 1. Total Canadian Health Care Expenditures by Category



in Canada are primarily a function of resource allocation and service capacity and not at all about an individual's access to coverage or care due to income or employment status as they can be in the U.S. There are many Americans who face extended or permanent "wait times" for care due to their insurance status. It is relevant to further note that the decision to be placed on a wait list is usually driven by medical necessity and something the treating physician is managing, with the patient, and not a top-down directive from the public payor.

Overall, Canadians are not fans of wait times and queues but express a positive attitude toward the public nature of their system. Dr. Bob Woollard of Canadian Doctors for Medicare shared some results from the Romanow Report during his presentation that drew from in-depth focus groups with the public. They found strong support among Canadians for both the equitable nature of the system and the focus on access that was not linked to ability to pay.

III. Conclusions and Implications for the United States

Canada does not purport to have the optimal health care financing and delivery system. Their own experts are quick to point out flaws and to agree that the country and individual provinces struggle with many of the same challenges we face in the U.S.

Ken Peacock, the Director of Economic Research for the Business Council of BC, shared that, while Canada appears to be making a decent recovery

On the larger scale, in 2014 Canada will have to grapple with the upcoming renewal of the Canada Health Accord. There are predictions of difficult negotiations between the provinces and the federal government on the levels of federal transfers for health care expenditures. It remains to be seen if provinces band together to enhance their leverage and whether discord over the public budgets opens the door to more discussions around privatization of the system. This negotiation may test how far the Canadian cooperation and common purpose extends.

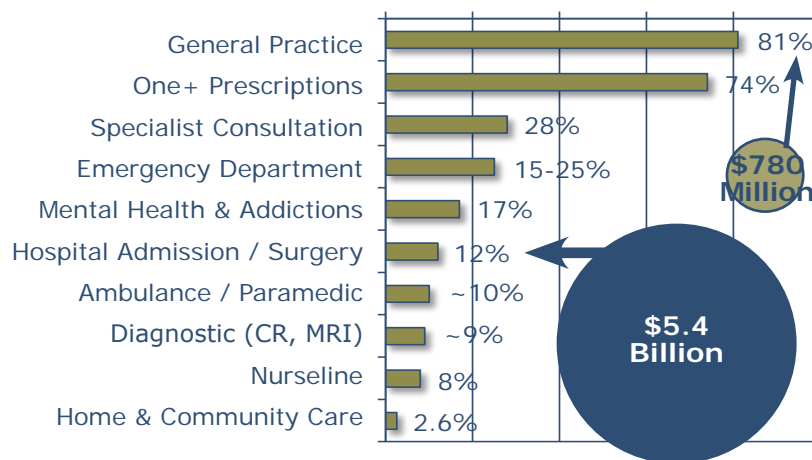
What Canada really does have going for it is a more aligned delivery system supported by an underlying value set that promotes cooperation, equality and fairness. One way to conceptualize this difference as it relates to the U.S. is to recall that Canada was founded on the principles of “Peace, Order and Good Government” while the U.S. was founded on the creed of “Life, Liberty and the Pursuit of Happiness.” That being said, there are many lessons learned from our study of Canada’s health care system. Some of the take-aways are more conceptual in nature but there are plenty of jewels to be mined from what the AIHS delegation was presented with in Vancouver.

Here are three areas of potential focus for the U.S. that stood out upon reflection after the study mission:

1. A renewed focus on primary care physicians as the critical link in the chain and a focus beyond just incentives.

The Canadian perspective that primary care was essential to the overall performance of the system is not a revelation in itself and something that many in the U.S. understand and embrace. What is unique may be the holistic approach through a robust campaign to improve professional dynamics. In the U.S., we tend to focus on compensation issues and overrely on incentives to achieve the behaviors we seek. The attention paid

Chart 2. British Columbia Medical Association Service Line Usage Data



after the recession, it is faced with several key hurdles related to the financing of health care. Canadians see unexplained practice variation both within BC and across the provinces. Ken also expects that an older and more diverse population will strain the system and is forecasting accelerated per capita health care costs that could outstrip the economy. At the same time, Ken sees a powerful cost driver in the adoption of new health care services and technologies. He also acknowledged some of the limitations in fostering innovation and moving away from a short term price-focused mentality within a monopsonist (i.e. large single buyer) environment.

in BC to the enhanced training and physician office infrastructure supports, as well as the work done to rebuild and sustain a strong sense of professional commitment by the physicians to each other, their patients and to the system may be what makes the difference.

Accountable Care Organizations (ACOs) may be one avenue to begin shifting more in this direction. A specific tip would be to consider the practice management redesign efforts being undertaken by the BCMA. The creation and deployment of training modules such as those around Advanced Access or End of Life Care would be good places to start, as would exploring the BCMA model around the creation of divisions of family practice, local or regional clusters of PCPs that are encouraged and support to work together for a common group of patients. For more information see the BCMA website at <https://www.bcma.org/>

2. A second (or third) look at Fee-For-Service Reimbursement.

After saying that reimbursement isn't the Holy Grail for transformation, it would be negligent to not at least mention the decision that BCMA has made to embrace FFS (again) and why the U.S. may want to consider another look. The physicians in BC have decided that FFS with additional funds in the form of targeted incentives is the best way to go. The structure is simple and well understood and also includes reimbursement for alternative modalities including both telephonic and electronic sessions with patients. It emphasizes primary care and, according to Dr. Dan McCarthy of the BCMA, has resulted in system savings, improved patient care and a feeling of being "properly" paid by the physician members.

While the momentum in the U.S. has been to explore alternative forms of reimbursement, our mission to Vancouver offered some fuel that perhaps the old ways do have merit. A specific tip to consider was reimbursing specialists on visits at the same

rate as PCPs for care that could have been provided by the PCP. This helps to align incentives and motivate all providers to focus on where they add the most value. In addition, consideration of more prevalent and more generous reimbursement for e-visits is also a strategy worth exploring further here in the U.S.

3. Promote standardization.

Given its structure, Canada has many inherent advantages in its ability to standardize and centralize data and processes. This promotes administrative efficiencies and allows for enhanced opportunities for health services research and quality improvement projects. While the U.S. and Canada have a relatively low adoption of Electronic Health Records (EHR), Canada could pull ahead as it has two key agencies that support these efforts. The Canadian Institute for Health Information (CIHI) acts as a coordinating body on data and standards and supports others in health policy development through analyses and reports on topics such as wait times, mortality rates, and workforce projections. The Canada Health Infoway is an independent not-for-profit charged with working with each province to operationalize some form of EHR system.

Like Canada, the U.S. health system tends to focus below the federal level and have the individual states take the lead, which can create unnecessary complexity. The U.S. federal government provides some funding to the states, as it did with the American Recovery and Reinvestment Act of 2009 (ARRA) overall and specifically with the subsection of ARRA on Health Information Technology for Economic and Clinical Health (HITECH).

In the latter instance, the federal government created new agencies such as the office of the National Coordinator of Health care IT (ONCHIT). However, we do not yet have the top-down force directing national standardization of health care information systems. A specific tip here would be

to more study the PharmaNet system that was put in place in BC. PharmaNet is a comprehensive drug information system that links community and hospital-based pharmacies as well as other stakeholders including emergency rooms, clinics, physician offices and the Ministry of Health. The system supports dispensing, medical reconciliation, treatment decisions, research, and is working to enable e-prescribing.

Overall, there is much to be learned from Canada, especially as both nations try to balance

the concerns of access, cost and quality. This will take place within each country's existing financing and delivery systems and through their distinct cultural and political lenses. The AIHS study mission answered one set of questions but generated another, which is precisely what the delegates sought. This experience clearly validated the importance of taking the time for a continued look at what Canada is doing and searching for additional insights that might inform how best to move forward here in the United States.

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