
Hello, my name is
Canadian Medicare, I
am broken

BACKGROUND

What Canadian medicare is

Canada's medicare legislation mandates provincially administered health care programs under which all Canadians are entitled to any and all medically necessary services except drugs taken out of hospital. Comprehensive drug plans have long been under discussion in most provinces and seem likely to be enacted within the next few election cycles. Direct funding for Medicare is shared between the federal and provincial governments.

According to a recent study by the Fraser Institute¹, Canada's leading conservative think tank, provincial health care expenditures rose by an average of 7% per year between 1996 and 2006, while average provincial revenues grew by only 4.4% - and that disparity is increasing: over just the last five years in the period health care expenses rose by about 7.3% per year while revenues rose by only 4.3% per year. As a result the Institute projected that health care would absorb 50% of all Canadian provincial and federal government revenues by 2017 - but because recessions affect tax revenues more than they do health care system costs, the reality is that health care costs should reach 50% of all government expenditures in Canada by 2015.

Medicare is the subject of intense political interest in Canada. Not only are these programs pawns in the perennial struggle for financial and social control between the federal government and the provinces, but medicare itself is a major icon of Canadian nationalism endlessly invoked to prove, exemplify, or disprove a wide range of political opinion.

So how good is the system?

We don't know - nobody knows: not the taxpayers, not the people who work in the system, no one. The entire health care industry in Canada, from op-ed writers and political posturers to nurses on the job, is characterized by a deluge of data unaccompanied by the contextual, historical, and normative information needed either to separate opinion from reality, or to support general conclusions about either the cost or the quality of the services provided.

1. See: Esmail et al, [Waiting Your Turn: Hospital Waiting Lists in Canada](#), 16th Edition, (The Fraser Institute, Oct., 2006)

There are three main reasons for this: the widespread use of disconnected data to support agendas while hiding the absence of critical thought; structural impediments to data recognition, collection, and interpretation; and, a general refusal to recognize or account for social costs incurred by a socially owned and operated system as costs of that system.

*Data, data,
everywhere and nary
a stop to think*

The most obvious problem is that the industry has become increasingly effective at managing public access to information - making most direct questions about the management and effectiveness of the system unanswerable from public data.

Fifteen years ago every provincial health department offered at least some open research support and made at least some operational detail available to anyone interested. The average Canadian could, furthermore, visit any major library or one of many Statistics Canada offices to read and freely copy available statistical publications summarizing what was known federally about health care system operations.

American Fiction: Canadian Reality

The American movie *John Q* starring Denzel Washington was a classic leftwing indictment of the evils of corporate health care. The poor black hero facing the uncaring capitalist monolith takes his gun (and perfect teeth) into the beast's own lair to extort justice - payable in the form of free medical care.

Nice movie; but on December 31, 1999 a guy named Henry Masuka tried it for real in Canada. Unable to get emergency care for his infant son - *care he was fully entitled to receive* under Canada's health care legislation - he took a pellet gun into the emergency room and demanded service.

The police response was prompt and efficient: they shot him three times and left him handcuffed while he bled to death on the floor of one of Toronto's leading hospitals.

Today the provincial health departments normally offer the public little more than mission statements, top level budget information, and an annual statistical summary; Statistics Canada places steep monetary, knowledge, and technical barriers in the way of access to highly aggregate information; and most of the health care information dissemination role has been handed to the [Canadian Institute for Health Information](#) [CIHI].

The CIHI produces many erudite and voluminous reports, mostly filled with point estimates and Microsoft Office style graphs from which the actual numbers cannot be read, and produced in an informational snippet style providing highly focused analysis of the kind more useful to a reporter looking to pad out a column or story than to someone trying to understand system wide operations.

The CIHI is chartered to provide usable research data about health care in Canada and is widely said to do so - although I've been unable to find even a single instance of an unapproved viewpoint supported by data obtained through the CIHI.

See no evil, report no evil

A more subtle problem exists because an organization funded for some set of procedures cannot effectively collect, process, or interpret information about other procedures - and statistics on quality of care computed on the basis of what these institutions can see and report are correspondingly untrustworthy.

Hospital ownership and funding

During the 1990s provincial governments across Canada undertook "regionalization" - a process in which they divided their provinces into health care regions and instituted hospital specialization - a system under which health care bureaucrats allocated work to individual institutions by diagnostic group and then funded fixed numbers of specified procedures within each group.

Thus hospitals became procedure execution services shuffling patients with problems they weren't funded to deal with in midnight taxi rides - because ambulances weren't funded for this, social services funding allowed them to pay for cabs, and shifting the patient at midnight maximized hotelling cost claims for both centers involved.

On the American television program *House*, for example, a team of dedicated physicians considers and then reconsiders each patient diagnosis *in terms of the whole of available medical and surgical knowledge* - but in the real world of Canadian medical care, hospitals, and functional groups within hospitals, are funded only for specific procedures -and diagnosis therefore has to precede admission with any post-admission second guessing typically handled by an intern whose *time, allowable decisions, and access to test procedures are limited by what the hospital or group is funded for.*

Ask a typical American hospital operator what their outcome distribution for cases of non-Hodgkin's Lymphoma looks like, and you'll be able to trust the approximation they provide because their clinicians are free to change a diagnosis as information develops. In contrast a Canadian cancer center can only treat cancers and a coronary treatment center can only treat heart disease - meaning that financial necessity combines with institutional blindness to unfunded diagnostic choices to make it impossible for a reviewer to guess which, if any, patients counted as successes on discharge simply never had the specific problem to begin with.²

Notice that some patients found to have been incorrectly admitted are transferred to other service providers - but how long that takes, what the percentages are, how accurate that secondary diagnosis tends to be, or what the effect is on the statistics reported by the centers involved, cannot be known for any specific service combination and time period without a gold standard review of all applicable records, and therefore these things are essentially unknowable for the system as a whole.

It ain't no cost, until I say it's a cost

The most important costing problem arises because most non cash costs incurred by the health care system are simply not considered to be health care costs.

Consider, for example, these four classes of applicable non cash cost:

1. the near total absence of legal redress for medical wrong in Canada means that there is no effective Canadian mechanism for costing the consequences of delayed, reduced, or inappropriate health care - meaning, for example, that health span (duration of full function well-being) reductions experienced by someone who is denied either, or both, prompt treatment and adequate long term support, have no recorded cost to the health care system;
2. the increased paperwork burden imposed on all health care practitioners through operation of the regionalization and funding systems

2. Thus, for example, the Alberta Cancer Board's November 2008 final report claims survival rate improvements for most major cancers between the pre-regionalization period from 1990 to 1994 and the first post regionalization period from 2000 to 2004, that exceed comparable period gains in the United States - but the same page has a different table showing Canada wide survival rates are still well below those expected in the United States. So does the disproportionate increase in Alberta survival rates signal the board's success at treatment? system-wide improvements in early detection? a change in population demographics? or the system's weakening ability to diagnose and stage cancers correctly?. There's no effective way for the public to know.

increases waiting lists, reduces hours available for patient care, disproportionately rewards careerists over professionals, and motivates many health care professionals to either move to the United States or seek alternative careers - but goes completely unrecorded on the cost side of the present system;

Waiting Lists

In Canada medical services are free, but access to many services is filtered through admission to three sequential waiting lists.

We do not know how long the average Canadians waits to see a GP, but, in 2005, the average waiting period between seeing a GP and seeing a specialist was 8.3 weeks, while the average wait between seeing the specialist and starting treatment was nine weeks^a.

Waiting lists are generally long and getting longer with more than 4% of Canadians waiting for services on any given day - but one reason for our national focus on waiting lists is simply that some reasonable data on these is available.

In contrast data on facility, diagnostic, and procedure outcomes is not; data on laboratory and diagnostic accuracy is not; data on healthspan costs to patients is not; data on case costs is not; data on system costs is not; and, data on iotrogenics is not.

a. See: [Waiting Your Turn](#) (Fraser Institute, 2006)

3. some widely adopted policies have enormous hidden costs. For example, most provinces cap annual physician billing (total medicare claims paid) by provider id. As a result many physicians learn to work around the system -meaning that even insiders with access to data cannot trust that data - while others simply shut down their offices for regular vacations - meaning that this practice effectively idles from about 5% to perhaps 8% (caps vary across Canada because provincially imposed) of the GP infrastructure and thus, in the long term, creates demand for new infrastructure through the systematic under use of existing skills, facilities, and patient records.
4. the pretence that everyone gets treated equally applies mostly to the working middle class - people who are given no choice in what they spend on health care, how it's spent, when it's spent, or with whom. The economic consequences of this removal of choice from the health care buying equation are not usually considered a cost of Canadian health care, but the absence of consumer choice both imposes costs on consumers and prevents system renewal.

For example, the economic and human costs of time spent waiting for services - on any given day in 2006 an average of roughly one million Canadians were on waiting lists for medical services, with those waiting for knee or hip surgery waiting an average of forty weeks - are not considered costs of the system.

In a free market a 32 week average wait for neurosurgery would signal new entrepreneurial opportunities, eventually leading to industry wide productivity and performance improvements. In Canada this renewal process does not happen because the absence of consumer choice in a single provider system means that no entrepreneurial response is called forth.

For the same reason capital expenditures incurred by government, most notably for the monumental new facilities built by regional health authorities all over the country, have no effect on the industry's economic productivity - and the difference between what is and what could be is both directly attributable to nationalized health care and not considered a cost of the system.

More subtly some risks forced on the system through the funding methods used, particularly both procedure based funding and the separation of capital from operating monies, should be considered costs to the system but are simply not recognized.

but at least Canada treats everyone equally...

A woman with a heavy eastern European accent bringing an older gentleman with an intermittent speech disability to Toronto's University Hospital Emergency Center told staff he suffered sudden severe headaches accompanied by a loss of vision.

After keeping her waiting most of the night, a nurse told her to take him home and give him Tylenol - and his death later that morning didn't happen because he wasn't entitled to medical services, but because the staff saw no reason to provide them.

On the other hand, when Alberta's premier experienced a tight feeling in his chest, the local University Hospital made its chief cardiologist available to him within minutes of his arrival - and found him a well staffed private room that night.

For example, the funding system encourages administrators to compete for operating budget through expanded diagnostic coverage, then demand the buildings that go with their new service authorizations, and finally fight to keep the operating costs associated with those facil-

ities in their budgets, As a result the more bureaucratically successful hospitals grow to enormous physical size, often comprising 20 or more buildings on one site, while maintaining strict bucket to bucket financing on operations.

The resulting lack of service diversity poses an enormous, and entirely uncosted, public health hazard: Alberta, for example, has about 3.2 million people and a land area little smaller than Texas but only two major hospital complexes (and eight secondary centers) either, or both, of which could be shut down by a single infectious outbreak.

*Horror Stories as
performance
indicators*

The City of Calgary, Alberta's second largest city, has long been the center of Canada's oil and gas industry and was until very recently at the center of Canada's fastest growing regional economy - driven by booming demand for conventional oil and gas production, growing pre-development engineering on coal bed gas extraction, and the engineering and administrative work associated with more than \$120 billion dollars in infrastructure investment going into Alberta's Athabasca tar sands region.

Alberta has been throwing money at medicare - averaging an 11.4% increase in health care spending for each of the last five years.

In that context, consider therefore these horrific extracts from recent stories carried in the [The Calgary Herald](#) - starting with these paragraphs, about two miscarriages, from the January 27, 2007 issue:

Health region defends miscarriage surgery delay

Care plan 'well-designed' say officials

The Calgary Health Region says it acted appropriately in the case of a mother who has to wait nine days to have her fetus removed from her womb because of a miscarriage.

"Our review indicated there were no clinical issues. Our staff did act very appropriately and a care plan is well-designed and in place," said Lynda Phelan, spokeswoman for children and women's health.

"We don't anticipate changing our processes based on this case review."

The 25-year-old woman was 19 weeks into her pregnancy when her water broke Sunday. Her membrane has ruptured, but she hasn't gone into labour. She isn't certain whether her fetus remains alive or has since died.

Lalonde's ordeal brought back Friday painful memories for another Calgary woman who suffered a similar "excruciatingly long nightmare."

An ultrasound earlier this month showed 28-year-old Christine Markholm's 11-week-old fetus had stopped developing and was no longer living.

Her doctor, however, wasn't able to confirm the radiologist's news for four days because her test results were misplaced, Markholm said.

She then found herself waiting several days for the health region to phone about scheduling surgery to remove her fetus. After several calls on her part, a date was finally set, but it proved too late.

Markholm instead delivered her fetus over three days.

Seeing material like this in the newspapers is unusual in Canada, but not unprecedented. Here's a second example, this one from a [Calgary Herald](#) story published exactly six months earlier:

A top Calgary Health Region executive conceded Wednesday his organization "dropped the ball" and "lost the human touch" when a local woman experienced a miscarriage in a crowded emergency ward waiting area.

Dr. Chris Eagle said the woman -- who was about three months pregnant and bleeding on the floor -- should have been allowed privacy even if no hospital bed was available.

The July 18 incident occurred when Rose Lundy, 34, miscarried in front of about 40 patients at Peter Lougheed Hospital during a three-hour wait in emergency. Her husband, Rick, pleaded for help from staff, but was told there were no beds.

I picked these examples for three reasons. First because, if the term “depraved indifference” had a non legal meaning, these cases would illustrate it.

Secondly, I picked these cases because the fact that rational people can see them as part of a pattern in which health care officials use the press to pressure politicians to provide additional funding illustrates the kind of extreme cynicism fostered by the lack of public accountability and public information in the system.

The most obvious thing about these reports is the absence of reportorial context: there is no reporting leading up to them and no follow-up reporting; there is only coincidental reporting - like this story, published January 03/06 under the headline: “\$200M baby hospital planned”

A new hospital dedicated to expectant moms and newborns is on the drawing board for Calgary’s northwest, as the health system grapples with a baby boom that is straining local maternity wards.

Program funding

Notice that capital and operating monies come from different pockets and are closely tied only during the first year or two after facility completion.

Politicians committing to facilities are, however, implicitly committing to operating monies. Thus a hospital administrator with an empty floor or wing may not be able to obtain funding for the staff and services needed to use that space, but may be able to obtain stable funding for the operation of a new facility - even if that facility is an extension to an existing, and under used, building.

One side effect of this is the creation of funding silos - parts of the same facility operating under different funding regimes in which a diagnostic change becomes primarily a financial decision because a patient admitted to one funded service cannot be seen by someone working under another without first being discharged, admitted, and moved across an imaginary line.

Calgary Health Region executives decided in December to prepare a proposal for a maternity-newborn facility -- expected to cost \$200 million to \$300 million -- that

would be built beside the new Alberta Children's Hospital.

The regional health authority expects to forward the proposal to the Alberta government this spring. Officials do not have a timeline for when the facility may be built, should it receive the necessary provincial funding.

One incident does not make a trend, but since then we've seen a flurry of reports about the horrors created by the absence of a hospital facility in south west Calgary followed by the recent start of construction on a new facility there; and, currently, we're seeing another spate of press reports about the forced separation of elderly couples through the operation of the geriatric care system -coupled with pressure to build new facilities.

Consider, for example, this bit from a August 7th, 2009 Calgary Herald story:

Niels Bach doesn't relish public speaking, but last year the retired Strathmore farmer told a crowd of people -- including Premier Ed Stelmach--how his wife had been placed in a Vulcan care facility nearly 100 kilometres from his home.

After hearing the story, Stelmach promised Bach and others at an election campaign event that a long-awaited nursing home would be built "as quickly as possible" to alleviate Strathmore's shortage of long-term care beds.

A year and a half later, however, Alberta's medical super-board said it's still considering what kind of care centre will be built in Strathmore. Alberta Health Services is conducting similar reviews of planned seniors facilities around the province, including a \$64-million project in Calgary.

"I feel disappointed," says Bach, 77, whose wife Mariane passed away last summer. "My wife is gone, but the problem is still there. I still feel we've been shortchanged in Strathmore."

And, thirdly, I picked these stories as background to a much more general, and correspondingly more troubling, fact - a single indisputable

number: one showing that even something as cut and dried as the rules laid out for the Canadian emergency room triage system can be gamed by system insiders.

Here's how the City of [Calgary's website](#) described the city's ambulance fleet in early 2006:

Calgary EMS operates 39 primary response vehicles: 18 units 24 hours per day, 14 units 12 hours per day, as well as 6 Paramedic Response Units and a 24-hour Air Medical Crew.

Additionally, EMS has on standby a Medical Support Unit (MSU) and Medical Rescue/Support Unit for incidents where numerous casualties are involved, 1 MCI Supply Unit and 2 Superintendent Response Units.

Do the arithmetic and you'll find that the maximum possible number of duty hours for 2005 was just about 272,000. According to another Calgary Herald story (Jan. 25/06) 31,000 (11%) of those hours were spent at engine idle waiting for patients to be unloaded on delivery to hospital emergency wards - an average of more than 21 minutes per call.

The patients involved are ordinary Canadians, suffering ordinary problems, delivered by an over worked EMS service to hospitals, and then forced to wait in the ambulance outside *because the triage waiting period begins³ when the patient crosses the emergency room threshold* -and not when the ambulance enters the parking bay⁴.

This problem is endemic: here's a typical provider's view of another consequence of this, taken from a story in the Edmonton Journal - but note first that when a Canadian health care official says that there are no beds or that all beds are full, they're almost always saying that the facility concerned is operating at its funding limit, not that there physically are no beds available. It is quite common for facilities with unused wings or floors to stack patients on pallets in emergency room hallways because those empty beds aren't funded.

3. I have not found a public source for The Canadian Emergency Department Triage and Acuity Scale - but there are many reviews, commentaries, and extracts on the web. See, for example, <http://www.ahrq.gov/research/esi/>.

4. The city of Calgary charges the patient (ambulance service is not covered under medicare) \$148 per hour for idle time - or about \$52, on average, for time spent waiting to unload at the hospital.

Dr. Raj Sherman... estimates that at peak times on the busiest days, 20 to 30 per cent of patients are leaving the emergency waiting room because of frustration and impatience. Those busy days happen more frequently, said Sherman, who can't remember a single day in the last two months when the 56 beds in the Royal Alex's emergency department weren't at least half-filled with admitted patients who couldn't be moved elsewhere because of gridlock.

Sherman said a relative of his went to emergency with chest pain and had to wait 50 minutes before receiving an electrocardiogram and another five to six hours to see a doctor. Such patients are supposed to have an ECG within 10 minutes and see a doctor within 30 minutes.

Sherman said he sometimes arrives at work to see six ambulances waiting to offload patients, but unable to do so because all the beds are full.

So what's going on? The information we have about the miscarriages mentioned in the *Calgary Herald* lets us hope that these are exceptions, but the information about ambulance idle time summarizes system wide behavior over a year - in other words it's descriptive of business as usual in Canada's national health care system.

Current public policy discussion

There is now, and has been for decades, a raucous on-going debate about the costs and future of medicare in Canada. Various governments periodically create commissions to investigate or bless options, pressure groups call news conferences to denounce those commissions, and newspapers and other media players editorialize endlessly.

In general, however, the debate isn't about health care as much as it is about money, politics, and the battle for control between the federal and provincial governments.

At present the major public agenda items are:

1. since essentially all health care groups in Canada agree that they need more money, there are almost always active commissions or other high profile organizations debating and publicizing many different schemes to raise more money for the system;

-
2. there is an emerging consensus that provincial drug plans can and should be used to ameliorate the impact drug costs have on the health care consumer. Draft legislation to expand and publicize existing drug programs has been circulated by the federal government with support from a number of provinces; and,
 3. several groups, both pro and con, have successfully focussed media attention on so called privatized or two tier health care. In particular the government of Alberta was at one time quite forthright in its support for the introduction of some for profit services and has been correspondingly condemned by the press and various interest groups.

All of these people agree on one thing: their part of the system, whatever it is, needs more money - even the Fraser Institute report quoted earlier offers this prescription for change:

- Requiring patients to make co-payments for publicly insured health services;
- Acknowledging the individual right of patients to pay privately (via private insurance or out of pocket) for all types of medical services, including hospitals and physician services;
- Allowing providers to charge extra fees directly to patients above the public health insurance reimbursement level and to receive reimbursement for their services from any insurer, whether public or private, without practice restrictions; and
- Permitting private sector (both for-profit and non-profit) health providers to compete with the government sector for the delivery of publicly insured health services.

Some ancient history

Most Canadian histories of medicare credit its start to a politician named Tommy Douglas and his role as Saskatchewan's premier during the creation of the Saskatchewan Hospital Insurance plan in 1947. There is no doubt that Douglas campaigned tirelessly on medicare issues throughout his political life, and little doubt that Canadian medicare today is remarkably similar to the system Mr. Douglas tried to implement in the 1946 Swift Current trial most media players in Canada credit as the start of Canadian medicare.

Beyond that, however, there is little truth to the Douglas myth. In reality, the publicity given Lord Dawson's 1920 report to the British parliament on appropriate social response to war amputees and flu survivors sparked a number of proposals for publicly funded medical insurance programs - both in the United States and across the former British Empire.

One such proposal came from Matt Anderson, then a councilor for the rural Saskatchewan municipality of McKillop, who proposed to the 1927 annual meeting of the Rural Municipalities Association that the provincial government be asked to fund such a plan.

He failed to get adequate backing, but brought the proposal back each year until 1937 when he convinced the Patterson (Liberal) government to approve a trial in the rural municipality of McKillop subject to a local referendum - which passed. In 1944 that same Patterson government then passed his draft legislation to enable the first public health insurance plan in Canada.

Patterson lost the 1944 election to Tommy Douglas and the CCF (now known as the NDP or New Democratic Party).

Patterson's plan had called for the evolution of publicly funded health care on the Dawson model as proposed by Anderson, but the CCF's strident socialist agenda conflicted with the Patterson legislation -leading to stealth nationalization during the Swift Current trial, the enforcement of state planning through the imposition of a regional health authority, and ultimately the imposition both of fee caps on providers and a usage deterrence fee on consumers.

In 1944 the CCF won 47 of 52 legislative seats; in 1948 they won only 31, largely because the Swift Current pilot project so exuberantly praised by journalists writing in Montreal, London (Ontario) and Winnipeg, was seen as an abject failure in Saskatchewan because it produced no obvious public health benefits while driving regional government into debt, antagonizing the physician community, virtually destroying the local hospital, and driving health care users to seek services outside the region⁵.

Douglas did not continue his "experiment in practical socialism." Instead he increased provincial funding for non government groups wanting to build and operate small hospitals in rural communities, and returned to Anderson's vision of public involvement through provision of universal insurance coverage rather than through the direct provision of services.

5. For supporting information, bibliographic detail, and discussion of the issues raised, please see: The Co-operative Commonwealth Federation, Health Care Reform and Physician Remuneration in the Province of Saskatchewan, 1915- 1949; a master's thesis submitted to the University of Regina in 1998 by Gordon Lawson.

The new funding for small hospitals allowed his MLAs (Members of the Legislative Assembly) to show their constituents the value of voting CCF, while the insurance metaphor both backed away from nationalization and allowed many in the business and medical communities to believe that this program would simply “top up” pre-existing private insurance plans without seriously affecting service delivery.

Both of those ideas worked politically, and became widely recognized as vote getters. As a result most provinces responded positively when the federal government introducing a capital funds subsidy program for provincially managed hospital construction in 1953, and set national standards as a condition for a federal subsidy for provincially administered hospital insurance programs in 1957.

In 1962 Douglas, still Saskatchewan’s premier, tried again; passing legislation setting up the first comprehensive publicly funded medical (meaning services outside of hospitals) care program in Canada. This act re-introduced many of the ideas that had failed in 1946, but a bitter 3 week strike by the provincial medical association put payment back on a fee for services basis, led to the continuation of the insurance metaphor, and put the government focus back on hospitals.

That political compromise was then incorporated into the 1965 Hall Commission report recommending national adoption of the plan and so became the basis for Bill 227 - a federal act establishing provincial jurisdiction over health care delivery while promising to fully match provincial funding for plans meeting a single national standard. By 1970 most provinces had plans in place, and administrations for them with names like “Department of Hospitals and Medical Care” to clearly recognize the difference between funding for medical (practitioner office) and funding for hospital (institutional) care.

By 1977 extra billing, the practice of asking the patient to pay something over and above the amount reimbursable from the provincial health plan, was again a hot political issue and, in 1984, the federal government moved both to reduce its share of costs down to about 30% and to ban extra billing.

The Canada Health Act of 1984 (and subsequent regulations) banned private enterprise from health care delivery and established the five principles quoted below for shared federal-provincial medicare funding:

-
- public administration: the administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority;
 - comprehensiveness: all medically necessary services provided by hospitals and doctors must be insured;
 - universality: all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;
 - portability: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and
 - accessibility: reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

*But that's not the way
things actually
operate*

Despite the obvious continuation of the insurance metaphor, the 1984 legislation largely codified the 1946 CCF agenda - with judges in BC and Ontario quickly ruling that “failure to pay premiums is not a barrier to coverage for those who meet the basic enrollment eligibility criteria⁶” (i.e. residency) and therefore that no Canadian can be denied services under the act -whether premiums are paid or not.

More than 20 years later, however, the insurance registration and claims systems still dominate departmental policy making and Canadians are correspondingly still required to apply for, and present, health care entitlement cards - just as if it really were still an insurance program.

Essentially nothing else in Canadian medicare functions in strict accordance with what the public has been led to believe either. Thus the provincial plans violate the accessibility principle through the imposition of long waiting periods for services; violate the comprehensiveness principle through the imposition of idiosyncratic funding caps, service quotas, and service delistings; violate portability by refusing to meet all extra-provincial service costs; violate universality by using the insurance pretence to lock the invisible poor out of higher quality service channels; and violate the public administration principle by means varying from public sector service out-sourcing to support for private executive service plans.

6. Quoted from the BC portion of the 2004 Canada health Act annual report. - See: http://www.hc-sc.gc.ca/hcs-sss/medi-assur/pt-plans/bc_e.html

Billing the patient for medical services outside the medicare system is not legal in any province but common place in all of them. The federal health minister charged with enforcing the act is, for example, covered by a privately operated executive health plan.

Similarly hotelling upgrades can generally only be paid for privately as can necessary physio-therapy, ophthalmology, and other services exceeding provincially set patient quotas.

More importantly, most provinces now aggressively pursue third parties like insurance carriers whose premiums include coverage for medical expenses - thereby extra-billing the insured by imposing additional costs for health care without providing either choice or additional services.

*So how did things go
so far wrong?*

One significant causal cluster involves ideology, not economics or health care. The core ideology animating current medicare practice is that favoring centralized, state controlled, planning and execution of economic activity, but the people who espouse that ideology with respect to medicare in Canada have so consistently, successfully, and extensively used anti-Americanism as both the lever and fulcrum for getting their way, that anti-Americanism has become a deeply embedded part of their belief set.

Thus the major reason Canada has been unable to learn from American health management experience is that the American origin of the practices involved both blinds Canada's left wing to their potential value and allows that left wing to whip up public sentiment against anyone who might otherwise be tempted to consider the ideas involved

What's being both reinforced and exploited when anti-Americanism is used to prevent discussion of an alternative medicare structure is one of the bedrock beliefs of Canadian nationalism: specifically that Canadians are morally superior to Americans because the Canadian health care system is better, cheaper, and fairer than the American one.

It's important to recognize two things about this belief: first that questioning this meme is a career stopping move in Canada's academic, political, and bureaucratic circles; and, secondly, that there is no clear evidence for any of the component claims.

For example, the numbers most often quoted to prove that Canada's government run system is cheaper than the American one come from OECD GDP comparisons - in 2001, for example, OECD numbers put Canada's

More on waiting lists

Waiting lists in the United States generally result from shortages - for example organ transplant programs grow waiting lists because of compatible donor shortages and some specialities, especially high risk ones, suffer doctor shortages, allegedly as a result of aggressive legal action.

In Canada waiting lists are largely consequences of government policy.

At the practitioner level, government action to reduce medical school enrollments (as a long term strategy aimed at reducing fee for service claims) in the late eighties produced today's GP shortages. Similarly nursing, and nursing school, cuts imposed during the early nineties budget cutbacks contributed significantly to today's nurse shortages.

Most importantly, however, the installation of regional administrators eager to improve hospital efficiency through enforced specialization changed the role of hospitals from one of diagnosis and treatment to one of procedure execution. As a result general practitioners could no longer use hospitals as diagnostic centers and were forced to rely on third party laboratories and specialists for pre-admission diagnostic confirmations rather than risk losing all admitting privileges for sending patients to the wrong hospital.

That created today's waiting lists, increased specialist billings to the system by about half, more than doubled total laboratory and radiology costs, and created undocumented, but probably significant, new demand for palliative care -in practice mainly time off, over the counter drugs, and various forms of "alternative medicine".

health care costs at 10.2% of GDP and the American one at 13% for a 22% Canadian cost advantage.

Those numbers are real, but comparisons based on cost alone assume a service comparability denied by both sides - meaning that such comparisons are at best misleading and at worst dishonest.

The cost issue is, furthermore, widely conflated with two other beliefs: that the absence of the profit motive from Canada's tax funded system makes it morally better than its American counterpart, and that Canada's higher taxes are correspondingly justified by our access to free medical care.

Canadian taxes really are higher - but American governments pay out more per capita for public health care than Canadian governments do

Budget numbers contradict this belief: the American per capita government contribution to health care costs is higher than Canada's. Here's how the Fraser Institute's Jason Clemens summarized⁷ the 1999 OECD numbers on this issue:

According to the OECD's latest report on health care, Canadian governments spent \$1,738 per person in 1999, measured in US dollars using Purchasing Power Parity (PPP)-a fancy economic method for translating currencies based on the different costs of goods and services in different countries. In the same year, US governments spent \$1,938 (US) per person on health care. On a PPP-adjusted dollar basis, then, American governments actually spent \$200 more per person than Canadian governments on health care

In reality, furthermore, governments on both sides of the border pay about the same percentage of total health care costs. Thus the CIHI's year 2000 report and a review of relative expenditure in major OECD countries⁸ carried out at Johns Hopkins both show that Canada's private insurers paid about 30% of total health care expenditures in 1998 while the comparable US number was 33%. The Canadian number has been rising steadily, the American one declining and recent changes in U.S. drug entitlements have almost certainly reversed the ordering.

The evidence on "better" is weaker than the evidence on cost: there is essentially no comparative data on outcomes available to the Canadian public - meaning that the basis for the Canadian side of the comparison is at best anecdotal and at worst fictional.

On the anecdotal side, furthermore, the evidence points the other way: not only do Canada's rich now routinely carry American health insurance, but a common tactic among health region administrators across Canada faced with capital funding needs or collisions between resource limits and high profile cases is to use access to the American health care system as a combination bogeyman and relief valve.

On February 7, 2007, for example, the Calgary Herald carried a front page story headed: "*Alberta Mother Praises U.S. Care*" making the point

7. See the forum reports at: http://oldfraser.lexi.net/publications/forum/2001/10/section_12.html

8. See: http://www.cmwf.org/programs/international/ihp_1998_multicompsurvey.pdf

A comparison of ambulance costs

The City of Madison (WI) [publishes its ambulance rates](#) on the web.

Their charges are simple: there is a fixed \$10.00 per mile charge, coupled with a minimal cost depending on the patient's residency status and which of three care levels applies for a total of six cost categories.

Thus a ten *mile* round trip for a resident needing transport plus "Advanced Life Support (ALS) assessments and routine treatments" costs \$500 in total.

The city of Calgary [also publishes its rates](#) - but they're a little more complicated, falling into 22 separate billing categories.

Thus a minimal distance local resident transport would incur a transport fee (\$272), a minimum transport expense (\$69.69), a minimum response fee (\$148), a minimal response travel fee (\$30.30), and, at \$148/hr., an average of \$52 for time spent waiting to unload - meaning that the average charge has to exceed \$571 Cdn or just about \$520 USD.

Madison adds a \$100 charge for non-residents; Calgary adds \$420 for non Albertans.

Calgary offers about a 35% discount for "seniors and social services."

Madison's website says "Generally health insurance, Medicare or Medical Assistance will pay all or part of the cost of an ambulance conveyance. For any unpaid amounts, after insurance is billed, the City of Madison does have a waiver policy based on income."

that pediatric ICU resources which could not be made available under Canada's regionalized health care system were both effective and available on demand in Great Falls, Montana.

The "fairer" claim is, of course, the centerpiece of the belief - and here the argument is clear:

1. Canada provides, by law, all medically necessary services to all Canadians regardless of skin color or wealth;
2. the United States does not; and,
3. therefore Canada has the moral high ground.

But surveys say the quality of care is great!

Health care satisfaction questions are regularly added to national political and other omnibus surveys. According to reports generated from these surveys about 85 percent of Canadians are deeply satisfied with the quality of Canada's health system.

A casual reader might ask how they know - most respondents have neither health care knowledge nor experience with any other health care system, and so base their responses on not wanting to offend against the social content of personal interactions with a few health care workers.

A statistician might point out that survey companies correct for the disproportionate "oldster" response telephone surveys generate by over-weighting responses from young, generally healthy, people -- meaning that some kid's "ok, I guess" will be given greater weight in estimating population percentages than multiple angry rants from seniors.

A true cynic might, however, point out first that the survey companies don't get paid by people rejoicing in negative results; secondly, that such surveys are never done in waiting rooms; and thirdly that these questions are often grouped near the end of long, omnibus, surveys - meaning that respondent stress correlates well with failure to answer that part of the survey and that this biases the result toward responses from those not on waiting lists or otherwise involved with the health care system.

Thus whenever threats to leftist political control of the health care system arise, the mass media (particularly TV) can be counted on to show the Canadian public heartbreaking stories of a racially diversified (but non white) group of American families condemned to poverty, or life without the dearly departed, by the callous indifference of some giant American health care corporation.

Reliable numbers on access, for either side of the border, are hard to find. Here's an extremely suggestive snippet from the CDC year 2000 Fact book

In 1997/98, about 7% of children under age 18 had no usual source of health care. More than 25% of children without health insurance coverage had no usual source of health care.

Notice first that 75% of children without health insurance coverage did have a usual source of health care - a reflection of the American right to self insurance - and that none of the American kids were refused treatment - a reflection of the American county and charitable care systems.

In comparison, unpublished research done at the University of Alberta shows that roughly 6% of children visiting Canadian hospital emergency departments do so more than five times a year - and are accompanied by people who are unable to list a “family doctor” on the intake forms.

What is easy to demonstrate, however, is that the Canadian commitment to entitlement is not accompanied by any comparable commitment to service delivery - thus a recent Fraser Institute analysis⁹ found that approximately 1.2 million Canadians (about 4% of the population) are unable to find family practitioners or other sources of routine health care.

As a result the one indisputable reality in the goodness morass is that a middle class Canadian facing an emergent medical problem can get on an airplane, check into an American hospital for diagnosis and treatment, and get home with the problem taken care of in less time than it would take to see a Canadian GP to get tests done to get on a waiting list to see a specialist to get tests done to be put on a waiting list for eventual treatment in Canada.

Thus the bottom line on all three major medicare related beliefs in Canada is simply this: the information usually used to justify these claims does not stand up to even the simplest of tests; the Canadian data needed to make fair comparisons may exist but is generally not public; and the little evidence the public does have access to contradicts all three beliefs.

What we actually know: Canada is good at entitlement, the U.S. is good at delivery

What we can reasonably say, therefore, is that:

1. the Canadian system focuses on entitlement, the American one on service delivery;
2. government pays about 75% of system wide costs in both countries;
3. the average U.S. patient gets treatment much sooner; and,
4. that broadly similar proportions of legal residents in both countries fall through the cracks.

9. See Esmail et al, [Canada's Physician Shortage: Effects, Projections, and Solutions](#), (The Fraser Institute, 2006).

One of the things to notice about the use of anti-Americanism in shaping Canada's health care debate is that it has consistently been used to block or limit debate on possible changes to the system -and not, at least publicly, to proactively drive change in the system.

And yet, the evolution of the system to the mid eighties wasn't unreasonable - so what happened to tip the system into its present state of apparently permanent crisis?

The obvious thing that happened was the Canada Health Act of 1984 and subsequent judicial rulings supporting the system's silent nationalization through the removal of any factual basis to private ownership and the insurance metaphor from the system.

Less obviously, but equally importantly, health care delivery world wide underwent structural change during the seventies - change that made it to Canada in the eighties, and left policy makers facing an information vacuum - a vacuum that was then filled by opinion.

What drove change worldwide was the co-evolution of medical and surgical technology with patient access to transportation and communications - changing medical service markets, changing the GP workload, mandating expensive equipment and well coordinated practice teams working in large urban hospitals, and driving up customer expectations in terms of diagnostic accuracy and the effectiveness of treatment.

When the change hit Canada, rural politicians generally faced constituency pressure to protect small rural hospitals, and the government departments in charge of health care funding turned out to lack even the most basic information - things like the number of active beds in the system or what they were used for - the politicians needed to counter demands that hospitals, and hospital jobs, be kept in their communities.

Unfortunately provincial health departments across the country unani- mously responded to the sudden need for cost and performance informa- tion by launching large scale information technology projects - exactly none of which produced results the politicians needed to make or sell rational decisions.

What filled the resulting information vacuum was mythology - deeply held, but erroneous, beliefs. In particular, a myth known as "Roemer's Law" quickly became the dominant rationale for both political and bureaucratic decision making about health care.

“Roemer’s law”

Roemer’s law holds that health care providers create their own markets; i.e. that supply availability is the principal determinant of health care services demand. There is a lot of empirical evidence for this: make a new service available, whether that’s a doctor’s office, a hospital bed, or an operating theatre, and pretty soon it will be fully utilized.

The logical response to Roemer’s law is quite simple: if you want to cut service costs, don’t make the service available - and that logic justified government policies such as practitioner billing caps and the late eighties and early nineties reductions in Canadian medical and nursing school enrollments.

Today, of course, Canada has nationwide practitioner shortages - and reason to suspect that jobs stresses have increased to the point of significantly driving up iatrogenic error, missed diagnoses, repeat billings, patient “recidivism” (re-admissions, usually on different diagnoses), and the rate at which good people are leaving the health care professions.

Thus history proves the policy response wrong, but the phenomenon nevertheless exists: demand does seem to rise with supply, and therefore needs to be understood.

The consensus explanation for Roemer’s observation is that health care practitioners create their own demand; that “take two aspirins and see me in the morning” is a prescription for a second billable service. While some of this undoubtedly goes on, the problem with treating this explanation as the rule rather than the exception is that it contradicts almost everything we know about practitioner motivation and patient behavior.

In other words, the conventional explanation requires us to assume industry wide professional malfeasance aided by stupidly complaisant patients - and those beliefs simply don’t make sense.

What does make sense is the opposite assumption: that people seeking medical help need medical help, because then the reality of Roemer’s phenomenon forces us to conclude that they don’t always get what they need -and that interpretation predicts exactly what actually happened with nationalization: specifically that any attempt to control demand by managing supply will just make the problem worse.

Thus the explanation for the phenomenon giving rise to “Roemer’s law” is simply that demand *seems to increase* with supply *because the quality of supply does not satisfy the demand*; i.e. people look for, and use, additional services because existing services don’t meet their needs.

That's an effect of human fallibility, not deceit or corruption. Medicine in particular (as opposed to surgery) is caught between ever increasing public expectations for miracle cures and the reality of assembly line medicine, ambiguous presentation, stressed and confused patients, poor health information support, financial conflicts, and a flood of utterly extraneous demands on practitioner time.

The reality is that medicine is hard. Doctors are human first, diagnosticians second: if you present with a mild fever, some localized skin flushing on the chest, and a complaint about aching joints; a doctor who has seen eight other probable flu cases that day, will reasonably see you, not as a person with Korean leptospirosis, but as another flu case.

Most ambiguous cases presented in clinical offices in the United States and Canada lead to one of four outcomes:

1. the problem just fades away;
2. the problem resolves to something unambiguously recognizable and is dealt with to the limits of available resources, knowledge, technology, and patient co-operation;
3. the problem is mis-diagnosed and the resulting treatment (or the absence of treatment if the patient is simply placed on a waiting list to see a specialist prior to having a procedure done) either does nothing or has independently negative effects requiring further treatment; or,
4. the physician dismisses the reality of the patient's problem.

In most of the unresolved cases only the patient continues to regard the problem as unresolved, because only the patient knows for sure. Since this amounts to a loss of trust between the patient and doctor, many patients respond by means such as doctor shopping, using patent medicines, giving allegiance to cults and miracle cures (aka "alternative medicine"), or by learning to live with the disability.

Unfortunately all of these coping responses are increasingly common in Canada, and all produce negative consequences for both the patient and the health care system.

What's going on in these cases is not professional malfeasance, but a failure of information because the symptoms are ambiguous, communication between patient and the doctor is imprecise, the doctor is working under time pressure, and yesterday's flu bulletin leads to a predisposition to see flu in today's patients.

Thus the prescription for two aspirin and a day's delay isn't proof that doctors create their own demand, it is an attempt to reduce ambiguity in the information presented so that the doctor can make a better decision. To the extent that it is proof of anything, the use of delay as a common diagnostic tool is proof that Roemer's law reflects the failure of medical information systems to keep up with consumer expectations for health care.

*A hidden
consequence of
particular concern in
Canada*

As noted above the perception that doctors create their own demand is partially a consequence of diagnostic ambiguity, but the hidden assumption throughout the Canadian response to Roemer's law is simply that doctors always get negative diagnoses right.

In reality, however, medical ambiguity and the absence of both time and information in the system can easily lead practitioners to overlook real problems.

In particular, the present system under which general practitioners are considered infallible on negative results but need to refer to specialists for pre-treatment screening on positive results, means that there are essentially no remaining short term checks on false negatives.

For example a GP who responds to an apparently functioning patient's unfocused complaint about occasional muscle cramps and general fatigue by noting his dirty fingernails, ordering a TB test, and taking no further action when that comes back negative, will leave no traces in the system - and correspondingly face no consequences when the patient's burgeoning thyroid cancer kills him.

Notice that, in general, the issue here is not incompetence or dereliction of duty by the physician; diagnosis is often extremely difficult and the working environment is not usually conducive to good decision making. The issue here is that the American system contains checks on medical infallibility, while in Canada the bureaucratic need to direct work flows has largely removed them - and, of course, the data needed to understand the effects this has had are not publicly available.