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# Comparing the Canadian and US Systems of Health Care in an Era of Health Care Reform

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The purpose of this article is to provide an informed comparison of health care in the United States and Canada along multiple dimensions. Specifically this article looks at coverage, access, cost, health outcomes, satisfaction, and underlying ideology. Canada fares better than the United States with regard to coverage, cost, and health outcomes. While overall access is better in Canada, patients are sometimes required to endure longer wait times than in the United States. Reports of satisfaction levels vary across studies, but most evidence points toward comparable levels of satisfaction in Canada and the United States. Strong ideological differences underlie the Canadian and American systems, making the acceptance and implementation of certain reforms difficult. The potential impact of the US Patient Protection and Affordable Care Act (PPACA), as well as recent Canadian health care reforms on coverage, access, cost, and health outcomes are also discussed. Key words: *health care, health insurance, Canada, United States.*

The United States is renowned for the research and development of innovative and effective medical treatments and technologies.<sup>1</sup> Because of this, one often hears the statement that the United States offers the best medical care in the world. A survey by the Harvard School of Public Health and Harris Interactive found that 45 percent of respondents felt that the United States has the best health care system in the world, with the proportion feeling this way increasing to 68 percent among Republicans.<sup>2</sup> While American health care surpasses many others in certain areas, there is more to achieving high quality health care than simply good medicine<sup>3</sup> as is evidenced by the 37th place ranking of the US health care system by the World Health Organization.<sup>4</sup>

During the public discussions of health care reform in 2009 in the United States, the Canadian approach to health care was both idealized as a potential model to emulate and demonized as a disastrous and un-American direction in which to move. Much of the evidence used to support these positions was vague, distorted and anecdotal, leading to misconceptions about the Canadian approach to health care

and how it compared with US health care. The purpose of this article is to clear up some of the misconceptions that have emerged and provide an informed comparison of health care in both countries along multiple dimensions. Specifically, this article looks at coverage of people and services, access, cost, health outcomes, satisfaction, and underlying ideology. The potential impact of the US Patient Protection and Affordable Care Act (PPACA), as well as recent Canadian health care reforms on these comparisons are also discussed.

## Coverage—People

The current health care system in the United States provides health care coverage in a patchwork fashion. Details on US coverage by type of health insurance in 2009 are presented in Figure 1.

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**Figure 1. US Health Insurance Coverage Status and Type of Coverage, 2009**

Private, Public, or No Insurance		Type of Insurance	
Private Health Insurance	63.9%	Employment Based	55.8%
		Direct Purchase	8.9%
Government Health Insurance	30.6%	Medicaid	15.7%
		Medicare	14.3%
		Military Health Care	4.1%
No Insurance	16.7%	No Insurance	16.7%

*Notes:* Types of coverage are not mutually exclusive; individuals can be covered by more than one type of health insurance during the year.

*Source:* US Census Bureau, Historical Health Insurance Tables, Table H1A-2.

The majority of Americans are currently privately insured through employer-based insurance. Included in this category are family members of an employed individual who are covered as dependents under their employer-based insurance. While this type of 'dependent' coverage is usually dismissed as a variation of employer-based coverage, some argue that it is important to look at it as a distinct form of coverage because access to insurance for dependents is indirect and tied to their relationship with the individual who qualifies for employer-based coverage. Approximately 48 percent of those with employer-based insurance in 2010 were covered as dependents, including nearly 100 percent of those younger than 18, 32.7 percent of adults age 18 to 64, and 24.6 percent of adults age 65 and older.<sup>5</sup> There are also considerable gender differences, with women being more likely to be covered as a dependent than men, placing women at higher risk of losing health insurance coverage due to marital separation or divorce.<sup>6</sup> As a result, access to employer-based health insurance coverage in the United States

varies not only by one's own employment benefits, but by age, gender, and marital status as well.

The other major type of insurance coverage is government-sponsored health insurance. Together, Medicaid, Medicare, and other public health insurance programs (*e.g.*, State Children's Health Insurance Program (SCHIP), military-related coverage etc.) covered almost one in three Americans in 2009. This statistic underestimates the number of Americans who have their health care supported by public dollars, because employees of federal, state, and local governments are classified as having employer-based insurance, even though public dollars are being used to purchase this private insurance. Those who do not qualify for employer-based, dependent, or public health insurance have a third option of purchasing private, non-group insurance in the individual market. Almost one in ten Americans were covered by private, non-group health insurance in 2009. Some of these policies are purchased to make up for insufficient coverage in a primary insurance policy.<sup>7</sup>

Such fragmentation of health care coverage has resulted in many Americans falling through the cracks and being uninsured. This instability in insurance coverage is captured in Figure 1; the percentages do not add up to 100 percent because individuals are moving between different types of coverage (including non-coverage) during the year. This approach to coverage left 16.7 percent of Americans (over 50 million, including more than 7.5 million children), without any type of health insurance for at least part, if not all of 2009.<sup>8</sup> These national statistics disguise the disparity across individual states. Using data from the National Health Interview Survey from 2004–2006, Cohen and Makuc estimated that the percentage of persons under age 65 who were uninsured for at least part of the previous year ranged from 10.4 percent in Hawaii to 31.9 percent in Texas.<sup>9</sup> Some of the uninsured are only experiencing a temporary gap in insurance coverage. As individuals' circumstances change so does their eligibility for employer-based and publicly funded insurance. When they are no longer eligible, they must seek alternate insurance and are left without coverage while that search takes place. Then, even after signing up for a new plan, there are often waiting periods before benefits come into effect.

It is expected that the current economic recession will result in even greater numbers of people joining the ranks of the uninsured and underinsured, primarily because employer-based coverage is susceptible to such slowdowns, placing workers' benefits and coverage at risk.<sup>10</sup> While the Consolidated Omnibus Budget Reconciliation Act (COBRA) gives persons who leave a job with insurance coverage the right to continue that

coverage for the next 18 months provided they pay the entire premium, the high cost of covering the entire premium often prevents individuals from taking advantage of this opportunity. In 2011, the average annual health insurance premium for employer-sponsored health benefits was \$15,073 for a family policy and \$5,429 for an individual policy.<sup>11</sup>

The PPACA,<sup>12</sup> which was enacted in 2010 and is being phased in over the next four years, has a number of specific policies which directly affect coverage. Some of these policies have already been implemented, including extending dependent coverage to young adults who do not have insurance available to them through their own employment through age 26, eliminating denials of coverage due to pre-existing conditions for children under the age of 19, prohibiting the rescinding of health insurance benefits except in cases of fraud, and a small business health insurance tax credit that will be increased in 2014.

Support has also been provided to expand coverage for early retirees and to provide new coverage options to individuals who have been uninsured for at least six months due to a pre-existing condition. These programs will no longer be necessary by 2014 when new insurance exchanges will be available to provide more affordable health insurance options in the individual market, and denials of coverage due to pre-existing conditions will be prohibited for all age groups. An expansion of Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line is being phased in and should be complete in 2014. Tax credits for individuals without access to public or affordable employer-based insurance that have incomes from 100

to 399 percent of the federal poverty level will also come into effect in 2014.

The PPACA also includes an individual mandate requiring all individuals to have health insurance coverage by 2014, with penalties for not having coverage being phased in through 2016. The individual mandate is perhaps one of the most controversial parts of the legislation, and the only part to receive some support as being unconstitutional by the courts. The individual mandate is essential to having everyone covered by some form of health insurance. Otherwise healthy individuals with low risk of needed medical services may be inclined to opt out of coverage, contributing to adverse selection in the insurance pools. The US Court of Appeals for the Eleventh Circuit ruled in August 2011 that the individual mandate is unconstitutional, although the Sixth Circuit US Court of Appeals previously ruled that it was constitutional. These conflicting findings mean that the US Supreme Court will ultimately have to rule on the mandate's constitutionality, leaving its potential impact on universal coverage uncertain. Oral arguments for this case were held in March 2012 and as we go to press the US Supreme Court is still deciding the fate of the PPACA. While the various policies in the PPACA have the potential to obtain near universal coverage for all Americans, the patchwork approach will continue to result in a lot of movement between different types of coverage. A recent study looking at monthly changes in income concluded that under the PPACA, 35 percent of adults below 200 percent of the poverty level will cross the eligibility threshold for Medicaid at least once over a six-month period.<sup>13</sup> This movement between different types of coverage has the potential to also result in

different levels of coverage and out of pocket expenses, and access to different doctors and specialists, threatening the continuity of care for these individuals.

Health care coverage in Canada is dramatically different from health care coverage in the United States. Essentially all legal residents of Canada are covered by a publicly funded plan for certain health care services. However, contrary to popular belief, there is no single 'Canadian health care system.' What exists is a set of publicly financed, provincially run insurance plans that typically adhere to five federal guidelines laid out in the Canada Health Act:

1. Public administration;
2. Comprehensiveness;
3. Universality;
4. Portability; and
5. Access.<sup>14</sup>

Provinces are not required to follow these guidelines; however, the transfer of federal tax dollars to help finance the plans is contingent on adhering to them. At present, all of the provinces and territories follow these federal guidelines.

Two of the guidelines directly relate to coverage of persons: universality and portability. Under the guideline of universality, the health care insurance plan must cover all legal residents of the province or territory on identical terms and conditions. The maximum residency or waiting period to be eligible is three months. In order to ensure consistent health care regardless of location of employment, members of the Canadian Forces and the Royal Canadian Mounted Police are exempt from the provincial health insurance plans and have their own health care coverage. Prisoners are also exempt

from coverage under these health insurance plans, but have essential health services provided to them in prison. The portability guideline mandates that provisions be in place for the orderly transfer between provincial plans. This ensures that Canadians never have to experience a gap in coverage when they move between provinces. Typically, individuals are covered by their previous plan for three months after moving to a new province or territory, after which coverage in their new province or territory begins.

### **Coverage—Services**

While the majority of Americans have some form of insurance, there is considerable variability between insurance plans in the types of services that are covered. Individuals have to educate themselves about the specifics of their insurance plan and pay particular attention to the definitions of terms contained within. One of the provisions in the PPACA is for the development of uniform explanation of coverage documents and standardized definitions in language that is understandable for the average enrollee. The Secretary for Health and Human Services in conjunction with the National Association of Insurance Commissioners (NAIC) have developed these guidelines, with implementation delayed until September 2012.<sup>15</sup>

With regard to the types of services covered by insurance, the PPACA has provisions to increase coverage of preventative health services for insured persons. Since September 23, 2010, all group health plans and insurers offering group or individual health insurance are required to provide coverage for specific preventative services and not impose any cost-sharing requirements such as copayments, coinsurance, or

deductibles for these services when they are provided by in-network providers. Insurers still have considerable flexibility in determining the frequency, method, treatment, and setting of these preventative treatments if specific guidelines and recommendations are not provided.<sup>16</sup> In 2011, older adults in Medicare became entitled to additional free preventive services, including an annual wellness visit and in 2013 additional funding will be provided to state Medicaid programs that choose to cover preventive services at little or no cost.

Beginning in 2014, the PPACA will also require new qualified health plans in the individual or small group markets to cover essential health benefits including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services. The extent of coverage and cost sharing for these essential services can vary across four different plan tiers. While these provisions in the PPACA will increase access to preventative and essential health services, there remains room for considerable variability across insurance plans in frequency, method, treatment, setting, and out-of-pocket costs for these services.

In Canada, the medical services covered by the different provincial and territorial health care plans also vary to some extent. However, as a result of the federal guideline of comprehensive coverage, all medically necessary hospital and physician services must be included. These services are universal across plans in Canada. Variability in what is covered occurs when different

plans extend their coverage beyond medically necessary hospital and physician services to other services such as home care or pharmaceuticals.

Within each plan, the federal guideline of universality also states that the plan must guarantee the same coverage to all insured persons on uniform terms and conditions. There can be no 'Cadillac' plan offering enhanced services to special individuals, nor can there be any exclusions for certain groups, such as those with pre-existing conditions. It should be noted that this federal requirement of universality does not preclude provinces and territories from offering enhanced services for select groups *outside* of the provincial/territorial health care plan. For example, Alberta has the Alberta Adult Health Benefit, which is separate from the Alberta Health Care Insurance Plan, and provides access to prescription drugs, dental and vision services, emergency ambulance, and diabetic supplies for low income Albertans.<sup>17</sup>

A private health insurance market also exists in Canada. Rather than being in competition with public insurance plans, these private plans complement them. Private insurance companies are not allowed to cover the same services as the public plans. Instead, private insurance companies cover additional health services such as dental, vision, and prescription drugs. As a result, coverage of these types of health services is not universal; however, many Canadians enjoy supplementary private insurance plans as part of their employment benefits.

The final report of the Royal Commission on the Future of Health Care in Canada (commonly known as the Romanow report) recommended revising the Canada Health Act to include coverage for home care services in priority areas, and taking steps to

incorporate prescription drug coverage into Canada's health care system.<sup>18</sup> In 2003, the First Ministers' Accord on Health Care Renewal included provisions to determine the minimum home care services to be provided, and a commitment to provide first dollar coverage for these minimum services.<sup>19</sup> Among other provisions, First Ministers also agreed to collaborate to reduce pharmaceutical costs and develop catastrophic drug coverage for Canadians suffering undue financial hardship because of necessary drug therapy. The following year, these commitments were renewed in the ten-year plan to strengthen health care.<sup>20</sup> To facilitate this plan, the federal government committed \$41 billion dollars in new federal funding over ten years, with some money specifically targeted at home care and catastrophic drug coverage.<sup>21</sup>

### Access

With or without health insurance, individuals need to be able to access the health care system. In the United States, access to health care varies dramatically between the insured and uninsured. A few of the ways uninsured Americans have access to health care are through emergency room services, safety-net hospitals, and free clinics. Regardless of an individual's ability to pay, emergency departments in the United States are required by law to assess and stabilize any patients presenting themselves for treatment. As a result, the emergency department has become a primary source of care for those who cannot afford treatment elsewhere. This is, however, an inefficient and expensive way of providing care that results in unnecessary spending on conditions that could have been prevented, or treated elsewhere at a lower cost.<sup>22</sup>

The growth of managed care plans, coupled with cutbacks in Medicaid and Medicare subsidies for uncompensated care, has eroded the pool of free care funds available to hospitals to finance the care of the uninsured. Safety-net hospitals are having trouble competing with other hospitals for insured patients to help cover costs, whereas there is no competition for the uninsured. While there has been a growth in the number of free clinics in the United States,<sup>23</sup> this does not seem like a viable option for providing comprehensive medical services to millions of uninsured Americans.

Even with 5 to 10 percent more doctors per capita in the United States than Canada,<sup>24</sup> Americans are less likely to have access to a doctor. According to the Joint Canada/US Survey of Health, Americans are less likely than Canadians to have a regular medical doctor and to have had any contact with a medical doctor in the last 12 months.<sup>25</sup> However, when Canadians are compared with *insured* Americans, there is no difference in access to a regular medical doctor.

While insured Americans often have to deal with insurance restrictions on which doctors and specialists they can visit, or pay extra for out-of-network versus in-network doctors and hospitals, Canadians can call any physician in their province to see if the physician is taking new patients. In 2007, approximately 20.2 percent of family physicians in Canada were accepting new patients without restrictions.<sup>26</sup> In the United States, the proportion of physicians accepting new patients is higher but varies depending on health insurance type. Using 2008 data, approximately 30.8 percent of family/general medicine physicians accepted new Medicaid patients without restrictions, whereas 49.1 percent accepted new Medicare patients,

and 52.1 percent accepted new privately insured patients without restrictions.<sup>27</sup>

Canadians do not need a referral to see a specialist, although there are reimbursement incentives for specialists to see patients with a referral from another physician.<sup>28</sup> An international study of sicker adults found that 53 percent of Canadians surveyed had difficulty seeing a specialist when needed, compared to 40 percent of Americans.<sup>29</sup> Canadians were more likely than Americans to cite long wait times (86 percent versus 40 percent) or lack of local facilities or services (24 percent versus 13 percent) as the source of their difficulty, whereas Americans were more likely than Canadians to report being denied or waiting for a referral (31 percent versus 10 percent) or lack of private insurance or ability to afford (17 percent versus 3 percent) as the difficulty.

Despite having universal health insurance coverage, Canadians do experience problems with access to needed health care services. The top reason for unmet health care needs in Canada is wait times.<sup>30</sup> While these wait times were framed by some during the recent health care reform debates in the United States as government rationing of health care, most Canadians would argue that the Canadian system provides a fairer allocation of health care resources. On the surface, wait times in the United States are much less than in Canada; however, these wait times fail to include the substantial minority of Americans without health insurance that are waiting indefinitely.

Wait times are a recognized issue in Canada, but their reality has been greatly exaggerated, as well as their consequences. Wait lists for medical services in Canada are triaged by medically trained professionals.<sup>31</sup> Patients in critical condition are moved to the front of the line, while patients who are

stable and have less urgent care needs are pushed back. Who gets moved to the front of the line and who waits is determined by medically trained professionals informed by best practices in medicine. While relatively few people die waiting for medical services as a result of wait times, many are forced to endure conditions that limit their quality of life as well as deal with the uncertainty of when they will receive treatment while waiting. On the other hand, it is estimated that a number of lives are saved each year by delaying surgeries, as some of these conditions resolve on their own prior to surgery.<sup>32</sup>

Just how long are the wait times for medical services in Canada? According to a recent report, the median wait time for diagnostic services such as non-emergency magnetic resonance imaging (MRI) is two weeks, for specialist physician visits it is 4.3 weeks, and for non-emergency surgery it is 4.3 weeks.<sup>33</sup> While 50 percent of Canadians waiting for these services receive them in the specified timeframe, some have to wait much longer; 10.5 percent of those waiting for non-emergency diagnostic services, 13.6 percent of those waiting for a specialist physician visit, and 17.8 percent of those waiting for non-emergency surgery wait longer than three months.<sup>34</sup> The federal and provincial governments are making targeted efforts to further reduce wait times, and in many circumstances maximum wait times are being established. If services are not provided within that timeframe, then the provincial health insurance plan will pay for medical services, including transportation and other related expenses, to be received elsewhere (in another province or even the United States). As part of the federal investment in the ten-year action plan on health, the federal government established a Wait Times Reduction Fund with \$4.5 billion

in funding, in addition to a \$500 million investment in medical equipment.<sup>35</sup> These investments have resulted in an increase in CT scanners from 10.3 per million population in 2003 to 14.4 per million population in 2010, and an increase in MRI machines from 4.7 per million population to 8.4 during that same period.<sup>36</sup>

If resources in Canada were allocated to a degree that eliminated wait times for some services, this would increase the per capita cost of providing health care, mainly to reduce personal inconvenience and discomfort. As wait times increase to unacceptable levels, this indicates areas that may need additional government funding. This then becomes a political choice made by government, which is accountable to the people in the normal democratic fashion. The PPACA also has provisions in place to improve accountability in the American system. Specifically, group plans must incorporate the Department of Labor's claims appeals procedures, and all plans must comply with state external review processes that include minimum standards for consumer protection.

## Cost

US health care costs are the highest in the world.<sup>37</sup> American per capita health care spending in the year 2009 was 82 percent higher than Canada's (in US dollars and adjusting for purchasing power parities) and the highest of all OECD countries.<sup>38</sup> Even as a percent of its gross domestic product (GDP), the US spending on health care was higher than any other OECD country in 2009 at 17.4 percent, whereas the next highest spending country was the Netherlands, coming in at 12.0 percent.<sup>39</sup> There are certainly some legitimate reasons why American



health care might cost more than in other countries. If Americans were using more health care services than other countries, it would be understandable that health care costs overall would be greater. However, Americans tend to use a volume of medical services that is comparable to other OECD countries, and in some cases even lower.<sup>40</sup> For example, US patients on average have shorter hospital stays and fewer physician visits than other OECD countries. In 2008, the United States had an average of 3.9 doctor consultations per capita and the average length of stay in the hospital for acute care was 5.5 days, whereas Canada had an average of 5.5 doctor consultations per capita and the average length of stay in the hospital for acute care was 7.7 days.<sup>41</sup>

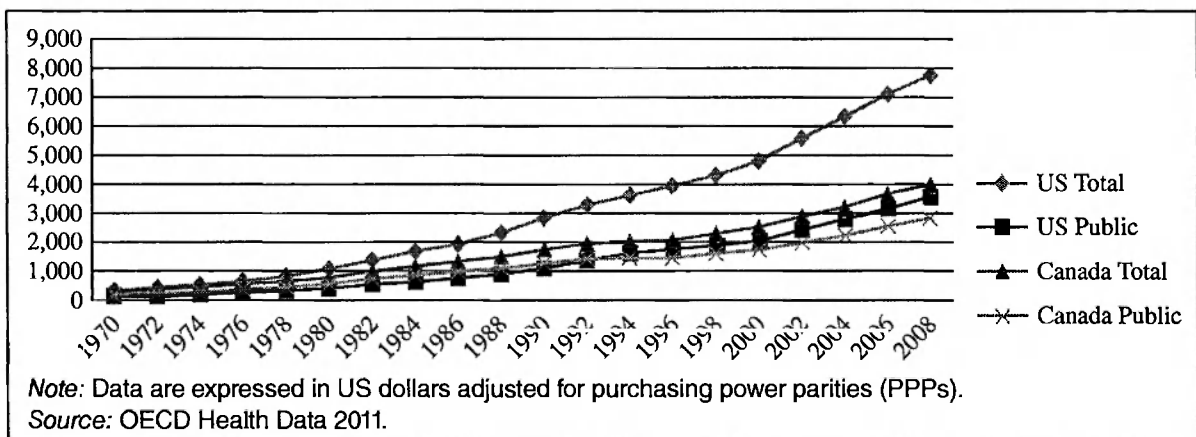
A major concern about adopting a publicly funded health care system in the United States is fear that it would result in a dramatic increase in taxes. Americans point to the higher level of taxes in Canada as support for this claim. While it is true that Canadians do pay more in taxes than Americans, these taxes go to support a number of social policies and programs different from those in the United States,

not just health care. A more accurate way to compare the burden placed on tax payers directly related to health care is to compare public spending on health care. Most Americans would be surprised to learn that the United States already spends more public dollars per capita on Medicare, Medicaid, and other publicly funded health insurance plans than governments in Canada spend to fund their entire population. In 2009, the US government spending on health was approximately \$3,794.9 USD per capita, while public spending in Canada was approximately \$3,081.1 USD per capita.<sup>42</sup>

Figure 2 demonstrates the growth in total and public spending on health care in Canada and the United States from 1970 until 2009. Total per capita health care spending in Canada and the United States was very similar in the early 1970s. Most of the subsequent divergence is a result of dramatic increases in private health care spending in the United States. Public spending in Canada exceeded the United States until the early 1990s, which corresponds with cutbacks in government spending on health care in Canada during this time.

The market-based nature of the American system makes it more difficult to contain

**Figure 2. Public and Private per Capita Health Expenditures, United States and Canada, 1970–2008**



health care costs than in Canada, where the government determines reimbursement rates for services and regulates the cost of pharmaceuticals for the general population and the administrative costs associated with health care delivery are much lower.<sup>43</sup> Powerful corporate interests in the United States make it difficult for the government to take direct action to reduce the escalation of health care costs.<sup>44</sup> In 1991, the General Accounting Office estimated that 33.5 percent of total health care costs in the United States were used to pay for managers, marketers, lawyers, and other administrators, compared to only 3 percent in Canada.<sup>45</sup> A more recent analysis found that private insurers in both the United States and Canada have higher overhead (11.7 and 13.2 percent, respectively) than public insurance (Canada 1.3 percent, US Medicare 3.6 percent, US Medicaid 6.8 percent).<sup>46</sup> With health care administration costs running dramatically higher in the United States than in Canada, it is estimated that if the United States was able to reduce administrative overhead to Canadian levels, the cost savings would be enough to provide full insurance coverage for all uninsured Americans.<sup>47</sup> Furthermore, in a market-based system large sums of money are spent on advertising and marketing.<sup>48</sup>

Overall, fewer tax dollars (per person) are used to pay for medical care in Canada than in the United States. In addition, the out-of-pocket medical costs are also substantially lower. Only two provinces, British Columbia and Ontario, charge modest health insurance premiums. Ontario just recently re-introduced health insurance premiums in order to target the issue of wait lists. Otherwise, the plans are funded entirely through federal and provincial corporate and individual income taxes, with some provinces

receiving additional funds from sales taxes, payroll levies, and lottery proceeds. Services are free at the point of use, meaning there are no copayments or deductibles for medically necessary hospital or physician services. Physicians and hospitals are not allowed to levy additional charges directly on patients for covered medical services; as a result, most Canadians never see a bill for the medical services they receive. The bill is sent directly to the provincial government, which pays the bill in full (at their negotiated reimbursement rates). Accordingly, Canadians are less likely than Americans to spend time on health insurance paperwork, or disputes related to medical bills or health insurance.<sup>49</sup>

Most private insurance policies in the United States utilize premiums and some combination of copayments, coinsurance, and deductibles (if not all three) to pay for health services. As a result of the economic downturn in the United States, many employers are reducing the scope of health insurance coverage and shifting more of the burden of cost onto workers. While employer-based health insurance premiums for family coverage have increased 113 percent between 2001 and 2011 (from \$7,061 to \$15,073 annually) the portion that employees have to pay has increased 131 percent (from \$1,787 to \$4,129 annually).<sup>50</sup> As many as 60 percent of Americans with insurance are categorically underinsured, meaning that despite having health insurance coverage, they do not have sufficient financial protections against the costs of more serious medical conditions.<sup>51</sup> A single health problem could bankrupt them or force them to go without necessary treatment because their insurance company does not cover their particular condition, or because the deductibles and copayments are so high. It is estimated that in 2007,

62.1 percent of bankruptcies were medically related, and three quarters of those medical bankruptcies occurred among individuals with health insurance.<sup>52</sup> In addition, unmanageable medical bills have been connected to nearly one quarter of home foreclosures.<sup>53</sup>

A number of provisions under the PPACA are designed to address issues of cost and affordability. Lifetime limits on essential benefits were eliminated in September 2010 for new and renewed policies, protecting individuals with extreme medical expenses. Annual limits on the amount of essential benefits have been restricted and are being phased out by 2014. The expansion of Medicaid and individual and small employer tax credits will also decrease individual and employer costs, but place an increased burden on public spending. Under the PPACA and effective January 1, 2011, insurers must demonstrate that 85 percent of the premiums they collect from the large group market and 80 percent in the small group and individual markets are used to pay for clinical services and activities that improve health care quality; otherwise, they will be required to provide a rebate to consumers. In addition, unreasonable premium increases are now subject to external review.

The PPACA also provided for the establishment of the Center for Medicare and Medicaid Innovation. The purpose of this center is to explore innovations in health care delivery that will improve quality of care and health outcomes, and lower costs. Additional policies encourage integrated health systems and reduce paperwork and administrative costs. Canada is also working to improve the integration of health services, which will lower costs and improve health outcomes, by providing \$2.1 billion of funding to accelerate the development of electronic health records.<sup>54</sup>

## Health Outcomes

One could probably justify the high cost of health care in the United States if it led to superior health outcomes. Unfortunately, this is not the case. Canada has a higher life expectancy and a lower infant and maternal mortality than the United States.<sup>55</sup> A meta-analysis of 38 studies comparing a variety of health outcomes in the United States and Canada, found that 14 favored Canada, five the United States, and the remaining 19 showed mixed or equivalent results.<sup>56</sup> Of course, life expectancy and infant and maternal mortality are influenced by more than just health care. It has been argued that the amenable mortality rate is more reflective of a country's health care system because it represents deaths from causes that could have been prevented with timely and effective health care.<sup>57</sup> In a recent study comparing amenable mortality in the United States with 18 other countries (mostly in western Europe but also Canada, Australia, New Zealand, and Japan), not only did the United States have the worst amenable mortality rate, but it was an outlier compared to all other countries in the study with regard to how much amenable mortality was reduced between 1997–1998 and 2002–2003; only 4 percent compared to the average of 16 percent across the other countries.<sup>58</sup> If the United States could reduce its amenable mortality to the average of the other countries analyzed, the authors estimate that approximately 75,000 lives could be saved annually.

These notable differences in mortality are not simply a reflection of existing racial disparities in the United States.<sup>59</sup> Part of the reason the United States has such poor health outcomes is the large number of uninsured individuals. Uninsured individuals are

much less likely than insured individuals to obtain preventative care such as pap smears, mammograms, regular check-ups, and prostate exams.<sup>60</sup> Uninsured individuals with chronic conditions are also less likely than insured individuals to receive proper maintenance and continuous care. Even when medical attention is sought, uninsured individuals often forgo recommended treatment, for example, by skipping a recommended medical test or treatment, or failing to fill a prescription.<sup>61</sup>

In general, uninsured individuals lack a regular source of continuing care. As a result, uninsured individuals have a higher probability of preventable emergency room visits and hospitalizations,<sup>62</sup> are more likely to be diagnosed with late-stage cancer,<sup>63</sup> and suffer adverse clinical health outcomes and higher mortality rates.<sup>64</sup> In the end, the overall health of uninsured individuals is compromised, and tax-payers usually end up footing the financial bill for health outcomes that could have been avoided.

According to the Joint Canada/US Survey of Health, Americans were more likely to have unmet health care needs than Canadians, but the difference between the two countries was small (13 versus 11 percent).<sup>65</sup> However, when Canadians are compared to uninsured Americans, the disadvantage is much more apparent as 40 percent of uninsured Americans reported unmet health care needs. Only 10 percent of insured Americans reported unmet health care needs, which was not significantly different from those of Canadians. However, a 2007 survey of privately insured adults, reported that when participants were asked whether they had avoided or delayed getting needed medical care because of its cost, including whether in the past year they had skipped a medical test,

treatment, or follow-up recommended by a doctor, not filled a prescription, not gone to a doctor or clinic when sick, or not seen a specialist when a doctor or the respondent thought it was needed, 34 percent said yes.<sup>66</sup>

Another factor contributing to the relatively poor health of Americans is the market-based health care system that makes decisions about the quality and quantity of health care services made available based on cost cutting and profit-making strategies. In fact, for-profit health plans have been shown to provide lower quality care than not-for-profit plans in terms of clinical performance measures and patient satisfaction.<sup>67</sup> In Canada, the federal guideline about public administration requires that the plans be operated on a non-profit basis.<sup>68</sup>

It is presumed that with provisions in place to increase coverage and facilitate access to health care that the PPACA will have an impact on improving health outcomes and reducing unmet health care issues. The PPACA also has provisions directly targeting the overall health and wellness of Americans. For example, the PPACA calls for the establishment of a new council called the National Prevention, Promotion and Public Health Council charged with recommending changes to US policy to achieve national goals related to health and wellness. In addition, the Prevention and Public Health Fund was created to fund programs for prevention, wellness, and public health activities, and the Education and Outreach Campaign was organized to establish a national, science-based media campaign on disease prevention and health promotion. Finally, Community Transformation Grants, and Healthy Aging, Living Well Grants were designed to help fund public health projects at the state and local levels.

## Satisfaction

American consumers are not as satisfied with their health care system as compared to consumers in other countries. These results are not just due to dissatisfaction with the system from the uninsured. Even after controlling for uninsured individuals, Americans report lower levels of satisfaction with their health care system compared to consumers in other countries.<sup>69</sup> Satisfaction rates in Canada have been falling over the past few decades, but still remain relatively high; 90 percent of Canadians report being satisfied with physician care and 80 percent are satisfied with hospital and community care services.<sup>70</sup> A cross-national comparison of health care in 2001 showed that 54 percent of Canadians rate their overall medical care as excellent or very good, compared with 57 percent of Americans (results not significantly different).<sup>71</sup> However, when the analyses were restricted to respondents who had been hospitalized themselves or had a family member hospitalized in the past two years, 54 percent of Canadians rated care as excellent or very good, compared with 50 percent of Americans.

Another aspect of satisfaction with medical care is satisfaction on the part of medical providers. One study on physician satisfaction sampled physicians who had worked in both the Canadian and American health care systems (with an average of ten years practicing in each country), and found physicians currently practicing in Canada to be three times more enthusiastic about the health care system they were working in than physicians working in the United States.<sup>72</sup> A more recent study looking at Canadian and American pediatric surgeons trained in Canada found that those who had experience working in

Canada and the United States did not have an overwhelming preference for one system over the other; 24 percent preferred the United States, 26 percent preferred Canada, and 50 percent had no preference.<sup>73</sup> Interestingly, the authors found that these results were strongly influenced by citizenship, with 32 percent of the Americans favoring the US system and 50 percent of Canadians favoring the Canadian system. When asked about specific aspects of each system, the surgeons who had practiced in both countries rated the financial compensation and promptness of care as more favorable in the US system; whereas, for paperwork, bureaucratic issues, lawsuits, and less attention to financial issues when treating children the Canadian system was rated significantly more favorable.

Hospital executives in the United States are also less satisfied with their system of health care than their Canadian counterparts. Only 8 percent of hospital executives in Canada reported being not very satisfied or not satisfied at all, compared to 49 percent of American hospital executives.<sup>74</sup> Conversely, 16 percent of Canadian hospital executives were very satisfied compared with 4 percent of their American counterparts.

## Ideology

Canadians feel very strongly that health care is a public good and a right of citizenship, not a commodity or business venture.<sup>75</sup> In the United States these 'rights of citizenship' are labeled as entitlements and often discussed in a negative context. Americans have a national ethic of individualism,<sup>76</sup> which is consistent with the notion that each person should pay what he or she owes. Redistributing the cost of health care so that everyone pays roughly the same (with

some accommodations made for ability to pay) is viewed as unfair by those who would use less services or at least be at less risk of using services.<sup>77</sup> However, this preoccupation loses sight of the fact that insurance as a social institution was invented to pool and spread risk,<sup>78</sup> and by fragmenting the insurable population into smaller and smaller risk pools and assigning them different premiums based on different risk levels, we are no longer pooling and sharing the risk.

In addition, Americans generally have more negative attitudes about the government than other democratic countries.<sup>79</sup> Those who oppose the involvement of government with health care financing play upon this distrust of government. By criticizing the history of government-run programs in delivering high quality services, they paint the picture of a massive, incompetent government bureaucracy controlling the medical care industry with all of the problems associated with other government-run programs.<sup>80</sup> While in principle many Americans support the idea of universal coverage, there is skepticism over the government's ability to achieve it and manage it.<sup>81</sup>

## Conclusion

This comparison of health care in the United States and Canada in the areas of coverage, access, cost, health outcomes, and satisfaction reveals a number of strengths and weaknesses in both countries. However, Canada has been more successful at providing health care to a larger proportion of its population, and for less cost, than the United States. Canadians also demonstrate better health outcomes over a range of health indicators than Americans, although not all of these advantages can be attributed to

health care. While overall access is better in Canada, patients are sometimes required to endure longer wait times than in the United States. Finally, reports of satisfaction levels vary across studies, but most evidence points toward comparable levels of satisfaction for patients in Canada and the United States.

In the recent health care reform debates in the United States, the Canadian system was misconstrued and used as an example of why a single-payer model would be undesirable for Americans. The findings in this article are a first step in debunking some of the Canadian health care myths, and educating policy makers and the general public about how health care in Canada really compares to health care in the United States. Many of the provisions of the PPACA will not be implemented until 2014, and it may be several years after that before the promised benefits of these reforms are realized. At the same time, Canada will be coming to the end of its ten-year action plan on health that has poured substantial new resources into health care to revive it. Both countries are taking bold moves to invest in and protect the future health and well-being of their citizens, but are doing so in dramatically different ways.

While there is reason for optimism about the potential impact of the PPACA, these reforms may not go far enough to address problems arising from the largely for-profit, employer-based, market-driven, patchwork approach to health care. We must never underestimate the ability of insurance companies to adapt in ways that will reduce the impact of new laws on their bottom line. For example, although insurers must provide pre-existing condition coverage for sick children covered by policies in the individual market, they are not required to sell insurance to those with pre-existing

conditions and could opt to increase premiums to cover additional costs.<sup>82</sup> Just before the new health reform laws came into effect, many health insurance companies ceased offering child-only insurance policies, rather than be forced to cover children with pre-existing conditions.<sup>83</sup>

Poignant ideological differences between Canada and the United States have contributed to their very different approaches to health care, and may prevent the United States from adopting and accepting changes

that could reduce costs, broaden coverage, and improve the health and well-being of its citizens. The very future of the PPACA itself is uncertain, with a litany of pending lawsuits and an upcoming presidential election that may bring with it a change in leadership to one that is against government involvement with health care. The next decade will be a telling one for the future of health care in these two countries as they enact and respond to reforms in the midst of weak economies and aging populations.

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