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Access Denied: Canada's Healthcare System Turns Patients Into Victims Kerri Houston

During the recent Senate debate over adding a massive prescription drug benefit to our nearly bankrupt Medicare system, Senator Ted Kennedy (D-MA) endorsed the plan, referring to it as a “down payment,” noting that the lesson learned from the failure of President Clinton’s universal healthcare scheme was the need for incrementalism.¹

Senator Kennedy is clever. His end goal is bringing nationalized, socialized healthcare to America. Undoubtedly, his model will be Canada. As such, we should immediately start screaming “no!” and continue until this idea is completely erased from the landscape of contemporary political debate.

America’s system needs reform, but not one modeled on the unmitigated healthcare disaster currently taking place north of our border. Canada calls its program a “one-tier” plan. In reality it is a “zero-tier” healthcare delivery system where everybody equally gets virtually none.

In contrasting the Canadian and U.S. healthcare systems, a critical distinction must be made: the difference between health *care* and health *insurance*. The challenges in our country are with our financing methods, but we have the best health care in the world. In Canada, the opposite is true – abundant health insurance, but a profound lack of health care.

The High Cost of Free

Canada’s system, called Medicare, is a shared venture between the federal government and the country’s thirteen provinces and territories. It found its roots in Saskatchewan during the 1940s, and grew *incrementally* until 1972 when a nationwide system was established. The current regulatory and funding scheme was incorporated under the Canada Health Act in 1985.

The price of Canada’s “free” healthcare system is borne by its citizens through high taxes and employer

contributions. Revenues are generated at federal and provincial tiers through income and sales tax, and employer-based premiums. As with any other employee deduction, these premiums reduce income and additional benefits available to workers.

Initially the two governmental layers shared costs equally, but as shifting demographics and increased costs pressured the system, federal transfers decreased, culminating in Ottawa’s dramatic slashing of provincial healthcare budgets by \$45 billion in 1995. This resulted in further erosions of healthcare as provinces closed beds, tightened reimbursements to doctors (yes, they are paid through the government), limited medical and nursing school enrollment, and halted investment in new technologies.

As a country, Canada is the lone monopoly in the public provision of health insurance.² Although it spends more on healthcare than any other universal care industrialized nation,³ it ranks at the bottom on access ratios in comparison to the thirty nations of the Organization for Economic Co-operation and Development (OECD). It is 17th out of 20 for its doctor/patient ratio—only 1.8 doctors per 1,000 citizens, 17th for availability of CAT scanners, and 18th for MRIs.⁴

Canadian taxpayers also bear transportation costs and medical protocols in U.S. dollars as provinces regularly send cancer, orthopedic and cardiac patients to American facilities for treatments not available in Canada.

Free healthcare? Hardly.

Fleeing Like the Geese

The assault on Canada’s sick people has several fronts. Lack of access to technologies, drugs and the closing of hospital beds are real problems, but the most deadly is the physician shortage.

About 10,000 doctors left Canada during the 1990s.⁵ Doctors' pay is based on "billing thresholds" determined by patient volume, regardless of how comprehensive the care provided. If they reach the threshold, they must send overpayments back to the government. In the first seven months of 1999, 251 Ontario physicians wrote checks to the province totaling \$7.2 million. Pressures on doctors are so extreme that they continue to migrate south year round—with no plans for a spring return.⁶

Compounding the problem of mass exodus is the lack of replacements for retiring doctors due to mandated medical school enrollment limits. According to the Canadian Medical Association, there were only 1,530 medical school graduates in 2002—the lowest number since the 1970s.⁷ In its 2003 budget, Ontario touted its new medical school—the first new training facility in thirty years!⁸ In Ontario, nearly 80% of its regional communities are listed by the provincial government as being "underserved" due to physician shortages.⁹

With provinces already facing a doctor scarcity, the Canadian Nurse's Association reports an anticipated shortage of 78,000 nurses by 2011.¹⁰ Devastating hospital bed closures are a direct result of this crisis. But in a bizarre twist of reasoning, Ontario is turning to nurses to replace its bolting doctors. It's "creating" 369 new positions for nurse practitioners to take up the slack for the doctor shortage. This plan is not based on nurses' training or patient care, but on their average salaries and provincial officials' budget concerns. These nurse practitioners are paid \$80,000 versus \$168,000 for doctors.¹¹

Sick? Hang on!

Canada's preeminent think tank, the Fraser Institute, does a yearly study of "waiting times." Never mind the results, just that Fraser finds it necessary to *do* a study is telling enough. The data is harrowing.

Results based on 2001-2002 information are:

- total waiting time between referral from a general practitioner (GP) and treatment was 16.5 weeks;
- Saskatchewan had the longest wait at 32.6 weeks; and
- wait to see a radiation oncologist was 8.5 weeks (an eternity for those with a brain tumor or Hodgkin's Disease.)¹²

Diagnostic waits were:

- 5.2 weeks for a CT Scan;
- 12.4 weeks for an MRI; and
- 3.2 weeks for an ultrasound.¹³

Canada-wide, the total number of procedures for which people were waiting was 1,094,264. At any given time, 3.52% of Canadians—sick Canadians—were waiting.¹⁴

In some instances, patients die waiting as they become too ill to tolerate a procedure. Patients needing hip replacement often end up non-ambulatory while waiting an average of 20 weeks for the procedure—after waiting 13 already just to see the specialist. Couple this with waiting to get diagnostic scans and then waiting for the radiologist to read them, and you have just arrived in Cleveland—the hip replacement capital of Canada.

Big Fat Drug Lies

There is no prescription drug benefit in Canadian Medicare. And drugs aren't cheap there.

Some provinces offer public plans, for which patients pay. There are private sector plans, for which patients pay. Over 51% of Canadians—including the elderly—either pay for private prescription drug coverage or directly out of pocket.¹⁵ Another 49%¹⁶ opt for provincial coverage that includes co-pays, deductibles and/or limits.

Prescription drugs are regulated and re-regulated by the federal and provincial governments. New drugs take years to pass through a dual-tier approval process before being placed on an "approved" list, but many are still not available due to provincial pricing schemes. This applies to chemotherapy agents, emergency room "crisis" drugs, as well as maintenance drugs for diseases such as arthritis, allergies and heart disease. Newer, more effective—and more expensive drugs—are regularly out of reach to Canadians willing to pay for them. They go to the U.S. to buy them.

Canadians are also subjected to "mandated switching" which means that although one drug in a pharmaceutical family works best for your unique physiology, you are stuck with the version the government "carries." In 1999, 27% of British Columbia doctors reported having to admit patients to the emergency room or hospital solely as a result of government mandated switching.¹⁷

A 1999 study from University of Pennsylvania's Wharton School¹⁸ concluded that some drugs were less expensive in Canada, but most were higher than those in the United States. For those drugs that are actually available in Canada, the extremely favorable rate of the U.S. dollar vs. the Canadian combined with exploitation by politicians and the media provides a dangerous illusion of "cheap" drugs.

In an April report to the Canadian government, the Senate Social Affairs Committee headed by Liberal

Michael Kirby concluded, “Canada’s publicly funded healthcare system is not fiscally sustainable.”¹⁹ The report offered solutions such as further rationing, increasing taxes (Canada’s taxes are already among the highest in the world), or a two-tier system wherein patients can pay for services.

Canadians no doubt recognize something that many Americans do not—the value of a good healthcare system. Not the cost; the value. As Canadian reformers, both liberal and conservative,

work to allow private services to creep into Canada, we must not let its “free” system creep over our borders—either incrementally or in large chunks.

When it comes to healthcare, American patients and taxpayers simply cannot afford the high cost of free.

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¹ Hulse, Carl. “Kennedy’s Stance on Medicare Angers Allies,” *The New York Times*, 22 June, 2003.

² Esmail, Nadeem and Michael Walker, Ph.D. *How Good is Canadian Healthcare? An International Comparison of Health Care Systems*, Fraser Institute. August 2002.

³ Ibid.

⁴ OECD, 2002.

⁵ Bueckert, Dennis. “Shortage of Doctors and Nurses Could Hurt Medicare Reforms,” *Canada News*; March 5, 2003.

⁶ Ontario Ministry of Health and Long Term Care; January 2000.

⁷ Canadian Medical Association, *CAPER Annual Census of Post-MD trainees*. 2002.

⁸ Ontario Provincial Government; *The Right Choices: Investing in Healthcare*, 27 March, 2003.

⁹ Ontario Ministry of Health and Long Term Care, *Report on Health Care Providers Underserviced Areas Program*, April 2003.

¹⁰ Eva Ryten. *The Future Supply of Registered Nurses*, Canadian Nurse’s Association, Updated June 2003.

¹¹ Dave Rogers. “Health Care’s New Front Line,” *Ottawa Citizen*, 30 October, 2002.

¹² Esmail, Nadeem and Michael Walker. *Waiting Your Turn: Hospital Waiting Lists in Canada*, The Fraser Institute, Vancouver, British Columbia, September 2002.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ The Honourable Michael J.L. Kirby, Chair. *The Health of Canadians – The Federal Role, Final Report*, the Standing Senate Committee of Social Affairs, Science and Technology; Government of Canada, April 2003.

¹⁶ Ibid.

¹⁷ Dr. McArthur, William. *Prescription Drugs Costs: Has Canada Found the Answer?* Pfizer Forum, June 2000.

¹⁸ Danzon, Patricia M. Ph.D, *Price Comparisons for Pharmaceuticals: A Review of U.S. and Cross-National Studies*, The Wharton School, University of Pennsylvania, April 1999.

¹⁹ The Honourable Michael J.L. Kirby, Chair. *The Health of Canadians – The Federal Role, Final Report*, the Standing Senate Committee of Social Affairs, Science and Technology; Government of Canada, April 2003.