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THE CANADIAN AND AMERICAN HEALTH CARE SYSTEMS

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TABLE OF CONTENTS

Page

INTRODUCTION 1

THE ROLE OF GOVERNMENT AND PRIVATE SECTOR IN HEALTH CARE 1

HEALTH CARE SYSTEMS IN PROFILE 4

A. Access to Health Care Services 5

B. Financial Barriers to Care 6

C. Extent of Benefits 6

D. Administration 7

COST CONTAINMENT 8

A. Level and Rate of Growth of Health Care Costs 8

B. A Single Payer May Lower Costs 10

RATIONING AND QUALITY OF CARE 12

CONCLUSION 15

SELECTED REFERENCES 16

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THE CANADIAN AND AMERICAN HEALTH CARE SYSTEMS

INTRODUCTION

The United States is currently studying various proposals to reform its health care system and that of Canada is often cited as a possible model. Curiously, Canadians sometimes look to the United States for ways to improve their system. This search for improved health care has led to abundant but conflicting documentation about the relative merits of the two systems. The available literature emphasizes the relative efficiencies of public versus private intervention. While many maintain that Canada's public system is both better and cheaper, still many others contend that the privately-oriented American system provides more efficient and better quality services.

This paper presents a comparative description of the Canadian and American health care systems and reviews the most recent literature. The first part briefly examines the reasons for and against government involvement in health care; the second part compares both systems in terms of access, financial barriers to care, extent of benefits, and administration; the third section deals with cost containment. Finally comparisons are made in terms of the quality of care.

THE ROLE OF GOVERNMENT AND PRIVATE SECTOR IN HEALTH CARE

Both Canada and the United States devote a high proportion of their national wealth to health care. Estimates for 1990 show that Canada spent more than 9% of its GDP, or $60 billion dollars on health care,(1) while the United States contributed $660 billion or 12% of its GDP.(2) The health care system in Canada is characterized by strong government intervention. As can be seen in

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(1) House of Commons, Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, *The Health Care System in Canada and its Funding: No Easy Solutions*, Ottawa, June 1991, p. 2.

(2) Julie Kosterlitz, "A Sick System," *National Journal*, 15 February 1992, p. 383.

Table 1, of total health care spending in Canada, 72% was funded through federal, provincial and local governments. Canadians spend out of pocket only for services not covered by their provincial government insurance plan; this amounts to 21% of total health care expenditures. By contrast, the health care system in the United States relies heavily on the private sector; American individuals and their private insurance companies contributed more than half of total health care expenditures, while the federal, state and local governments accounted for 43%.

TABLE 1

HEALTH CARE FINANCING BY SOURCE OF FUNDS, 1990

	Canada	United States
	Percentage of Total	
Federal Government	28	30
Provincial/State and Local Governments	44	13
Out-of-Pocket Spending and Private Insurance	27	52
Others	1	5
Total	100	100

Source: Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, *The Health Care System in Canada and Its Funding: No Easy Solutions,* Ottawa, June 1991, p. 7; Julie Kosterlitz, "A Sick System," *National Journal*, 15 February 1992, p. 383.

Government intervention in the health care field is a source of controversy, with solidly based arguments both for and against. In Canada, health care is treated as a public service, which Canadians believe should not be subject to the laws of the marketplace and the mechanism of price and profit. By contrast, Americans favour limiting government assistance to those in need and allowing the private sector to have a great portion of the market. They contend that market mechanisms, the motive force of classical economics, can ensure cost control, efficiency, and top-quality services through effective competition.

Canadian government intervention in health care is generally explained with reference to certain market failures. In the private sector, resources are generally allocated according to the law of supply and demand. The resulting price levels ensure optimal allocation of resources, provided certain conditions relating to supply and demand are met. These conditions do not always prevail in the area of health care, however. First, it is difficult for the market system to ensure an adequate supply of health services because the very nature of these services implies costs and benefits that the market system does not take into account. Furthermore, consumers cannot

make informed decisions, because there is always uncertainty about illness and the future state of one's health. Consumers are often unable to determine for themselves the type of health services they need and must delegate the decision-making process to those who provide the health services. Government involvement in health care is also justified by reference to social fairness and economic inequality. In a free market system, low-income people with health problems pay the same as high-income people, so that the economically disadvantaged pay a relatively larger share of their income for health costs. For these reasons, federal and provincial governments in Canada have preferred a public system providing health insurance to all residents, regardless of their ability to pay.

By contrast, the market-oriented health insurance system of the United States is based on choice rather than on ability to pay. In recognition of the fact that specific groups need public protection, Medicare and Medicaid provide for the poor and the elderly. This reflects government action to resolve some market failures. The American system is based on the assumption that the vast majority of people are perfectly capable of providing protection for themselves against illness and its consequences and that most of the population are not denied care for financial reasons. Under the market approach, the consumer is free to choose the extent and form of insurance protection. Some may choose an appropriate level of coverage, while others may choose to be inadequately covered or not covered at all. When deciding how to insure themselves against costs of health services, people consider how they value health services compared to other things, given their level of income and their willingness to pay. Although Americans can choose the type of health insurance they want to buy, the use of health services requires specialized knowledge, so that doctors remain providers of information and advice. Thus, in a fee-for-service scheme, physicians could be in a conflict of interest. Most Americans contend, however, that an effective competition between doctors and hospitals ensures good quality medical care at a reasonable price.

In summary, there is no unanimity on the basic principles that should underlie the health care system. Social arguments seem to favour government intervention, while other considerations, such as freedom to choose and the efficiency of the interaction between demand and supply, call for the involvement of the private sector. These different philosophies have resulted in a relatively simply structured system in Canada and a very complex system in the United States.

HEALTH CARE SYSTEMS IN PROFILE

Canada provides universal insurance coverage to all its residents through provincial health insurance plans jointly financed by the federal and provincial or territorial authorities. Although private insurance companies exist, they are not allowed to cover services provided under provincial plans. In each province, only one public insurance entity is responsible for reimbursing hospitals and physicians. Patients are free to choose their physicians, but they do not reimburse these physicians or hospitals for insured health care services. Most physicians are in private practice and are paid on a fee-for-service basis. Most hospitals are private, non-profit organizations financed by provincial governments' overall budgeting.

Similarly, American providers of care, including physicians and hospitals, are largely private. The majority of patients receive care on a fee-for-service basis and are generally free to choose their own providers. However, the United States provides health insurance through a combination of public programs and private initiatives, including employer-provided arrangements and the individual market.

U.S. employers may provide their employees with self-insurance plans or insurance plans contracted out with third-party insurers. Self-insured employers usually operate and administer their own health plans; a few of them even run their own health care facilities. In addition to commercial plans, third-party insurers include Health Maintenance Organizations (HMOs), which both insure and deliver health care services, and Preferred Provider Organizations (PPOs), which offer health insurance plans but allow patients to choose from among a specific group of medical care providers. It is recognized that HMOs, PPOs and employer-sponsored plans somewhat restrict patient's choice among health care providers.(3) Individuals who do not have access to employer-based coverage may obtain health insurance coverage by purchasing it directly from commercial insurers or HMOs.

Access to health care for particularly needy population groups is provided through public programs. Medicare is a national, federally administered program with uniform eligibility and benefit protection serving the elderly and disabled persons. It covers hospital and physician services and is financed by a combination of enrolled premiums and general revenues. It also incorporates user charges such as deductibles and co-insurance. Medicaid is a medical assistance

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(3) David W. Conklin, "Why Canada's System is Better and Cheaper," *Policy Options*, May 1990, p. 18.

program for low-income groups. Under this program, the U.S. federal government provides matching funds to state governments, which operate and administer Medicaid within federal guidelines, although eligibility requirements, benefit levels, and provider reimbursement schemes vary greatly from state to state. Other federal and state government programs target specific population subgroups such as pregnant women, native Americans, and people suffering from renal disease and cancer.

A. Access to Health Care Services

In Canada, the health care system is characterized by its universal access. All residents of a province are entitled to the insured health services provided for by the public health insurance plan on uniform terms and conditions. In addition, health care provided to someone who is temporarily visiting another province is reimbursed under the insurance plan of the patient's home province. Canadians moving from one province to another continue to be covered for insured health services by their home province during any waiting period (not to exceed three months) imposed by their new province of residence.

By contrast, there is no universal public health insurance in the United States and access primarily depends on the type and extent of coverage. As shown in Table 2, Americans have varying degrees of health insurance coverage, from comprehensive to none at all. In 1991, almost 62% of Americans were covered under private health insurance plans; public health insurance plans covered 25% and 14% had no insurance.

TABLE 2
HEALTH INSURANCE COVERAGE IN THE UNITED STATES, 1991

Type of Coverage	**Number of Persons** (millions)
Covered by privately operated medical insurance plan	156
Covered under Medicare	35
Covered under Medicaid	27
No coverage at all	35
Total U.S. Population	253

Source: William Lowther, "Medicare to the Rescue," *Maclean's*, Vol. 105, 13 January 1992, p. 33-34.

B. Financial Barriers to Care

There is no financial barrier to care in Canada. All Canadians have insured access to medically necessary hospital and physician services under their provincial government health insurance plan. Under the *Canada Health Act*, the provinces must not permit user fees for publicly insured services, except for extended care for those with chronic illness living in hospitals, nursing homes and similar institutions. If they permit such charges, provinces are subject to dollar-for-dollar deductions from the federal cash contributions provided to them under the Established Programs Financing (EPF) as well as any other federal cash transfers. This ensures that individuals are not forced to forgo needed care because of expense. Canadians spend out of their own pocket, or purchase private insurance, only for services such as dental care, cosmetic surgery, and additional hospital-room amenities that are not covered by their provincial plan.

In the United States, access to health care is often limited by financial barriers, such as the high cost of private insurance, inadequacies in public programs and user charges. On the whole, Americans who can afford to pay are able to purchase medical care that is better or more readily available than that open to people who are less well off. Although U.S. federal and state governments help reduce the effect of individual financial constraints through Medicaid, Medicare and state assistance programs, millions of Americans still lack either public or private health insurance coverage. Indeed, Medicare and Medicaid do exclude many Americans. These uninsured must either pay out-of-pocket or rely on public hospitals, or clinics offering free or subsidized care. In recent years, the large number of patients without insurance has resulted in an increase in "uncompensated care."(4)

C. Extent of Benefits

Under the principle of comprehensiveness underlying the *Canada Health Act*, provincial health insurance plans must cover all medically necessary hospital services, physicians' services, and certain surgical dental procedures. Provincial governments also have considerable flexibility in terms of the range of services they may provide. They may and do include other benefits, such as prescription drugs for the poor and the elderly that are not required under the

(4) "Uncompensated care" consists of services for which the hospital or physician receives partial payment or no payment. See Congressional Research Service, *Health Insurance and the Uninsured: Background Data and Analysis*, Library of Congress, May 1988, p. 148-150.

federal guidelines. There are no dollar limits to the amount of "necessary" medical care that individuals may receive. Private health insurance covers uninsured services.

The extent of benefits in the United States varies widely among insurers. Most insurance sold by private companies is regulated by the state, and therefore must provide state-mandated minimum benefits. Self-insured employer plans, which do not fall under the jurisdiction of state insurance laws, cover about half of insured workers. Employment does not, however, guarantee coverage. As a matter of fact, among the 35 million Americans without any insurance, 25 million are in families where at least one member has a full-time job.(5) Some firms, particularly small businesses, do not offer health insurance to their employees. This presents a potentially significant impediment to moving from one job to another – a situation not found in Canada. Furthermore, when working people retire, they lose the health insurance benefits provided by the employer, and, as we have seen, Medicare provides standard benefits to only some Americans.

D. Administration

In Canada, the health insurance plan is administered in each province by a public agency which operates on a non-profit basis and is responsible to the provincial government. Provincial governments determine overall increases in hospital budgets and physicians' fees and regulate the acquisition of major equipment and facilities. While most physicians in private practice are paid on a fee-for-service basis, most hospital-based physicians are salaried employees of the hospital. Most hospitals receive funds under a global budgeting system negotiated with the provincial government. On the whole, government is the sole payer for all insured health services.

In the United States, responsibility for administering and controlling the health care system is diffused, and involves private insurers, employers, and federal, state and local governments. With the variety of reimbursement systems, U.S. providers are often paid different amount for the same services, depending on the consumer's insurance carrier. Furthermore, co-payments and deductibles are common, and it is not unusual for health care providers to bill the patient for charges in excess of the standard insurance reimbursement. No authority has responsibility for the condition of the system as a whole.

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(5) William Lowther, "Medicare to the Rescue," *Maclean's*, Vol. 105, 13 January 1992, p. 34.

COST CONTAINMENT

Two major issues arise when comparing health care spending in Canada and the United States. The first is the level and rate of growth of health care costs; the second is government's ability to control health care expenditures.

A. Level and Rate of Growth of Health Care Costs

Health care expenditures expressed as a percentage of GNP or in per capita terms take into account the different sizes of the Canadian and American economies. As shown in Table 3, since the early 1970s Canada has spent a smaller proportion of its total economic output on health care than has the United States; Canadian spending has also been lower on a per capita basis. Furthermore, the rate of growth in health care expenditures as a percentage of GNP has been lower than the comparable U.S. rate. For these reasons, many studies conclude that Canada, with its public health care system, is doing better than the United States: it provides coverage to all Canadians, spends less on health care and is more successful in containing costs. For example, the U.S. General Accounting Office (GAO) notes that:

> Canada's relative success in containing costs is evidenced by its slower rate of growth in health care expenditures since 1971, the year publicly funded health insurance was implemented in all provinces. As a result, health care expenditures per capita and as a proportion of gross national product (GNP) remain significantly less than the Unites States. This gap is due to differences in how the two countries finance and deliver health care as well as socio-demographic differences.(6)

Other analysts argue that these comparisons between Canada and the United States are simplistic and misleading. They suggest that comparisons of the two nations' health spending as a proportion of GNP exaggerate Canada's success in containing health costs. They argue that faster GNP when growth, rather than lower health spending, explains why health's share of GNP has stayed lower in Canada.(7) From that perspective, Neuschler concludes that "Given very similar

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(6) United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, Report to the Chairman, committee on Government Operations, House of Representatives, June 1991, p. 13.

(7) Edward Neuschler, "Is Canadian-Style Government Health Insurance the Answer for the United States' Health Care Cost and Access Woes?" *Canada-U.S. Outlook*, National Planning Association, Vol. 2, No. 4, September 1991, p. 49. A similar argument is presented by Edmund F. Haislmaier in "Northern Discomfort: The Ills of the Canadian Health System," *Policy Review*, Fall 1991, p. 34.

growth rate of per capita health spending, the country that expands economic output more rapidly will spend a smaller proportion of that output on health care."[8] However, another study shows that faster GNP growth in the United States would indeed have led to an even higher level of health care expenditures: "If U.S. income had grown as fast as Canada's, health spending would have increased more and per capita spending would have been even higher than the current U.S. levels."[9]

TABLE 3

TOTAL HEALTH CARE EXPENDITURES AS A PERCENTAGE OF GROSS NATIONAL PRODUCT AND IN PER CAPITA TERMS

	Canada		United States	
	Percent of GNP	Dollars Per Capita	Percent of GNP	Dollars Per Capita
1960	5.5	120	5.2	149
1965	6.0	174	5.9	206
1970	7.1	293	7.4	349
1975	7.3	540	8.3	591
1980	7.5	943	9.1	1,055
1985	8.7	1,605	10.3	1,696
1990	9.5	2,321	12.2	2,566

Source: Health and Welfare Canada, *National Health Expenditures in Canada 1975-1987*, Ottawa, 1990, p. 27 and 137. Preliminary figures for 1990 were provided by the Department in May 1992.

Another indicator of the effectiveness of health care cost controls used in the literature is the ratio of per capita spending in Canada as a percentage of per capita U.S. spending. In his study, Neuschler shows that this percentage has fluctuated in a very narrow range (approximately 75%) over the past three decades. He concludes that Canada has not really been more successful than the United States in containing health care costs and hence: "The factors leading to different levels of health care spending in the two countries, therefore, must be more basic than the difference in health care financing arrangements."[10]

(8) Neuschler, (1991), p. 55.

(9) United States General Accounting Office (1991), p. 16.

(10) Neuschler (1991), p. 53.

Overall, comparisons show that health care costs are lower in Canada than in the United States but there is no unanimity as to whether cost containment is better achieved in this country.(11) Although both countries are facing financial pressures, these pressures are exerted differently. As the study of the GAO indicates,

> In both Canada and the United States, health care is limited by financial resources. However, each country approaches access to health care services in a different way. In Canada, financial constraints are applied to the entire system, but not directly to an individual's utilization. In the United States, financial constraints are placed directly on individuals' utilization - ability to pay is an important factor in obtaining access and amount of care – not on the system as a whole.(12)

In summary, the burden of health care expenditures is shared collectively in Canada, while it is borne by the individual in the United States. In the former country, payment is made indirectly but equitably through the tax system; in the latter, most of it is paid directly by consumers. On the whole, however, the systems are similar in the sense that individuals ultimately pay for them; one can thus conclude that the burden of health care costs is less for Canadians than for Americans.

B. A Single Payer May Lower Costs

Although there is no consensus on government impact on health care, some studies indicate that the Canadian system, by concentrating financial responsibility in a single payer, permits more efficient administration and results in better control over health care costs. As shown in Table 4, Canadian spending on health was, in 1987, some $450 per person less than in the United States. The GAO study indicates that most of the difference between U.S. and Canadian per capita spending on health care comes from administrative costs and physicians' and hospital services.

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(11) Clearly, there is not unanimity among empirical works on the impact of government involvement in the health care market. For example, in an extensive study on differences in health care expenditures among the OECD countries, Pfaff show that health care systems relying on some form of government control of spending generally exhibit lower health care expenditures than those relying on market mechanisms. A study by Santerre *et al*., however, also using OECD data, reaches an opposite conclusion. Specifically, this regression analysis shows that government financing does not necessarily lead to lower total health care spending. For further details, see Martin Pfaff, "Differences in Health Care Spending Across Countries: Statistical Evidence," *Journal of Health Politics, Policy and Law*, Vol. 15, No. 1, Spring 1990, p. 20-21, and Rexford E. Santerre, Stephen G. Grubaugh and Andrew J. Stollar, "Government Intervention in Health Care Markets and Health Care Outcomes: some International Evidence," *The Cato Journal*, Vol. 11, No. 1, Spring/Summer 1991, p. 1-12.

(12) United States General Accounting Office (1991), p. 21.

TABLE 4

**HEALTH CARE EXPENDITURES PER CAPITA BY SECTOR, 1987
(IN 1987 U.S. $)**

	Canada	U.S.
Hospital and Construction	659	802
Physicians' Services	241	369
Insurance Overhead	18	95
Other Professionals	20	84
Dentists' Services	82	108
Research	13	36
Other Health care	42	49
Other Institutions	156	158
Public Health	67	58
Drugs and Appliances	209	196
Total	1,507	1,955

Source: United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, Report to the Chairman, Committee on Government Operations, House of Representatives, June 1991, p. 29.

In 1987, Canada's per capita spending on insurance administration was only one-fifth that of the United States. Accordingly, the GAO points out that Canada's publicly financed single-payer system eliminates the costs associated with the marketing of competitive health insurance policies, billing for and collecting premiums, and evaluating insurance risks.(13) Danzon believes, however, that overhead costs in Canada would tend to be higher than comparable costs in the United States, if hidden costs were taken into account. She argues that a public insurer has fewer incentives than private insurers to take into account all the costs for patients and providers.(14)

Canada also exhibits lower physician and hospital costs than the United States. The GAO argues that, since Canadian provincial governments are the sole payer for insured medical services, they are able to negotiate physicians' fee schedules and hospital budgets from a position of strength. Within the U.S. system, hospitals and physicians are reimbursed by numerous payers using widely differing procedures and coverage. According to the GAO, the fact that no single entity is managing the U.S. system results in piecemeal measures to control costs.(15)

(13) *Ibid.*, p. 29.

(14) Patricia M. Danzon, "Other Models and Hidden Costs," *The American Enterprise*, Vol. 3, No. 1, January-February 1992, p. 71.

(15) United States Federal Accounting Office (1991), p. 27.

Other health experts also believe that government regulation in Canada does not necessarily reduce the quality and quantity of health care services. For example, Conklin recognizes that the control of physicians' fees has in real terms kept physicians' incomes below the levels they would otherwise have reached, but he believes that this has not resulted in poorer health care in Canada. He contends that the higher expenditures in the United States do not necessarily indicate the delivery of more health care, and explains that higher U.S. spending only represents higher incomes for health care workers.(16) He also believes that limits placed by provincial governments on hospital budgets are cost-effective. For instance, hospitals must compete for the right to adopt a new technology and they do so by presenting convincing arguments to the provincial government. Since hospitals have freedom in resource allocation within their budgets, this process encourages cost minimization.(17)

Although government control may lower costs, the GAO suggests that this can also reduce the potential to manage costs as effectively. "For example, Canadian hospitals have been described by physicians as having underdeveloped information systems. Unlike the U.S. reimbursement system, the global budgeting approach provides hospitals with fewer incentives for careful tracking of costs per patient day or costs per case."(18) Furthermore, some believe that Canada is limited in the development of innovative approaches (such as HMOs) to health care financing and delivery.(19) Finally, it has been argued that government control in the health care sector in Canada has resulted in rationing and declining quality.(20)

RATIONING AND QUALITY OF CARE

A number of weaknesses have been identified in the management of both the Canadian and American health care systems. One common problem relates to health care rationing. This is defined as a limitation on the availability of beneficial interventions whereby some persons are permanently or temporarily denied useful services.(21)

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(16) David W. Conklin, "Health Care: What Can the United States and Canada Learn From Each Other?" *Canada-U.S. Outlook*, National Planning Association, Vol. 2, No. 4, September 1991, p. 8.

(17) *Ibid*., p. 6.

(18) United States General Accounting Office (1991), p. 33.

(19) Stuart Butler, "Freeing Health Care," *National Review*, 22 December 1989, p. 35.

(20) Neuschler (1991), p. 65-66; Beth C. Fuchs and Joan Sokolovsky, "The Canadian Health Care System," *CRS Report for Congress*, Congressional Research Service, Library of Congress, 20 February 1990, p.11.

(21) David Naylor, *The Canadian Health Care System: an Overview and Some Comparisons with America*, University of Toronto, Department of Medicine, 1991, p. 14-16.

Canada tries to provide uniform standard care to the entire population according to relative medical needs. There is no price rationing based on the ability to pay. However, non-price rationing does take place and results in waiting lists for selected surgical and diagnostic procedures. Some ill people may thus have to wait for treatment and risk the possibility of seeing their condition deteriorate. Some Canadian patients experiencing delays in obtaining specialized medical services have even crossed the border to seek care in the United States.(22)

By contrast, in the United States rationing is based on the ability to pay. Such price rationing comes about because some individuals have inadequate coverage, or are deterred by user charges from using services. As a result, access to and quality of care vary significantly among the U.S. population; the poor and the poorly insured experience long waiting periods and substandard facilities, if they receive care at all. Some aspects of American medical care, such as limited immunization, a large number of pregnant women without regular medical attention, and risk of bankruptcy through illness, are the direct result of price rationing and would probably be considered intolerable in Canada. Furthermore, non-price rationing exists even in federal and state government programs. Although the poor, the elderly and the disabled receive free treatment for most major illnesses and many routine services, the availability of high-quality treatment is constrained by the escalating cost of Medicaid and Medicare.

Critics of the Canadian health care system suggest that the rationing of services results from government constraints placed on hospital budgets and the number of facilities used for specified high-technology services. It is true that Canada has less expensive technological equipment per capita than has the United States (see Table 5) and that some expensive facilities are not as available in this country. Many critics view the slower diffusion and limited use of some new technologies as evidence of lower quality of care. If high quality is defined as more high-technology services regardless of relative effectiveness, then the United States indeed offers higher quality medical care. If, on the other hand, quality is defined by health outcomes, there is no evidence of a Canadian disadvantage. Specifically, Marmor maintains that if life expectancy and infant mortality measure the quality of a health care system, Canada has a definite advantage.(23) As can be seen in Table 6, Canadian indices of population health status are superior to American. Nevertheless, some claim that there is no definite link between medical care outcomes and the functioning of the health care system.(24)

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(22) Douglas J. McCready, “Don’t Copy Canada’s Health Care System,” *Policy Options*, October 1991, p. 9-10.

(23) Theodore R. Marmor, “National Health Care: Is Canada the Model System?” *Current*, No. 341, March-April 1992, p. 13.

(24) Conklin (1991), p. 7.

TABLE 5

AVAILABILITY OF SELECTED MEDICAL TECHNOLOGIES
(Units per Million of Population)

	Canada	**United States**
Open-Heart Surgery	1.23	3.26
Cardiac Catheterization	1.50	5.06
Organ Transplantation	1.08	1.31
Radiation Therapy	0.54	3.97
Lithotripsy	0.16	0.94
Magnetic Resonance Imaging	0.46	3.69

Source: Beth C. Fuchs and Joan Sokolovsky, "The Canadian Health Care System," *CRS Report for Congress*, Congressional Research Service, Library of Congress, 20 February 1990, p. 9.

TABLE 6

HEALTH STATUS INDICATORS

	Canada	United States
Infant Mortality Rate (per 1,000 live births, 1985)	7.9	10.5
Maternal Mortality Rate (per 100,000 live births, 1984)	3.2	8.0
Life Expectancy at Birth (men, 1985)	71.9	71.2
Life Expectancy at Birth (women, 1985)	79.0	78.2

Source: Beth C. Fuchs and Joan Sokolovsky, "The Canadian Health Care System," *CRS Report for Congress*, Congressional Research Service, Library of Congress, 20 February 1990, p. 13.

CONCLUSION

An overview of the recent literature reveals that the health care systems in Canada and the United States both have problems and limitations. Moreover, much of the debate reflects different philosophical attitudes to government involvement in health care; it will always be difficult to reconcile a market orientation with the belief that health care should be provided on the basis of medical need rather than ability to pay. Comparing the Canadian and U.S. health care systems should, however, highlight both the strengths and drawbacks of each and help find solutions best suited to each approach.

Overall, one must recognize that Canada has achieved a balance between cost, quality and access. It must now build upon its strengths and make the system more cost-effective. The United States still has to make its system more efficient, less expensive and more inclusive. Deber summarizes the issues now facing the two countries:

> [In Canada], the old agenda looked at accessibility and universality, asking questions such as: What services are available? Where? At what cost to the patient? The new agenda has had a different focus - on efficiency, outcome and the appropriate role for government.(...) The United States, in contrast, has not yet reached that point; much argument is still focused on how care can be provided for those with poor (or no) access to it.(25)

On the whole, improving Canada's health care system may not depend on putting greater reliance on the private sector. Likewise, it may not be feasible for the United States system to accept greater government involvement. It may be better for each country to develop its own system's strengths and, where appropriate, to incorporate features from that of the neighbouring country.

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(25) Raisa B. Deber, "Philosophical Underpinnings of Canada's Health Care System," *Canada-U.S. Outlook*, National Planning Association, Vol. 2, No. 4, September 1991, p. 42.

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