The Monthly *is determined not to give up on finding big solutions to the health care problem. Everybody else seems to have decided on tiny incremental steps, which, worthy as they may be individually, lead along conflicting paths. That's why we ran the article in April by Eric Schnurer ("A Health Care Plan Most of Us Could Buy"), because we thought it presented a major solution that would solve the problem for the largest segment of the population, the middle class.*

But the working poor were left out of that plan. And the way they can be included, as they are not now in any program, is with the Canadian Plan, which we continue to favor above all others. It not only has the merit of universality, but also has a strong practical appeal to physicians who used to oppose it just because it sounded socialistic, but now realize that its freedom of choice of doctors offers them a better life than they're leading under the HMOs.

The Best Solution

Questions and answers on Canada's health care system

BY PAT ARMSTRONG AND HUGH ARMSTRONG
WITH CLAUDIA FEGAN

How much does it cost?

There are various ways to answer the question of public health care costs. One way is to look at the cost of health care goods and services exchanged as a percentage of all goods and services exchanged — the Gross Domestic Product (GDP). In 1995, Canada spent 10 percent of GDP on health, compared to 14 percent in the United States. In 1995, Canada spent $2,049 per person, or about 55 percent of what Americans spent per person.

A much better way to look at the Canadian system is to focus on public costs and the share paid for from the public purse. In 1995, Canada's governments spent just under 7 percent of the GDP on health, a figure that is not very different from the 6.6 percent that comes from tax dollars in the United States. Although the proportion of public money spent in Canada and the United States is very similar, Canadians get much more for their health dollar and many more Canadians receive care from these public expenditures. This public money covers every Canadian for a wide range of services. In contrast, fewer than 30 percent of Americans are covered by government Medicare (13 percent), Medicaid (12 percent), and military (4 percent) care plans combined.

Another way to look at costs is to examine what individuals pay. For services covered by public insurance, most Canadians pay nothing. Unlike Medicare and Medicaid in the United States, there are no deductibles or user fees, no limits related to contributions or nature of the plan, no restrictions on which of the insured services can be used, and no means tests. For most there are no premiums to pay for basic care, only taxes.

Why does Canadian health care cost less?

The simple answer to the question of why Canadian health care costs less is that so much of it is publicly financed. Before medicare, there were no significant differences in what Canadians and Amer-

From UNIVERSAL HEALTH CARE: WHAT THE UNITED STATES CAN LEARN FROM THE CANADIAN EXPERIENCE, *by* PAT ARMSTRONG *and* HUGH ARMSTRONG *with* CLAUDIA FEGAN, *published by The New Press.*

icans spent on health care services. Since the introduction of the Canadian health care system (which they call medicare with a small "m"), the differences in expenditures have steadily and significantly increased. What the Canada Health Act calls "public administration" has kept Canadian health care spending under control while providing quality care to the entire population. There are several reasons why public administration makes for cheaper care. One of the most important areas for cost savings is in administration itself. When Larry Haiven was released from a U.S. hospital after his heart attack scare, he received an itemized bill, detailed down to the sample tube of toothpaste, the aspirin pill, and the laxative he didn't take. In Canada, Larry did not receive a bill at all after his first hospital stay with a real heart attack. The Canadian hospital had no reason to collect the kind of details he was later to receive from the U.S. hospital. It would have been wasteful to go to the trouble of allocating the cost of insignificant items like toothpaste tubes to individuals patients. Indeed, it would have been wasteful to allocate the cost of medications or surgical supplies to individual patients. Instead, the hospital simply purchases the supplies it needs and in turn provides them to the patients who need them.

Hospitals in Canada save on administrative costs not only because they do not have to keep detailed accounts for each patient, but also because they do not have to send each of them, or their private insurer, a bill. Moreover, Canadian hospitals do not have to send out these bills according to the different criteria and forms used by different insurers, do not have to worry about whether they can collect, and do not have to calculate how many "charity" cases they can afford to take on.

All this contrasts sharply with the situation in the United States, where, according to one study, hospitals "must keep more extensive records in order to facilitate billing to the state and federal governments, insurance companies and patients, and in anticipation of malpractice suits." Comparing hospitals in California and Ontario, this study estimated that "roughly half" the difference in hospital costs could be explained by higher administrative expenditures south of the border.

As one Canadian doctor who tried practicing in the United States explained, "I wasn't making any more money [in the United States]. My overhead was so much higher." He returned to Saskatchewan after two years in Idaho, not only because he made less but also because, south of the border, "People did not come until they were very ill," in order to avoid the expense of care. For example, this doctor could recall only one occasion during his 11 years of practicing in Saskatchewan when a leg had to be amputated because of complications with diabetes. It happened four times during his brief stay in Idaho.

Administration also costs less in Canada because no effort is required to separate the eligible from the ineligible. No time is taken up with means tests to determine who qualifies for Medicaid, or filling out forms to make sure applicants are old enough for Medicare. No time is spent ensuring that insurance coverage is up to date, that the right hospital is being used for a specific insurance plan, or that the required service is covered by that plan. Because all Canadians, and most health care services, are included in the public health insurance scheme, this kind of scrutiny to assess eligibility is largely unnecessary.

In the Canadian system, hospitals and doctors are not alone in enjoying light administrative loads. Patients also have much less paperwork to fill out than do their U.S. neighbors. Canadians sign up but once for medicare, receiving one identification card good for the entire range of services. This card is all they have to produce when they enter the hospital, visit the doctor, or use any of the other services available under their provincial program. There are no bills to juggle at the end of the month, no calculations to make about which insurance company to choose or to charge.

Is health better?

The most important measure of care quality must be health. As a mass of research makes clear, health is determined by a range of factors. The most critical are food, shelter, jobs, and joy. But health services also have an impact, so it is useful to look at the overall health of a population in assessing the quality of its health care services.

On such measures, Canada comes out ahead of the United States. Take babies, for example. More babies die in the United States. In 1994, six out of every 1,000 babies born in Canada died within the first year; this was the case for eight out of every 1,000 American babies born that year. In other words, out of every thousand babies born, two more died in infancy in the United States. Maternal mortality rates in the United States were double those in Canada in 1988, with seven out of every 100,000 dying in Canada compared to 14 in the U.S.

Canadians also live longer than their American counterparts. In 1995, for example, Canadian male babies could be expected to live for 75.3 years on aver-

age, while male babies in the United States could be expected to live 72.5 years. Women in both countries can be expected to outlive men on average, but Canadian women have the edge. They are likely to live to be 81.3 years, compared to 79.2 years for American women. More importantly, Canadians have a better chance of living free of disability. By the late 1970s, Canadian women and men averaged 66 years of disability-free life. In the United States, both sexes averaged 60 years free from disability.

Can Canadians choose their doctors?

Individual Canadian patients and family physicians choose without outside interference who will be seen, how often, and by whom. On referral from a family physician, Canadian patients can go to any specialist or hospital, as frequently as medically appropriate and for as long as medically necessary.

Doctors too enjoy a wide range of choices and freedom from supervision. There is little restriction on where they locate. In fact, a recent court decision in British Columbia struck down a provision in the fee schedule that penalized new entrants to medicine if they chose to set up their practices in heavily served urban areas. In this instance, the problem appears to be too much individual choice in the public system, not too little. Physicians are guaranteed that their fees will be paid at the negotiated rate, and their activities are very seldom scrutinized. Usually the monitoring of physicians' fees simply takes the form of letters sent to a random sample of patients inquiring whether they visited a specific physician on a specific date. The fee-for-service system under which nine out of 10 Canadian doctors are paid allows them considerable choice about their hours of work and, ultimately, about how much income they will receive.

What about high-tech care — MRIs, organ transplants, etc.?

Although it must be conceded that the Canadian system is more equitable than the U.S. alternative, it is on occasion argued that the quality of care is inferior in Canada, especially when it comes to advances related to research and technology. As we have seen, measuring quality is no simple task, and neither country is very good at it. However, none of the research on quality reveals significant differences in the health care in Canada and the United States. Although there is relatively more technology in the U.S., there is little evidence that all of it is necessary or altered to improve care quality. There is, however, evidence that Canada distributes its technology more appropriately and equitably. Third, although neither country has developed rigorous ways of measuring quality, the establishment of well-funded research centers in Canada with mandates to focus on evaluation and utilization concerns may bode well for the future. The existence of a publicly administered health care system in Canada enhances the likelihood that research conducted there and abroad will be translated into improved care.

What if you get sick away from home?

It may seems obvious to point out that people can fall ill or have an accident anywhere, but this fact has quite important implications for health care coverage. Its recognition led those developing Canadian medicare to make portability a central principle of the system. Public health insurance coverage follows Canadians without a break from service to service, from job to job, and from province to province. It even provides some coverage outside the country.

Portability is not restricted to specific geographical areas. Increasingly, people commute long distances to work. Or they travel even longer distances at irregular intervals. Or they move for months, even years, to another location. Illness and injury do not necessarily occur near home, however, and often the need for health care cannot be planned. Like many of these people, Pat had moved out of Toronto for a couple of years. And like many of them, she needed health care while she was away. Her provincial health card from Ontario gave her immediate entry to the full range of services in Ottawa, her new home during these years.

Portability in this sense means moving throughout the provincial system. Because it is a public health system, people have access to the entire provincial system rather than to a single service organization or to a specific network of providers, as they usually are in managed care. This means that traveling for work need not mean moving away from access to paid care.

It also means that patients can travel to the services that are seen to be best for their needs. While she was living in Ottawa, Pat could still visit the specialist in Toronto who did her regularly required specialty tests, even though it was quite possible to find a new specialist in Ottawa.

This portability is particularly important for those Canadians who live in rural areas or small towns scattered throughout this enormous country. With portable insurance, they have access to medical services in major urban centers where a choice of specialists and a wider range of services are more likely

to be found.

This portability of services within the province contrasts sharply with the American private system, which channels health care primarily through employment. This results in two major differences between the two systems. First, Canadians are much less tied to their employers through health care coverage. Although Canadian employers do offer some health care benefits, these are extra to the medically necessary services provided under the public plan. To change employers, then, does not mean sacrificing the right to necessary care. Choosing a new employer is not related to coverage for basic health care services. Nor need it be related to the kind of plan available or its conditions. Canadians therefore have more choice about moving from employer to employer as a result of their portable health care plan.

Second, work restructuring has little impact on health care in Canada. In both countries, employment has become more contingent, that is, more precarious, temporary, and insecure. A growing number of jobs are part-time, short-term, or simply insecure. A majority of this contingent work is done by women; women who in their middle years are much more likely than men to need regular health care. Yet only a small proportion of such workers are likely to receive health insurance as part of their employment contracts. With portability under the Canadian public plan, coverage is not linked to either employment or neighborhood, so Canadians have many more choices about services whatever their place of employment or indeed whether or not they are employed.

Problems

1. Waiting lists. Comparisons between Canada and the United States do reveal differences in waiting times for some kinds of surgery. In the case of knee replacement surgery, for example, Canadians waited significantly longer than Americans. While waiting for knee surgery may be inconvenient or even painful, it is unlikely to be life-threatening. It is not surprising then that only 15 percent of Canadians felt their waiting time was unacceptable for this surgery.

Canadians do not wait for care that is required immediately. Alice had her surgery booked in the doctor's office while she was assimilating the news of her diagnosis. Emergency rooms are readily available in all urban centers, and all patients urgently requiring care can be admitted without regard to ability to pay, health care plan, or place of residence. In rural areas, ambulances on the road or in the air can deliver patients quickly to emergency centers.

Surgery that is deemed medically necessary on an urgent basis is also done quickly. As a recent survey of the Canadian system put it, "in virtually all cases, Canadians who need emergency or urgent care receive it in a timely fashion; it is extremely uncommon for patients on surgical waiting lists to die." Indeed, there is no evidence that they are more likely to die than their American counterparts. There is, however, evidence to suggest that in the United States "the uninsured receive less trauma-related care and have a higher mortality rate." We can assume no such differences exist in Canada, given that everyone is covered for care.

2. Drugs. Canada does have a problem with drugs. Per capita spending on drugs increased by over 100 percent in real terms between 1975 and 1996, rising to $C 362 for every man, woman, and child. Drugs now account for more than 14 percent of all health care expenditures, virtually the same amount as that spent on physicians and second only to hospitals in terms of expenditure share.

One reason for this dramatic increase in the amount spent on drugs is that only three provinces have universal drug plans, and only British Columbia uses a reference-based pricing scheme to help control costs. In its first 10 month of operation, British Columbia saved an estimated $21 million by generally paying for only the lowest-cost drug in each of three designated "therapeutic categories." In consultation with physicians and pharmacists, the province is working to introduce more therapeutic categories to the scheme, but other provinces have not yet introduced similar approaches. Those provinces without universal plans have multi-payer systems that are comparable to those prevailing in the United States. With such systems, not only are many individuals left out, especially among the "working poor," but it is very difficult for any particular plan to control costs. At the same time, each of them faces unnecessarily high administrative costs. ●

Bad Air

Cleaner vehicles are here — so why is the industry turning out gas guzzlers?

By Robert Worth

WALKING DOWN HARLEM'S 125th street is like stepping back into the history of black America. As you dodge past the vendors and musicians who line the curb near the Apollo theater, the street names alone conjure up a legendary past: Frederick Douglass, Adam Clayton Powell Jr., Malcolm X. But unless you live nearby, you're likely to notice something else first: the filthy air. Diesel trucks and buses charge along Harlem's great boulevard, belching out sooty, foul-smelling clouds of smoke. Six of New York's seven bus depots are north of 96th street, and trucks — barred from the West Side highway — thunder through the neighborhood at all hours of night and day. When EPA officials measured Harlem's air in late 1996, they found levels of pollution that exceeded federal air quality standards by 200 percent.

This kind of pollution is more than unpleasant. A growing body of medical research links the sooty particulates found in diesel fumes to asthma, lung cancer, and other respiratory diseases. These studies led the California Office of Environmental Health Hazards Assessment to issue a report in March officially declaring diesel exhaust a "toxic air contaminant." Meanwhile, gasoline exhaust remains a major health risk as well. A study conducted by a group of New York City doctors in 1996 found that the primary cause of asthma-related emergency-room visits was smog and soot from all motor vehicles — cars as well as diesel buses and trucks. That's not news to residents of Harlem, where asthma rates in some neighborhoods are 12 times the national average, and children die of lung ailments at rates far above the rest of the country.

Back when the U.S. environmental movement first started gathering steam 30 years ago, motor vehicles were a target for two reasons: They contributed to air pollution, and they weren't practical, because fossil fuel supplies were rapidly dwindling. The second argument melted away with the discovery of new oil reserves, and it's not likely to come back while gas remains as plentiful as water, and almost as cheap. (Actually, gas is now about a fourth the price of Evian.)

Yet the first threat has only expanded. In late April the Centers for Disease Control and Prevention reported that the number of asthma cases in the U.S. rose 75 percent between 1980 and 1994, while the death rate for children rose 78 percent, in part due to air pollution. Almost simultaneously, the EPA released a study suggesting that it could not meet its air quality goals without cleaner vehicles. It's not that we haven't already made progress; thanks to catalytic converters and other pollution control technology, the average vehicle of today is a lot cleaner than it was in 1970. But the four-wheeled population has literally exploded. The total number of vehicle miles traveled has almost tripled in the past 25 years, virtually erasing some of our achievements in pollution control. (In fact, emissions of nitrogen oxide — the main cause of smog —increased during that period.) Meanwhile, the threat of global warming is getting larger and more plausible every year. Motor vehicles play a major role, because the fossil fuel they burn accounts for the single largest portion of the man-made "greenhouse gases" that help to heat the atmosphere and may ultimately change the Earth's climate in catastrophic ways.

So why haven't we done more? Low emission cars are finally on the market, and they're not just electric go-carts anymore. Natural gas, a much cleaner and soot-free alternative to gasoline, has been an option for almost a decade. It's also cheaper than gasoline (despite higher upfront costs for