Canadian One Tier Health Care
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By Dr. Gordon Guyatt

Nine years ago my mother, who was dying of breast cancer, needed admission to hospital. Because of a shortage of hospital beds, she waited over night and most of a second day in the emergency room. It was noisy, the nurses were busy, and there was minimal privacy.

After going to the ward, my mother received good nursing care, and the necessary tests and procedures took a couple of days to complete.

If we lived in the United States or Australia, or in most countries in Asia, Africa, or South America, my upper-middle class family would have taken my mother to a private hospital. There, she would have been admitted immediately to a private room, received top quality nursing care, and had tests and procedures completed immediately.

If my family were poor, the care my mother received in Canada would have been no different than the care she did receive. However, in a public inner city hospital in the US, Australia, or the developing world, waits would have been far longer, and nurses and doctors far less available. The result might well have been increased suffering for my mother, and increased anguish for my family.

My mothers story illustrates how, in Canada, patients or their families cannot purchase better, or faster, physician or hospital care. For physician and hospital services, our "one tier" system contrasts with countries such as the United States, Australia, and developing countries. In these countries "two tier" systems, the care you receive depends on your ability to pay.

Among countries that ensure largely equal access to health care mostly in Western Europe and Scandinavia Canada is unusual in its focus on physician and hospital services. How did our one tier system develop?

In 1968, the Liberal government of Lester Pearson wanted to establish a national system of physician and hospital care. Since, according to our constitution, health is a provincial responsibility, they had to use an

indirect approach to create the system they had in mind.

Holding much more of the taxation power, they offered to pay each province 50% of the costs of administering a health program if that program met certain conditions. These conditions included coverage of all necessary physician and hospital services for the entire population.

By 1970, all ten provinces had signed up. Many physicians were philosophically opposed to the plan. However, the financial offer was very generous. As a result of the new health plan, physician income jumped from 3.5 times the average income of workers in Canadian industry the "mean industrial wage" to 5.5 times the mean industrial wage. As a result, physicians offered minimal resistance.

In its first years, the plan worked well. However, during the late 1970s, economic growth slowed. Governments, responding to the financial pinch, offered physicians minimal increases in fees.

Physicians, in their turn, began to make direct charges to patients beyond what the government insurance plans would pay. Canada's one tier system of physician services was falling apart.

In 1984, Pierre Trudeaus Liberal government responded with the Canada Health Act. The legislation, championed by Health Minister Monique Begin, penalized provinces one dollar for each dollar of user fees they allowed.

By 1986, each province had taken measures to end direct user charges. In Ontario, it is illegal for physicians to charge patients for insured services. The Canada Health Act proved the salvation of one tier physician and hospital services.

The Canada Health Act did not, however, end opposition to one tier care. That opposition has been very active in recent years.

One argument that enthusiasts for a two tier system offer is that we don't really have a one tier system now. After all, if you are close friends with an eye specialist, you may be able to jump the queue for your cataract surgery. If you are ready to pay enough, you can certainly go to the United States for quicker treatment. So why not let people pay for quicker or

better care at home?

As anyone who reads the newspaper knows, if you are close friends with a politician, you may be able to arrange political favours. Does that mean we should allow people to pay directly for those favours? Of course not.

Our goal, never absolutely achievable, should be fair and equitable political decisions, and fair and equitable health care delivery.

As for the US, Canadians receive only a tiny fraction of their health care in a year – well under 1% – south of the border. Most of that care is for people who fall ill while spending their winter months in southern states Canadian "snow birds" rather than those seeking quicker or better care.

The solution to deficiencies in Canadian care that may tempt the wealthy sick to go south is to correct those deficiencies, not to import US-style two tier care.

Thinking back to my mothers prolonged stay in the emergency department, I was frustrated with some of the causes – hospital beds occupied by patients waiting for chronic care, for instance. However, my inability to pay for my mother to get a bed, and leave patients who could not afford it in the emergency department, did not frustrate me.

The reason that inability to pay for better care did not frustrate me is that I place a high value in equitable delivery of health care. Canadians who share that value should be ready to fight for one tier delivery of physician and hospital services. They had better be ready, because the battle is on.