

## **Medicare criticisms simplistic**

The Winnipeg Free Press and Straightgoods – October 4, 2004

**By Dr. Gordon Guyatt**

Smoking rates are much higher in France than Canada. The French have lower rates of coronary artery disease than Canadians. So, to cut coronary risk, Canadians should increase their smoking, right?

That's ridiculous, you say. Just because two countries differ on two attributes -- smoking and coronary artery disease -- doesn't mean that one causes the other. Unfortunately, participants in health-care debates sometimes rely excessively on simplistic cross-national comparisons.

Take a for-instance. The Fraser Institute, a right-wing think tank, points out that many countries allow user fees and private insurance for physician and hospital care. Some of these countries spend less on health care than Canada, while remaining competitive in health outcomes. Therefore, they argue, if we abandoned the Canada Health Act and allowed user charges for medically necessary physician and hospital services, our performance would improve.

But just as we don't know whether France's lower coronary risk happens because of, or in spite of smoking, we can't be sure whether our health-care problems are because of the Canada Health Act, or despite it. A more sophisticated analysis can help.

First, let's get the question straight: What is the best way of funding our health care? Through the public purse, from taxes; or privately, through insurance companies and out-of-pocket expenditures?

Next, we need to widen our scope beyond physician and hospital services, and consider all health services. In areas such as drugs, home care and eye care, Canada relies more on private funding than do most industrialized countries. The result is that 71 per cent of Canada's health-care funding is public, the rest private. Among 30 industrialized countries, 18 have higher proportions of public versus private funding-- that is, public funds pay for over 71 per cent of expenditures. All but one of these 18 countries spends less of their GDP on health than Canada. So perhaps we could get more efficient by increasing, rather than decreasing,

our ratio of public to private expenditures.

The next step in a more sophisticated analysis is to consider the entire spectrum of industrialized countries. The latest international figures show that a cluster of 12 countries spend between 8.6 and 11.1 per cent of their GDP on health. Canada is in the middle of this pack, at 9.7 per cent. The United States, at 13.9 per cent, spends far more than any other country.

Americans have a lower life expectancy than Canadians, a higher infant mortality rate, and worse outcomes in a wide variety of specific health problems, from asthma to hepatitis. Their higher expenditures don't translate into better health.

What distinguishes the U.S. system from the others? The U.S. has by far the lowest proportion of publicly funded health care, only 44 per cent. If private pay were a good thing, why is the American performance so disastrous?

Because there is so much variability in health systems, and in determinants of health, we still need to move beyond between-country comparisons of overall costs and overall health.

One additional source of evidence is a within-country comparison examining different aspects of Canadian health care. In the last decade, costs of the publicly funded parts of the Canadian system -- physician and hospital services -- have remained stable. Costs in the privately funded areas, particular pharmaceuticals, have exploded. These results suggest that when governments fund services, they have the motivation, and the means, to control spending. Perhaps the most informative comparison is to look more closely at how private and publicly funded systems actually work. Because getting seriously ill involves gigantic costs, private insurance immediately springs up in user-pay systems.

Private insurance companies must develop insurance packages, market those policies against the competition, explain the policies to potential users, evaluate applications for insurance, assess claims, and still satisfy their investors with profits in the order of 10 per cent.

Public health-care plans, like our medicare, bear none of these costs. This

explains why private insurers, which dominate the U.S. system, have overhead costs averaging 11.7 per cent. That compares to 3.6 per cent for U.S. Medicare, and 1.3 per cent for provincial health plans in Canada. It explains why the U.S. spends 31 per cent of its health-care dollars on administration, while Canada spends only 17 per cent.

When the National Health Forum of 1997, the Kirby Senate report, and the Romanow Commission studied our system carefully, they each recommended enlarging the scope of publicly funded health care. That's because a dispassionate look at the evidence that avoids simplistic cross-national comparisons shows that public payment -- whether for physician and hospital services, for drugs, or for home care -- provides better value for money.