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Is the Canadian health system an option for the U.S.?

IN RECENT MONTHS, American newspapers and journals have raised concerns about the accessibility and cost of health care services in the U.S. In a system where health care costs are skyrocketing, and millions of people are uninsured—some even facing personal bankruptcy due to the cost of their medical treatment—there have been calls to create a comprehensive public health insurance program in the United States.

It is, perhaps, natural that American health analysts and policy makers would look to their neighbor to the north where universally accessible government-funded health care has been a legislated reality since 1968. The Canadian system now is being used by many to prod Congress into fashioning a more universal system to replace the current ineffective and restrictive Medicaid and Medicare programs.

For this reason, our editor in chief asked that I write this editorial. I will discuss the topic with a brief historical summary, identify its implications for dentistry, and point to some of the Canadian system's current problems.

Canada's health system is admired around the world. Yet even though Canadians like to see themselves as progressive, they actually lagged behind other countries, such as Great Britain, most western European countries, and New Zealand, in enacting this important social legislation. Government health insurance was debated in Canada at least since 1919, but it was only in 1968 that the legislation for a complete system was in place.

Before one can consider whether or not it is feasible to translate Canada's health system to another country, it may be helpful to summarize briefly the political and social circumstances that gave rise to the Canadian system.

Universal health care in Canada was the result of a long, often bitter, struggle among physicians, government, and the general public. However, the origins of the issue lie in the development of medicine itself. As nutrition, hygiene, medical knowledge, and technology advanced from the 1920s onward, treatment procedures became ever more sophisticated and successful. More and more people came to accept the viability of medical treatment, leading to increased demand for access to medical care. Paying for health services was not only difficult for the poor, but for the working and middle classes as well. However, since free care had traditionally been provided to the very poor, it was the middle class to whom the concept of health insurance appealed most strongly.

As in other countries, the implementation of government health insurance was largely the result of popular pressure. Special interest groups and the political parties of the left lobbied for health care reform. Many historians point to the agrarian-based farmers' parties of the prairies, especially Saskatchewan, as the key influence in fashioning the Canadian health insurance program.

Under the British North America Act, health care was the responsibility of the individual provinces, making the creation of health insurance one of many constant constitutional wrangles. The years following World War I produced the first efforts. In 1919, social insurance (including health insurance) was part of the Liberal party platform. However, as prosperity returned, these programs lost their momentum. With the arrival of the "dirty thirties", when indigent patients filled hospitals and people simply couldn't pay for medical care, renewed demands came from populist groups for some form of health insurance.

World War II was another turning point. A good deal of attention was paid to post-war reconstruction, and a committee was appointed to investigate health insurance. The committee's recommendations were later to be adopted—a universal government-administered system to be financed jointly by the federal and provincial governments.

Actual reforms were a long time coming. The province of Saskatchewan took the lead, implementing hospital insurance in 1947. This was followed by the Federal Health Grants in 1948, and the enactment of a nationwide hospital insurance program in 1957. Again in 1962, Saskatchewan introduced medical care insurance. In 1968, parliament passed the Federal Medical Care Act.

Ironically, it was also Saskatchewan where the bitterest opposition erupted in a doctors' strike which forced many compromises into the legislation. The physicians' rights to bill on a fee-for-service basis was of primary concern.

In 1984, the Canada Health Act superseded the act of 1968. Today, Canadians have comprehensive coverage for the services of physicians and surgeons, all hospital inpatient procedures, and many outpatient and extended care services as well.

As the system is organized now, the federal government makes a per capita payment to each province's health insurance plan, and the province administers the plan. The provinces finance hospitals through global budgets which take into account inflation and the increase in patient care needs. Physicians are paid fee-for-service rates negotiated between the province and its doctors.

Each province has its funding system worked out, whether by charging premiums or drawing money from general revenues. For example, beginning January 1990, the province of Ontario which until now has charged families premiums of about $60 per month, will now finance its health plan by charging employers a 1.95% payroll tax.

Has the Canadian health insurance legislation, a system for which the country spends about 8.5% of its GNP, accomplished universal accessibility? On the positive side, research has shown that utilization patterns are determined more by medical needs than economic status. Trends show the average length of hospital stay has decreased in the 25-44 age group (about 7 days) but has risen in the over 65 age groups (approximately 15 days). Office visits to physicians, which account for the largest proportion of services, rose from 3666 per 1000 in 1977/78 to 4345 in 1984/85. The number of active physicians in Canada increased from 1:605 in 1974 to 1:506 in 1984. In the same period, the number of active dentists increased 49%, and programs in dental care have increased as well.

Germane to our readership is an understanding of how dentistry fits into the Canadian national health scene. Although dentists may be reimbursed for a few in-hospital services, such as consultations or specific surgical procedures, dental care generally is not covered by the national health insurance plan. However, each province has its own plans to fit needs and budgets. For example, the province of Saskatchewan (obviously the most left-wing leaning) has had a children's dental health plan operated with New Zealand-type dental nurses for almost two decades. More recently, the province of Quebec also has initiated a dental care plan for children.

Ontario, reputed to be Canada's most industrialized province, has approached dental care differently. In the early 1970s, the province of Ontario was leaning toward a children's dental health plan. Recognizing the budgetary implications of such a move, the notion of a universally available government plan was abandoned. Instead, specific groups have been targeted for government assistance. Some of these groups include old age pensioners and the chronically ill.

The provincial government assistance plans have been particularly helpful to pediatric dentists. As the literature has shown, lower income groups, often having poor nutrition and dental interest, frequently produce many of our caries-prone patients. Fortunately, most welfare patients receive some form of dental coverage. Similarly, new immigrants arriving in the country often have children in dire need of dental treatment. Again, our government agencies usually make funds available to attend to the needs of these children. A new CINOT (acronym for "children in need of dental treatment") program has been most helpful to the working poor whose children frequently had been uninsured and untreated.

Other groups also have been targeted for assistance with their dental expenses. Four years ago, a

program was established, mainly through the efforts of several pediatric dentists, to assist cleft palate children. Since that time, any child with a craniofacial syndrome requiring special dental needs may receive assistance through this plan. The plan specifically reimburses dental specialists at the rate of 75% of the customary fee.

The developmentally disabled also are assisted by a provincially sponsored government plan. Unlike the previously mentioned plan, which has an upper age limit of 22 years, this plan has no age limit. However, the coverage under this scheme is fairly basic. Thus, in the province of Ontario and throughout most of the other provinces, various government assistance plans are available for specific groups. This obviously creates imbalances across the country.

Although our national governmental health plan does not provide universal dental coverage, indirectly, it has a major impact on pediatric dentistry. Patients requiring in-hospital treatment under general anesthesia for justifiable reasons, usually will have most or all of their hospitalization, drugs, and anesthesia services covered while in hospital. This removes a large portion of the expense burden. As noted in a previous publication (Wright and Chiasson 1987), Canadian pediatric dentists tend to use hospitals more often than their American counterparts. Accessibility to hospitals undoubtedly has influenced behavior management techniques in Canada.

If questioned about popular satisfaction with our health program a few years ago, I would have said that it was probably the best system available. Lately, the cracks in the Canadian health system have become more evident. Recent media coverage has highlighted the growing reality of long waiting lists for surgery, and in some cases, patients dying before they are treated. Deficit-ridden hospitals are having to cut back services. There is an increasingly serious nursing shortage, most notably in critical care nursing. The need for chronic care facilities and extended care programs cannot keep up with the demand.

The stark reality is that the wondrous capabilities of modern medicine have outstripped the government's (and the public's) ability to pay. As new demographic and societal trends impact significantly on the health system, Canadians are having to come to terms with the fact that the government is not a bottomless pit of unlimited funds.

Several factors are pushing the cost of health care relentlessly upward. First, universal coverage means that Canadians have come to expect a high level of care, and access to that care, as a right. Second, medical technology has awe-inspiring capabilities—in imaging techniques, laser surgery, and so forth—but technology costs millions and devours tax dollars.

Third, there is one enormously significant trend influencing all health care systems in North America and Europe—the "greying" of the population. Life expectancy has risen well into the 70s for both sexes. By the year 2020, 20% of Canadians will be over 65. With most killer infectious diseases a thing of the past, diseases associated with lifestyle and with aging—heart attacks, cancer, stroke, and chronic disabling conditions such as arthritis—have presented an even more serious challenge to the health system because they require long-term, often expensive, management.

Also, AIDS, the number one killer of young men between 20 and 40, shows no signs of abating, and thus may be a very serious drain on the health system financially. Its spread to the heterosexual population is not encouraging news for the health system.

In a time of such increasing demands and decreasing resources, which necessitates a philosophy of cost containment, health providers face the very real possibility of rationing certain services and prioritizing others. Troubling questions of ethics versus financial policy will become more central. Humane decision making in the face of constraint, public expectation, and human rights legislation will prove a difficult process as Canadians struggle to preserve the principle of universal access while balancing costs. There will be no easy answers. Similarly, there are no easy answers for our friends south of the border.

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