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## Comparison of Health Care Systems in the United States and Canada

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### ABSTRACT

*Insuring access to quality healthcare to the citizens is one of the fundamental responsibilities of a 'Welfare State'. The purpose of this research paper is to compare health care systems in two highly advanced industrialized countries: The United States of America (USA) & Canada. The research paper will provide a description of the health care systems in USA & Canada while exploring historical-cultural & political-structural causes of embarking upon divergent paths to health reform. Further, the paper will analyze their healthcare policies and evaluate them against parameters of 'equity' & 'efficiency'. Finally, USA & Canada's response to COVID-19 will be assessed to determine whether the government financed universal health-care system of Canada or the combination of government-financed group-specific health coverage and private health insurance in USA is a panacea for public health emergency?*

**Keywords:** National Health Insurance, Single Payer System, Multi Payer System, Global Budget Payments, Medicare, Medicaid

### 1. INTRODUCTION

*"The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people."<sup>1</sup>*

*—Franklin Delano Roosevelt*

Healthcare is one of the fundamental needs of human beings and it is intrinsically related to their 'Work Ability'. Thus, formulating and implementing policies that make health-care affordable and accessible is vital for producing a productive population. Policy making process is influenced by social forces, state & non-state actors, state structures and political institutions.

Modern Welfare State imbued with democracy and welfare besides capitalism is obliged to cater to the basic needs of the citizens. USA & Canada as welfare states are responsible for the socio-economic well-being of their citizens and hence, have established institutions to frame public health policies. However, despite sharing a long border, having similar economic institutions and similar heritage in terms of language & culture; the structure of their public health-care systems starkly contrasts. The political institutions embedded in constitutional settings and shaping party systems, rapidly developing economic institutions with growing significance of private sector and rhetoric of post-war security entwined more complexly than ever before to lead the two countries on diverging paths to public health administration in the post-World War II era, thus it is a critical juncture in the health reform chronicle of USA & Canada.

### 2. HEALTH CARE SYSTEMS IN CANADA AND USA

Access to health care based on need rather than ability to pay was the founding principle of the Canadian health-care system. Canada has a National Health Insurance program (a government-funded health insurance system providing all the Canadian citizens a well-defined medical benefits package). This Universal Health Coverage is financed using General taxes through 'Single-Payer System'<sup>2</sup>

. Consumer co-payments are negligible and physician choice is unlimited. Production and delivery of health care services is private; physicians receive payments on a negotiated fee for service and hospitals receive Global Budget Payments.<sup>3</sup> Canada's health care system known as **Medicare** provides coverage to 37 million people spread across 10 provinces and 3 territories. Since Canadian constitution places health care under provincial jurisdiction reforms in the healthcare system emanated from provinces. In 1940s certain provinces introduced compulsory health insurance, province of **Saskatchewan** set up a hospitalization plan<sup>4</sup> immediately after WWII.<sup>5</sup> Till then jurisdictional uncertainty surrounding social policy had restrained federal initiative. However, in 1956, the federal parliament enacted the Hospital and Diagnostic Services Act laying the foundation for a nationwide system of hospital insurance. By 1961 all 10 provinces and 3 territories had hospital insurance plans of their own with the federal government bearing 50% of the costs. By 1971 Canada had NHI plan, providing coverage for both hospitalization and physician' services. Rapid development occurred in a decade, thanks to the emergence and consolidation of a Social Democratic Third Party, a policy "entrepreneur" that brought serious alternatives to health policy agenda and sustained them as prominent national issues.

Till 1971 both USA & Canada devoted approximately equal share (7-5%) of their GDP to healthcare, however spending in the USA grew much more rapidly after 1971 despite large proportion of uninsured or minimally insured population. Thence, the health care system of the two neighbours moved in different directions. While Canada established publicly funded NHI, USA still relies largely on private financing, provision and delivery of healthcare.

In 1984 **Canada Health Act** was enacted, defining the contours of the current healthcare system. The health-care system of Canada is more a decentralised collection of provincial and territorial insurance plans than a true national system. Thus, administration and service delivery are highly decentralised, although coverage is portable across the country. With minimal exceptions, health insurance is provided to all citizens with no out-of-pocket expenditure. Physicians are paid on a fee for service basis and have a great deal of practice autonomy<sup>6</sup>. Private health insurance for covered services is illegal.<sup>7</sup> Most Canadians have supplemental private insurance for uncovered services, such as prescription drugs<sup>8</sup> and dental services. Patients have nothing to do with the reimbursement process, it exclusively takes place between the government and the health care provider. The ministry of health in each province controls medical costs through fixed global budgets and predetermined fees for physicians. Global budget is fixed for hospital services and fees for physician services is predetermined by ministry of health in each province for controlling medical costs.<sup>9</sup> The right to extra billing has been abolished in all provinces.<sup>10</sup> Canada's key to control overall spending is the regionalization of high – tech services; administrative machinery guides the government in making resource allocation decisions.<sup>11</sup>

Provincial plans of Canada vary according to population size and fiscal capacity yet public-sector monopsony in each province uniformly holds down medical care prices below market rates, thus providing universal health coverage that is prized by Canadians. However, first dollar coverage for primary care is coming to them at the cost of access to modern medical technology. Per citizen availability of diagnostic equipment (MRI, CT Scan etc.) is significantly low as compared to USA, Canada deficits in several critical areas of medical care, like angioplasty, cardiac catheterization and intensive care. Moreover, waiting lists for certain surgical and diagnostic procedures are common in Canada. Elderly population is worst affected due to delays in treatment and lack of modern technology for critical surgeries (hip replacement, cataract surgery, cardiovascular surgery etc.).

On the other hand, USA spending 17.7% of its GDP on health sector has achieved considerably better ratio of diagnostic equipment per citizen. Moreover, its high investment in research & development of medical technology has paid off as many Canadians facing waiting lists for some critical medical services or needing high-tech specialty care approach USA's medical treatment. However, USA does not provide nationwide health cover to its citizens. Government funded health insurance is only for certain underprivileged groups rest of the population either purchases health insurance from the private sector (for-profit commercial insurance companies or non-profit insurers) or relies on employer-sponsored group health insurance.

Two major public health insurance programs are **Medicare** & **Medicaid**. **Medicare** being the largest health insurer of USA provides uniform health coverage to elderly (aged 65 or above) and disabled individuals<sup>12</sup>. It is administered by the federal government and financed through an amalgamation of taxes (Medicare Tax, Social Security Tax, Monthly Premiums and General taxes) besides the co-payment levied on patients. **Medigap**, a private health insurance plan offers to pay for medical bills not fully reimbursed by Medicare. Withal, **Medicaid** provides coverage for economically disadvantaged groups. Medicaid under provincial administration is jointly financed by the federal and state governments<sup>13</sup>. As eligibility criteria varies from state to state so is the coverage under Medicaid; it is the only public program that finances long- term nursing home stay. Moreover, employers provide health cover to their employees through **Managed Care Health Insurance Plan**, it integrates the financing and delivery of appropriate health care services to covered individuals by partnering with selected providers to furnish a comprehensive set of health care services to members and offers significant financial incentives to members to use providers and procedures associated with the plan. However, 16%<sup>14</sup> of the US population is still uninsured, it accesses health care services through public clinics and hospitals, state and local health programs, or private providers that finance the care through charity. The uninsured population frequently encounters medical impoverishment. In 2010 USA signed into law **Affordable Care Act** (Obamacare), to provide affordable health insurance coverage for all Americans however, it has been highly controversial. Republicans criticise it for leading to increment in tax and mounting workload & costs on medical providers.

Thus, although USA has the achievement of advanced medical technology, world leadership in pharmaceutical innovation, it is a failure when it comes to providing NHI, controlling unabated hike in medical services cost and high infant mortality rate. There are diverse explanations for lack of universal coverage in USA, prominent ones being the absence of a successful labour party, entrenched racial discrimination and American Medical Association's adamant emphasis on individual responsibility, free enterprise, and limited local government involvement in public health.<sup>15</sup>

### **3. EVALUATION**

Evaluation of the healthcare policies of USA & Canada against the parameter of 'equity' & 'efficiency' gives the impression that Canadian system is more effective than the U.S. system in following aspects: costs are lower, more services are provided, financial barriers do not exist, and health status as measured by mortality rates is superior, life expectancy is longer and infant mortality rate is lower in USA. However, the fact that USA has larger and more pluralistic population (330 million) than Canada (37 million) must be acknowledged.

Over and above all, consumer satisfaction is the ultimate scale to measure success or failure. Even in this aspect Canada defeats USA; Canadians are profoundly satisfied with their health care system while bulk of Americans want complete restructuring of their health-care system.

### **4. COMPARISON OF CANADA & USA'S RESPONSE TO COVID-19**

Canada's response to COVID-19 has been widely lauded for effectively controlling spread of the disease by consistent and large-scale testing; NHI played its role in keeping the mortality rate low<sup>16</sup>. Canadian officials and ministers have set aside partisan grievances for a collective effort and have consistently deferred to public health experts and scientists to drive policy decisions. Moreover, Canadians are placing trust in their Prime minister and are earnestly abiding by the COVID guidelines. On the other hand, USA is suffering rapid hike in cases and deaths. Various political and social reasons can be cited for this scenario, like leadership's scepticism of expertise and reluctance to accept responsibility, lack of coordination between federal and provincial governments, popular disbelief in leadership and passion for individualism and personal liberty.<sup>17</sup> However, Canada's successful response has not only political & cultural dimensions but demographic as well, it has small and sparsely distributed population that prevented community transmission of COVID-19.

Therefore, although Canada's response to COVID-19 is commendable and way better than USA, NHI is not the only element to thank. Political, cultural, social and economic factors cumulatively played their roles; noteworthy insight is that some of these factors are the same ones which prevent nationwide introduction of universal health coverage in USA. Thus, NHI of Canada nor the amalgamated healthcare system of USA is panacea for public health emergency yet NHI is an element of great significance while dealing with such crises.<sup>18</sup>

### **5. CONCLUSION**

Observation in nut shell is that there are several lessons regarding healthcare reforms for USA to learn from the girl next door like, since market forces are less able to achieve cost control relying on them for medical provisioning is absurd; single-payer model is better than multi-payer model in terms of low administrative cost & better cooperation in rural areas; provincial organization of universal health insurance allows flexibility to account for local circumstances besides reducing red-tapism.

Although Canada has prospering experiences to handover to USA it itself needs overhauling. Canadians are apprehensive about the survival of their healthcare system due to following reasons: unprecedented federal deficits have substantially reduced Canadian government's cash transfers to the provinces<sup>19</sup>; ageing population has put more demands on the system; providing uniform services across vast geography has always been a challenge and in the face of high rates of migration and increasing ethnocultural diversity it has turned out to be more difficult; long waits for some elective health-care services, inequitable access to services outside the core public basket and sustained poor health outcomes for Indigenous populations have plagued the system. Moreover, health policy has been damaged by the conflicts between the national and provincial governments since the balance between imposing national standards and respecting provincial jurisdiction to allow flexibility is complicated. Despite the angst the Canadians are hopeful about rejuvenation of the tripartite social contract (Governments, health-care providers and the public) underpinning **Medicare** by recommitment to equity, solidarity, and co-stewardship of the system.

### **6. REFERENCES**

- [1] Quoted in Gostin, 2000
- [2] Only one third-party payer is responsible for paying health care providers for medical services
- [3] <https://www.who.int/management/facility/hospital/Hospital%20Global%20Budgeting.pdf>
- [4] Global budget is overall spending limit or target. It will define the volume of service that is to be delivered and its aggregate price.
- [5] The rural, low-income province of Saskatchewan was plagued by shortages of both hospital beds and medical practitioners. The main feature of this plan was the creation of the regional system of hospitals: local hospitals for primary care, district hospitals for more complex cases, and base hospitals for the most difficult cases.
- [6] [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)30181-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30181-8/fulltext)
- [7] Thomas Clement Douglas, Social Democratic Premier of Saskatchewan, implemented universal public health insurance for the province in 1947 making it the first jurisdiction with universal health coverage in North America.
- [8] Policy makers believe extensive control is superfluous given that the hospital global budgets and physician expenditure targets tend to curb unnecessary services. Thus, virtually all physicians are forced to participate and each health plan effectively serves all residents in the province. Only component in Canada's healthcare system that uses a US mix of public and private financing—outpatient pharmaceuticals—is the one where costs have been rising most quickly and access is seen as most problematic.
- [9] The operating budgets of hospitals are approved and funded entirely by the ministry in each province and an annual global budget is negotiated between the ministry and each individual hospital. Ministry periodically negotiates with Provincial Medical Associations to determine the physician fees.

- [10] Extra billing or balance billing refers to a situation in which the physician bills the patient above the predetermined fee set by the government.
- [11] Resource allocation decisions deal with capital investment in hospitals, specialty mix of medical practitioners, location of recent medical graduates, diffusion of high tech diagnostic and surgical equipment etc.
- [12] The Medicare plan consists of two parts. Part A is compulsory and provides health insurance coverage for inpatient hospital care, limited nursing home services and some home health services. Part B the voluntary or supplemental plan provides benefits for physician services, outpatient hospital services, outpatient laboratory and radiology services and home health services.
- [13] Federal government's share in the fund depends on the per capita income in the state. Individuals who are elderly, blind, disabled or members of families with dependent children must be covered by Medicaid for states to receive federal funds. However, some states offer complementary benefits package in addition to the basic package of health care benefits stimulated by the federal government. 2012 data
- [14] Maioni Antonia, "Parting at the Crossroads: The Development of Health Insurance in Canada and the United States, 1940-1965"; Comparative Politics, Vol. 29, No. 4 (Jul., 1997), pp. 411-431
- [15] Vladeck Bruce, "Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future"; American Journal of Public Health | January 2003, Vol 93, No. 116 | Editorials
- [16] In Quebec and Ontario, the two worst hit cities; authorities promptly enlisted soldiers to help in hard-hit long-term care facilities.
- [17] Americans in general have more negative attitudes about government than people in most other countries. Historical explanation for this is the absence of a traditional aristocracy and the attendant social hierarchies in the New World- Alexis de Tocqueville
- [18] In 2001 bioterrorism attack had hit America, people had been exposed to anthrax from letters sent through the mail. Lack of coordination among federal, state and local official worsened the situation; laboratories were overwhelmed with testing of samples. Thus, a strong and effective governmental public health infrastructure is essential not only to respond to crises such as these but also to address mundane challenges such as preventing or managing chronic illnesses, controlling infectious diseases and monitoring the safety of food and water.
- [19] As government provides healthcare services to citizens free of cost its demand has escalated and expenditure increased. Provincial governments are forced either to raise more revenue or curb services. Several provincial health plans are compelled to reduce spending by withdrawing services from the approved list of the "medically necessary".
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