

Roatch Global Lecture Series on Social Policy and Practice

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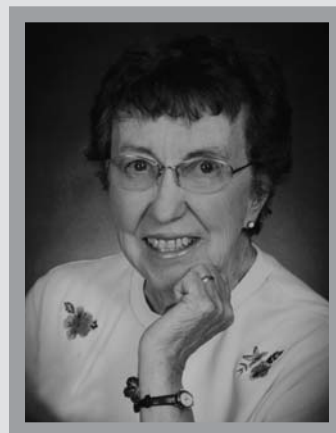
*Health Care in Canada and the United States:
Consumer Good, Social Service
or Right of Citizenship?*

Presented by
Gregory P. Marchildon, Ph.D.

March 3, 2006



*With gratitude
to Mary Roatch
The present*



The John and Mary Roatch Endowment was created by gifts made to the university by John and Mary Roatch. The endowment provides support for the Global Lecture Series, which are organized through the office of the John F. Roatch Distinguished Professor at University College.

John Roatch was born in Ellsworth, Wisconsin, on May 3, 1921 and died in Phoenix, Arizona, on July 2, 1997. Mary was born to missionary parents in Darjeeling, India and resides in Phoenix. The Roatches have four children, Virginia, Thomas, David, and Joseph.

Both Mary and John met and graduated from Hamline University in St. Paul, Minnesota. John also received a master of social work from Washington University in St. Louis, Missouri. He practiced social work and was director of the social work department at the Clinical Center of the National Institute of Health in Bethesda Maryland from 1965 to 1972. John came to Phoenix as director of the social service department at the Indian Medical Center, where he retired in 1979 with the rank of Captain in the United States Public Health Service. John then became a part-time financial consultant and real estate investor.

Mary Roatch was a teacher, a cottage-parent, and a tutor, but her real love was being a librarian and a consultant on libraries for persons with special needs. She worked at the Phoenix Public Library where she organized the first Special Needs Center in 1983. Mary is a very accomplished individual who has been an active speaker on issues affecting special needs programs in libraries. She was the recipient of the 1993 Francis Joseph Campbell Award from the American Library Association.

We continue to be indebted to John and Mary for their vision and to all the family for their continued support of the Lecture Series.

Emilia E. Martinez-Brawley
John F. Roatch Distinguished Professor
2006



Celebrating
John F. Roatch's
The memory
Legacy

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ear Friends and Colleagues

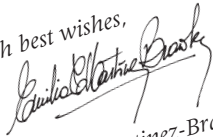
The John F. Roatch Global Lecture Series has always been at the forefront in covering timely topics. Each year, whether discussing language maintenance or human rights, the lecturers found an eager audience because the topics had entered center stage in Arizona public policy discussions.

Nearly two years ago, when we began planning the 2006 lecture, issues of health care policy in Arizona were important. We anticipated they would remain at center stage in 2006, but serendipitously, our local paper featured articles on health care policies in Arizona in January and February 2006, and the Arizona legislature saw a health insurance proposal introduced by Rep. Phil Lopes. Gregory Marchildon's careful analysis and examples of the Canadian and American situations will constitute a valuable addition to the dialogue in which all of us have recently become engaged. The contributions of our distinguished respondents, Dr. Len Kirschner and Susan Gerard, added locally based knowledge and information. We cannot doubt any longer that what is happening in the house of our neighbor to the north is important to us and can add to our experiences.

An enthusiastic audience welcomed Prof. Marchildon and the respondents and engaged in a very meaningful discussion. We believe the conversation about health care in Arizona has been launched and will continue as we strive to solve a serious policy challenge.

Our friend Monsignor Edward J. Ryle, recently deceased, whom we honored at this event through the message and reminiscences of Rev. Buz Stevens, would be particularly proud that we addressed health care in Arizona. May we keep his commitment to the poor.

With best wishes,



Emilia E. Martinez-Brawley
John F. Roatch Distinguished Professor

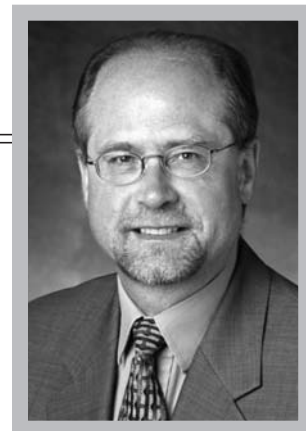


“The perception of essential health care as an economic commodity rather than a public good is a barrier to fundamental change in health financing in the United States. Perhaps it goes too much against the grain of American political culture, with its strong sense of individualism and its inherent anti-statism, to expect that an overwhelming majority of Americans will suddenly view health care as a social service. But it is possible that this country could one day leapfrog that step by concluding, through a court decision, that certain essential health services are a right of citizenship and must be provided to everyone on the same basis.”

Gregory P. Marchildon, Ph.D.

Canada Research Chair and Professor

GREGORY P. MARCHILDON holds a Canada Research Chair in Public Policy and Economic History and is Professor of Public Policy in the Graduate School of Public Policy at the University of Regina. He is also a Fellow of the School of Policy Studies at Queen’s University and a Trudeau Mentor with the Trudeau Foundation.



From 2001-2002, he was Executive Director of the Commission on the Future of Health Care in Canada also known as the Romanow Commission. The Commission’s Report, *Building on Values: The Future of Health Care in Canada*, was delivered to the Canadian Parliament in November, 2002.

From 1997 until 2000, Dr. Marchildon was Cabinet Secretary and Deputy Minister to the Premier of Saskatchewan. From 1994 until 1996, he was the Deputy Minister of Intergovernmental Affairs in the Saskatchewan government. From 1989 until 1994, he was a professor of Canadian studies and economic history at Johns Hopkins University’s School of Advanced International Studies in Washington, DC.

He has a doctorate in economic history from the London School of Economics as well as degrees in history, economics and law. He has written extensively on subjects ranging from public policy, including health policy, to public administration and economic history. His first book, *Profits and Politics*, was published by the University of Toronto Press in 1996. He has just completed a profile of Canada’s health system for the World Health Organization’s Regional Office for Europe and the University of Toronto Press. He has also edited or co-edited a number of books, including: *The Heavy Hand of History* (2005), *The Fiscal Sustainability of Health Care in Canada* (2004); *Changing Health Care in Canada* (2004); *The Governance of Health Care in Canada* (2004); *Canadian Agriculture at the Border* (2000); *The NAFTA Puzzle* (1994); *Canadian Multinationals and International Finance* (1992); and *Mergers and Acquisitions* (1991).

Scenes from the Lecture



Health Care in Canada and the United States:

*Consumer Good,
Social Service or
Right of Citizenship?*

March 3, 2006



I want to explore the extent to which health care is treated as a consumer good, a public social benefit or service, or a right of citizenship in both Canada and the United States.

*I*t is a great honor to give this year's John Roatch lecture, named in memory of a public servant who dedicated his life to improving the plight of the poor and marginalized in this country. Born in 1921, Mr. Roatch came of age during the Great Depression. He saw first hand the human devastation caused by the collapse of commodity prices and the impact this had on the farm belt.

In much the same way that drought-stricken farm states suffered the most in the United States, the province of Saskatchewan was at the epicenter of the same calamity in Canada. It is no accident that the people and government of that province were the first to introduce national health insurance in North America and that the political leaders and public servants of that province played such a critical role in building the postwar welfare state in Canada itself. Just as John Roatch dedicated his life to improving the community, working through government—the community writ large—so, too, did this generation of prairie progressives dedicate their lives.

Their names are now legendary. They include Tommy Douglas, the Premier of Saskatchewan during the 1940s and 1950s, a reformer whose stature has only grown with time. In fact, last year, during a popular television poll designed to pick the greatest Canadian of all time, Tommy Douglas was chosen instead of more visibly prominent individuals, including our first prime minister, Sir John A. Macdonald, and our famously charismatic prime minister, Pierre Elliott Trudeau. Why? In large part, it was because Tommy Douglas is known throughout the country as the father of Canadian-style Medicare. It was his small and rather impoverished provincial government that implemented the first working system of universal health care in North America.

As I interpret the recent spate of articles in your local paper, the Arizona Republic, universal health care is a goal shared by many here as well. Indeed, the newspaper's own poll suggests that just over 80 percent of registered voters in the state of Arizona say it is time that the state or the federal government "step in and create a health care system that ensures everyone has access to the medical care they need" (Crawford 2006). Great! The only problem is that everyone also disagrees on how this should be accomplished.

Today, I want to explore the extent to which health care is treated as a consumer good, a public social benefit or service, or a right of citizenship in both Canada and the United States. I want to ask if these current conceptions of health care are helping or impeding us in our collective efforts to improve our respective health systems.

Whatever happens, we know one thing for sure. Politicians, policy experts, professionals, and the public in both countries will be pointing to the experience of the other country to draw lessons, and no doubt some will continue to demonize the system across the border in an effort to buttress their respective cases. So, whether we like it or not, the manner in which our respective health systems are perceived or misconceived, purposely or otherwise, by politicians, pressure groups, and opinion leaders in both countries has major spill-over effects in our respective domestic policy debates. While we often talk about European and other countries in these debates, it is always our closest neighbor that we tend to focus on.

THE CANADA-US DYNAMIC

Let me start with an anecdote. In the very early 1990s, when I was teaching at Johns Hopkins University, I had brought a guest from Canada to speak to my students about social policy. After an erudite lecture and a pleasant question-and-answer session, we retired to a local bar for a few drinks. By the third boozy round, the conversation turned to health care, with my American students offering their views of public health care policy in Canada. At first, my Canadian guest batted away at some of the misconceptions by explaining how the Canadian system actually worked. But then, when one well-meaning but hapless student used the phrase "health care industry," he jumped on the remark, exclaiming: "There, that is the real difference. You see health care as an industry and we see it as a social service." Of course, he immediately looked my way to justify his use of the royal "we." I am embarrassed to say that I did nod my head, oh so slightly, in support of my guest even though I knew deep down that the statement obscured much more than it revealed.

The complex truth of the matter is that Canadians only view a part of their system as a social service. When it comes to hospital care, physician care, and public health, most Canadians see these so-called "essential health services" as social services and have done so for decades. I would argue that these services have come to be regarded as a right of citizenship over time because they are universal, although no court has yet confirmed this. Yet, when it comes to other health goods and services, this is patently not the case.

So, what health services are not considered "insured services" under the Canada Health Act and, therefore, not subject to that law's five principles of public administration, universality, accessibility, comprehensiveness and portability? They include prescription drug care, dental care, home care, nursing home care, some types of mental health care, and most types of rehabilitative care. These mixed and private services are often perceived by Canadians more as goods and services for which they are privately responsible through their job-based insurance plans and out-of-pocket payments. Nevertheless, Canadians seem to appreciate public subsidy programs that are aimed at the old and the poor, particularly when it comes to prescription drugs and nursing home care.

In other words, public attitudes towards health care in Canada run along a spectrum from right of citizenship, through social service or benefit, to consumer good depending on the position the good or service occupies on a public-private continuum of governance, funding, administration, and delivery.

It is only at the public, universal end of this spectrum that Canadian health care differs sharply from American health care. Indeed, I am fascinated by the extent to which the Canadian system of prescription drug care is a mini-version of the American system of health care. Job-based coverage for drugs is at the core of the system. In the 1970s and early 1980s, provincial governments moved in to fill the large cracks in this system by offering coverage to the poor and the old and, in a couple of cases, to children. Like the United States, this patchwork "system" has extremely poor cost control, with private and public plans growing well over 12 percent per year since 1997. The Quebec drug plan alone has been growing at an annual clip of 20 percent on average, a rate of growth that is clearly unsustainable (Marchildon 2006).

And what do we get for these growing expenditures? We get a prescription drug "system" that provides no coverage for some Canadians, particularly the working poor, and, given rising co-payments and deductibles, inadequate coverage for many others. I think you are all intimately familiar with this kind of problem.

I could go on, but the point I want to make is that, contrary to the conventional American perspective, the Canadian single-payer model of universal health care actually covers slightly less than 50 percent of all health services. It is a "narrow but deep" system; narrow relative to many Western European health systems but deep in the sense that Canadians are guaranteed universal access, with no cost at the point of delivery, for medically necessary hospital, diagnostic, or physician services that are defined as "insured services" under the Canada Health Act.

To be honest, however, I have also found that my fellow Canadians have numerous misperceptions of the American system. First of all, there is not one system. Public coverage and benefits vary considerably from person to person depending on age and income, from state to state given the quite different approaches to Medicaid, and, in particular, from job to job given the edifice of employment-based health insurance upon which Medicare and Medicaid have been built.

Second, it is not an entirely market-based system. Over time, there have been major public interventions to address the substantial market failures of private health care. This is not just Medicare and Medicaid but also the dense and expensive network of tax expenditure subsidies that support the job-based insurance system. Even without these tax expenditures counted in, Americans spend more per capita on public health care than Canadians. As wryly observed by Steffie Woolhandler and David Himmelstein (2002) of Harvard Medical School, Americans have been paying for "national health insurance and not getting it" for a long time.

There is a reason for avoiding the more common misperceptions we have of each other's systems. They do matter in policy terms. Geographically, culturally, and linguistically, we are the closest of neighbors. We visit each other on a regular basis. It would be hard to find two national societies that know—or at least think they know—each other as well as we do.

Finally, you do not need, as many Canadians believe, cash or a credit card in order to get access to emergency care in the United States. There are legal and other protections built into the system to ensure that emergency hospital treatment is provided irrespective of ability to pay at the time, although payment is generally sought afterwards. On this last point, let me digress with one personal experience.

Fifteen years ago, while living in Washington, DC, we thought our young son had ingested something poisonous. As young parents, we were easily panicked, and we rushed him to Children's Hospital. He was examined, his stomach pumped, and nothing was found—to our great relief. We were covered by Blue Cross-Blue Shield of Maryland through my university job. We paid Children's Hospital and then applied for reimbursement from our insurer. Having made the mistake of paying the hospital directly, our insurer nonetheless insisted we would have to recover from the hospital. We tried and tried but Children's Hospital refused to even concede that it had been double-paid. So I sued.

The amount was small but this, I convinced myself, was a matter of principle. Eventually, I ended up in small claims court only to discover two lawyers seated side-by-side representing various hospitals, using the small-claims process to get judgements on literally hundreds of unpaid bills. I am sure I was the only "customer" suing that day. When my case was finally called by the judge, the lawyers turned around just to see what kind of freak would actually sue for such a small amount. To my surprise, the judge demanded that my matter be put aside and "mediated," at which point one of the lawyers left his seat and waived me to the side where he gave me a check for the full amount that was owed. Angrily muttering that I wanted my day in court, I tried to reject the offer, but the lawyer assured me that, while he felt my pain and frustration, the judge would not be so patient with me if he realized that I had been offered the full amount of my claim. So off stage I went, but I shall never forget that enormous pile of unpaid bills awaiting judgment and execution. It is my mental image of the approximately two million Americans that go through medical bankruptcy every year.

Digression aside, there is a reason for avoiding the more common misperceptions we have of each other's systems. They do matter in policy terms. Geographically, culturally, and linguistically, we are the closest of neighbors. We visit each other on a regular basis. It would be hard to find two national societies that know—or at least think they know—each other as well as we do.

But when it comes to health care, because of our differing systems, we watch each other suspiciously. Canadians and Americans are fearful of reforms that originate from the other country. There are those who see the free market and, by extension, the American system with its emphasis on the consumer and demand-side incentives and disincentives as the potential saviour of Canadian health care. And, there are those who advocate in favour of national health insurance universality and Canadian-style single payer administration as the potential saviour of American health care.

LOOKING TO THE FUTURE IN CANADA

In Canada, we continue to have a hard-hitting debate about whether to push our system further in the direction of more public funding and administration or, alternatively, in the direction of more private funding and private administration through the market. Our Supreme Court recently entered the fray on the private side by suggesting that our waiting times in Quebec for elective surgery were too long and ordered the provincial government to review its legal prohibition of private health insurance for medically necessary health services. While many analysts agree that the legal consequences of the *Chaoulli v. Quebec* (Attorney General) decision may be minimal in the short run, it has re-energized a small but powerful minority of Canadians in favor of a private, market-driven system. While the clarion call for private, multi-payer insurance is based on efficiency and choice, I would argue that the underlying and rarely voiced opposition to the

Canadian model is its highly re-distributional nature. Without a doubt, for decades it has reallocated resources from the wealthy and the healthy to the poor and the sick. But if you think that health care is a consumer good, then it only makes sense that health resources should be allocated as an economic reward. You will be offended by the fact that 50 percent of health services are defined as public goods and allocated on the basis of medical necessity rather than ability to pay. If you see health care predominantly as a consumer good, then your question becomes: How can we afford to provide collectively what some people can't afford, and don't deserve, on an individual basis?

Before the Chaoulli case, individuals who held this view were careful not to pitch their arguments against the single-payer aspect of the Canadian system and in favor of multi-payer private insurance as in the United States. Instead, they pointed to Europe and Asia to support what they called "patient participation" through user fees, co-payments, or medical savings accounts. They suggested that more private delivery was required, conveniently forgetting the fact that, unlike the National Health Service in Britain, most delivery in Canada has been through private not-for-profit hospitals and other non-governmental organizations (Boychuk 1999).

Beginning in 2000, there were a number of commissions and committees that considered these questions. At the provincial level, there were three such reports and, at the federal level, a Senate Committee as well as a Royal Commission on the Future of Health Care in Canada established by the Prime Minister. The governments that sponsored these studies differed, and indeed the various reports and their recommendations also differed, sometimes slightly and sometimes much, on issues such as private-for-profit delivery and user fees.

Despite these differences, all ostensibly supported the principle of universality, and although the report from Alberta pushed for more private finance in the system, none recommended moving from a single-payer model of public funding to a multi-payer model of private and public insurers. Indeed, the two reports at the federal level carefully reviewed the merits and demerits of single-payer and multi-payer alternatives and came down firmly on the side of single-payer, based largely upon its administrative efficiencies. This consensus seemed to silence the small minority of single-payer critics.

Now, I must come clean with you and declare my interest. I was Executive Director of the Commission on the Future of Health Care in Canada, commonly known as the Romanow Commission, because Roy Romanow, the former Premier of Saskatchewan, was the chair. This Royal Commission reported to the Parliament of Canada toward the end of November 2002. After 18 months of amassing evidence and undertaking an ambitious and multi-faceted set of consultations, including the first-ever national citizens' dialogue, the Commission concluded that the universal, single-payer model was one of the greatest strengths of the public system, not one of its weaknesses (Canada 2002).

The real problems lay elsewhere. These problems included:

The lack of cost control on both public and private health services outside the single-payer system, in particular prescription drugs. In comparison, the growth in costs for hospital and physician services has been very restrained.

The deleterious impact of social program cost-cutting during the early- to mid-1990s, a belated response to debt accumulated by all governments in the country during the 1970s and 1980s. For example, cuts to provincial health spending forced greater rationing, sometimes through prolonging wait times for elective surgery.

The anemic implementation of primary care reforms throughout the country, the continuing separation of general practitioners from other professionals, and a broad range of frontline illness, wellness, and diagnostic health services essential to preventing or mitigating downstream acute and institutional care. Slow progress here reflects provincial government's historical compromises with, and dependence on, the collegial institutions of the medical profession (Tuohy 1999).

The under-investment in health infrastructure, including advanced diagnostic services, information systems, telemedicine in rural and remote areas, and applied research aimed at health reform objectives.

Despite the recent Supreme Court of Canada decision in Chaoulli case, deploying evidence and a chain of reasoning that I, along with a platoon of other analysts, have argued is highly dubious (Flood et al. 2005), I still think that the single-payer model will survive this challenge in Canada.

First, the overwhelming majority of Canadians support the universal, single-payer, approach to public health care. Public opinion studies demonstrate a strong sense of solidarity: The majority of the population still want everyone to receive essential health services on the basis of need. Few buy the argument that things will improve if we move to a categorical, multi-payer system; deep down, they know that choice in such a system would be based on ability to pay. Moreover, the increased investment that we have seen since the late 1990s is beginning to reap dividends in that, contrary to some media reports, waiting lists are getting shorter, MRIs are becoming more available, and patient satisfaction is on the rise again.

Second, the argument concerning the administrative efficiency of the single-payer system is hard to dispute given the evidence. In a 2003 article in the *New England Journal of Medicine*, it was estimated that total administrative overhead costs in Canada were \$307 per capita in 1999. This compared to \$1,059 per capita in the United States, well over three times the difference (Woolhandler et al. 2003). In the same issue of the *New England Journal of Medicine*, Henry Aaron of the Brookings Institution launched a frontal attack on the

estimates, claiming that the administrative cost differences were exaggerated. But in producing his own, more conservative, estimates, Aaron still ended up with almost three times the difference, admitting that he “would impose a very heavy burden of proof on any claim that the U.S. health care system does not spend more on administration than the Canadian system does, much of it to no constructive purpose” (Aaron 2003, p. 801).

Finally, since the late 1950s and 1960s, private health insurance in Canada—most of which is job-based—has supplemented public health insurance. The reverse holds true in the United States where Medicare and Medicaid were constructed on top of a foundation of job-based insurance. American policy scholar Jacob Hacker (2002) uses a path dependency model to illustrate why it is so hard to change once you have built the rest of your system around a core of either job-based private insurance or, as is the case in Canada, around a core of public, single-payer, hospital, and physician insurance.

The fact that, as I both predict and hope, the single-payer aspect of the Canadian system will endure should not be interpreted as complacency or blind support for the status quo. Au contraire, I am convinced that the public system is in need of major administrative and managerial change that will transform the very nature of health service delivery—a set of reforms that are much harder to implement successfully than changes to payment systems.

Indeed, we are in the midst of some fairly revolutionary change right now. Nine of ten provinces have recently regionalized their services through arm’s-length public organizations known as regional health authorities. These RHAs are integrating, consolidating, and coordinating a broad spectrum of health services, from acute and institutional care to home care, primary care and population health interventions. In other words, provinces are moving from acting as passive public health insurance agencies to publicly managing the system. They are doing this in an effort to reallocate funding based on population needs, keep a lid on costs, and to improve quality, timeliness, and access.

Two decades after universal Medicare was implemented in Saskatchewan, Tommy Douglas described the task in this way:

When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the whole delivery system—and, of course, that’s the big item. That’s the thing we haven’t done yet.

It is too early to assess results, but I think this quiet managerial revolution holds more promise than any financing reform yet proposed, most of which are really a retreat to the past. I would readily admit, however, that there are other parts of the health care system we seem to be incapable of fixing in Canada. Our mixed and fragmented system of financing and administering prescription drugs is highly resistant to fundamental reform for many of the path dependency reasons Hacker and others use to explain why major reform of the job-based health benefit system in the United States is so difficult to achieve. Similarly, we seem unable to address the fragmentation of health services for Indians and Inuit, among the poorest and most marginalized Canadians. This situation has helped produce health outcomes in parts of Canada that are more Third World than First World.

LOOKING TO THE FUTURE IN THE UNITED STATES

This now brings me to the question of health care change in the United States. I must say that I am more than a little intimidated by the prospect of even daring to suggest what change is needed here, but I shall give it a try. After all, you are free to discount my arguments and evidence now that you know where I stand in terms of health care change for my own country. Moreover, if you believe

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that single-payer is too “radical” an approach to ever be accepted into the mainstream political culture of this country, or that any viable reform here has to build upon the system of private, job-based, insurance, you can dismiss the Canadian experience as irrelevant in any event. Let me start with a negative proposition about what is not needed—more money. No country in the world spends more in per capita terms, publicly or privately, on health care. No country devotes more resources to health care as a share of Gross Domestic Product—about 16% compared to 10% among the highest-spending Organisation for Economic Co-operation and Development (OECD) countries, including Canada.

Without a doubt, the money has bought some of the best medical infrastructure, teaching and research in the world, including the well-funded National Institutes of Health, the highly-emulated Centers for Disease Control in Atlanta, prestigious medical hospitals and clinics including the Johns Hopkins University and Hospital and its associated schools of medicine, nursing and public health with which I am familiar, and the Mayo Clinic system including its hospital here in Phoenix, among many other examples.

Most observers agree that the key challenge for American health care policy continues to be one of financial access. As described by Jacob Hacker (2002, p. 277), a job-based system that determines coverage on the basis of the job you hold cannot offer “broad protection across both income groups and risk categories.” Although Medicaid and Medicare address some of the cracks created by a job-based system, they cannot fully offset the coverage problems inherent in a job-based system. Therefore, as long as reforms refuse to address the core of the system, as difficult as that is, the coverage problem will continue to fester.

Cost is a different kind of problem. The statistics tell you this country is in a league of its own when it comes to health care spending. This in itself need not be a problem. The wealthiest society in the world can decide that it wants the most expensive system in the world. As Princeton University health economist Uwe Reinhardt puts it, the real question is whether you are getting enough for your money, individually and collectively. You may or may not feel you are getting enough for the money you pay individually, but based upon two trends, the growing gap in coverage for medical care and deteriorating health status performance relative to other OECD countries, I would say that you are not getting value for public money. If this is the inescapable consequence of building public programming on an edifice of job-based insurance, then the funding structure will have to be changed quite fundamentally to reverse these trend lines.

I know that some, perhaps many, leaders in corporate America are also unhappy with the situation. Although it is hard to figure out exactly who pays the lion’s share of employment-based insurance: workers, through foregone salary and benefits, or employers, through the loss of

global competitive advantage through higher cost products and services. One thing seems abundantly clear: The country as a whole is now losing.

Certainly, business and labor both lose when American auto plants are shut down because of health benefit costs. During the Romanow Commission, I can remember the Canadian subsidiaries of the Big Three automakers signing joint letters with their largest union, the Canadian Autoworkers, expressing support for Canadian-style Medicare, stating that it provided them with an important competitive advantage relative their operations south of the border.

I can see exactly the same problem in microcosm in terms of prescription drug care in Canada. Canadians are losing because of the fragmented nature of coverage and the lack of adequate cost control. The sad fact is that, as bad as it gets, and no matter how large the coalition in favor of major change, fundamental reform remains extremely difficult to achieve.

Does fundamental reform in the United States require a single-payer approach? Perhaps not, although I do not think it should be rejected out of hand. I was intrigued by a proposal here in Arizona, originating from New Mexico. The proposal was initiated by Rep. Phil Lopes, a former health planner from Tucson. Instead of creating a new, single-payer administrative structure, the Lopes plan would pool existing health care funds from employers, Medicaid, and Medicare. Out of this single fund, the state would pay for universal coverage for at least catastrophic services and perhaps a few other essential services.

Why are we seeing such an initiative in Arizona? The reason is as obvious as it is difficult to contest. The trend lines are all wrong. Every year, more and more residents of Arizona are without adequate medical coverage. More and more residents have to go through the anguish of not knowing whether their loved ones will get the kind of care they need when they need it and the pain of personal bankruptcy to pay for services they cannot afford individually when an unexpected health crisis crashes in.

Len Kirschner, the director of Medicaid in Arizona from 1987 to 1993, argues that the three legs of the U.S. health care stool—job-based insurance, Medicare and Medicaid—are already broken. Coverage is getting worse, not better. Costs are climbing to the point that employers and governments alike are being pushed into reducing benefits for employees and coverage for the poor and the old.

Will a fiscal crisis be enough to force fundamental reform? It does appear that a broad-based coalition against the status quo is growing. If fundamental change through the political process is too difficult at the federal level, then perhaps some brave state—if not Arizona then another ambitious state—could launch a bold experiment that could be enough to break the impasse and provide a demonstration project for the rest of the country. Who knows?

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Still, it seems clear to me that the perception of essential health care as an economic commodity rather than a public good is a barrier to fundamental change in health financing in the United States. And perhaps it goes too much against the grain of American political culture, with its strong sense of individualism and its inherent anti-statism, to expect that an overwhelming majority of Americans will suddenly view health care as a social service. But it is possible that this country could one day leapfrog that step by concluding, through a court decision, that certain essential health services are a right of citizenship and must be provided to everyone on the same basis.

CONCLUSION: ESSENTIAL HEALTH AS A RIGHT OF CITIZENSHIP

Alexis de Tocqueville once observed: "There is hardly a political question in the United States which does not sooner or later turn into a judicial one." If this is true, then perhaps one day a court will decide that the lack of access to essential health services is, in effect, a deprivation of life, liberty, or property, in a creative interpretation of the Fifth Amendment, or perhaps a new amendment will be passed setting out the same. If this were to happen, then governments, federal and state, would have to redesign their systems of financing and administration to ensure basic access to all Americans as a right of citizenship. The means could not be proscribed by the courts, but the end result would be regulated through the judiciary rather than by governments.

In Canada, I do expect that some day some court will decide that essential health services are a right of citizenship, not simply a social service or benefit. We shall see whether that day comes before, or after, a similar decision in the United States.



SOURCES



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Respondent Susan Gerard



Susan Gerard

Director, Arizona Department of Health Services

Gregory Marchildon's insightful address points to an interesting contrast between Canada and the United States. While Canada debates adding private, market-driven elements to its health care system, the United States argues over shifting to publicly funded universal health care coverage. Both systems are struggling with rising costs, quality, access issues, and an aging population.

The Canada vs. U.S. discussion is an interesting one, yet it's time to move forward and look at something we all can agree really works to reduce health care costs and improve health: Promoting prevention, physical activity, and healthy lifestyles are critical to solving our nation's health care crisis.

Consider these staggering statistics:

Obesity cost the American economy \$117 billion in the year 2000. About 75 percent of our health care dollars are spent treating chronic diseases such as heart disease, cancer, and diabetes. And \$75 billion of that treats obesity alone.

These chronic illnesses—many of which can be prevented by healthy lifestyles—cause seven out of every 10 deaths. What's even more alarming is that our children are becoming increasingly heavy. Childhood obesity and diabetes rates are skyrocketing. Yet we know that an increased focus on prevention and disease management can make a real difference.

At the Arizona Department of Health Services, we are practicing what we preach. We have made healthy living and disease prevention a high priority. I instituted smoking cessation classes for employees, with free nicotine replacement therapy, and our Wellness Council offers a wide variety of classes. Twice a week, employees join me and other managers on a 15-minute "Director's Challenge" walk around the Capitol.

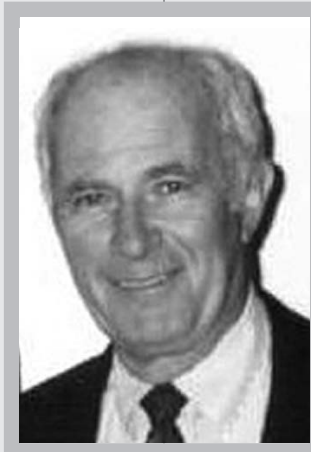
We're combating childhood obesity through the Governor's Call to Action; Maintaining Healthy Weight in Children and Families program, which features statewide nutrition and physical activity campaigns, focused on developing new programs to get our residents to be more active and to eat better.

Arizona was only one of four states chosen to receive a federal Steps Across America grant. We're using this grant to develop our steps along the border project to reduce the burden of diabetes, obesity and asthma by providing community and school interventions in Santa Cruz, Cochise and Yuma counties.

The bottom line is that if we're serious about reducing health care costs, we all can agree that adopting the right lifestyle habits and making good choices are the key. All of us have the responsibility to encourage healthy behavior in our communities, and in our families.



Respondent Name



Leonard Kirschner

Former Director, Arizona Health Care Cost Containment System

Gregory Marchildon's engaging and provocative discussion, "Health Care in Canada and the United States," reminds us of the key role played by political leaders in developing systems of social services. Tommy Douglas, the premier of Saskatchewan, in the period after World War II, played that role in the development of the Canadian health care system. His counterparts in the United States' political leadership played equally important but far differing roles.

Gregory uses five terms to describe the Canadian model: "public administration, universality, accessibility, comprehensiveness, and portability." The five words I use to describe the United States system, "chaotic, costly, inefficient, inequitable, and superb," reflect the different reality of our two countries and the paradox that these differences illustrate.

In the first decades of the 20th century, the Canadian and United States systems were quite similar, and it is only in the post-World War II period when they diverged in basic ways. Political leaders in both countries have grappled with the complex issue of health care for the past 100 years. Theodore Roosevelt, in 1912, running on the Bull Moose ticket, proposed a social system similar to the German model. It would be his cousin, Franklin Delano Roosevelt, who would return to this subject in the 1930s, but instead of a national health care system we got wage price controls and the employer based system that has dominated health care in this country for the past 60 years. Harry Truman fought valiantly for a national system but lost to the cries of "socialized medicine" from the American Medical Association. In 1964, Lyndon Johnson crushed Barry Goldwater in the presidential election and moved on to sign the Social Security amendments of 1965, giving the United States both Medicare and Medicaid. That signing ceremony took place at the Truman Library in Independence, Missouri, and Harry Truman became the first Medicare beneficiary. What wonderful symbolism!

Every President since Lyndon Johnson has dealt with our system of care in one fashion or another. Richard Nixon became "the father of managed care" after signing the Health Maintenance Organizations (HMO) Act and Ronald Reagan proposed massive changes to Medicare in the ill-fated Medicare Catastrophic Act of 1988. It was, of course, Bill and Hillary Clinton who raised the issue of reform to a new level with their Health Security Act. President George W. Bush signed the Medicare Prescription Drug Improvement and Modernization Act in December 2003, and the provisions of that law are playing out today.

Gregory asked the provocative question; "Is health care a consumer good, a social service, or a right of citizenship?" Both of our countries continue to struggle to find the right answer and the right balance. Is health care a right? Is health care a privilege? The United States system is supported by three financial legs: employer based coverage, Medicare, and Medicaid. All three legs are crumbling, and our political leadership will be forced to return to the subject of our health care system in the months and years to come. As Winston Churchill once said, "You can always count on Americans to do the right thing—after having first exhausted all other alternatives." We still have many alternatives to consider and, as our speaker noted, our close neighbor to the north may have alternatives we will want and need to consider.

