RECORD OF SOCIETY OF ACTUARIES
1995 VOL. 21 NO. 3B

HEALTH CARE REFORM IN NORTH AMERICA: WHAT CAN THE UNITED STATES LEARN FROM CANADA AND WHAT CAN CANADA LEARN FROM THE UNITED STATES?

Moderator: ROLAND (GUY) E. KING
Panelists: JOHN M. BERTKO
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Recorder: ROLAND E. KING

Experts will discuss the major features of each country's health care programs, including current deliberations that may change the way the programs work. Included will be an assessment of how certain aspects of each plan may be transferrable to the other country. Discussion will address universal coverage and/or availability, benefit designs, freedom of choice, and financing.

MR. ROLAND E. KING: We have the pleasure of having some real experts on the Canadian and U.S. systems here with us.

Our Canadian expert, who has been a proponent of privatizing the Canadian system for many years and whose voice and concerns are increasingly being agreed with by the Canadian Medical Association, is Victor Durnfeld, M.D. Dr. Durnfeld got his medical degree from the University of Manitoba and spent his internal medicine residency at St. Boniface General Hospital in Winnipeg, Manitoba and at the University of Utah in Salt Lake City. He's certified in both Canada and the U.S., and he has also practiced medicine in both Canada and the U.S. In fact, he practiced medicine in the U.S. before he came to Canada.

He's the president of the British Columbia Medical Association, and he's the chair of the utilization committee of the British Columbia Medical Association. He's also the chair and has been a member for 15 years of the council on health policy and economics for the Canadian Medical Association.

Our other speaker is John Bertko. John, of course, is an actuary from the U.S. He recently received an education on the Canadian system when he was in Nova Scotia for a week helping with its health care system. He has extensive experience in the U.S. dealing with states on health care reform. He has consulted on health care reform and policy issues in at least 15 states.

DR. VICTOR DURNFELD: I'm delighted to be here to speak about the Canadian health care experience. My intent here is to give you some historical perspective about the Canadian health care system—how it evolved, what its many strengths are, what the tensions are, where they come from in the Canadian health care system, what some of the constraints are, and what some of the directions are that are being proposed by governments and by medical and health care providers, particularly physicians. I should start out by saying that Canadians overwhelmingly love their health care system. They

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value it as one of their treasures. You heard earlier from Jane Fulton that Canadians need not fear that they will become sick and be destroyed financially by their illness. They need not worry that they can't move from province to province, or from job to job and lose their health care coverage. It is a function of our universal health care system that won't occur.

Physicians also, overwhelmingly support the public Medicare health care system in Canada. Recent surveys have shown this in various provinces in the country as well as across the country. But there are problems, and the problems all started with the big giveaway.

It started in a very rational way to be coverage for catastrophic illness to prevent bankruptcy. And then it expanded to cover necessary things. And then it expanded to cover almost everything. And as one of my colleagues said about three years ago at a national meeting of the Canadian Medical Association, for years we have been spending like drunken sailors, and now it has come home to haunt us. (I'll come back to that soon.)

I will give you a brief history of Canadian health insurance. There had been a history of prepaid hospital coverage as early as the 19th century, in the 1800s. But by 1934 there were 27 individually-based prepayment plans in six of ten provinces. Blue Cross emerged in 1939, and it pooled risks for groups of hospitals. Then, as you heard earlier from Jane Fulton, a little fellow by the name of Tommy Douglas emerged. He was a firebrand socialist, a populist in the province of Saskatchewan.

Saskatchewan introduced in 1946 the first provincewide-sponsored hospital insurance program. It was funded by premiums and a 1% sales tax allocation. Then during the next few years, other provinces, seeing the mood of the time and the popularity of the program, followed suit. By 1957 the federal government, not to be outdone, introduced a Hospital Insurance and Diagnostic Services Act, and this was cost-shared at 50%.

What did that mean? It meant that the federal government would kick in 50 cents for every dollar spent. Obviously, it was an open invitation to expansion, and that was the intent. And so Canada went on a building and spending spree for hospitals until about six or seven years ago.

Community-based insurance plans began in the 1930s. In 1940 the British Columbia Medical Association, of which I am currently president, introduced the first provincewide plan for physician services. It was called a metropolitan statistical area (MSA). Subsequently, others followed suit. There were different groups; for example, the automotive retailers association. Seniors were covered under a separate plan. There were premiums for membership in the plan. Each plan was not-for-profit. Physicians billed the rate of the plan, and the subscriber, the patient, was not charged privately. And it worked. It worked so well that 85% of the population was covered by these voluntary prepayment global-risk plans. Other provinces saw how well this worked and they followed suit again. Some did it in conjunction with Blue Cross; others had physician-sponsored plans.

In July 1962, the province of Saskatchewan did it as a political entity and undertook a plan of its own. This was a very bold step: for the first time a government was

insuring all the population in its jurisdiction. In fact, this did not occur without some conflict; this was brought in over the protest of the medical profession in that province. As a result of the conflict between the political philosophy and the move of the government of the day, the medical profession went on the first-ever strike, withdrawal of services. As a result of this strike, which was acrimonious and pitted one member of a family against another member of the family—neighbors literally fought over it; there were significant modifications to the way in which the plan was brought in. But it stuck, it stayed, and it ultimately flourished.

British Columbia followed suit. And then, in 1964, the Canadian government saw the handwriting on the wall. It did what Canadian governments always do: strike a royal commission. It got Emmett Hall, who was then Justice of the Supreme Court of Canada, to review the health care system and make some recommendations. His recommendation was to have a universal health care system in Canada. He annunciated some principles. He made some projections that turned out to be wrong. And those projections were that Canada's population would grow at a certain rate. (He projected us to be at about ten million more than we are now.) He suggested that we open more medical schools, train more doctors, open more hospitals, and provide more beds.

We ended up with too many hospitals, too many beds, too many doctors, and too much cost. That all had to be readjusted. But at any rate, we did have in 1966, based on Hall's recommendations, the federal Medical Care Act. Saskatchewan was the first to join in 1968, and the other provinces followed suit, the last one being three years later in 1971. Why? Because the federal government of Canada said, if you join this universal health care coverage scheme across our country, we will pay you 50% of any cost incurred for any health-care-related program that you might introduce. Provinces therefore jumped on the bandwagon, finally. They could not lose this bonanza of buying things for 50-cent dollars. Hall was resuscitated in 1984 to review the health care system again, which was about 20 years after he had originally done it. He produced another report, which we call Hall Two, and this is the Canada Health Act. That's the universal medical care scheme that we all work under now.

But before we talk about that I want to talk about how physicians have fared under universal Medicare in Canada. It has five basic principles: universality, accessibility, comprehensiveness, portability, and public administration. Under these principles, physicians had a certain kind of relationship in determining how they would be compensated for their services.

About 67% of doctors now in Canada are remunerated on a fee-for-service basis. About 27% are remunerated on salary or sessionally. In other words, if they work half a day they get so much for half a day. The remainder (6%) are remunerated on what's called a capitation base. That is the number of patients who are enrolled in their practice, who are rostered in their practice. They'll get so much for each, and they are responsible for delivering comprehensive health care, no matter how much or how little, for all the people registered in their plan. It is similar to Kaiser and other HMOs.

Over the years, with much blood on the table and with a lot of acrimony and bitterness, there has emerged in Canada some sort of accommodation, some consensus on the relationship between government and the physicians of the country. It is a monopsony—a single payer. In fact, for any insured service in seven of the ten provinces,

there is legislation that says private insurance shall not be offered for any insured service that's provided by the provincial government plan. You can't do it by law, and penalties are severe. There is threat of similar legislation in the other four provinces should anyone try to introduce a plan to cover people privately for what the public system covers.

In an attempt to try and bring some sanity to the relationship, an accommodation of sorts was reached by various provincial medical associations with their respective governments. There are conflicting agendas. Governments have a limited pot of money. There is a limit to the amount they can tax the population, and they have a wide spectrum of responsibility for services they must provide to the population.

To the extent that any group makes a demand on that tax base, there is a conflict with the government's ability and desire to pay. And it is compounded when the government is empowered by a particular ideology that demeans or wishes to marginalize the medical profession.

But, across the country we have reached some accommodation, and those accommodations have fallen one by one across the country. I am happy to say that in British Columbia we are still cooperating and comanaging the system with our government. In December 1993 we reached an agreement with the government whereby the traditional increase in costs projected from past experience was on a trendline. So the cost to the province for delivery of health care, assuming a certain population growth, would have been about $1.54 billion.

By negotiation we agreed with government that we would keep it under a global cap of about $1.34 billion, and the difference between the two amounts would be comanaged by the government and by us. I happen to be chair of the utilization committee of the British Columbia Medical Association. It's my job to point out to doctors the areas of utilization and growth that are alarming, that are inappropriate, and that should be reviewed. We are keeping almost within budget.

And it's by this continued cooperation between us and government that peace and a reasonably hopeful outcome will result. Now there is considerable chafing by the physicians of my province. They don't think they are being adequately compensated for the work that they do. Nevertheless, we still cooperate with government in this area.

The federal government has a strong presence, and I've alluded to the fact that it has provided a certain amount of funding for health care in provinces throughout the country. Its mandate, through both the Medical Care Act and the Hospital Insurance Act, is to ensure reasonably comparable levels of benefits and access in various provinces across this country.

Please understand that we have a diversity of wealth in this country. For example, British Columbia and Alberta have a very high level of industrial output, of natural resource output, and of wealth. Ontario is called the engine that drives Canada. It is the manufacturing center of Canada, as opposed to that of Saskatchewan, Manitoba, and the Atlantic provinces. Prince Edward Island, Newfoundland, and Nova Scotia are in trouble financially. They don't have the resource base or the wealth that we do. As

a result, the federal government said we will have reasonably similar health care availability right across the country, and we're going to fund it. How? We will play Robin Hood by taking money from the have provinces—British Columbia, Alberta, and Ontario—and redistribute it for purposes of improving social services such as welfare, postsecondary education, and health, to bring those have-not provinces up to an adjusted national average. That's called equalization.

That's what has been happening during the past 25 years. However, in 1977 the federal government suddenly realized that it couldn't continue this open-ended funding. It couldn't allow provinces to begin programs because the provinces were only spending 50-cent dollars, including pharmacy care. Jane Fulton's graph at the General Session showed the cost of pharmaceuticals is really expanding markedly. So it had to put a lid on things. In 1977 it introduced what it called established program financing (EPF); no more 50/50 sharing, no more open-ended program. Instead, it was a block funding arrangement based on the tax point transfer and annual cash funding. It was related to population growth, the growth of the gross national or gross domestic product, and it was adjusted in certain ways.

Even this EPF was too rich for our federal government to afford. So between 1982 and 1995 the federal government made six downward adjustments to decrease the amount of money flowing from the federal government to the provincial governments.

That culminated in the debt crunch of our federal government. The fiscal reality was that in the budget of February 27, 1995, the federal government announced that it would reduce transfers for Canada as a whole by $4.3 billion for health care, which means about a 36% decrease in transfers from the federal government to the provincial governments for health care.

In British Columbia it amounts to $563 million on a total health care budget of $6 billion. So its about a 5% decrease. Now that's a significant cut for a province, which, although we are doing well, has had an annual deficit with an accumulating debt that is very serious. So serious is this fiscal crunch that our provincial government is trying to balance its books. It is not being successful. And governments that haven't been able to balance their books were defeated at the polls three weeks ago in Ontario. The New Democratic Party (NDP), a socialist government, was defeated for being so fiscally irresponsible.

Now the 50/50 cost-sharing has gone down to less than 25%. The federal government is now funding about 23% of health care costs. The Canada Health Act was passed in 1984. The implications of the Canada Health Act and the transfer payments of cash are that the federal government has no power in health care. But it has some clout because it can ensure that those five principles of the Canada Health Act can be upheld by withholding transfer payments.

Now it's true that the federal government only now is transferring 23% of health care costs to the provincial governments. But it says if you transgress any of these principles—universality, accessibility, comprehensiveness, portability, and public administration—it will withhold dollar for dollar the amount that you transgress. For example, if doctors are allowed to (what the federal government calls) extra bill, it will deduct that amount in transfer payments. And it has been deducting millions of dollars from

provinces that heretofore have allowed doctors to do this sort of thing. Each province has introduced legislation to prevent it, but some maverick doctors think that they are not bound by these agreements.

The provincial administrations are given control of the health services. There is public administration, as I mentioned, and no extra billing for physicians. There are no user fees for physician services, and no private system is required for physician services. So the federal government can't legislate this because it's a provincial jurisdiction. But it can use money to get provincial governments to prevent privatization.

So just very briefly, as of four years ago, the provincial share of national health care cost was 46%. The federal share was 24% and the private share was 28%. Now you may ask, where does the private share come from? Well, it comes from services that aren't insured, such as medications, dental care, extended health services, crutches, wheel chairs, etc. The major portion of it is drug costs. The total health care expenditure in 1993 for Canada was $72 billion.

In British Columbia hospital costs amount to 50%; medical, 21%; preventative cost, 14.5%; and other, 14.5%. What are the other costs? The other costs are either private or are paid by government for physiotherapists, chiropractors, podiatrists, and drugs.

Now, the debt crisis in Canada is what has fueled a lot of the changes in the health care financing across the country. Why? As you heard from Jane Fulton, our national debt has escalated markedly. In 1981–82 our national debt was 154 billion, which was 35% of our gross domestic product. In 1994 it was about $775 billion, which is 100% of our gross domestic product. When New Zealand, as it is said, hit the wall in its fiscal crisis, its national debt was about 65–70% of its gross domestic product. As a result, to attract investment, we have had to keep high interest rates. Our interest costs are even higher than they would be ordinarily because Standard and Poor's (S&P) has said that our economic performance is so bad and our debt percentage of gross domestic product is so high (now 100%) that we are considered a poorer risk than we were ten years ago. And it has downgraded our risk rating and has increased our lending costs.

The cost of servicing our national debt, 40% of which goes out of Canada, has risen so much that our government just doesn't have any wiggle room in terms of how much money is left from revenue raised by taxes for other things. And so it has recognized this crunch and is saying we must reduce the amount we're spending on social services, such as postsecondary education, welfare, and health. Our ministers of health and finance said we are in hock up to our eyeballs, and this was about four months before they introduced his tax legislation, and our government said that Ottawa wants more control of debt.

One of the points that must be made is that doctors (and, of course, I represent doctors, and that's the constituency that interests me most) have not been responsible for significant escalation of that cost. In 1975 physician expenditures represented 15.7% of the cost of health care expenditures in Canada. In 1990 it was 15.2%, and in 1994 it was probably in the region of 14.8%. So payment to physicians has gone down, and the cost for physicians has gone down, relatively speaking. Why? Because in a monopsony the single payer can virtually dictate the terms, and conditions, and the

amounts, subject, of course, to job actions, persuasions, public utterances, and public support that the medical profession can martial.

In British Columbia, fortunately, we've been very successful in martialing that public support for various reasons we can talk about later. So in our jurisdiction there has been an attenuation compared with in other provincial jurisdictions where doctors have seen their fees and pot of funds decrease across the country by up to 8% or 9%, with their overheads continuing to increase. Our prime minister says that health care costs must be sliced to save Medicare.

This is to give you a taste of the environment in which we're working. These are the difficulties that must be considered when dealing with a single-payer system that is government oriented and government controlled. So the budget came down four months ago, and in 1996–97, the effect will be a decrease of 20% in funds. To British Columbia that amounts to $203 million. In Canada as a whole it's a decrease of $1.6 billion, which represents 23%.

Regarding health care, the percentage change for Canada as a whole is 38% that the federal government will be decreasing to provinces across the country. You, I am sure, can appreciate the consternation and the impact of that substantial decrease of federal money to the provinces in what they can do to finance health care. That's part of the crisis that we're working under now.

We think that health reform as a result has flat-lined. The reason is that you can't expect health care providers (and I don't care whether it is physicians, or nurses or physiotherapists, or hospitals) to deliver the same or more service with less money. There was some fat in the system. It has been cut. Many hospitals have been removed. Many beds have been closed. Across the country health care providers have lost their jobs. But we have been constrained by the following.

The federal minister of health, Diane Marleau, has warned Alberta that she will not tolerate a two-tiered health care system. What is meant by a two-tiered health care system? The public system and the private system. What is conjured up? The specter of the Americanization of Canadian health care. "We will not allow that to occur."

Now this is a sophistry; it is dishonest. In Canada we cannot have the Americanization of the health care system. Why? Because they talk about the 37 million in the U.S. who aren't insured. They talk about the people who can't move from job to job etc. But in Canada those of us who are proponents of a private parallel health care system (and we eschew the term, we avoid the term *second tier*, because of all the connotations and because its so pejorative) think it would coexist with the public system, which is well established, which is universal, and which would cover everybody who wanted to be in it. But a private parallel system would allow choice and would allow an alternative. And it would allow for the infusion of discretionary funds by people who want to spend it, if government would remove the legislation that prevents insurance for health services in virtually every province in the country.

Again, in British Columbia, our minister of health says that a two-tiered health care system is ruled out. And this is consistent with what the federal government has said,

and is partly ideologically driven by our particular government, which is an NDP government, which is a socialist government.

So there has been a changing environment in Canada. I've spoken about the fiscal pressures. In fact, in Ontario in 1986, Bill 92 said that even if a doctor opts out of the provincial health care plan, even if a doctor has never been in that plan, that doctor, even if he or she has a contract with his or her patients, cannot charge more than what the government allows, what is set out in the schedule of fees in the province.

Ontario is the most populous province in our country. It passed this law. Doctors think that is against the Canadian charter of rights. We initiated a challenge to the law in the Supreme Court of Canada. But after four years and $1.5 million, the doctors in Ontario and the Canadian Medical Association opted to abandon the challenge. It is an odious law. It is completely repressive. It says that the state will tell you what you're worth. It is price control. It is selective in that it selects only physicians in a private system. Anybody else can do what they want. Teachers can go out and tutor privately and charge what they want. A law enforcement officer can become a private security guard, leave the police force, and charge whatever he or she wants. But a doctor in Ontario can only charge what the government says to charge.

As a result of the fiscal pressures, the closure of hospitals, and the decrease in funding operationally, there has occurred a decreased accessibility with longer waiting lists for procedures and care. Radiation oncology has a wait time that is two to three times longer than it is deemed scientifically and medically reasonable. It takes about a year to get elective orthopedic surgery. That's the median for the longest wait. Some wait up to two years for hips. Yet you can't access it in the private system. However, as Jane Fulton pointed out, people in this country are affecting choice. They don't want to wait. And so they take a billion Canadian dollars to the U.S. so that they can get access to care sooner.

As a result of these fiscal constraints, and because of deemed or perceived physician oversupply, we have entered into a program of physician supply management and regionalization of health care in which there has been divulsion of health care from the provincial jurisdictions to local municipalities and regions in the country. The key question is, how do we continue to pay for an increasing scope of health care services with an ever-tightening pot of money, particularly in an age with new technology, an aging population, and an increased expectation of the population?

Now we've run over much of this but the impact on physicians is that the fee-per-service mode of payment is being strongly challenged by provincial authorities. They are saying that the fee for service is too expensive; we should be put on salary or on capitation, such as in HMOs in the U.S. Many physicians or physician organizations are very strongly and aggressively resisting this move. Nurse practitioners and other alternate health care providers are being proposed as being cheaper, as an effective way of providing health care services to replace physicians.

Well, there has been such a drumming up of that proposition that the Canadian Medical Association reviewed english literature on alternative health care providers in terms of the cost-effectiveness. Their reviewers called 155 papers from the literature that could reasonably be attributed to deal with the subject of cost-effectiveness in alternate care.

Of those, 114 were virtually useless. Of the remaining 41, there were substantial flaws such that there could be no conclusions drawn that alternate care providers were more cost-effective than physicians in providing services. They did agree that in very circumscribed and limited circumstances, nurses, for example, could work in a blood pressure clinic. Or they could work in a well-baby clinic. But the nurses' function in those settings would be very circumscribed and very limited. The outcome for that particular problem may not have been very different, and the cost perhaps less, but as far as the overall care of that individual, there was no evidence to show that nurses or other alternate care providers would be more cost-effective.

The studies were short; they were not long term. The sample sizes were small. They did not compare independent nurse practitioners with independent physicians. Virtually all the studies were of nurse practitioners who were working in concert with or as part of a team or under the supervision of a physician. That was an area where we are responding to this pressure. That study was reviewed by two senior analysts, Tammy Tengs from Duke University and Julia Abelson from the University of Bath in England. They concur with the findings and the results, and they are independent academic health economists.

Midwives have gained popularity across Canada. We don't know how that's going to sort itself out, particularly with home births. As far as physician supply management, in 1992 the federal and provincial governments decided that they were going to cut Canadian graduates by 10%. And they have done this and there are now 10% fewer physicians graduating from Canadian medical schools. Hall's projection was wrong.

About 50% of our physicians are general practitioners and 50% are specialists. One of the problems has been that there has been a continued net loss of physicians, a net migration of physicians out of Canada, almost all to the U.S. In particular, our specialists who are in short supply are going to the U.S.—like our orthopedic surgeons and our neurosurgeons. Canada graduates nine neurosurgeons from residency programs per year. For the last two or three years running, eight of the nine, have all gone to the U.S. We are losing our native neurosurgeons, orthopedic surgeons, cardiologists, obstetricians, and gynecologists to the U.S. If health reform goes in the U.S., we will probably lose a substantial portion of our Canadian general practitioners.

So the future options and implications are the status quo, user pay, private care alternatives or alternative care providers. I've spoken about the alternative care providers. Let's look at the status quo. The reasons why the status quo can't continue is because of the pressure of debt. The Canadian governments collectively can't afford to fund Medicare the way they have been. As a result, this is being addressed now by waiting lists or rationing in this country.

We're getting near the end. User pay is contrary to the Canada Health Act. It's contrary to the thinking of many provincial governments. But 60–80% of the medical profession supports user pay, 50–60% of the public supports it, and some segments of the population don't support it. Seniors are angry over the proposal of a means test to cut the cost of drugs to the provinces. We have universal pharmacy care. A multimillionaire can still go to the drug store and have his or her drugs paid for by the provincial government. It doesn't make any sense, yet this group refuses a means test.

As we polled across the country, and I've kept a record of these polls, the opinions for cost-sharing by users have been remarkably steady during the last decade from 1985 to 1994 at about 60%. The public agrees that to save the system there should be cost-sharing.

Virtually nobody wants to raise taxes. Nobody wants services decreased. But they are willing to pay for more services. In the context of privatization I ask you to consider the core-services concept of Oregon. That is, government should cover only a very certain and specified group of core services; the rest should be left to the private sector. What are those core services? That is to be agreed upon and determined by governments, physicians, and most importantly, the population at risk.

Private treatment facilities, such as magnetic resonance imaging (MRI) facilities, are under the gun from the governments in every province, saying they shouldn't be provided privately. What do I mean by privately? They're not insured services. Instead of going to the U.S. to get the MRI of their back or head or knee, now Canadians can go to private facilities and pay out of pocket. But these are at risk of being legislated out by various provincial governments of Canada.

Other surgeries, such as eye surgeries and cataracts, are springing up in private clinics because of these pressures. People don't want to wait 6, 8, or 10 months to have their cataracts removed. They're willing to pay out of pocket. Governments are resistant to this or have been until recently, and I think movement is starting to occur.

Optional, private-coverage insurance is the key to this. The Canadian Medical Association polled its members. Seventy percent of doctors said that the recent budgetary change in Canadian Medicare would result in a radical change that puts the system in jeopardy. With respect to whether they could deliver health care properly, 88% said that physicians would have less professional freedom. Eighty-seven percent said that there would be more balkanization of services across the country. Eighty-five percent thought that their earnings would decline substantially, and 75% said that they would have a reduced ability as patient advocates.

Regarding the acceptability of various options, 71% of Canadian doctors said government should pay for a lesser range of services for coverage. And 76% thought that patients should pay for private insurance for some services.

Now what about the public? Here in British Columbia we surveyed the public in January [1995] in terms of support for privatization options. You'll see that 62% were in favor of the option to purchase insurance from the private sector, and almost 60% were in favor of private claims paid by user fees.

The Canadian Broadcasting Corporation took a poll in April [1995] regarding which program is most important to Canadians. Fifty-seven percent of Canadians thought health was the most important. Canadians are concerned about their universal, monopsonistic, government-provided health care system. How many are concerned in this poll? Eighty-seven percent of Canadians are either very concerned or are somewhat concerned because of the impact of government cutbacks in Medicare. And 45% think that fewer, but necessary, services will be covered. Forty-four percent of

Candians polled think only the most essential services will be covered, and most people will have to pay for health care services themselves.

MR. KING: John Bertko will now play devil's advocate by talking about how the single-payer system might be adopted in the U.S.

MR. JOHN M. BERTKO: When Guy asked me to play this role, I approached it with several elements of caution here. The first should be obvious. In listening to Dr. Durnfeld I'm assuming that most of the people from the U.S. here learned quite a bit about the way Canada has been looking at parts of its system. My visit to Nova Scotia last week was really in the nature of an intensive seminar to learn how it really works. I've worked with health care policy in various states. For the most part they don't have many clues about how the Canadian system really works.

Second, having lived in California for the last 25 or so years, we've had the experience of running through statewide debates with various advocates of single-payer systems. A couple years ago, the California Medical Association sponsored Proposition 166, which fell to about a 60/40 loss. Last year, Proposition 186 which was a single-payer system and probably as close to one of the Canadian province systems that could be made, fell to an even more resounding defeat of about 3 to 1. So the political climate at this point wouldn't indicate it.

Now, having said all that where could we go if we were looking to learn some lessons from Canada? I'm just going to make a few comments here. I will point out some of the differences between the Canadian and the U.S. system.

Canadians love their system. I heard that loud and clear. To make that statement that U.S. citizens love their system, you'd be laughed out of the room. Physicians in Canada support the system. I worked for a number of physician groups in California, and they are up in arms..

Another thing I would note here is that I think physicians today are receiving about the same percentage of the health care dollar that they have been during the last 20 years. I don't have any firm statistics, and our real experts here might tell me otherwise, but in California, because hospital costs have dropped, the physician percentage of the dollar has risen. Also real income of physicians in the U.S. has risen.

Now, I'll add one other comment here. If you're looking for specialists, we have them. California is overrun with them.

Another difference that I found in my brief visit to Nova Scotia was that literally, and I was astounded by this, Nova Scotia has too many family practitioners. Again, for most of you in the U.S., and in California, in particular, we have too few family doctors.

And then we are already further down the pike in terms of substituting nurse practitioners of various kinds for physicians here. I belong to Kaiser, and for the most part three of four of my visits, mainly for physicals, are taken care of by nurse practitioners.

What are some of the similarities, before we go forward on the single-payer role? First of all, Dr. Durnfeld noted a hospital building spree during the 1970s and early 1980s. The folks in Nova Scotia confirmed that there are hospitals in all sorts of absurd places (way out in the capes) because it was politically correct. Well, we did the same thing. The Medicare program in general basically provided the funds for the U.S. to go on an astounding building spree of hospitals. In California we have probably at least twice as many beds as we need. That's after the physical beds have been reduced to operating beds.

Second is the Medicaid program in the U.S. Virtually everything that Dr. Durnfeld said about the fiscal pressures in British Columbia would apply to all states. The Republican Congress, at least as I read it, in turning block grants, on making reductions, would only exacerbate those pressures. So in many ways our two systems are facing exactly the same pressures but are coming from opposite directions.

A third similarity is that there are a number of perverse incentives in both systems. In our case, one of them is that hospitals compete on the basis of making services available to providers. We have, I think, in the San Francisco Bay Area where I live, perhaps more MRI machines than in all of Canada. I'm not sure if that's completely true, but I don't think it's totally inaccurate.

In Canada, at least Nova Scotia has told me, that hospitals aren't in such great abundance. The perverse incentives are, in fact, to maintain usage because next year's budget depends on how much is spent this year. So, there, in fact, is very little in the way of pressure to reduce costs and hospital utilization.

So starting from all those points, what would a single-payer advocate say? Again, although our last initiative in California was defeated by a 3-to-1 factor, there are literally millions of single-payer advocates living in California who are willing to vote on this.

In one of the states that I completed some work on this spring, one of its three health care commissioners said he really would like to turn the state into a model based on the Ontario Health Care System. I said that to Canadians and they said, "What's wrong with you people?"

What could we do, though? I don't necessarily think we should follow the kind of single-payer system advocated in the last couple of years by Representative Jim McDermott [D; Washington] or Pete Stark [D; California]. But for any of you familiar with the Garamendi plan in California, I think it has some parts that come together and are worth considering.

One is that perhaps we should sever our funding link to employment. When people move around in jobs, I think most of you would agree that they suffer because of that. Change to something that is perhaps employment-related and have income-tax-based funding for those people who are employed. A single state agency would collect it under the Garamendi Plan, and the money would go into a bank account.

Then, of course, we must fix all the other problems. But those, I think, are separate problems. What do you do for retirees? My firm belief is to not give a windfall to

those companies that promised the moon to retirees over the years. Do something separate. What do you do for the uninsureds? What do you do for Medicaid today? There are ways to put those two systems together.

Now again, my devil's advocacy here is meant to provide you with a role that pushes it. I won't describe to you right now my true beliefs and which are my devil's advocate beliefs.

Second, in his talk Dr. Durnfeld used the term *monopsony*. I think that's a good concept to think about. The state buys health insurance, and it buys it from, in this case, not a single system that is delivered on a fee-for-service basis as in Canada, but rather through intermediaries. In California those intermediaries mostly go by the name HMOs. They could be Blue Cross/Blue Shield plans. They could be more traditional health insurers. There would be choice. But the payment mechanism would be funneled through the state, and a standard would be set up. Some standard benefits, some core services would be provided. But the delivery would be through these intermediaries.

How would this get paid? Probably through a risk-based voucher system. Could it be done? It has certainly been attempted through Medicare risk payment and Medicare risk HMOs in the U.S. It has not been entirely successful, but 2.5 million people or so are under that system in the states right now. So we, in fact, have models that probably could be improved.

There would be choice of health plans. That's where we can perhaps improve upon the way the Canadian system works now. Dr. Durnfeld, you and I use probably different language and have somewhat different concepts. But I think I heard your advocacy of choice within the Canadian model as well.

So any person in the San Francisco Bay area might have the choice of between 10 and 20 health plans. I'm associated with a small-group purchaser, the Health Insurance Plan of California (HIPC), which allows that now through employers at this stage, but individuals or families get to choose from 5 to 20 health plans, depending on the region of the state where they live.

There would be standard or core benefits. Going back to these five principles, I think most of them should be thought of in terms of how we reform the system; universal coverage, covering everybody, having good access, comprehensive services. This is where I think that the standard benefits need to be thought about. What's the level of the standard benefits? I don't know what that should be. That, in fact, is probably a good area of public policy. That's a decision, I think, for our policymakers to make with advice from actuaries.

The last comment that I'll make gives an interesting twist to this. I think we ought to have questions for Dr. Durnfeld as to whether this will ever happen. I think the political climate in the U.S. today says no on a political level. I would make a different suggestion though—that it's already happening on a marketplace level in some states. Again, I'll only refer to California.

As we go through our market reform, our HMOs are gathering greater and greater market power. It wouldn't be surprising to me to see the elimination of fee for service. And many of you who work for insurance companies know that California is a very difficult market for PPOs to be competitive. As the HMOs gather more power, it's going to get increasingly more difficult.

We may, in fact, have a defect monopsony of sorts through 10, perhaps 20, very large health care systems, each of which has one million or so members. Now, to put that in context, Nova Scotia has fewer than one million people in the whole province. Nova Scotia has about 800,000. I've worked in some states that have about a million to three million people. So we may get there before we know it. We just will call it something different and there will be, of course, a few speed bumps along the way.

MR. ROBIN B. LECKIE: As a Canadian, I would like to comment as to why I think that the American health care specialists who are here could not possibly buy into the Canadian system. Two reasons—the first is that there's no provision for private insured health care alternatives. And we need that in all areas of health care. Second, which I really do emphasize to Americans is that there is no correlation whatsoever in Canada between the health care cost for an individual and the health care usage or risk for the individual. There is a slight bit of premium in Alberta and in British Columbia. But all the cost is through a progressive income tax, and of course, the usage is reasonably predictable through actuarial studies and so on.

It is wrong, in my opinion, to have a system of health care that has no correlation there. There should be some transfer between those who can afford it and those who cannot. But in something that is as usable as health care, there must also be some recognition of the actual cost or risk for an individual, and there is none in Canada.

MR. RICHARD J. BARNEY: I just want to make sure I understand you correctly. The intent of the recent changes in the transfers will eventually lower the federal transfers to zero. If that is the club that the federal government is holding over the provinces, is it not in essence, taking the club out of its own hands? Won't the provinces be freer to act on their own? Or am I misunderstanding?

DR. DURNFELD: You are precisely right. The intent is to lower the amount that the federal government will have to transfer. Those who are federalists and those who champion a national insurance scheme have observed what you have. No case, no clout. That goes to zero in about 2003 in Ontario, and that will be the first province. There will be no mechanism of extracting compliance with the principals of the Canada Health Act.

Some other supporters, and particularly government policy advisors, say that we will find other ways to do it. But in analyzing the outcome, as the transfer dries up, the capacity for the federal government to exact compliance will be lost.

There is now a fight going on between the province of Alberta and the federal government. By the way, they have redefined what is being done in a private clinic: cataracts, hernias, MRIs. They are now calling them hospitals. They never used to be hospitals. They're not built with public money. They aren't even located near the hospitals. They're built on private land. Her bureaucrats, as well as her ideology, have

interpreted, for purposes of the Canada Health Act, that these can be deemed hospitals, and as such, cannot charge private fees. Diane Marleau, the federal minister of health has said, to the extent that you're charging these private fees, the government will deduct from the transfer payments, dollar for dollar, what you charge.

Heretofore, the province of Alberta has said, "Keep your money, we're going the way we think we should go." Now whether Alberta will continue to do that I don't know. It's a very right-wing, recently elected administration. There is still a very high approval rating in the province. And the administration may or may not decide to continue to take this attitude. But that's the attitude right now.

MR. KING: Are there other provinces, Dr. Durnfeld, that are as conservative as Alberta?

DR. DURNFELD: As of three weeks ago, the province of Ontario became as conservative. There was an overwhelming defeat of the socialist NDP government, which is very unpopular, even with the workers. They rolled back wages in what was called a social contract for unionized workers in the public sector because they were so deeply in debt. As a result, they lost that support, that voter base, and they got trashed at the polls.

The guy who got elected, a fellow by the name of Harris, ran on a simple platform: fiscal conservatism and responsibility, cutback in public programs, get government out of people's lives. They got a big majority. They'll be, I'm sure, just as conservative as Alberta. I'm not saying I necessarily agree with it, although I don't disagree with a lot of what they say.

MS. SHANNON M. PATERSHUK: I'm not sure if I should admit that I'm from Alberta. I'd like to know what tools the Canadian Medical Association has to ensure that the core benefits in Canada are meeting the basic health needs either under the current system, which is severely rationed, or under the inevitable parallel system?

DR. DURNFELD: The Canadian Medical Association began an exercise on core and comprehensive services in Canada two years ago and just finished. It produced a book last year on this topic. It considered core services through a series of five filters with the impact on: whether the service was effective, whether the service was ethical, and what the economic impact on the service would be.

It put that together as a package and said, use this as a template on how to determine what core services should be. That was brought to the parliament of Canadian physicians, the general council of the Canadian Medical Association, last year. That group of physicians said, "That's great, it's a good foundation. Now draw up a list that we can use for core services across the country."

The people in the working group said they couldn't do that, and the general council said, "You will do that." So in six weeks we will hear whether they can deliver for the Canadian Medical Association as a recommendation for what a list of core services should be region to region across the country.

FROM THE FLOOR: Just a question of curiosity. You talked about the number of neurologists graduating each year in Canada and the number leaving to go south of the border. Did the Canadian government conduct a study and find that it was actually economically feasible to pay for the services done in the U.S. as opposed to trying to get the neurologists to stay in Canada? That's saying they would require a 50% increase in compensation to have them stay in Canada. Does it make more economic sense to pay for the services to be done in the U.S. and just let them cross the border where they consider that? Or would that be a matter of pride?

DR. DURNFELD: Actually, they were neurosurgeons although we are losing neurologists as well. But the high-profile people are neurosurgeons. No, the Canadian government, to my knowledge, has not developed such a study. We have, in a microterm in British Columbia, tried to deal with this problem. We have lost three neurosurgeons from our province in the past year. That's a devastating blow to a province that has three million people.

The concern of the neurosurgeons has been not so much financial remuneration, not so much from financial gain, but the capacity to practice their craft. There is operating room time, technological currency, the new tools, the nuts and bolts that can be put into people that need them. An orthopedic surgeon, for example, wants to replace a hip. The community hospital says that no more hips will be replaced for the next four months because it hit the limit on the budget for artificial hips.

So when we talk of those who have gone south of the border, they usually for practice fulfillment. In terms of would they contract to have them taken care of in the U.S., the universal answer is no, with a caveat. When public pressure builds up too much, the government's hand is forced. It has a life span of four years and an attention span of four years. The politicians want to get reelected.

So our socialist government a year-and-a-half ago was faced with a mounting campaign from people who wanted coronary/artery bypass surgery, some of whom were dying. Their relatives said, look what the government has done. "My father could have been saved." The waiting list included about 400 or 500 patients. The government contracted our provincial government for approximately 250 procedures to be done in Seattle, Washington to get them out from under that terrible pressure.

There have been some other minor examples of that, including, for example, radiation therapy for cancer. Our provincial government has had to send people to Bellingham, Washington. It's shameful. The planning has been so poor and the funds have been in such a limited amount that we can't provide this. So national pride would dictate that won't happen except where there is such public pressure that the government has no alternative.

MR. BERTKO: Let me just add one comment here on the note that the grass always looks greener on the other side. We are currently, in California, doing some work with many of the academic medical centers. The same concept that you suggested, Dr. Durnfeld, about the neurosurgeon worring about having enough patients to practice on, in fact, because of the constraints of HMO payment mechanisms, is surfacing there. So I won't say that there's going to be some balancing back, and it will become less

attractive in the near term. But some of our subspecialists are, in fact, facing a different version of the same cost constraints, and, in fact, patient constraints.

FROM THE FLOOR: John, I was intrigued with what you said about California becoming a quasi-single-payer state due to what might become a super government of HMOs. I was also intrigued by what seemed to be a contradiction that the number of specialists in California is so high. The number of MRI machines in San Francisco is equal to or is higher than or is very close to the number in Canada. How do you see a future evolution of a quasi-private, single-payer system all through the U.S. coupled with what might be a very large supply of specialists and high technology? I just think you alluded to it in California, saying that some of these super specialists are being threatened. Would you be so bold as to say that a panacea is developing here? Will we have a very large private single-payer system with retention of specialists and high technology?

MR. BERTKO: Let me only confine my comments to California, because with 30 million people or so we're large enough almost to be considered a single nation, and most of the people in the U.S. probably think we are different.

The market forces that are in play, again, in my opinion, without saying this will happen, are big. The big guys, the elephants, are going to trample everybody else. I want to use a different analogy. The sharks will gobble up all the other little fish. They will enroll virtually everybody, primarily because of cost pressure.

The bigger you get the more efficient you become and the cheaper you can buy services. The input prices drop dramatically. Also, to talk just very shortly about specialists here, that is in full swing in at least two parts of the state, the Bay Area and in the Southern California L.A. Basin. It has been in the newspapers that the big medical groups have literally fired 70–100 specialists in one of the big medical groups in the Bay Area that has about 1,800 physicians. Seventy of their specialists were discharged and are now without contracts.

This is basically because more than 50% of people who buy insurance (that is, not the Medicare and Medicaid recipients, or uninsured, but people who are commercially insured in California urban areas), buy it through HMOs. The HMOs have incredible power over whom they contract with. At some point, we may see a turning of that power through the doctors and the hospitals getting organized in different ways.

The third pressure point here is that I think *monopsony* is the wrong term. But it is a different environment. I think the third pressure point will be the large purchasers. Calpers is remarkably effective and has been for the last couple years. The Bay Area business group on health, now called the Pacific Business Group on Health, got either a second or a third straight year of 5% rate reductions. The small-group purchaser of which we contract for 100,000 individuals got rate reductions again this year. Those purchasers are operating jointly, as opposed to individually, and you think of jointly as being much like a government but with incredibly more freedom to make decisions, have the power to turn the thumb screws on health plans. I hate to say this, but that's probably the direction we'll go. It has to be one where we don't drive health plans out. We want health plans to be profitable. We want them to continue what they're doing—being effective contracting agents in the delivery system. But we want them to

be responsible in holding down the growth of cost. So that would be my vision of California. Whether that expands across the country is problematic. In some states either we're there or we're around the corner from being there. In other states, such as Wyoming, we'll never be there. It will have its own alternative, which will look entirely different.