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Introduction

Health care systems in North America are sometimes criticized as being too expensive or socially irresponsible relative to comparable systems in OECD countries or regions. These perceived health system failures are often mistakenly attributed to greater private sector involvement in the delivery of medical care or the provision of medical insurance in Canada and the United States. However, the exact nature and scope of state involvement in the health care sector in Canada and the United States is also often misunderstood and underestimated. This paper presents a fact-based context for evaluating health policy in North America.

Myths about North American health care financing

Observers often note that in most OECD countries, government accounts for a larger percentage of total health spending than it does in North American health systems. Greater reliance on private sector health spending is frequently argued to be the cause of relatively higher total health care expenditures in North American health systems. However, the facts do not support such a view.

It is true, of course, that private sector health spending in the United States and Canada represents a much larger share of total health spending than in most other comparable OECD countries. Table 1 shows data on the public and private shares of total health spending for the 21[1] comparable OECD countries for which data was available in the most recent year, 2006. The US and Canada rank first and fifth respectively out of these 21 OECD countries as having the highest private sector share of total health spending in 2006.

It is also true that total health spending is relatively higher in North America than in the rest of the OECD. Out of 21 OECD countries (Table 1) the US and Canada rank number one and seven respectively in terms of total health spending as a percentage of GDPin 2006.[2]

However, what many people do not know is that, as a percentage of each country's GDP, government health spending in both Canada and the United States are at equivalent levels—despite having fundamentally different health systems. Even more importantly, at 7 percent of GDP in 2006 (Table 1), the level of government health spending in North America puts Canada and the United States in the ranks of the top ten of these 21 OECD countries in terms of having the highest levels of government spending on health as a percentage of GDP. In fact, the share of GDP accounted for by government spending on health in North America is higher than the OECD average (excluding Canada and the US) of 6.8 percent.

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1 Japan, Korea, Mexico, Slovak Republic, Australia, Turkey, Denmark and the Netherlands were excluded either because they were not considered to have comparable levels of economic development or there were incomplete data reported to the OECD.

2 These comparisons do not adjust for differences in the age profile of national populations which could affect relative rankings.

Table 1. Public and Private Shares of Total Health Spending; and Total Health Spending as a Percentage of GDP, in 21 Comparable OECD Countries, 2006: Ranked Highest to Lowest by Private Share

Countries	Public expenditure on health % gross domestic product	Private expenditure on health % gross domestic product	Total expenditure on health % gross domestic product	Public expenditure on health % total expenditure on health	Private expenditure on health % total expenditure on health
France	8.9	2.3	11.1	79.7	20.3
Germany	8.1	2.4	10.6	76.9	23.1
Austria	7.7	2.4	10.1	76.2	23.8
Iceland	7.5	1.6	9.1	82.0	18.0
Sweden	7.5	1.7	9.2	81.7	18.3
New Zealand	7.3	2.1	9.3	77.8	22.2
Norway	7.3	1.4	8.7	83.6	16.4
United Kingdom	7.3	1.1	8.4	87.3	12.7
Portugal	7.2	3.0	10.2	70.6	29.4
Canada	7.0	3.0	10	70.4	29.6
United States	7.0	8.3	15.3	45.8	54.2
Italy	6.9	2.0	9.0	77.2	22.8
Switzerland	6.8	4.5	11.3	60.3	39.7
Luxembourg	6.6	0.7	7.3	90.9	9.1
Finland	6.2	2.0	8.2	76.0	24.0
Spain	6.0	2.4	8.4	71.2	28.8
Czech Republic	5.9	0.8	6.8	87.9	12.1
Hungary	5.9	2.4	8.3	70.9	29.1
Ireland	5.9	1.6	7.5	78.3	21.7
Greece	5.6	3.5	9.1	61.6	38.4
Poland	4.3	1.9	6.2	69.9	30.0

Source Data: OECD 2008.
Note: Totals might not sum perfectly due to rounding at one decimal place.

Table 2. Total Health Spending as a Percentage of GDP and Per Capita GDP in 21 OECD Countries, 2006

Countries	Total expenditure on health % gross domestic product	Gross domestic product per capita, US$ purchasing power parity
Luxembourg	7.3	59,176
Norway	8.7	51,947
United States	15.3	43,864
Ireland	7.5	40,893
Switzerland	11.3	38,119
Canada	10	36,814
Iceland	9.1	36,561
Austria	10.1	35,695
Sweden	9.2	34,870
United Kingdom	8.4	32,961
Finland	8.2	32,728
Germany	10.6	31,949
France	11.1	31,048
Spain	8.4	29,383
Italy	9	29,168
Greece	9.1	27,232
New Zealand	9.3	26,234
Czech Republic	6.8	22,042
Portugal	10.2	20,851
Hungary	8.3	18,155
Poland	6.2	14,674

Source Data: OECD 2008.

France has the highest government health expenditure to GDP rank, but is only 1.9 percentage points higher than the percentages of GDP accounted for by government health spending in North America. More importantly, in France, Germany and Austria, government spending on health care is both a larger percentage of total health expenditure and a larger percentage of GDP than it is in Canada. Despite a relatively higher level of government health spending, France, Germany and Austria also have higher total health expenditures as a percentage of GDP than Canada.

So there is not necessarily a link between the percentage of total health spending coming from private sources and the overall level of health spending. There are many factors that determine the total level of spending on health in any country. As examples, these factors include socio-economic and demographic differences between populations in OECD countries, as well as consumer demand preferences regarding quality and quantity of medical resources, treatments and technologies.

The United States and Canada are also among the wealthiest countries among 21 OECD countries for which the most recent data was available (Table 2), so it is not surprising that these North American countries tend to also be among the highest spenders on health care. Wealthy people who have most or all of their basic needs satisfied might prefer to spend the rest of their incomes on extra quantities of medical goods and services, or better quality health care technologies and facilities instead of spending more on other types of consumer goods and services. Generally speaking, preferences for health care versus other goods and services might simply rise with income.

Nevertheless, these aggregate health spending statistics say little about the actual scope and structure of government involvement in the health sector in North America.

The Canadian health system

In Canada government spending on health is about 70 percent of total health expenditures. The remaining 30 percent of total health expenditures are paid for by either private sector health insurance or personal direct spending. However, these figures hide the true nature of government funding for health care in Canada. The fact is that in Canada, government funds virtually 100 percent of all health services defined as "medically necessary" by the state, which usually means all hospital and physician

services. In Canada, the government also accounts for nearly half (48 percent) of all expenditures on prescription medicines in Canada.[3]

There is a qualitative difference in the public-private split to health care funding in Canada versus comparable countries. In most other countries, parallel private sector insurance is available for the same medical goods and services that are also insured by the state. This is not the case in Canada.

The fundamental essence of the Canadian health care system is that the state has a de facto monopoly over the market for medical insurance. Each provincial and territorial government acts as a single-payer within their particular jurisdiction, effectively prohibiting private payment for all health services deemed "medically necessary" by each particular government. In practice this means private sector payment for any hospital or physician service that is funded by government is prohibited. The entire population is eligible for public medical insurance which is funded from general government revenues.

Governments at the provincial and federal level also act as insurance payers for prescription drugs and other health care goods and services for specific sub-populations like seniors, low income people, aboriginals and the military,[4] but private payment for these things is not prohibited.

The health care sector is funded and regulated such that hospitals operate under incentives similar to what would occur under direct public ownership and health professionals face incentives increasingly similar to those of government employees. The market for prescription medicines is also affected by the scale and design of public drug programs and government health insurance, as well as by other direct interventions by the state in the form of price controls and marketing approvals.

The proportion of the health care market that is occupied by government because of this policy environment represents a large percentage of total

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3 In Canada in 2007, private expenditure on prescription drugs was Cdn $11.7b; government spending on prescription drugs was Cdn $10.8b; therefore total spending on prescription drugs was Cdn $22.5b (CIHI 2008).

4 The province of BC's public drug benefit program is a universal system with a deductible. Expenses above the deductible are defined as "catastrophic" financial costs and are publicly insurable. This structure is different from Medicare's first dollar coverage for hospital and physician services.

health spending in Canada. In 2006, public sector spending on hospitals and other institutions (including capital expenditures), physicians and the direct administrative expenses of running government health insurance accounted for approximately 52 percent of total health spending in Canada (Table 3). The rest of health spending is accounted for by government funding for "public health" (e.g. infectious disease control) and "other" areas (10.8 percent) which can arguably be classified as natural public goods and which are not contested by private sector insurers; as well as goods and services for which there is a mix of public and private funding (37.1 percent).

Yet the available evidence, suggests that this particular structure of Canadian health policy is not performing optimally from the public interest perspective of patients and taxpayers. To start, Canadians spend a lot on health care relative to comparable countries. Yet this high relative level of spending does not buy Canadians as many health care resources as patients in other countries enjoy (Esmail & Walker 2007a). Shortages of medical resources, as well as improper economic incentives within the Canadian health system have resulted in growing waits for access to publicly funded medically necessary goods and services (Esmail & Walker 2007b). The available evidence indicates that these wait times are longer in Canada than in almost all other comparable countries. Not only has our high level of spending not produced better access to health care, government health spending has also been growing at rates that are faster than our ability to pay for it through public means alone (Skinner & Rovere 2007). This has resulted in health care consuming ever greater shares of the revenue available to governments, leaving proportionally less available for other public responsibilities and obligations.

The Canadian state has reacted to the growth of government health spending by using its *de facto* monopoly over medical insurance to restrict access to publicly funded health care. Examples include ending public coverage of previously insured goods and services and refusing coverage for new drugs and medical technologies; inadequate capital investment in the stock of medical equipment; forced reductions of hospital capacity and the capital deterioration of existing facilities; and state-imposed reductions in the effective supply of health professionals. All of this has coincided with increasing waits for hospital and physician services and for new medicines. A summary (see Skinner, Rovere & Warrington 2008) of some of the more well known failures of the Canadian health system are shown below:

Table 3. Percentage of Health Care Market Monopolized by Governments in Canada, 2006

	Health Spending Monopolized by the Government as a Result of Universal Eligibility for Public Health Insurance						Health Spending that is a Natural Public Good				Mixed Public and Private Health Spending (all)
	Hospitals	Other Insti-tutions	Capital	Physi-cians	Admini-stration	Total	Public Health	Other Health Spending	Total	Drugs/ Other Profes-sionals	
Millions Current Cdn $	40,096.5	10,036.0	4,905.1	19,160.6	2,834.5	**77,032.7**	8,564.7	7,457.9	**16,022.6**	54,958.8	**148,014.1**
Percentage of Total Health Spending	27.1%	6.8%	3.3%	12.9%	1.9%	**52.0%**	5.8%	5.0%	**10.8%**	37.1%	**100.0%**

Source: Data from CIHI (2007a; 2007b); Calculations and presentation by author.

- In 2007 an estimated 1.7 million Canadians were unable to find a regular family physician.
- In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2007, wait times had almost doubled to 18.3 weeks.
- Median wait times in Canada are almost double the wait that physicians consider clinically reasonable.
- In 2005, a Statistics Canada survey showed that, of the patients who finally did get access to health-care services within the year, 11% waited longer than three months to see a specialist; 17% waited longer than three months to get necessary non-emergency surgery; and 12% waited longer than three months to get necessary diagnostic tests.
- Public drug programs in Canada often refuse to cover many new drugs at all. When new drugs are covered by public drug programs, patients that are dependent on these programs have to wait on average up to one year longer than privately insured patients to gain access to them.
- Between the fiscal years 1997/98 and 2006/07, on average across all 10 Canadian provinces, government spending on health care grew at a rate of 7.3% annually, compared to 5.9% for total available provincial revenue, and 5.6% for provincial economic growth (GDP). This means that in Canada government spending on health care is growing faster than the ability of the government to pay for it.
- Not accounting for the increased cost burden of the aging population, it is estimated that in six out of the 10 Canadian provinces public health spending is on pace to consume more than half of total revenue from all sources by the year 2035.
- As of 2004, the unfunded liabilities of future government funding obligations for health care in Canada reached CDN$364 billion (296 billion US PPP $) or 28% of the country's 2004 total economic output (GDP) of CDN$1.2 trillion (1 trillion US PPP $). Unfunded liabilities for healthcare continue to increase steadily, rising 20.7% between the years 2000 and 2004.
- In June of 2005, the Supreme Court of Canada struck down the province of Quebec's single-payer health-insurance monopoly, ruling that long waiting times violate individuals' right to preserve their own health. In two other provinces, patients are challenging Canada's government monopoly on health insurance in court on constitutional grounds.

It is not unreasonable to argue that these outcomes represent the failure of the Canadian health system, but these failures are not a result of too much private sector involvement in Canadian health care. These health system failures are a result of Canada's single-payer government-run health insurance monopoly over hospital and physician services, and its dominance of over half the market for sales of prescription medicines.

Canadian health policy is also characterized by glaring double standards and contradictions. For example, 6 out of 10 provinces ban private insurance for core medical services like hospitals and physicians. Yet at the same time all provinces allow private health insurance to cover important medical goods and services like prescription drugs and dental care. The Canada Health Act (CHA) bans user fees and extra billing for publicly insured medical services. Yet Canadian governments charge user fees and deductibles to recipients of public drug insurance programs (covering about one-third of the population) and also use a form of extra billing through reference based reimbursement under public drug programs. And the CHA explicitly exempts workers' safety and insurance boards from the ban on private payment for core health services. This allows worker's compensation patients to jump the public queue in provincial Medicare programs—and pay prices set by market forces. Yet at the same time governments refuse to allow the general public to pay privately for faster or better service than Medicare can deliver.

The American health care system

One primary criticism of the US health system is the large numbers of people who have don't have formal health insurance coverage. However, as with Canada, the problems with US health care have much to do with government intervention in health care markets.

For example, the US tax code distorts the health insurance market by giving tax preference to health insurance paid for by employers. The effect of this policy is that when people change jobs in the US they often temporarily lose health insurance benefits. The self-employed also pay an effectively higher price for insurance because they must buy it from after-tax income. This discourages them from buying it. These two groups of people explain a large percentage of the population without health insurance in the US (Mays & Brenner 2004; BCBS 2005).

According to the US Census Bureau's Current Population Survey (CPS) 47 million Americans lacked health insurance in 2006 (US Census Bureau 2007). However, estimating the number of people without health insurance in the United States is the subject of much debate. Because of the way in which the US Census Bureau collects data on the issue, the government's survey questionnaires cannot be relied upon to reflect reality accurately.

Table 4 illustrates the problems with the CPS: It shows the numbers for the estimated US population in each of the survey categories for health insurance coverage. Note that the total number of people with private health insurance, government health insurance, plus those without health insurance exceeds the Census Bureau's estimate for the entire population of the United States—an obvious impossibility. The number of responses to the CPS questionnaire is inaccurate by a margin of at least 32 million people.

An accurate estimate must take account of the particular characteristics of the survey population, including (BCBS 2005):

- people who are temporarily uninsured only for a short period because they are between jobs and have for the time being lost employer-based health insurance; or who are students transitioning between family, school and work coverage;
- people who are eligible for public health-insurance programs like Medicaid and SCHIP programs for children but who are reluctant to enrol until the moment they require health care services;
- people who have sufficient income to buy health insurance but choose not to;
- people who are uninsured for long periods of time because they lack employer-based insurance or the income to buy health insurance themselves

Researchers who have looked at the inaccuracies in the CPS survey have estimated that the actual number of uninsured is about half of the figure reported by the US Census Bureau and that being uninsured is usually only a temporary condition (Herrick 2006; Graham 2006).

Of course this is not to deny that there are probably significant numbers of people who need, but cannot afford, health insurance coverage in the United States. But again, the overall magnitude of coverage problems in the US is made much worse as a result of government interference in the health sector. For instance, US federal and state governments heavily over-regulate and improperly regulate health insurance markets. And as shown earlier,

Table 4. Inaccuracies in the 2006 US Current Population Survey Questionnaire on Health-Insurance Coverage among Americans

Survey response	Estimated population
Had private health insurance	201,690,000
Had government health insurance	80,270,000
No insurance coverage during the year[1]	46,995,000
Total of above	328,955,000
Total CPS US Population	296,824,000
Estimated magnitude of inaccuracy	32,131,000

[1]The figures reported by the US Census Bureau for the year 2006 indicate values that are potentially flawed. The report notes that the CPS (Current Population Survey) estimates reflect point-in-time coverage rather than the number of people uninsured for the entire year.

Source: US Census Bureau 2007.

nearly half of all health spending in the US is publicly funded. Opponents of economically liberal health policies typically fail to disclose the whole story about health care in the US which is, that government is a major part of the problem with cost and coverage issues for health insurance observed in America.

Additionally, lacking health insurance is not the same thing as not having access to health care. The uninsured in the United States are not prohibited from obtaining health care through direct payment, and in all American states it is illegal for hospitals to refuse urgent life-saving care. In other words, being uninsured in the United States is not an absolute barrier to getting necessary medical care.

Nevertheless, there is a very real political risk that if American policy-makers do not address the demands for universal coverage soon, some American state could end up making the same mistakes Canada made by imposing a single-payer health system.[5]

5 California has recently come close to making this potentially disastrous legislative decision.

In fact, a direct comparison of the Canadian system to the US system is a useful way to illustrate the relative failure of the Canadian approach and bust some of the myths of success attributed to government involvement in health care. The following are some comparative statistics (excerpted from Skinner, Rovere & Warrington 2008) on health care resources using the most recent available data:

- In 2006, Canada had 2.1 practicing physicians per 1000 population, compared to 2.4 in the United States –equivalent to 300 fewer doctors per 1 million residents.
- In 2006, Canada had 8.8 practicing nurses per 1000 population, compared to 10.5 in the United States –equivalent to 1,700 fewer nurses per 1 million residents.
- In 2004, 45 in-patient surgical procedures per 1000 population were performed in Canada, compared to 90 in the United States.
- In 2006, the supply of MRI diagnostic machines in Canada was 6.2 per million population, compared to 26.5 per million population in the United States.
- In 2006, the supply of CT Scanners in Canada was 12.0 per million population, compared to 33.9 million in the United States.
- In 2004, 25.5 MRI exams per 1000 population were performed in Canada, compared to 83.2 in the United States.
- In 2004, 87.3 CT exams per 1000 population were performed in Canada, compared to 172.5 in the United States.
- In 2003, the average hospital in Ontario (Canada's largest province) was 40 years old; the average hospital in the United States was 9 years old.
- After adjusting for the purchasing power of the currencies, in 2005 Canadian physicians earned only 40% as much as their American counterparts on average. In the same year, Canadian nurses earned only 71% as much as American nurses on average.
- Thousands of Canadian-trained and previously active physicians have already left Canada for better opportunities and working conditions in the United States. American doctors, however, are not moving to Canada for better opportunities or working conditions.

Policy alternatives

So, how can North America and the rest of the OECD achieve universal health insurance coverage without suffering the enormous costs and failures associated with a single-payer, health-insurance monopoly like that in Canada?

It is absolutely crucial for the reader to understand, that achieving universal health-insurance coverage does NOT require a publicly-funded, government-run, single-payer health-insurance monopoly. It is worth repeating that a single-payer health insurance system is actually the worst way to achieve universal coverage.

The Canadian experience is instructive of the fact that universal, tax-funded, health insurance is not even necessary. Research (Skinner 2005) using Canadian data on the individual-level distribution of illness and income in the population indicates that:

- Only about 4% of the population has health expenses that can be considered catastrophic (even when generously defined) compared to other kinds of expenses; and
- Less than 1% of the population has catastrophic health expenses (even when generously defined) *and* also lacks the income to pay directly or buy private insurance for their health care needs if it were available.

Even though so few Canadians actually need public financial assistance in paying their medical expenses, the Canadian system publicly subsidizes all medical expenses on a universal basis. The politicization of eligibility and coverage decisions under a tax-funded universal, single-payer health-insurance monopoly creates pressures upon policy makers to agree to first-dollar coverage for everything. However, taxpayers should not be paying the cost of affordable medical care for the nearly 99% of the population who do not need a public subsidy. A more rational approach would be to provide public financial assistance only for those few people who are truly in need, by supplementing their incomes on the basis of an income and assets means test so they can afford to buy private health insurance.

If, however, universal health-insurance coverage is considered politically necessary, then the least intrusive approach is to require the population to privately and individually purchase mandatory basic health insurance in a

regulated, competitive market, and directly subsidize those who are too poor to pay for it on their own.[6]

This is the fairest way to impose a government guarantee of universal health insurance coverage for those who need it. It is simply better to require everyone to prioritize the allocation of their *own* income toward the purchase of their *own* health insurance before obligating taxpayers to subsidize anyone else's health care. Taxpayers should have some reasonable assurance that the recipients of public subsidies are truly unable to afford health insurance, and are not simply spending their disposable income on unnecessary items and later demanding free health care from the government if they become ill.

This is similar to the way health insurance works in Switzerland, where individuals are required by law to purchase private health-insurance policies for which the premiums are "community rated," that is, the same for each person in a particular region or municipality taking out insurance with a particular company or non-profit organization, regardless of individual risk rating. People are guaranteed a free choice of insurance provider and can change their compulsory health-insurance provider up to twice a year. Insurance providers are not allowed to refuse an individual's application for a compulsory health-insurance policy, and high-risk insurers are cross-subsidized by the entire insurance sector acting as a single cooperative risk pool through a government-controlled mechanism. The insurance providers compete based on the level of the premium, and price competition works. To reduce the social impact of premium costs on low-income people, taxpayers partially subsidize compulsory health-insurance premiums

6 This is not a radical departure from other types of insurance regulation in the United States and Canada. In most states and provinces, motorists are already familiar with legislated, compulsory purchase of auto insurance. Scandlen 2006 and Graham 2007 have both rejected health insurance mandates, arguing that a percentage of drivers ignore such mandates for auto insurance. However, health-insurance mandates could be enforced through the income-tax return system on a means-tested basis, something not done with auto insurance mandates. There could also be exemptions from the mandate for those who can demonstrate financial capacity instead of insurance\emdash similar to auto insurance in many states. Finally, the important practical point is that, once a person refuses to obey the mandate, they have revealed their preference and have thus surrendered any moral claim on the state to provide them with health insurance. Therefore, even if a mandate did not actually achieve universal coverage, it would eliminate the real need for it. The mandate would also de-legitimize any political demands for a single-payer system.

through a means-tested subsidy that varies according to the income and assets of the insured person (Federal Office of Public Health 2007).

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