Socialized Medicine: The Canadian Experience

by Pierre Lemieux

The Canadian public health system is often put forward as an ideal for Americans to emulate. It provides all Canadians with free basic health care: free doctors visits, free hospital ward care, free surgery, free drugs and medicine while in the hospital—plus some free dental care for children as well as free prescription drugs and other services for the over-65 and welfare recipients. You just show your plastic medicare card and you never see a medical bill.

This extensive national health system was begun in the late 1950s with a system of publicly funded hospital insurance, and completed in the late 1960s and early 1970s when comprehensive health insurance was put into place. The federal government finances about 40 percent of the costs, provided the provinces set up a system satisfying federal norms. All provincial systems thus are very similar, and the Quebec case which we will examine is fairly typical.

One immediate problem with public health care is with the funding. Those usually attracted to such a "free" system are the poor and the sick—those least able to pay. A political solution is to force everybody to enroll in the system, which amounts to redistributing income towards participants with higher health risks or lower income. This is why the Canadian system is universal and compulsory.

Even if participation is compulsory in the sense that everyone has to pay a health insurance premium (through general or specific taxes), some individuals are willing to pay a second time to purchase private insurance and obtain private care. If you want to avoid this double system, you do as in Canada: you legislate a monopoly for the public health insurance system.

This means that although complementary insurance (providing private or semi-private hospital rooms, ambulance services, etc.) is available on the market, sale of private insurance covering the basic insured services is forbidden by law. Even if a Canadian wants to purchase basic private insurance besides the public coverage, he cannot find a private company legally allowed to satisfy his demand.

In this respect, the Canadian system is more socialized than in many other countries. In the United Kingdom, for instance, one can buy private health insurance even if government insurance is compulsory.

In Canada, then, health care is basically a socialized industry. In the Province of Quebec, 79 percent of health expenditures are public. Private health expenditures go mainly for medicines, private or semi-private hospital rooms, and dental services. The question is: how does such a system perform?

The Costs of Free Care

The first thing to realize is that free public medicine isn't really free. What the consumer doesn't pay, the taxpayer does, and with a vengeance. Public health expenditures in Quebec amount to 29 percent of the provincial government budget. One-fifth of the revenues comes from a wage tax of 3.22 percent charged to

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employers and the rest comes from general taxes at the provincial and federal levels. It costs $1,200 per year in taxes for each Quebec citizen to have access to the public health system. This means that the average two-child family pays close to $5,000 per year in public health insurance. This is much more expensive than the most comprehensive private health insurance plan.

Although participating doctors may not charge more than the rates reimbursed directly to them by the government, theoretically they may opt out of the system. But because private insurance for basic medical needs isn't available, there are few customers, and less than one percent of Quebec doctors work outside the public health system. The drafting of virtually all doctors into the public system is the first major consequence of legally forbidding private insurers from competing with public health insurance.

The second consequence is that a real private hospital industry cannot develop. Without insurance coverage, hospital care costs too much for most people. In Quebec, there is only one private for-profit hospital (an old survivor from the time when the government would issue a permit to that kind of institution), but it has to work within the public health insurance system and with government-allocated budgets.

The monopoly of basic health insurance has led to a single, homogeneous public system of health care delivery. In such a public monopoly, bureaucratic uniformity and lack of entrepreneurship add to the costs. The system is slow to adjust to changing demands and new technologies. For instance, day clinics and home care are underdeveloped as there exist basically only two types of general hospitals: the nonprofit local hospital and the university hospital.

When Prices Are Zero

Aside from the problems inherent in all monopolies, the fact that health services are free leads to familiar economic consequences. Basic economics tells us that if a commodity is offered at zero price, demand will increase, supply will drop, and a shortage will develop.

During the first four years of hospitalization insurance in Quebec, government expenditures on this program doubled. Since the introduction of comprehensive public health insurance in 1970, public expenditures for medical services per capita have grown at an annual rate of 9.4 percent. According to one study, 60 percent of this increase represented a real increase in consumption.[1]

There has been much talk of people abusing the system, such as using hospitals as nursing homes. But then, on what basis can we talk of abusing something that carries no price?

As demand rises and expensive technology is introduced, health costs soar. But with taxes already at a breaking point, government has little recourse but to try to hold down costs. In Quebec, hospitals have been facing budget cuts both in operating expenses and in capital expenditures. Hospital equipment is often outdated, and the number of general hospital beds dropped by 21 percent from 1972 to 1980.

Since labor is the main component of health costs, incomes of health workers and professionals have been brought under tight government controls. In Quebec, professional fees and target incomes are negotiated between doctors' associations and the Department of Health and Social Services. Although in theory most doctors still are independent professionals, the government has put a ceiling on certain categories of income: for instance, any fees earned by a general practitioner in excess of $164,108 (Canadian) a year are reimbursed at a rate of only 25 percent.

Not surprisingly, income controls have had a negative impact on work incentives. From 1972 to 1978, for instance, general practitioners reduced by 11 percent the average time they spent with their patients. In 1977, the first year of the income ceiling, they reduced their average work year by two-and-a-half weeks.[2]

Government controls also have caused misallocations of resources. While doctors are in short supply in remote regions, hospital beds are scarce mainly in urban centers. The government has reacted with more controls: young doctors are penalized if they start their practice in an urban center. And the president of the Professional Corporation of Physicians has proposed drafting young medical school graduates to work in remote regions for a period of time.

Nationalization of the health industry also

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has led to increased centralization and politicization. Work stoppages by nurses and hospital workers have occurred half a dozen times over the last 20 years, and this does not include a few one-day strikes by doctors. Ambulance services and dispatching have been centralized under government control. As this article was being written, ambulance drivers and paramedics were working in jeans, they had covered their vehicles with protest stickers, and they were dangerously disrupting operations. The reason: they want the government to finish nationalizing what remains under private control in their industry.

When possible, doctors and nurses have voted with their feet. A personal anecdote will illustrate this. When my youngest son was born in California in 1978, the obstetrician was from Ontario and the nurse came from Saskatchewan. The only American-born in the delivery room was the baby.

When prices are zero, demand exceeds supply, and queues form. For many Canadians, hospital emergency rooms have become their primary doctor—as is the case with Medicaid patients in the United States. Patients lie in temporary beds in emergency rooms, sometimes for days. At Sainte-Justine Hospital, a major Montreal pediatric hospital, children often wait many hours before they can see a doctor. Surgery candidates face long waiting lists—it can take six months to have a cataract removed. Heart surgeons report patients dying while on their waiting lists. But then, it's free.

Or is it? The busy executive, housewife, or laborer has more productive things to do besides waiting in a hospital queue. For these people, waiting time carries a much higher cost than it does to the unemployed single person. So, if public health insurance reduces the costs of health services for some of the poor, it increases the costs for many other people. It discriminates against the productive.

The most visible consequence of socialized medicine in Canada is in the poor quality of services. Health care has become more and more impersonal. Patients often feel they are on an assembly line. Doctors and hospitals already have more patients than they can handle and no financial incentive to provide good service. Their customers are not the ones who write the checks anyway.

No wonder, then, that medicine in Quebec consumes only 9 percent of gross domestic product (7 percent if we consider only public expenditures) compared to some 11 percent in the United States. This does not indicate that health services are delivered efficiently at low cost. It reflects the fact that prices and remunerations in this industry are arbitrarily fixed, that services are rationed, and that individuals are forbidden to spend their medical-care dollars as they wish.

Is It Just?

Supporters of public health insurance reply that for all its inefficiencies, their system at least is more just. But even this isn't true.

Their conception of justice is based on the idea that certain goods like health (and education? and food? where do you stop?) should be

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made available to all through coercive redistribution by the state. If, on the contrary, we define justice in terms of liberty, then justice forbids coercing some (taxpayers, doctors, and nurses) into providing health services to others. Providing voluntarily for your neighbor in need may be morally good. Forcing your neighbor to help you is morally wrong.

Even if access to health services is a desirable objective, it is by no means clear that a socialized system is the answer. Without market rationing, queues form. There are ways to jump the queue, but they are not equally available to everyone.

In Quebec, you can be relatively sure not to wait six hours with your sick child in an emergency room if you know how to talk to the hospital director, or if one of your old classmates is a doctor, or if your children attend the same exclusive private school as your pediatrician's children. You may get good services if you deal with a medical clinic in the business district. And, of course, you will get excellent services if you fly to the Mayo Clinic in Minnesota or to some private hospital in Europe. The point is that these ways to jump the queue are pretty expensive for the typical lower-middle-class housewife, not to talk of the poor.

An Enquiry Commission on Health and Social Services submitted a thick report in December 1987, after having met for 30 months and spent many millions of dollars. It complains that "important gaps persist in matters of health and welfare among different groups."[3] Now, isn't this statement quite incredible after two decades of monopolistic socialized health care? Doesn't it show that equalizing conditions is an impossible task, at least when there is some individual liberty left?

One clear effect of a socialized health system is to increase the cost of getting above-average care (while the average is dropping). Some poor people, in fact, may obtain better care under socialized medicine. But many in the middle class will lose. It isn't clear where justice is to be found in such a redistribution.

There are two ways to answer the question: "What is the proper amount of medical care in different cases?" We may let private initiative and voluntary relations provide solutions. Or we may let politics decide. Health care has to be rationed either by the market or by political and bureaucratic processes. The latter are no more just than the former. We often forget that people who have difficulty making money in the market are not necessarily better at jumping queues in a socialized system.

There is no way to supply all medical services to everybody, for the cost would be astronomical. What do you do for a six-year-old Montreal girl with a rare form of leukemia who can be cured only in a Wisconsin hospital at a cost of $350,000—a real case? Paradoxically for a socialized health system, the family had to appeal to public charity, a more and more common occurrence. In the first two months, the family received more than $100,000, including a single anonymous donation of $40,000.

This is only one instance of health services that could have been covered by private health insurance but are being denied by hard-pressed public insurance. And the trend is getting worse. Imagine what will happen as the population ages.

There are private solutions to health costs. Insurance is one. Even in 1964, when insurance mechanisms were much less developed than today, 43 percent of the Quebec population carried private health insurance, and half of them had complete coverage. Today, most Americans not covered by Medicare or Medicaid carry some form of private health insurance. Private charity is another solution, so efficient that it has not been entirely replaced by the Canadian socialized system.

Can Trends Be Changed?

People in Quebec have grown so accustomed to socialized medicine that talks of privatization usually are limited to subcontracting hospital laundry or cafeteria services. The idea of subcontracting hospital management as a whole is deemed radical (although it is done on a limited scale elsewhere in Canada). There have been suggestions of allowing health maintenance organizations (HMO's) in Quebec, but the model would be that of Ontario, where HMO's are totally financed and controlled by the public health insurance system. The government of Quebec has repeatedly come out against for-profit HMO's.

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Socialized medicine has had a telling effect on the public mind. In Quebec, 62 percent of the population now think that people should pay nothing to see a doctor; 82 percent want hospital care to remain free. People have come to believe that it is normal for the state to take care of their health.

Opponents of private health care do not necessarily quarrel with the efficiency of competition and private enterprise. They morally oppose the idea that some individuals may use money to purchase better health care. They prefer that everybody has less, provided it is equal. *The Gazette*, one of Montreal's English-speaking newspapers, ran an editorial arguing that gearing the quality of health care to the ability to pay "is morally and socially unacceptable."[4]

The idea that health care should be equally distributed is part of a wider egalitarian culture. Health is seen as one of the goods of life that need to be socialized. The Quebec Enquiry Commission on Health and Social Services was quite clear on this:

> The Commission believes that the reduction of these inequalities and more generally the achievement of fairness in the fields of health and welfare must be one of the first goals of the system and direct all its interventions. It is clear that the health and social services system is not the only one concerned. This concern applies as strongly to labor, the environment, education and income security.[5]

A Few Lessons

Several lessons can be drawn from the Canadian experience with socialized medicine.

First of all, socialized medicine, although of poor quality, is very expensive. Public health expenditures consume close to 7 percent of the Canadian gross domestic product, and account for much of the difference between the levels of public expenditure in Canada (47 percent of gross domestic product) and in the U.S. (37 percent of gross domestic product). So if you do not want a large public sector, do not nationalize health.

A second lesson is the danger of political compromise. One social policy tends to lead to another. Take, for example, the introduction of publicly funded hospital insurance in Canada. It encouraged doctors to send their patients to hospitals because it was cheaper to be treated there. The political solution was to nationalize the rest of the industry. Distortions from one government intervention often lead to more intervention.

A third lesson deals with the impact of egalitarianism. Socialized medicine is both a consequence and a great contributor to the idea that economic conditions should be equalized by coercion. If proponents of public health insurance are not challenged on this ground, they will win this war and many others. Showing that human inequality is both unavoidable and, within the context of equal formal rights, desirable, is a long-run project. But then, as Saint-Exupéry wrote, "Il est vain, si l'on plante un chêne, d'espérer s'abriter bientôt sous son feuillage."[6] □

1. Report of the Enquiry Commission on Health and Social Services, Government of Quebec, 1988, pp. 148, 339.
2. Gérard Bélanger, "Les dépenses de santé par rapport à l'économie du Québec," *Le Médecin du Québec*, December 1981, p. 37.
3. Report of the Enquiry Commission on Health and Social Services, p. 446 (our translation).
4. "No Second Class Patients," editorial of *The Gazette*, May 21, 1988.
5. Report of the Enquiry Commission on Health and Social Services, p. 446 (our translation).
6. "It is a vain hope, when planting an oak tree, to hope to soon take shelter under it."

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The British Way of Withholding Care

by Harry Schwartz

The problems associated with socialized medicine can be symbolized by the fate of two children, David Barber and Matthew Collier, who died in early 1988 in the British city of Birmingham.

Both children needed heart transplants to survive. Their parents became so desperate that they sued Britain's National Health Service to force the NHS to provide the necessary medical care. Their efforts were in vain: Neither child got the operation, and neither child is alive today.

The point is not that those who run socialized healthcare systems would rather see children die than give them the care they need to survive. Rather, the point is that all socialized systems lack one thing: enough money to provide quality medical care and to take full advantage of modern medical technology.

In other words, the propagandists are stretching the truth a long way when they insist that socialized medicine provides a bountiful distribution of all the medical care people could want or need. In reality, medical care is rationed in socialized systems. Managers must decide which patients will be sacrificed because the total amount of care provided is based on the total amount of money available.

J. Enoch Powell, a former British cabinet member who ran the NHS for three years, summed up the situation when he said that the demand for free medical care is infinite and cannot be satisfied by a country's limited resources. David Barber and Matthew Collier are two depressing examples of what can happen when the demand for care outstrips the supply of money.

Britain is not the only country plagued by the pitfalls of socialized medicine. Until recently, the Soviet Union's medical system was praised to the skies by Soviet propaganda and by naive Americans who were taken in by that propaganda.

But now that the current Soviet ruler, Mikhail S. Gorbachev, has called for open and honest discussion of his country's problems, the truth has emerged: Russia's health-care system is—and has long been—a disaster. Basic medicines are in short supply, while equipment to treat serious illnesses such as kidney disease is virtually unavailable.

For instance, the Soviet media have revealed that the country's infant-mortality rate in recent years has been two-and-a-half to three times greater than that of the United States. The death rate for all Soviet citizens actually is rising, and many hospitals lack even basic supplies and equipment. These revelations explain why, for most of the past two decades, the Soviet Union hasn't bothered to report statistics on its infant mortality and death rates.

As more and more of American medicine is socialized through the Medicare program for senior citizens and the Medicaid program for the poor, rationing—the denial of care to save money for the government—is becoming evident here, too.

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