

Big differences matter: Canadian and American health care finance

THE FUNDAMENTAL DIFFERENCES

There are two ideas that distinguish the Canadian health care system from the U.S. system. Like the majority of OECD nations, Canada ensures reasonably comprehensive health insurance for all citizens, regardless of capacity to pay, as a function of citizenship. Through a series of fiscal and administrative levers (and some legal bars), however, Canada remains the *only* jurisdiction in the OECD where there is no way to buy your way to the front of the line for medically necessary medical and hospital services, short of crossing the border into the United States. In spite of all the rhetoric on this, as the Canadian Institute for Health Information has found, recent factual assessment on such migrations suggests that far less than 1 percent of Canadians actually cross the border for health care and the majority are “snowbirds” who are already in the U.S. when their health needs arise. This “solidarity of access” idea fills up much of our public discourse on health reform.

Second, Canadian health policy has embraced—albeit with more rhetoric than substance—the growing evidence on the social and economic determinants of health, and the need to look beyond conventional health care spending for improvements in the health of the nation’s population. We refer to this as the “social production of health idea.” This embrace includes a long tradition of “official” federal and provincial reports supporting action on the social determinants, as well as a strong scholarly tradition reinforced most recently through the work of the Population Health and Human Development Programs of the Canadian Institute for Advanced Research (CIAR). Both of these ideas face serious chal-

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lenge in the marketized *regime discourse* of health services consumption ideas that dominates in the United States.

INCOME INEQUALITY AND HEALTH

Much of the current fracas surrounding private clinics in Alberta is about the solidarity of access issue and how this idea may be threatened by for-profit medicine. The more interesting problem, in my view, is how to sustain the methods by which we finance (not deliver) health care services in Canada.

One area associated with the social production of health that has attracted

quite a lot of heat and, at least, a little light has been the relationship between income *dispersion*—that is, degree of income inequality and health. Richard Wilkinson caught the attention of the policy community by arguing that Britain could add two years to its overall life expectancy if it were to adopt a more egalitarian income redistribution policy.

The relationship between income inequality and health status in advanced economies has moved from one of controversy and conflict to one of exciting empirical and theoretical work. Much of this originates in the United Kingdom, thanks to the efforts of Wilkinson and his colleagues. Recent work in the United States has replicated and refined the measurement issues, especially which measures of income inequality appear optimal for exploring the links. In this regard, a recent study published in the *British Medical Journal* highlights some comparative work being carried out by a group of Canadian and American researchers looking at income disparities and health in Canada and the United States, supported through the Canadian Population Health Initiative.

Nancy Ross, Michael Wolfson, and colleagues carefully examined the relationships between household income inequality (measured at the census metropolitan level) and mortality in Canada and the United States. They found that Canadian provinces and census areas generally had less income inequality and better mortality rates than U.S. states and census metropolitan areas. When age was considered, the relationship between income inequality and mortality was most pronounced for the working-age populations where a 1 percent increase in the share of income to the poorer half of households resulted in a decline of 21 deaths per 100,000. In

fact, within Canada, income inequality and mortality were not associated, either at provincial or metropolitan area levels.

One can easily see from the figure on this page, “Working-age (25-64) mortality by median share, U.S. and Canadian metropolitan areas,” that the slope of the gradient in proportion of income received by the less well off 50 percent of the population is far steeper in the United States than in Canada.

This raises questions about the social arrangements and material conditions between the two countries that buffer (Canada) or exacerbate (United States) the relationship between inequality and mortality.

The authors from both countries suggested two complementary explanations for these findings. First, economic segregation in large U.S. cities creates a mismatch between workers’ housing and job locations, and also creates inequalities in locally financed public goods and services like schools, policing, recreation, etc., by pooling individuals with high social needs in municipal areas with poorer tax bases. Second, health care and high-quality education are more sensitive to the marketplace and ability to pay in the United States. By contrast, in Canada, they are publicly funded and universally available. Public and social infrastructure in the United States is more market sensitive (based on the ability to pay) than in Canada. This fact may go some way to explain the selective income disparity/mortality relationships between our two countries.

DISTRIBUTIONAL IMPACTS

One of the most significant features of the Canadian health care system has been the distributive consequence of health care financing and health use. Cameron Mustard and colleagues calculated estimates of the incidence of household tax payments and the use of public insured health care services. Using a cross-sectional analysis of Manitoba households, Mustard and colleagues linked insured hospital serv-

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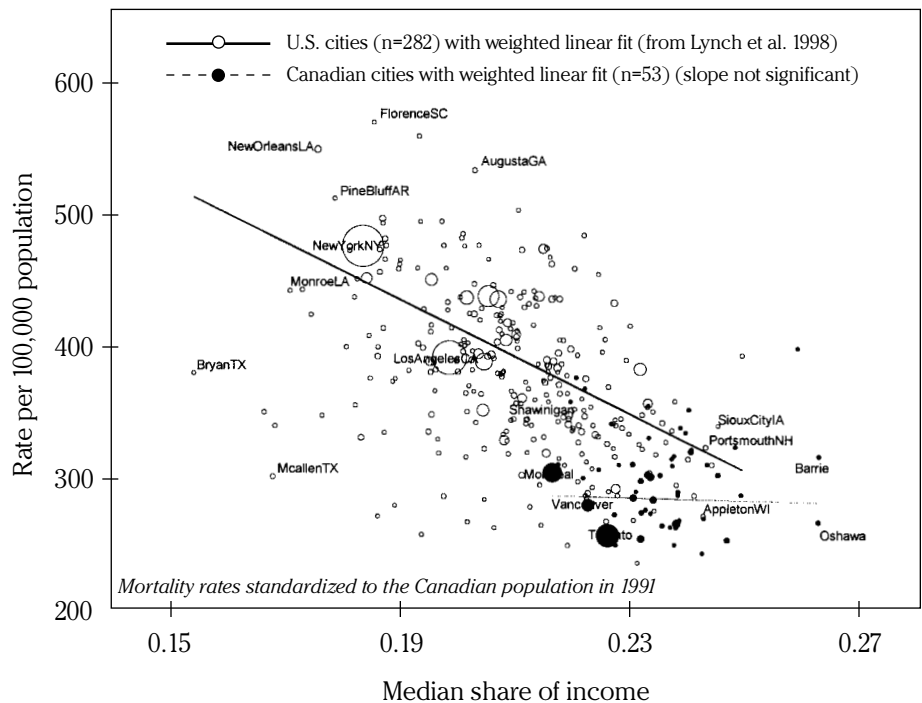
ices, long-term care, and medical services with 1986 census records at the individual level for 16,627 Manitoba households (representing about 5 percent of the Manitoba population).

In 1986, 42.4 percent of the public portion of health expenditures was generated by tax revenues from the top income quintiles and 6.4 percent from the bottom income quintiles. By contrast, health care services were distributed in an inverse fashion: 11.7 percent of

health care service expenditures were received from the top income quintiles and 24.6 percent from the bottom income quintiles. The progressive redistributive effects of health care financing and benefits in Canada are significant. This work stands in stark contrast to the regressive effects of private insurance and out-of-pocket payments in the United States and Switzerland—the two

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Working-age (25-26) mortality by median share, U.S. and Canadian metropolitan areas



“Working Age Mortality by Proportion of Income Belonging to the Less Well Off Half of Households, U.S. (1990) and Canadian Metropolitan Areas (1991).” From N. Ross, M. Wolfson, J. Dunn, J.-M. Berthelot, G. Kaplan, J. Lynch, “Income Inequality and Mortality in Canada and the United States: A Cross-Sectional Assessment Using Census Data and Vital Statistics” (2000), 320 *British Medical Journal* 898-902.

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organizations to address this situation. Convinced that cultural diversity, like biodiversity, must be maintained and seeking partners in the face of strong American opposition, Minister of Canadian Heritage Sheila Copps has fostered the development of a government organization to make the case for

sustaining cultural sovereignty in the face of economic liberalization. At the same time, the Canadian Conference of the Arts has assumed a leadership role in developing an international network of cultural NGOs to promote cultural diversity and to develop an agreement designed to remove culture from

the discipline of international trade agreements.

What is really at stake in this discussion is whether, in an increasingly integrated economic environment, a sovereign nation is able to create, produce, and disseminate arts and cultural products that reflect its own experience. ❁

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OECD countries with predominantly private financing mechanisms.

While there continues to be much hopeful (some would say fanciful) talk in the Canadian reform debate on “influencing” the social and economic determinants of health, it may be that national, provincial, and local tax structures, and their consequences on health care use, constitute the invisible hand that buffers the effects of income inequality on the health status of Canadians. One of the main “influencers” on the health status of Canadians and health inequalities in Canada may well be progressive tax and equalizing benefit structures of the Canadian state, relative to the United States. Canadian health data show a strong relationship between health status and income, but unlike the United States and Britain, the apparent particular effects of income disparities may be muted at least partially by tax policies and health use benefit incidence that implicitly favour social equity!

MORE MONEY FOR CANADA'S AILING HEALTH CARE SYSTEM

On September 11, Canada's First Ministers' Meeting agreed to invest \$23.4 billion federally over the next five years on health care, with \$2.2 billion of this devoted to early childhood development. This is at once tremendous news and disappointing. The social reinvestment of major transfer dollars is a welcome contrast to the downward fiscal pressure of the early 1990s.

This social reinvestment in transfers, with its progressive distributive conse-

Health data show a strong relationship between health status and income.

quence, is welcome in light of what we are beginning to understand as the health consequences of polarized income shares on the health of populations and how these consequences are felt in Canada and the United States. The agreement may also begin to buffer the panic talk about the fundamentals of the Canadian health care system.

On the other hand, the first ministers' announcement is disappointing for two important reasons. There are no new conditions on the new Canada Health and Social Transfer funds (http://www.scics.gc.ca/cinfo00/80003807_e.html). Why is this a problem?

In the last 15 years, the proportion of health services covered under the mandatory sweep of the *Canada Health Act* has shrunk from something in the order of 57 percent to something in the order of 45 percent of all health services. This shrinking base of coverage has occurred in part because of passive privatization—the shifting of costs for pharmaceuticals and care from hospitals where they are virtually completely publicly financed to community and home care where the base of public coverage has a threefold variation from one province to the next.

National health reform in Canada requires the extension of insured coverage under the *Canada Health Act*, if

only to keep up a reasonably comprehensive base of public coverage. Although there is a political imperative, nothing in the first ministers' agreement compels any extension of coverage in the form of a national standard.

The government of Canada has at once bought political silence in a pre-election period and shrewdly reinvested in a progressively distributed social benefit. These moves will not only ease the panic in our delivery system, but may well help to sustain the health of our population because of the salutary health effects of this progressive social transfer.

This is in stark contrast to the United States, where the main “big ideas” being considered by Congress are the expansion of medical savings accounts and tax credits. Both of these measures will send people into the marketplace of insurance, where carriers still weed out those with health problems. If they do offer policies to sick people, the cost of such policies effectively shut them (and the poor) out of the market.

As Larry Levitt from the Kaiser Family Foundations says of these U.S. developments: “It's potentially a cruel hoax to give people something and then there's nothing to buy.” These are not small differences between our two countries. ❁