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Trade-Offs: Pros and Cons of Being a Doctor and Patient in Canada

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We will begin with a modest question.

What are you willing to sacrifice for sustainable universal health insurance coverage?[1] Higher taxes? What about losing rapid access to non-emergency endoscopy, MRI, and subspecialist consultation? What about having your mother wait 6 months for her hip replacement (40% of procedures in British Columbia and 13% in Alberta exceeded this threshold in 2015)?[2] Or having your father-in-law spend 24 h waiting in an emergency department corridor for an inpatient bed to become available upstairs, only to be moved to an overflow cot in a bustling ward hallway for his 3-day hospital stay?

These downsides are real, and we (a US citizen now living in Canada [PC] and two lifelong Canadians [ID and JLK]) feel them when we pay higher taxes, wait for care for our loved ones, and face delays in providing care to our patients. But the upsides are also real and, from our perspective, worth the sacrifices.

The upsides include fewer billing requirements (despite using ICD-10), because we have a single payer and reduced clinical documentation requirements. We don't have the angst of wondering if our patients or family members will lose their health insurance if they lose their job or develop a chronic illness. And while income taxes are high in Canada—approximately 50% for the highest earners—provincial health plans have no deductibles for physician and hospital care, though public coverage for outpatient medications is patchy. Interestingly, Tommy Douglas, generally considered the father of Canadian universal healthcare, says that the absence of even a nominal co-payment model could weaken the public's appreciation of the true value of universal healthcare.[3] But an absence of cost sharing does have some benefits, particularly for patients with lower incomes or multiple chronic conditions, where even modest copays can become barriers to care.[4]

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We all know the numbers. The United States spends about $1.00 on healthcare for every $0.60 spent by other developed countries with roughly similar per capita income (Canada, United Kingdom, Germany).[5] The 67% additional spending in the US is often is portrayed simplistically as waste: excess testing and procedures, administrative costs for unnecessary bureaucracy, and profiteering by hospital and insurance industry executives.

This is not entirely true. The extra spending buys some good stuff: for example, more sophisticated electronic health records (EHRs) and timelier access to stem cell transplants.[6,7]

But…Americans do not get 67% better health, or even 67% better healthcare. Americans do not live longer and do not score higher on other measures of well-being than Canadians, Britons, or Germans.[8]

Phrased differently, the publicly funded Canadian system has some major advantages over the patchwork of public and private insurance in the US. However, we in Canada also have some significant problems, as noted by scholars including former University of Toronto President David Naylor, Allan Detsky, and Uwe Reinhardt.[9,10]

In the next few paragraphs we will address some of the nuances of Canadian healthcare using several dimensions of quality chosen by the US Institute of Medicine.[11]

1) Efficiency: In the US, fee-for-service reimbursement simultaneously incentivizes both excess utilization and efficiency. Excessive utilization is encouraged, because each additional admission, clinic visit, or diagnostic test generates additional payments to physicians, with no effective shut-off valve.[12,13] At the same time, innovations like diagnosis-related group (DRG)-based reimbursement for acute care and episode-of-care payments incentivize hospitals to reduce waste, because prolonged hospital stays and excessive testing erode hospital profits. Historically, although the US has been highly efficient on certain measures of "throughput," like hospital length of stay, excess utilization has largely overshadowed efficiency in US healthcare.[14,15]

   In Canada, efficiency in certain areas is excellent, imposed by provincial funding models. Inpatient beds, operating room time, and imaging

availability are rationed and scarce. Physicians are left to prioritize which patients require costly tests and treatments and which do not. Efficiency, as measured by sustainable levels of per capita utilization of procedures, is high. Unfortunately, efficiency as measured by length of stay is impeded by constraints in the availability of imaging tests, endoscopy, and operating room slots. Likewise, provinces limit the supply of post-acute care, so patients often wait in-hospital for long-term care. There is even a Canadian designation for inpatients who remain in the hospital for weeks or even months while acute care hospitals search for suitable long-term-care: "alternative level of care" [ALC] patients (the UK equivalent is "bed blockers").

2) Timely access: Timely access to care in Canada is a significant problem across the country.[16] While international comparisons are fraught with methodological concerns, Canada has fewer physicians and inpatient beds per 1000 population (2.5 and 1.8) than most other OECD [Organisation for Economic Co-operation and Development] countries, including the US (2.6 and 2.7), UK (2.7 and 2.7), and Germany (4.1 and 5.7).[5] Only 37% of Canadians report that they can get an appointment with their primary care physician within 48 h, and data from primary care physicians themselves similarly suggest timely access is not good when compared to other OECD countries.[17,18] Family doctors are the backbone of the Canadian healthcare system, providing virtually all primary care; they also serve as the gatekeepers for accessing specialty care. Many family doctors have very small practices, such that only 48% of family doctors report after-hours coverage for their practice without resorting to the emergency department.[17]

As a result, many Canadians are forced to seek care in overtaxed emergency departments, where wait times can be excessive; crowding has been associated with delays in treatment of conditions ranging from asthma to myocardial infarction.[19] Access is also problematic for patients needing to see specialists ranging from geriatricians to psychiatrists to neurologists, though links between prolonged wait times and worse patient outcomes are quite limited.[20,21] Canadian patients are known to partake in medical tourism to obtain services that cannot be obtained locally,[22,23] though precise estimates of overseas travel are uncertain.[24] It is also important to note that a culture of "workarounds" has developed, whereby most industrious clinicians have ways to assist their patients in getting the care they need. But the system is far more difficult than it needs to be. I (PC) sometimes wonder whether my colleagues or family in the US would accept waits for non-life-threatening care if it were a precondition for universal insurance coverage.

3) Equity: In many ways, our different healthcare systems reflect the different values of our countries. The Canadian system prioritizes community; the US prioritizes competition and autonomy. A limited body of empirical research suggests greater equity and smaller disparities in Canada. For example, new immigrants to Canada have less of a healthcare disadvantage than immigrants to the US.[25] Likewise, there is evidence of improved breast cancer survival for lower-income Canadians compared to Americans,[26] again potentially reflecting the benefits of universal insurance.

4) Patient centered: mIf there were one area where we might fault the Canadian system, it would be patient-centeredness. International comparisons of patient experience are extremely complex, reflecting both random and non-random (i.e., cultural, societal) differences in how certain populations view healthcare delivery.[27] What instruments should we use? How do we account for differences in socioeconomic status, health insurance coverage, or deeply ingrained cultural differences between the two countries?

Nevertheless, structural issues play an important role. In the US, hospitals compete for patients. The undesirable effects of hospital competition in the US are well recognized,[28] but the benefits are too often ignored. Hospitals invest in comfortable birthing suites and welcoming waiting rooms, and train staff to treat patients and families nicely.[29] Hospitals, physicians, and all members of inter-professional teams have a strong incentive to provide both good outcomes and good patient experience.

Contrast this with Canada, where care is generally provided free of charge, but hospitals, as part of the public sector, act more like the postal service, tax collector, or the much-maligned department of motor vehicles than like restaurants or hotels. While there is hope that Canadian healthcare can adopt the best practices of large government-run healthcare systems, including the US Veterans Administration,[30,31] recent scandals and setbacks within the VA are a reminder that the road is not easy, nor success guaranteed. Recognizing the potential benefits of small doses of competition, there are periodic calls for the creation of a parallel private system in Canada to motivate improvements.[32] So far, tangible progress has been negligible, with the exception of modest funding reform efforts in some provinces.[33] Furthermore, there is concern that a two-tier system will undermine the country's commitment to healthcare equity.[32]

In sum, Canada's public healthcare system provides more equitable care, a more robust safety net (particularly for those in the bottom half of the income scale), and a level of comfort for everybody (including many of the wealthy) that illness will

not lead to bankruptcy. At the same time, many persons will pay more taxes, wait longer, and receive less patient-centered care than they are accustomed to.

Tradeoffs we strongly accept, but tradeoffs nonetheless.

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