

Section 6: International Health Care Systems

Opponents of public health care spent many years trying to convince Canadians that we should drop universal medicare and adopt the U.S. private-insurance model. It didn't work. Now, proponents of a two-tier system would have us believe that the "European" model is the solution to all of Canada's health care woes. The truth is their arguments are riddled with misinformation.

Studying the Swedish, French and British health care systems can help us as we look for ways to improve the Canadian health care system, but as these examples also demonstrate, there isn't one "European solution" that can be applied to Canadian health care problems. If the European examples prove anything, it is that publicly administered non-profit health care is the best way to ensure high-quality and timely care for patients.

Note: There are two main types of universal health insurance. A "Beveridgian" system is based on a single-payer public insurer, funded by general taxes, like our system in Canada. A "Bismarckian" system is based on mandatory private insurance, funded by payroll taxes; this system exists in Germany.





6.1 The French system

France is often touted as a model to follow for changes in Canada's health care system. After all, it was the best system in the world, according to the 2000 WHO study (see 5.3). France's system has very short wait times and great access for most procedures, including hip replacements and MRIs. France accomplishes this while spending roughly the same amount per capita as Canada. Proponents of for-profit care say France's health care system is superior because it has a mixed public-private system. They are wrong.

1. France has 50 per cent more physicians per capita than Canada, but pays them about 40 per cent less. Wait times are shorter because there are more (lower-paid) doctors. France also has more acute care beds than Canada, at lower costs.
2. France has no waiting lines for MRIs and CT scans, while having fewer MRI and CT units than Canada, because French physicians are less likely to prescribe unnecessary (and expensive) tests than Canadian physicians.
3. Until 2000, only workers and retirees were covered by public health insurance, paid by employer and employee contributions. The unemployed were not insured, so the system wasn't truly universal. Since 2000, French health care expenditures have been growing much faster than in Canada, which has become a public policy concern.

6.2 The British system

The National Health Service (NHS) is the oldest single-payer model and has its roots in the 1942 Beveridge Report.

The NHS has traditionally been the most frugal health care system in Europe. Most British physicians are paid by the size of their patient roster or by salary rather than by fee-for-service, which partly explains the lower expenditure. But the system has also suffered from lengthy waiting lists since the 1980s, when it was strangled by deep cuts. In 1990, the Thatcher government reformed the NHS to introduce “internal markets.” Instead of actually running hospitals, the government now “purchases” care from hospitals. Doctors, in turn, have become “fund holders,” and they purchase care for their patients. Still, waiting lists have not shortened because of these privatization initiatives. In fact, the two-tier British system gives an incentive to work in the for-profit system, keeping wait times longer in the public system.

What did contribute to the recent decline of wait times in the United Kingdom was the British government’s decision to hire 14,000 doctors and 50,000 nurses between 1997 and 2002. These doctors and nurses work in the public system, and help offset the disparities caused by the private component of the U.K.’s health care program. The U.K. government recently announced it will stop contracting out surgeries to for-profit clinics (see section 5.5).



A stylized, grayscale representation of the Swedish flag, featuring a white cross on a dark background, is positioned on the left side of the page. The flag is partially obscured by a white curved shape that frames the text.

6.3 The Swedish system

Sweden has a single-payer, universal health care system that – like Canada’s health care system – is mainly funded by income taxes. It is managed by 21 regional or county councils.

Much has been said about the Stockholm Model, where county governments still funded health care, but health care providers could be owned by private individuals or companies. As a result, the Stockholm-based St. Göran’s hospital has been privatized and sold to the Capio corporation by the conservative county government. The Swedish government has abandoned the Stockholm Model and only four hospitals now operate privately. In January 2006, new national legislation closed the door to further privatization of public hospitals and sharply limited the room for private enterprise in delivering health care across the country. St. Göran has been lauded as a model of efficiency, but there is mounting suspicion among health policy researchers that this efficiency is accomplished through “cream-skimming,” where the hospital takes patients with less complicated cases, leaving the more complicated ones for the public system.

Concerns about long wait times for elective surgeries led Sweden to establish wait time guarantees in 2005, promising speedy access to the public or private system. It is still too early to tell if lower wait times are obtained at the cost of higher health expenditure as a proportion of GDP.

6.4 The German system

The German health care system has changed little since it was developed in 1883. It is funded mainly through payroll taxes, with the costs split between employers and employees on a 50/50 basis. The money is pooled in “sickness funds,” which are non-profit private or public insurance trusts. No discrimination is allowed and the same premium rates are paid regardless of age or health. Insurance is mandatory for everyone earning up to 46,000 euros (about CAN\$67,500) a year. Opting out is allowed above that level, but only about eight per cent of the German population chooses to do so.

Wait times for elective surgeries remain low in Germany, for two reasons. First, German patients can get in to see a specialist without going through their general practitioner. Second, health care capacity in Germany is greater than in Canada because there are about 50 per cent more physicians and 60 per cent more acute care beds. On the other hand, German specialists earn, on average, about 30 per cent less than Canadian specialists. However, this comes at a cost: the German health care system as a share of GDP is third costliest in the world, and 10 per cent higher than in Canada.



6.5 The Swiss system

Switzerland has the second most costly health care system in the world, after the United States. The Swiss spend \$4,177 U.S. per capita and 11.6 per cent of their GDP on health care. Their system provides quality health care, with very low wait times, and is funded through a system of mandatory insurance. This means health insurance is provided by private companies, not by a single payer like the government.

Swiss law defines the benefits to be provided in basic non-profit insurance, with extra benefits available through for-profit, supplementary insurance. As in the case of Germany, wait times for elective procedures in Switzerland are very low because there are about 75 per cent more physicians and 40 per cent more nurses than in Canada. There are also 24 per cent more acute care beds. The trade-off is a system about 25 per cent more expensive than Canada's.

The Swiss system is also considered the most regressive of all universal health systems. Premiums are fully paid by the individual (not through income or payroll taxes), so large families can be seriously hit by premiums that can reach US\$200 per person per month. Also, the insurance plans carry a mandatory deductible (from \$320 to \$1,600 per year) as well as a mandatory 10 per cent co-insurance, up to a maximum of \$750 a year.

6.6 The New Zealand system

New Zealand had a Canadian-style health care system until it opened it up to the private sector in an attempt to decrease wait times. However, New Zealand's public sector market-oriented reforms of the 1990s failed to achieve their promises. While they had some success in constraining health costs, elective surgery waiting lists have grown rapidly and the government decided that structural change was needed. New Zealand is now in the process of reinvesting in public health care.

On the positive side, New Zealand has also established national standards for access to care. According to the Canada Health Council, non-profit, independent group of Canadian physicians and health care experts:

“New Zealand's policy is comprehensive and specifies how patients should be managed while waiting for any elective or non-urgent health care service ... If a patient's need for treatment does not meet a certain level of urgency, treatment in the public health care system is not assured. The national standard states that patients who meet the urgency threshold for publicly-funded care should receive service within six months, and for those below the threshold, their health status should be reviewed every six months.”



Conclusion

Many factors determine a country's competitiveness. While taxation does play a role, it is no more nor less important than the price of utilities; the cost of housing; the availability and skills of the local labour force; access to markets, customers and suppliers; and even crime rates.

While we often hear about how taxation levels affect a corporation's ability to compete in the global marketplace, we rarely hear about the major advantage Canadian businesses have over their U.S. counterparts because of universal health care. Canadian businesses clearly have the advantage, because most of their employees' medical costs are covered by our universal public health care system. And though many pay for extended coverage for services such as dental care and pharmaceuticals, the costs aren't anywhere close to what U.S. companies must absorb.

Promoters of privatization ignore the fact that not-for-profit clinics and hospitals are cheaper to operate than for-profit institutions. It has been repeatedly well documented that private clinics end up costing governments and patients more. And if Canada continues down the road to privatization, it will cost Canadian businesses a great deal.

We've learned the harsh lessons of privatization from our neighbours to the south. The United States spends nearly twice as much per person on health care as Canada does, and more than 40 million people have no health care whatsoever. For-profit health care provides less coverage to fewer people. It costs more, and results in lower life expectancies and higher infant mortality rates. It removes money from the system and gives it to corporate shareholders. And despite the loud claims of some politicians and private health care lobbyists, for-profit health care will not shorten wait times.

It certainly doesn't help that groups like the Canadian Federation of Independent Businesses have been among the biggest pushers of private medicine. While the big insurance companies may be eager to cash in on Canada's health care market, the vast majority of businesses would suffer under an employer-paid insurance system and for-profit delivery of health services.

Now is the time to stand up for Canada's public health care system, and to work together to develop and implement public, non-profit solutions to wait times.

Profit is not the cure for Canadian health care.



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