Woodrow Wilson International Center for Scholars

THE CANADA INSTITUTE

1 2 One Issue, Two Voices

Health Care in Crisis: The Drive for Health Reform in Canada and the United States

Drawing on expertise from both sides of the Canada-U.S. border, the *One Issue, Two Voices* series is designed to stimulate dialogue on policy issues that are key to understanding the bilateral relationship. This ninth issue is a special expanded edition looking at the Canadian and American health care systems. Authors Antonia Maioni of McGill University's Institute for Health and Social Policy and Theodore Marmor of the Yale University School of Management are leading international health policy experts. Together they provide a comparative perspective on the medical care systems in both countries and outline the disputes over reform.

In the past two decades, the health care systems in Canada and the United States have been scrutinized as either the cure for all ills or the spectre of what not to do in health care reform. Today, significant majorities of Canadians and Americans are demanding reform—universal coverage in the United States and privatization in Canada—but disagreeing on what it should ultimately be. Each author assesses the issues prompting reform and describes the different principles of access and funding between the two medical systems.

Marmor points out that in the 1970s the United States and Canada each spent about 7 percent of GDP on medical care. Thirty-five years later, the United States spends almost 50 percent more than Canada, and patients pay the highest out-of-pocket charges in the world. These costs and the rate of increase are at the core of the coverage problems in the United States.

According to Maioni, the principal challenges to Canada's much-vaunted universal health care system are the fiscal capacity and political will of governments to foot the bills for health care and the increased reliance on private spending in some areas. In theory, health care is available to all on an equal basis but, in practice, up to 5 million Canadians go without consistent care because of the shortage of primary care doctors.

The Canada Institute thanks the authors for their contributions to the understanding of a vital topic in the ongoing bilateral dialogue. We are grateful to the Canada Institute on North American Issues for its support.

Stephanie McLuhan
Program Consultant (Toronto), Canada Institute
April 2008

ISSUE NINE

Theodore R. **Marmor**

American Health Care Policy and Politics: The Promise and Perils of Reform

2007–08: Looking Back, Looking Now

The continuities of American medical politics, despite the surges of reform enthusiasm, are impressive. As the presidential election of 2008 draws closer, all the candidates feel compelled to offer plans for universal health insurance. That was the case in the buildup to the presidential election of 1992, and what followed was the birth and death of the Clinton reform plan. Now, as then, huge majorities of Americans claim they want reform—universal insurance coverage—and disagree about what that would be. Then, as now, interest groups mobilize for battle, trading sound bites and horror stories both attacking and defending particular reforms. At the same time, the more quiet politics in health care continue to unfold off the front page and the evening television news: the moral disputes over abortion, euthanasia, and stem-cell research; the distributive, intense local politics of hospital closures and clinic openings; the Washington and state capital fights in hearing rooms over the rules governing the practices of nurses, chiropractors, and physicians; and the armies of lobbyists struggling to start or stop health insurance reforms in the states. The cost of health insurance—public and private—dominates the surface of discussion, but the distributive realities of who bears those costs continue to bewilder commentators. To understand all these variables in the American medical political agenda, it is essential to shift from the details of medical care to the ordinary categories of policy and political conflict.

The broad history of American medical care from the 1970s to the first decade of the twenty-first century is one of diverse conflicts, turbulent change, and a persistent sense that the vast health expenditures of these decades failed to provide good value for money.[1] Senator Edward Kennedy's 1972 book, *In Critical Condition: The Crisis in America's Health Care*,[2] reflected in its title the atmosphere of urgency at the time. Indeed, this sense of trouble—of seemingly continuous inflation, a complex and fragmented organization of care, and under-insurance and lack of coverage for many millions—was so widespread that Republicans and Democrats, liberals and conservatives, competed over which form of national health insurance to offer in response. The regulations that emerged, however, were bureaucratically dispersed, disconnected from the major public programs financing care and celebrated with visions of eventual success that no reasonable analyst should have accepted. Professional Standards Review Organizations (PSROs), for instance—established by the federal government to monitor quality of care—were relegated in 1972 to a different set of agencies, dominated by physicians and disconnected in practice from the payment systems of Medicare, Medicaid, or private health insurance plans. Medicare and Medicaid, once separate organizationally, were technically joined in an agency known as the Health Care Financing Administration (HCFA). This new organization (now the Center for Medical Services) failed to unify Medicare and Medicaid administrations, much less have an impact on health planning. In all these cases, the political struggles were intense, dominated by groups with financial and professional interests in the policies, and reported in the trade press and professional medical journals. But they all fell short of the national attention that debates over universal health insurance always prompt.

All through the 1970s, commentators complained about the uneven distribution of care and the high rates of inflation in medicine, but few fundamental changes were made.

The Nixon administration tried wage and price controls, but gave up on them. The Carter administration supported legislation to contain hospital costs, but was defeated by opposition from hospitals and general skepticism that the federal government could accomplish what it promised. Inflation continued unabated amid naïve rhetoric about a "voluntary effort" to control costs by the health industry. Looking back from the perspective of 2008 to this earlier flurry of proposals and stalemate over universal, government-financed health insurance, it all seems very long ago.[3]

In the 1980s the picture was different, politically, economically, and intellectually. Few prominent figures promoted government-financed universal health insurance, either for the nation or for a particular state. The deficits of the Reagan and Bush years continued to dominate political discourse, and reformers turned first to bureaucratic realignments as a means to rationalize medical care provision and then to financing through such policies as diagnostic-related group payments to hospitals (DRGs). When those strategies failed, many reformers looked to competition and privatization as their panacea, appealing both to the ideology of market competition and to the grief caused by the persistent relative inflation in the costs of health care.

The earlier attention to national health insurance gave way to a wide variety of other initiatives. At the state level, there were earnest but unsuccessful efforts to expand insurance coverage. At the business level, there were noteworthy attempts to broaden the benefits in employment-related health insurance. And there were innovative experiments in financing second opinions, wellness programs, pre-paid group practice plans, and exercise facilities at the workplace. Medicare and Medicaid tried a variety of payment reforms, including the diagnosis-related group method of paying hospitals and complex formulas to adjust physician fees to standards of relative value.

However, the fundamental reform of the rules of the American medical game was off the political agenda, and the major changes that were attempted were basically private initiatives. Attracted by the gold mine of funds flowing through a system of retrospective, cost-based reimbursement, the captains of American capitalism came to see opportunity where the politicians had found causes for complaint. In the hospital world, small chains of for-profit hospitals—the Humanas and Hospital Corporations of America, for example—grew into large companies. "Health maintenance organizations" (HMOs)—a Republican-backed variant of the pre-paid group practice model of American liberals that increasingly reorganized the delivery and financing of care for Americans—were soon dominated by for-profit firms and expanded rapidly. Industrial giants like Baxter-Travenol and American Hospital Supply took their conventional dreams of competitive growth and extended them to vertical and horizontal integration.[4] A glut of physicians started to come into practice, weakening the traditional market power of doctors to determine their terms of work.

All these changes in the structure of American medicine took place within the context of increasingly anti-regulatory and anti-Washington rhetoric. Democrats and Republicans alike had been influenced by a generation of academic policy analysts, mostly economists, who ridiculed the costliness and captured quality of the decisions taken by supposedly independent regulatory agencies in Washington. The Civil Aeronautics Board and the airlines industry came to represent the distortions likely to happen when government regulates industry. With time, the convention of describing any set of related activities with economic significance as an "industry" demythologized medicine as well. So, even before the Reagan administration came into office, the time was ripe for celebrating "competition" in medicine, getting government off the industry's back, and letting the fresh air

The United States is now the only major industrial nation without a universal or near-universal health care program.

of deregulation solve the problems of access, cost, quality, fragmentation, and the sheer complexity of health care. The irony is that the most consequential health initiative of the 1980s—Medicare's prospective payment system by diagnosis-related groups—was an exceedingly sophisticated, highly regulatory form of administered prices.

The Contemporary Scene

After more than 30 years of talk about an American medical world in critical condition, little progress has been made in the search for a major policy change. The United States is now the only major industrial nation without a universal or near-universal health care program. Rather, Americans get health insurance from a mix of private and public sources—employers (60%), private individual plans (9%), and various governmental financing programs (27%). The largest government plans are Medicare (the federal social insurance program financing more than 40 million elderly and disabled Americans) and Medicaid (the state-administered, means-tested program covering 38 million low-income Americans). The public share of financing, however, is more than half of the $2.1 trillion Americans spent on health care in 2006; this total includes not only the major programs noted above but the Veterans Administration network of hospitals and clinics, special programs for Native Americans and the Armed Services, and the tax expenditures that help to finance the employment-based coverage that insures most working Americans (and is fraying).

At any one time, some 46 million Americans are without health insurance, though emergency care at hospitals is legally available to all, whether they can pay or not. Still, medical bills remain the second major cause of personal bankruptcy. The problems of access have worsened, and the list of the uninsured and the under-insured has grown. (The number of those who are uninsured within a two-year period, it is estimated, is nearly twice the 46 million noted above.) The relative rate of medical inflation has continued, and its relentless rise shows no signs of slowing, despite the extraordinary changes that have been made in the rules of the professional medical game: the United States spent about 7 percent of its national income, or GNP, on health in 1970, over 9 percent by 1980, more than 11 percent by 1990, and something close to 16 percent in 2008. With the highest health cost per capita of any country in the world, the United States was ranked 37th in overall performance by the World Health Organization (WHO). The WHO also evaluated American health care first in the world in level of responsiveness and 72nd in level of general health for its population. Since Canada was 33rd in overall performance and Oman was 8th, one should use these figures with caution. It is simpler to say that Americans spend the most and feel among the worst about their value for money.

Before elaborating on this contemporary portrait of American medical care and its politics, there are some analytical preliminaries to address. First, there is no such thing as a common politics of American medicine. One can rightly emphasize the politics *in* the nation's medical care, but not a politics *of* American medical care. In practice, that requires distinguishing among the most prominent varieties of political dispute and resolution:

- ***System reform***: ideologically controversial disputes about whether and how to change the major features of a medical care system—whether financing, quality, costs, or delivery. The struggles over state insurance reform in Massachusetts and California in 2007 and 2008 exemplify these politics.
- ***Rationing***: disputes about the extent to which and the explicitness with which medical care is apportioned at any one time—a topic of differential intensity across national

borders and within them. These struggles are usually dominated by professional medical care groups but find expression in the mass media, as with the denial of access to organ transplantation.

- ***Prevention***: disputes about the effectiveness and cost implications of efforts to prevent illness, disease, and injury, as well as conflicts over the benefits and costs of so-called healthy public policies. There is great variability over time and space in the salience of these disputes, with current attention in the United States focused on wasteful treatment as compared to possible improvements in preventive care.
- ***Professional accountability, autonomy, and power***: the extent to which the medical profession is being subjected to external scrutiny and losing control over its own activities. These issues are obviously of greatest interest to the affected professional parties.
- ***Panics***: issues where public anxiety and governmental action are generated by unexpected or unpredicted epidemics or health crises (e.g., AIDS, BSE, contaminated blood, SARS). These episodes result initially in a period of strict order, followed by intense politics and struggles that dominate the mass media for a time before they disappear.
- ***Consumer empowerment***: disputes over efforts to increase the role of ordinary citizens, whether patients, taxpayers, or caregivers, in the making or implementation of policies in health care. While highly variable in salience over time and space, this topic has emerged in the current Bush administration under the rubric of "consumer-directed health care." In practice, that euphemistic phrase refers to high-deductible health insurance plans with or without the tax incentives represented by medical savings accounts (MSAs).
- ***Moral crusades***: disputes about abortion, stem-cell research, euthanasia, smoking bans, alcohol control, and other contentious issues of individual versus social choice.

These categories should help us to explore the distinctive configurations of interests, institutions, and processes shaping current debates about specific health care issues.

Competition versus Regulation

Is the idea of complete government control over and administration of medical care financing the answer to the continuing debate over containing health care expenditures? Some Americans—policy-makers and medical care professionals as well as ordinary citizens—think that the only way to get the problems of the United States' health care system under control is to follow the model of the British National Health Service.[5] That model, however, invokes the unhappy image of severe rationing of care and long waits for all but the most pressing medical problems. It also conjures up images of "socialized" medicine, with all the loss of individual control and freedom of choice for both practitioner and patient that the slogan implies. The widely acknowledged seriousness of American medicine's present problems has not produced clear public support for the British policy. By contrast, considerable support has been expressed at various times for versions of national health insurance modeled on medicare, the Canadian national health insurance program. Interestingly, that is less so in 2008 than in either the early 1970s or the period leading up to the Clinton reform struggle of 1993–94.

Alternatively, at the other extreme in American health policy, is the answer a set of ideas known as the "competitive health strategy?"[6] Though their arguments vary, advocates of competition believe that restructuring financial incentives is crucial to restraining medical inflation and controlling both public and private health expenditures. Their central policy prescription is the introduction of greater price competition in the delivery of care. In the

Where medical care is concerned, the public worries more about access, financial protection, and quality than about value for money.

presence of widespread health insurance, these advocates argue, there is scope for price competition in premiums. They also argue that substantially increased cost-sharing by patients is helpful on the demand side of the market.

The eventual outcome of any thoroughgoing competitive health care strategy was and remains uncertain. The strategy has not been implemented on a wide scale anywhere in the postwar period. For all these reasons, the reality of health politics from the 1980s on has been incremental steps of both a regulatory and a competitive variety—what we might call "agitated incrementalism."[7] There was little coherent public concern about the rising costs of health care in the United States, though polls revealed continuing public anxiety. The concerns that mattered were the costs of care to individuals (in premiums or cost sharing when ill), to firms (in increased expenditures for employee health insurance), and to governments (in rising outlays for particular programs—Medicare for federal officials; Medicaid for state and federal officials). Concern about relative inflation in medical care—the concern that the society is spending more for care in the aggregate than its citizens receive in benefits—is an academic's problem. The United States may well be, as Brian Abel-Smith wrote some years ago, a country where we receive insufficient "value for money."[8] But, where medical care is concerned, the public worries more about access, financial protection, and quality than about value for money. And that is why, at this point, the concern about the dismantling of employer-related health insurance has prompted so much national attention.

Cost containment, when seriously attempted, arises from actions to control the rising burden of medical care to particular payers, most prominently the federal government but hardly less so to particular states and corporations.[9] The problems with that approach are all related to the obvious fact that actions that save federal (or state or corporate) dollars do not necessarily constitute anti-inflationary successes. Indeed, actions that have substantially shifted costs among payers have had little or no effect on total health care expenditures.

Turning now to delivery, the dispensing of American medical care "can be simultaneously described as a system on the brink of crisis and as a strong and growing industry, with seemingly equal accuracy."[10] In attempting to explain this situation, we need first to emphasize the enormous influence of providers in the imbalanced political marketplace of many of the health policy struggles. And worsening that imbalance is the lack of sustained public opinion marshaled around any one of the various formulations of the problems of cost, access, and quality of American medicine. A large part of the explanation for the United States' current health situation is the pluralism of American politics and the parallel dispersion of countervailing power in both the political and the economic marketplaces. Our federalism has spread the authority for regulating medical care between the national government and the many states. Our financing splits private and public payers, with considerable discrepancies among them in each sector.

Two explanatory factors for the cost pressures in American medicine become central. Medical care is widely regarded as a merit good, still widely insured through work and a part of the U.S. private and public welfare state. The fragmentation of financing has meant that, once payers are aroused, the problem they separately address is that of their own costs, not the cost of American medicine. Pluralistic finance, combined with extensive third-party coverage, is a predictable recipe for inflation. Only those regimes that have concentrated the stakes of medical payers—Great Britain, Canada, Germany, for instance—have been better able to restrain the forces of medical inflation. And such countervailing power is but the necessary condition for restraint. Political will is also

At any one time, some 46 million Americans are without health insurance, though emergency care at hospitals is legally available to all, whether they can pay or not. Still, medical bills remain the second major cause of personal bankruptcy.

essential. In some instances, as in Sweden, the governments with concentrated authority have chosen to spend more on medical care—as governments in Canada have, too, in recent years. Those countries made these choices through balancing the gains and losses of increasing expenditures. In the United States, in contrast, we have discovered our inflating health outlays, not chosen them.

Rapidly inflating medical care costs are not only a central problem that reformers must address but also a major barrier to sensible reform debate in the United States. The controversies over the American Medicare program in the period after the Clinton reform failure (1995 to the present) illustrate clearly this feature of contemporary health politics. Budget politics provided the setting, but the themes were much broader. They help us to understand the context facing the United States in the presidential battles of 2008.

Medicare: Affordability, Fairness, and Modernization

Medicare, largely ignored in the battle over health care reform in the early 1990s, returned to center stage following the Republican congressional victories of 1994. Given bipartisan calls for reductions in the nation's budget deficits and hostility among some Republicans to Medicare's social insurance roots, it was almost certain that this program would again generate intense and very public debate and conflict. Moreover, like Social Security pensions, long-term projections of Medicare spending prompt worries about unsustainable budget outlays—especially in light of the aging population and the hugely expensive medical technologies and prescription drugs increasingly becoming available.[11] The public commentary about Medicare in the 1990s incorporated arguments that were to reappear in vivid language over the next decade and more. Unaffordability, unfairness, and somewhat masked ideological objections—operating under the banner of "modernization"—all these terms were applied to social insurance itself and, by extension, to "government medicine."[12]

Affordability

The truth is that fearful projections of Medicare's fiscal future reflect a problem of U.S. medicine, not a crisis caused by Medicare's structure. In fact, for most of Medicare's history, program spending grew about as rapidly as outlays in the private medical economy. Figure 1 shows a number of temporal shifts, which help explain particular episodes of fearfulness. From the early 1990s, per capita medical costs grew much faster than per capita

gross domestic product (GDP) in both the private sector and Medicare. But from about 1993 through 1997, private health outlays grew far less rapidly than Medicare outlays. This discrepancy itself prompted many cries of alarm. Since then, however, the relationship has shifted back and forth. The important reality in the period after 1997 is rapid inflation in U.S. medical care generally, not just, or even particularly, in Medicare.

Over the long run—from 1970 to 2001, for instance—Medicare spending per enrollee grew less rapidly (9.6 percent per year) than spending for the privately insured (11 percent). Over the period 1990–2003, spending rose at similar rates for both Medicare and private insurance.[13] These data give no reason to be complacent about the costs of U.S. medical care. But nor do they support the claim of Medicare's incapacity to control medical inflation.

The experience of the past 30 or more years demonstrates that fragmented U.S. arrangements for financing medical care are comparatively weak instruments for controlling spending growth.

Yet, whenever there has been a more rapid rate of increase in Medicare spending in combination with projected deficits in the Medicare Part A Trust Fund, critics use projections of Medicare's future outlays to suggest that the program must be fundamentally reformed now. Suggestions for reform are often fabulously complex, but they tend to have these common features: the explicit or implicit claims that the "common pool," or social insurance features of Medicare are the cost-control culprit; and the idea that adding choice, competition, and individual responsibility ("consumer-driven health care" now) will solve the problem.

The common-pool feature of Medicare cannot plausibly be a cause for fiscal concern. In other developed countries, experience has repeatedly demonstrated the superior capacity of more universal social insurance programs to restrain growth in overall medical spending. As noted earlier, any comparison of growth in health spending of the United States and social-insurance nations like Germany, the Netherlands, and France would show U.S. spending growing more rapidly in recent decades. And these other countries have older populations and more widespread use of health care than is the case in the United States.[14]

One might argue more plausibly that fiscal restraint is difficult because Medicare does not cover everyone. Indeed, Medicare has few instruments to control capital spending. But its powerful constraints on payments to hospitals and doctors spill over onto pressures on private payers. The latter fight back by adapting some of Medicare's techniques, which then increase political pressures from providers to ease up on cost control. The experience of the past 30 or more years demonstrates that fragmented U.S. arrangements for financing medical care are comparatively weak instruments for controlling spending growth. That does not indict Medicare, but it does highlight a serious problem that Medicare (and the rest of the medical economy) will have to confront.

Critics—especially those concentrated in the pro-market wing of the Republican Party—have increasingly appealed to individual responsibility, choice, and competition as the "solution" to the problems of both U.S. medicine generally and Medicare's fiscal problems in particular.[15] One response is the broad proposal for health savings accounts (HSAs). Instead of participating in group insurance at the place of employment or paying the health insurance portion of *Federal Insurance Contributions Act* taxes, Americans are urged to contribute, tax free, to health savings accounts to cover their medical care needs. A version of such accounts was included in the 2003 *Medicare Prescription Drug, Improvement, and Modernization Act* (*MMA*). The buildup in these accounts, along with an inexpensive "high-deductible" or "catastrophic" insurance policy, would, it is claimed, provide sufficient reserves for medical care both while employed and during old age.

There are major transitional problems with this scheme, but those need not distract from the main line of argument. For the young, the healthy, and the affluent, a health savings

Figure 1. Trends in Health Care Costs Per Capita, United States, 1991–2003

	Percent change by spending category			
	GDP per capita	Non-medicare health services	Large employer premiums	Medicare per enrollee
1991–1993	3.3	6.2	10.1	_*
1994–1997	4.4	2.4	2.4	_*
1998–2000	4.6	6.7	5.0	0.3
2001–2003	2.8	9.0	13.3	7.2
1990–1995	3.7	(4.5)	(7.4)	(8.7)
1995–1997	4.8	(2.6)	(1.3)	(6.5)

Source: J. White, "Transformations of the American Health Care System: Risks for Americans and Lessons from Abroad" (Unpublished manuscript, 2006).
Note: GDP is gross domestic product.
* *Not available*

account approach is a great deal, particularly so if, as is virtually certain, these tax-free savings could be tapped for other purposes once a sufficient cushion was achieved. What happens to the rest of the population is only slightly less clear but broadly predictable. With "good risks" now not in the insurance pool, bad risks must be "insured" by general taxation. In short, instead of medical care as a part of a national pool of social insurance financing (or its Canadian equivalent), the system would move rapidly toward segmentation: private insurance for the young, healthy, and relatively well-off; welfare medicine for everyone else.

An alternative "privatization" approach retains Medicare's social insurance coverage for the elderly but attempts to save public funds by having privately managed care plans compete for Medicare patients. This alternative poses no direct threat to social insurance. Rather, the worrisome issue is whether managed care can both save money and deliver decent medical care at the same time to the elderly, or to anyone else. These are crucial questions for the whole of U.S. medicine, not just Medicare.

Fairness

A more fundamental issue than affordability is financial fairness in medical care. Should the insurance risks of ill health be dealt with in a universal, contributory, or tax-financed "public insurance" program or left to a patchwork system of private payment, private insurance, and diverse public subsidies for veterans, the aged, the poor, participants in employment-based health insurance, and so on?

The place of Medicare in this more fundamental discussion is, in 2008, odd. From the standpoint of universal protection, Medicare was and remains conceptually divided. It

separates retired workers from those still on the job, thus breaching one version of social solidarity and giving rise to concerns about unfair special treatment for one segment of society. And because Medicare covers only three groups of the population—those "retired" because of age, disability, or renal failure—it can all too easily take on the coloration of interest-group politics. These politics are not the vitriolic struggles of "us-them" welfare policy. But it is quite easy to claim as "unfair" the relatively generous treatment of Medicare beneficiaries compared with the circumstances of ordinary American families flailing in the sea of either uncertain insurance coverage or added constraints on their choices within insurance coverage. The question is whether the rest of the population shares this vision of unfairness, as opposed to wanting Medicare's security and choices in their own coverage.

Developments during the past two decades have undermined a common experience of health insurance coverage. Traditional private, non-profit Blue Cross, Blue Shield plans have largely disappeared. Where they exist, they mostly use commercial health insurance practices.

There is no evidence that any substantial number of Americans accepts "unfairness" claims or favors any moves to align Medicare's coverage with what has emerged in the private market. Nor, as the discussion of affordability reveals, is there any reason to believe that competition yields cost savings that will permit a "fairer" distribution of coverage. Indeed, the only "modernization" movement that has gained traction was the complaint about Medicare's failure to respond to changes in the nature of medical care, not changes in insurance plans. There the critics had obvious grounds for their charge. In 1965, drugs used outside the hospital were a modest part of the medical budget, and, in any case, Medicare reformers assumed that there would be persistent expansions of the populations and services covered. Neither development took place according to plan. As pharmaceuticals came to play a larger role in medical care and as the world of private U.S. health financing diverged from the older Blue Cross, Blue Shield model, Medicare became an outlier in form and, in substance, fell short of the breadth of services covered by many private plans. Medicare beneficiaries were not getting the drug coverage that had become standard for other insured Americans.

Modernization

As of 2003, Medicare could be perceived as unfair in two ways: Medicare beneficiaries had more comprehensive coverage and choice of providers than many insured non-retired people had, but less coverage of increasingly important and expensive prescription drugs. Enter the *Medicare Prescription Drug, Improvement, and Modernization Act* of 2003, a fantastically complex piece of legislation designed to combat both "unfairnesses" by rolling them into a common call for "modernization." Medicare beneficiaries would obtain drug coverage, but in a "choice of plans" form that relied on private insurance provision, competition, and consumer choice. Moreover, the statute went beyond drug coverage to pursue the "modernization" of other health insurance areas. These included a complex set of incentives and financing arrangements intended to promote movement out of traditional Medicare into private plans more like those available to most other insured Americans. Modernization in this form implicitly promised cost containment through competition. Indeed, the statute went so far as to prohibit the one proven cost-constraint mechanism in Medicare's arsenal: use of its market power to bargain down prices, a technique too close to government price setting to satisfy the Bush administration and its allies in the 2003 Congress.

This Act was, in many respects, legislation by stealth. Here and elsewhere, modernization has become a code word that masks ideological hostility to the public social insurance

structure with which Social Security and Medicare began. It holds out the hope that truly modern systems of social provision will be both more affordable and fairer than "relics" of our New Deal and Great Society past that have outlived their usefulness. And in the current U.S. political context, to be modern means to hold a distinctive ideological position—at least to every one of the Republicans who sought their party's nomination in 2007–08. It is the power of individual choice, market competition, and personal responsibility to remake social policy to fit the demands of the 21st century.

I believe these "hopes" to be profoundly misguided. Fragmenting risk pools will not increase the fairness of American medical care. And choice and competition have no proven record of cost control in medical care either in the United States or elsewhere. Modernization in this guise is a Trojan horse. Inside is a complex set of devices that increase individual risk bearing and decrease the economic security traditionally provided by government health insurance in its social insurance or tax-financed form. Nonetheless, the contemporary debate has been profoundly influenced by the struggle over Medicare in the period after the Clinton reform failure. What appears sensible to promote is constrained by the interpretations of affordability, fairness, and modernity just discussed.

Health Reform in 2007–08

Americans are not well served by their current medical care arrangements. Compared to our major trading partners and competitors, we are less likely to be insured for the cost of care, and the care that we receive is almost certain to be more costly. Though the leader in expenditures for medical research, U.S. medicine is not the undisputed leader in medical innovation, except in the costliness and ubiquity of high-technology medicine. Most Americans "covered" by some form of health insurance still worry about its continuation when they or a close family member become seriously ill. Some are locked into employment they would gladly leave but for the potential catastrophic loss of existing insurance coverage. Something needs to be done, as the presidential candidates all acknowledge.

One fact remains obvious: Americans have long been dissatisfied with the nation's medical arrangements, but our political system has been unable to come up with a solution that satisfies enough of the public to overwhelm the institutional and interest group barriers to reform.[16] There is now once again a remarkable consensus that American medical care, particularly its financing and insurance coverage, needs a major overhaul. The critical unanimity on this point bridges almost all the usual cleavages in American politics: between old and young, Democrats and Republicans, management and labor, the well paid and the low paid. The overwhelming majority of Americans (including Fortune 500 executives) tell pollsters that the medical system requires substantial change. This level of public discontent was good news for medical reformers in 1993, just as it is again.[17]

The bad news for reformers, then and now, is that, for ideological and institutional reasons, American politics makes it very difficult to coalesce around a solution that reasonably satisfies the requirements for a stable and workable system of financing and delivering modern medical care. Agreement on the seriousness of the nation's medical ills will not necessarily generate the legislative support required for a substantively adequate and administratively workable program. That is as true in 2007–08 as it was in 1948, 1971, 1993, and 2000.

The most obvious point is that the presidential competition for 2007–08 has already recapitulated the run-up to its parallels in earlier struggles. Contenders—particularly among the Democratic hopefuls—feel compelled to propose detailed plans or are put

Americans are not well served by their current medical care arrangements. Compared to our major trading partners and competitors, we are less likely to be insured for the cost of care, and the care that we receive is almost certain to be more costly.

on the defensive for not doing so. To date, the result has been depressingly familiar in a number of ways. Not one candidate has stated straightforwardly the core values health reform should express. Rather, the enumeration of complaints has dominated. The result is a pattern of problem identification and gestures toward complicated steps to broaden health insurance coverage. The differences in values between a plan presented by California Governor Schwartzenegger and any of the Democratic contenders are not easy to identify. None of the plans discussed—whether the expansions of child health insurance mentioned by Senator Hillary Clinton, the appeal to mandated coverage by Clinton and John Edwards (and incorporated in the California and Massachusetts plans), the proposal by Senator Barack Obama for incentives for health insurance expansion, or the Bush administration's embrace of medical savings accounts and changes in the tax code's treatment of employer-arranged health insurance celebrated by Republican policy experts—seriously address persistent medical inflation. Yet it is the contemporary costs (16 percent of national income) and the rate of increase (1.5 to two times the growth of American incomes) that is at the core of the coverage problems the United States faces.

There is now once again a remarkable consensus that American medical care, particularly its financing and insurance coverage, needs a major overhaul.

The gap between diagnosis and remedy is not an oversight, however. Candidates understandably are wary of announcing who the losers would be if their favored approach were actually to become a program fact. After all, if our medical arrangements are to become more affordable, some of those whose incomes constitute health expenditures must get less in the future than they might like. But so far, the presidential campaign of 2008 shows no sign of improvement over the Clinton period and has less clarity about values or program structure than the campaign of the early 1970s. That is not a healthy sign, but it is a good reason to reconsider the serious values debate—over values at stake, international experience, and a sober review of the United States' own history with the public and private financing of medical care.

Notes

1. The sketch of American medical politics and policy is drawn from my previous work: "Commentary," on Kenneth R. Wing, "American Health Policy in the 1980s," *Case Western Reserve Law Review* 36, 4 (1985–86): 608–85, at 686–92, and a review of Robert G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984), in *Journal of Health Politics, Policy, and Law* 11, 1 (1986): 163–66 (for an expanded version, see *Perspectives in Biology and Medicine* 30, 4 (1987): 590–96).

2. Edward M. Kennedy, *In Critical Condition: The Crisis in America's Health Care* (New York: Simon and Schuster, 1972).

3. In 1974, for instance, the now forgotten Kennedy-Mills proposal received extended consideration in the finance committees of the Congress, as did the Nixon CHIP plan and the catastrophic health insurance bill of Senators Long and Ribicoff. The politics of this period are reviewed in Lawrence D. Brown, *Politics and Health Care Organizations: HMOs as Federal Policy* (Washington, DC: Brookings, 1984); and T.R. Marmor, *Political Analysis and American Medical Care* (New York: Cambridge University Press, 1983).

4. For a varied discussion of these new elements in American medicine, see Jeffrey Goldsmith, "Death of a Paradigm: The Challenge of Competition," *Health Affairs* 3 (1984): 7–19; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1984); and T.R. Marmor, Mark Schlesinger, and Richard W. Smithey, "A New Look at Nonprofits: Health Care Policy in a Competitive Age," *Yale Journal of Regulation* 3 (1986): 313–49.

5. See, for instance, Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Health Care* (Washington, D.C.: Brookings, 1983).

6. See Alan C. Enthoven, *Health Plan: The Only Practical Solution to Soaring Health Care Costs* (Reading, Mass.: Addison-Wesley, 1980); Clark C. Havighurst, "Competition in Health Services: Overview, Issues, and Answers," *Vanderbilt Law Review* 34 (May 1981): 1115–78; and T.R. Marmor, Richard Boyer, and Julie Greenberg, "Medical Care and Procompetitive Reform," *Vanderbilt Law Review* 34 (May 1981): 1003–28.

7. These ideas are drawn from T.R. Marmor and Jon B. Christianson, *Health Care Policy: A Political Economy Approach* (Los Angeles: Sage Publications, 1982).

8. Brian Abel-Smith, *Value for Money in Health Services* (London: Heinemann Educational Books, 1976).

9. For an extended presentation of the politics of medical inflation, see Wing, "American Health Policy in the 1980s."

10. Ibid., 612.

11. Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Health Insurance Trust Funds, 2005 Annual Report, March 23, 2005, http://new.cms.hhs.gov/ReportsTrustFunds/downloads/tr2005.pdf (accessed February 27, 2006).

12. J. Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); and T.R. Marmor, *The Politics of Medicare,* 2nd edition (Piscataway, N.J.: Transaction Books, 2000).

13. C. Boccuti and M. Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," Health Affairs 22, no. 2 (2003): 235.

14. T.R. Marmor, "From the United States," in E. de Gier, A. de Swaan, and M. Ooijens, eds., *Dutch Welfare Reform in an Expanding Europe: The Neighbours' View* (Amsterdam: Het Spinhuis, 2004), 111–34.

15. For some illustrations, see S. Butler and D.B. Kendall, "Expanding Access and Choice for Health Care Consumers through Tax Reform," *Health Affairs* 18, 6 (1999): 45–57; and H.J. Aaron and R.D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* 14, 4 (1995): 8–30.

16. While substantial change took place in the United States in the decades from 1980 to 2000, most of it was privately generated. What is called the "managed care" movement altered the way most American physicians practice and get paid, and it had a lot to do with the changing ownership and shape of American hospitals. These changes stand in contrast to the publicly organized reforms in the United Kingdom (internal markets in the 1990s) or Canada (national health insurance in the period 1957–71). For more on health reforms, especially "non-public change," see Carolyn H. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford: Oxford University Press, 1999).

17. For more on the public desire for substantial change in health care, see Robert J. Blendon and John M. Benson, "American's Views on Health Policy: A Fifty-Year Historical Perspective," *Health Affairs* 20, 2 (March/April 2001): 33–46. A *New York Times*/CBS news survey in February 2007 confirmed this historical pattern, with "an overwhelming majority" saying that "the healthcare system needs fundamental change or total reorganization." Robin Toner, "U.S. Guarantee of Care for All, Poll Finds," *New York Times*, March 2, 2007.

Antonia **Maioni**

Health Care Politics and Policy in Canada

In recent decades, the health care systems in Canada and the United States have been viewed as either the panacea for all ills or the specter of what not to do in health care reform. Canada's "single-payer" system is based on very different principles of funding and access from the "two-tiered" health insurance system in the United States. Although Canadians were initially highly supportive of their medicare system, they have in the last decade demonstrated increasing concern about the future sustainability of their publicly financed system. In Canada, health is formally a provincial responsibility, so the "Canadian" health care model is actually a system of 10 provincial and three territorial health insurance plans, bound together by certain "norms." However, in the last half century the federal government has played an increasingly important role in health funding and policy.

Development and Financing of Health Care Systems in Canada

The decisive impetus for the development of public health insurance in Canada came from the province of Saskatchewan under the leadership of Premier Tommy Douglas and his social-democratic party. Once Saskatchewan introduced legislation for public hospital insurance in 1947, the prospect of federal funding encouraged other provinces to increase their health care initiatives too, and, in 1957, the *Hospital Insurance and Diagnostic Services Act* allowed the federal government to share the cost of provincial hospital insurance plans. By 1961 every province in Canada had set up such a plan. The next year the Saskatchewan government introduced a medical insurance program, using public funds to reimburse doctors for the services they provided to patients. In 1966 the federal government designed another cost-sharing mechanism under the *Medical Care Insurance Act* and, within five years, every province had such a plan in operation. Canada's health insurance system was fully in place. Although the federal government stipulated that, to receive funding, the provinces had to abide by certain conditions in the design of their health care systems, there was sufficient scope for provincial programs to reflect regional and local particularities. Quebec's health care system, for example, was based on integrated health and social services and an emphasis on community care.

Health care is still regarded as a public good in Canada, but there is growing resentment from the provinces that the federal government has changed the basic rules of health insurance funding. In the 1970s cost sharing was replaced with block funding, leaving the provinces to contend with cost increases in health care. In 1984 the *Canada Health Act* formalized the conditions for health transfers, including the equal access provision. And, in 1995, health funding was amalgamated under the Canada Health and Social Transfer (CHST) and subsequently reduced. Since the late 1990s the federal government has once again invested in health spending, but much of the damage from the earlier years, including provincial frustration and public dissatisfaction, has remained.

The 1999 federal budget earmarked additional funds to the CHST (including the injection of $11.5 billion over five years to health transfers to the provinces) and introduced measures to eliminate interprovincial disparities. The following year a health care funding agreement further increased transfers to the provinces, with a guaranteed minimum, but

still left provincial leaders concerned about their fiscal capacity to meet increasing health care costs. In 2003 the Canada Health Transfer (CHT) came into effect, providing increased funding through a Health Reform Fund for selected services.

After extensive negotiations at a First Ministers' Meeting in 2004, the premiers reached another agreement on health care funding. The federal government committed to a 10-year plan for increased health care transfers and a special fund to reduce waiting times—a matter that had become a thorny political issue. In all, the federal government estimated that this plan would inject $41 billion into health care across Canada. The accord was marked by several "side deals." One provided for asymmetrical treatment of Quebec, which refused to participate in the Health Council of Canada and other federally funded initiatives.

The federal government currently provides money for provincial health care in several ways. First, and the largest, is the contribution through the CHT—a direct cash and tax-point transfer that is tied to provinces that respect the five principles of the *Canada Health Act*: public administration of health insurance, comprehensiveness of benefits, universality of coverage, portability across provinces, and equal accessibility to services. Second, the federal government has entered into specific funding arrangements with the provinces for targeted initiatives (for example, the recent Health Reform Transfer, the Diagnostic/Medical Equipment Fund, and the Primary Health Care Transition Fund). Third, the federal government indirectly contributes to health care through equalization payments to eight provinces, to ensure that provinces can deliver comparable levels of services regardless of their revenue situation. Alberta and Ontario, the richest provinces in Canada, are net contributors to equalization and do not receive these funds. Fourth, the federal government directly contributes to health care for Aboriginal people, military personnel, and other groups that fall under federal authority. And finally, although the provinces spend money on public health, health promotion, disease prevention, and health research, the federal government invests heavily in these areas as well.

Hospital worker filing medical records

Intergovernmental coordination and collaboration is also required in those areas of health that have no borders: public health, infectious disease, and pandemics. During the spring of 2003 the SARS flu, a highly contagious viral illness, spread quickly through Toronto-area hospitals. Attempts to track and contain it had a ripple effect throughout the provinces and led to calls for a more coordinated approach to planning for and dealing with such problems. The taskforce set up to investigate the epidemic zeroed in on the need for better intergovernmental coordination and a "truly collaborative framework and ethos among different levels of government"; it concluded that "Canada's ability to contain an outbreak is only as strong as the weakest jurisdiction in the chain of P/T [provincial-territorial] public health systems." The Canadian Public Health Agency was established in 2004 with a mandate to ensure federal leadership in this area.

Structure of Health Care Systems in Canada

Canadians enjoy universal access to health care in the sense that all legal residents are eligible to enroll in public health insurance plans. In terms of both total and public spending on health care, Canada resembles the "big spenders" among industrialized countries: in 2007 total health expenditure in Canada was estimated at almost 10 percent of gross domestic product (GDP), as compared to 9 percent for the average of OECD countries. Selected indicators of population health, such as infant mortality and life expectancy, also point toward respectable standing within the OECD group. In this sense, Canada is neither an outlier (as is the United States) nor a vanguard (such as Norway) in health outcomes.

But the numbers also reveal several important differences. Health care spending in Canada declined dramatically in the 1990s, more so than in any OECD country. Even though spending levels have increased since then, Canada now ranks ninth in overall health care spending. This decline could be interpreted as a good thing, in that Canada has managed to control increases in health care costs more effectively than other industrialized countries. However, the fact that the percentage of physicians per capita and the availability of some forms of diagnostic technology are lower in Canada, and that Canadians are faced with waiting lists for certain non-urgent services, has led to growing concerns. Although wait times are not out of the norm for other OECD countries, the effect has been a decline in levels of satisfaction among Canadians with the health care system.

Health care services in Canada are paid for through general government taxes on income and consumption. In most provinces, all health care services deemed medically necessary must be provided at 100 percent of coverage, effectively banning co-payments and user fees. However, many of the services covered in some proportion in other countries are generally not covered by provincial health plans, leading to the relatively high proportion of private to public health care spending: 30 percent to 70 percent. And, although legislation varies across provinces, most plans prohibit doctors with billing numbers from accepting payment other than through the public system, just as they also prohibit private insurers from covering medically necessary procedures covered in public plans.

Basically, all medically necessary services and diagnostic testing delivered by physicians or in a hospital are insured, and they are accessible on the basis of medical need. No money changes hands between patient and provider. Some types of services—optometry, dentistry, outpatient prescription drugs, and physiotherapy—that may not be covered by provincial health care plans can be covered by supplementary private insurance schemes. Quebec is the only province to have a comprehensive drug insurance plan that covers any resident who is not covered by a group insurance plan. Most other provinces have in place some

Although Canadians were initially highly supportive of their medicare system, they have in the last decade demonstrated increasing concern about the future sustainability of their publicly financed system.

form of subsidies for prescription drugs; for example, Ontario covers government-approved drugs for residents over 65 years of age or those eligible for social assistance.

The key defining principle of public health insurance in Canada is the clear line of demarcation between public and private medicine—a distinction considered to be the historic "pact" between physicians and the state. Physicians must either work within the public system or opt out entirely; however, because of the scarcity of private insurance coverage, very few physicians choose to opt out. In theory, Canadian patients are supposed to access the public health care system through a primary care physician, who then refers them to a hospital or to a specialist. In practice, however, since Canadians have free choice of physicians and hospitals, there are multiple access points into the system and not everyone receives care in this structured manner. Canadians have come to rely far too much on specialists, walk-in clinics, and emergency rooms for the kind of care that could be provided much more cost-effectively in other settings.

Another problem is the need for more doctors—specifically, family practitioners and primary care doctors. It has been estimated that between three and five million Canadians do not have a primary care physician. They still can—and do—access public health care services, but they have difficulty in getting referrals, leading to increased wait times for certain services and emergency room crowding. Concerns over primary care stem from the realization that efficiency in the health care system depends on a reliable point of access to ensure appropriate treatment and proper continuity of care.

Provincial health care plans are publicly financed through general revenues, mainly through provincial taxes, supplemented by federal taxes and cash transfers. The money in the public system flows through the single payer, a "single tap," administered by the provinces. Physicians are not salaried but are reimbursed on a fee-for-service basis through a fee schedule negotiated with the provincial government or its public agency. In several provinces, specialists face salary caps, and new physicians are subject to differential billing depending on the concentration of medical supply in their region of practice. Hospitals have retained their voluntary status and are financed through global budgets set by provincial authorities. These budgets have provided a powerful tool for cost constraint, since hospitals are not supposed to run deficits, and this system of financing means that administrative billing overhead is relatively low, especially in comparison with the United States. The

Many policy makers and pundits have celebrated the health care system as the "jewel in the crown" of the Canadian welfare state, but, more recently, critics on both the left and the right have taken to lamenting the tarnished state of the crown and its lackluster jewel.

problematic issue has been the way in which global budgets have increased the incentives for the rationing of non-urgent care, particularly surgical interventions. Although hospital closures and amalgamations were frequent occurrences during the difficult decade of the 1990s, only recently have hospitals sought to deal effectively with the resulting emergency room crowding, and to coordinate wait-list strategies.

Health care represents the most impressive piece of social policy in Canada. It is now one of the key fiscal responsibilities of provincial governments (on average, 40 percent of provincial program budgets). It is also the social policy that differentiates Canada most markedly from other typically liberal welfare states, such as the United States: while Canada is usually classified as a "liberal" welfare state, the organization and financing of health insurance are inspired by a more social-democratic model. Many policy makers and pundits have celebrated the health care system as the "jewel in the crown" of the Canadian welfare state, but, more recently, critics on both the left and the right have taken to lamenting the tarnished state of the crown and its lackluster jewel.

Key Challenges in Health Care

Canada is facing considerable challenges in developing its social policies in the 21st century. This hurdle is especially true in health care, which is rapidly becoming the most expensive of social programs, one in which the complexities of expanding needs, rising expectations, and new technologies are reshaping the policy agenda. The key challenges in health care reform in Canada will be familiar to U.S. and other OECD policy makers:

Demographic pressures: As Canada's population ages, concerns have been raised about the potential impact on health care costs. The discussion in the scientific literature remains divided on this issue because the relationship between aging and health care is complex and the cost implications depend on other intervening factors such as the relative health of the aging cohort, opportunities for disease prevention and management, and the cost and availability of specific drugs or technologies. Still, in political terms, aging remains the

critical demographic issue in Canada and an important element in the consideration of policy alternatives and the estimates of cost increases.

New technologies: In Canada, as elsewhere, the impact of new technologies is a matter of concern in terms not only of cost but also of access. The controversial issues remain the extent to which these technologies are consumed, the decisions made as to who has access, and the responsibility for the cost of these advances. The fact that assessment of new technologies, including pharmaceuticals, is undertaken at the provincial level means that access to such services will vary from province to province. And, because of expenditure controls, it means that even if the technology is developed, it may not be considered cost-effective and thus widely available. In 2005 Canada had 11.2 CT scanners per million people, compared to an average of 20.6 in OECD countries, and 5.5 MRIs per million, compared to the OECD average of 9.8.

Rising expectations and diminishing confidence: The combination of the "boomer" generation with these new technologies has led to rising expectations for faster, better, and more extensive services without due consideration of the ensuing cost burdens. Because health care in Canada is rationed by need, the subsequent disconnect between expectations and access to services has fueled an erosion in Canadians' confidence in their health care system.

Health care human resources: This issue, related to both numbers and distribution, is hotly debated in the literature. In 1991 a controversial report on health human resources (Barer-Stoddart Report) suggested that medical inflation was, in part, being driven by medical professionals and inappropriate care. Most provincial health care systems responded by attempting to reduce the supply of physicians by cuts in medical school enrollment and postgraduate training. Today, concerns are being raised about the reduction in physician-patient ratio, the global competition for doctors and nurses, and the need to plan for more skilled workers in long-term care. The most recent Statistics Canada figures show that the number of registered nurses rose by 37,000 between 2001 and 2006, an increase that indicates a promising trend. The number of practicing physicians, meanwhile, rose by almost 5 percent over the same period. While medical lobbies are wary about accreditation of foreign-trained physicians, they have become vocal advocates for increasing physician numbers; in January 2008 the Canadian Medical Association launched an advertising and advocacy campaign for "More Doctors, More Care" to increase the number of physicians in Canada. Even now it is still not clear whether wait times and other problems are related only to the shortage of physicians. Moreover, the more vexing problems are not so much the quantity of doctors per se but, rather, such structural problems as the distribution across specialties, the decline in family practice, and regional needs, especially in rural and remote areas.

Emerging epidemics: Although obesity in Canada is less prevalent than in the United States, the stresses of this trend over time are now being felt. Figures from 2005 show that almost one-quarter of Canadians are defined as obese (23.2% as compared to 41.8% in the United States). While the effects of obesity have been estimated in terms of health problems and the ensuing economic impact on health care costs, the potential for health promotion and disease prevention has yet to be factored into the cost equation of health care (as those for tobacco, for example, already have been).

Health inequalities: In theory, health care is available to all on an equal basis in Canada but, in practice, enduring inequalities remain, particularly among socioeconomic groups such as low-income families and vulnerable populations such as Aboriginal people. For example, Aboriginal peoples in Canada tend to have a diabetes rate estimated at three to five times higher than the general population; and Type 2 diabetes is becoming prevalent among Aboriginal children as well.

The costs of health care: Two kinds of pressures are politically volatile in health care costs: first, the pressure on the public purse in relative terms (vis-à-vis other social programs); and, second, the pressure on the public purse in absolute terms (health care expenditures as part of provincial budgets and federal spending). Because of the attention focused on responding to consumer demand and reinvestments in the health care sector, less attention has been paid in recent years to a potentially more important issue: cost containment in the medium to long term, in both public and private spending. These costs include increases across all sectors, in particular in pharmaceuticals.

Key Political Issues in Health Care Reform

In light of these mounting challenges, Canadian governments are grappling with basic issues of health care organization and financing. There have been pressing concerns not only financially but also politically. Since the late 1990s, public opinion polls have tracked health care as the number one issue for Canadians, and, in 1997, 2000, and 2004, it was one of the most salient electoral issues in federal elections. During the past decade, every provincial government has produced a report or investigation on health care reform, while the federal government has sponsored three seminal reports stemming from research and consultation: the National Forum on Health (1997); the Commission on the Future of Health Care in Canada (Romanow Report, 2002); and the Report of the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Report, 2002).

While these reports differed in scope and recommendations, the latter two emphasized that Canada was at a cross-roads in heath care and needed to face reform challenges. Romanow recommended reinvestments in health care that could contribute to changes in the organization of delivery, including an emphasis on primary care, long-term care, and specific populations such as rural residents and Aboriginal populations. Kirby focused on financing, suggesting a new tax premium specifically earmarked for health care and a guarantee of timely access to health care services.

Into this mix has been added the role of the courts and the use of litigation based on the Canadian Charter of Rights and Freedoms to influence health care policy. The most dramatic example of this phenomenon is the 2005 case of *Chaoulli v. Québec,* involving a patient who claimed an overly long wait for surgery. By a narrow majority (4–3), the Supreme Court of Canada invalidated Quebec's prohibition against private insurance for core medical services provided through the public system (as in most of the other provinces). Because the judgment was based on the application of the Quebec, not the Canadian, Charter of Rights, its immediate legal impact is limited to Quebec. In response, the province has agreed that something will be done to ensure access to non-urgent surgeries, but not to opening the entire health care system to private insurance or allowing physicians to receive both public and private payment. Alberta and Ontario are now facing *Chaoulli*-inspired test-case litigation that attempts to extend the decision's reach both geographically and legally.

Given this political and legal backdrop, the key issues in health care reform can be summarized simply as *what, when, how, where,* and *who*.

What services should be covered by health insurance plans? This question refers to the principle of comprehensiveness and the services that should be publicly insured ("inside the medicare basket"). Many services key to modern health care, including outpatient pharmaceuticals, forms of therapy, and long-term care, may not be covered by provincial plans, leaving consumers of health care with the financial burden of these costs. The issue is also related to what kinds of new technologies and services should be covered, and under what conditions (guidelines in terms of patient age, for example). Few of these difficult questions have been raised outside clinical environments, even though they have financial and ethnical implications.

When should people have access to health care? This question echoes the debate over waiting lists, which is directly related to the *Chaoulli* decision. In public health care plans in Canada, services are rationed and, normally, the triage criteria are based upon need rather than the ability to pay. This issue is at the heart of the "equal access" provision of the *Canada Health Act* and is evident in most provincial health care legislation. Access-to-care surveys report that wait times are for the most part limited to non-urgent care or to specific kinds of specialty care, yet they have become a lightning rod in the critique of Canada's health care woes. The federal government has therefore directed its increased health care funding to provincial efforts to reduce wait times, with varying results. In many areas of access, wait times have been alleviated by targeted attempts in some provinces, such as oncology in Ontario and cardiac care in Quebec.

How should health care services be organized? The wait-time problems are symptomatic of larger issues: the organization of health care systems and the way access to this care is organized. Unlike many European countries, such as the United Kingdom, and even not-for-profit health maintenance organization (HMO) models in the United States, most Canadians do not have to access the health care system through a specific point of entry, nor do doctors have to choose between salaried or capitation methods of payment. In fact, many Canadians, in both urban and rural settings, have experienced difficulty in finding a primary care physician. Over the past few years, efforts have been directed at alleviating this situation, although the implementation of such reform has required extensive negotiation with physician associations and the difficult task of coordinating services with other health care professionals. In addition, several outstanding issues related to health care organization remain:

- the prevention and management of chronic disease (such as diabetes or obesity) not only among the general population but also among high-risk populations (such as Aboriginal Canadians);
- the costly and necessary but as yet unfulfilled attempts to improve information systems to collect and compare data and to move ahead more quickly on compiling compatible electronic health records; and
- the enduring problems with human resources, including the numbers and distribution of physicians (both regional and across specialties), the accreditation of foreign-trained physicians (currently shut out of professional associations), the potential for

Since the late 1990s, public opinion polls have tracked health care as the number one issue for Canadians, and, in 1997, 2000, and 2004, it was one of the most salient electoral issues in federal elections.

nurse-practitioners (still rare in Canada), and the remuneration of physicians (for the most part still paid on a fee-for-service basis). The infamous "brain drain" (to the United States, in particular) has in fact stabilized; from 2001 to 2006, for example, the number of physicians moving away from Canada decreased by nearly 60 percent, and there is now a net increase of Canadian doctors returning from abroad. The new migration challenge, however, is interprovincial, as Alberta and British Columbia continue to attract the net gains from other provinces, reflecting their economic promise and population increases.

There seems to be a growing dynamic toward injecting more money into the health care system through private markets rather than addressing the more pervasive issues of effective and coherent reorganization of health care services.

Where should decisions be made? And who pays for health care? Both these issues are part of a twofold question: "who decides" refers to which level of government should be making decisions about health care policy; and "who pays" refers to the proper division of payment between levels of government, and whether this burden should be shared with the private sector. The history of health care policy in Canada reflects an enduring conflict in Canadian federalism: provinces have the jurisdictional responsibility for increasingly expensive social programs, while the federal government has a larger fiscal capacity. The federal government's own jurisdictional responsibilities, including Aboriginal health and military health care, are now being re-evaluated. Public health, in particular in relation to pandemics such as SARS, has taken on a new importance, and the federal government has now put into place a pan-Canadian Public Health Agency.

In stark contrast to the 1990s, recent efforts have been focused on enlarging the total amount of money available rather than on cost-cutting in the health care sector. Although increased funds have been made available to the provinces through the 2004 federal-provincial agreement for multi-year funding, some provinces are pursuing efforts to find ways to ease the growing pressure of health care on the public purse. Political leaders in British Columbia, for example, have been engaged in a public debate over alternative sources of health care funding, especially with reference to European examples. In February, Premier Gordon Campbell changed tactics, suggesting that health care human resources needed to be better organized, including the licensing of foreign-trained physicians and the insertion of nurse-practitioners into the health care system.

In Quebec, the Ménard Committee that was set up following the *Chaoulli* decision painted a dire portrait of the health requirements of an aging population and the need for more private-sector initiatives in the delivery and financing of health care services. Bill 33, the legislative response, opened up the possibility of public-private partnerships in specific settings for knee, hip, and cataract surgery. In 2007 the "father of medicare," Claude Castonguay, was commissioned to investigate health care financing in Quebec. His report, which was made public in February 2008, emphasized the need to find new sources of funding to reduce the burden on the public purse. His suggestions, including the imposition of a health care premium based on frequency of use, a dedicated consumption tax through an increase in the sales tax, and the enlargement of the scope of private insurance and private medicine, were met with considerable opposition in Quebec; even the provincial government immediately distanced itself. This response is hardly surprising, given that none of these suggestions can be considered particularly innovative or useful, either to control overall costs or to improve access to care. In addition, imposing user fees and allowing physicians to receive both public and private payment would raise immediate compliance issues with the limits of the *Canada Health Act*. Castonguay, aware of these problems, also suggested that the Act is a major impediment to provincial health care reform—or, at least, his vision of it.

Because many of these ideas and initiatives may be at odds with the *Canada Health Act*, the trend may well be, in the short term at least, to engage in public-private partnerships or to allow private delivery only at the margins of the health care systems, such as for diagnostic testing or for de-listed services. At present, both the partition between public and private financing for medically necessary services and the directive that physicians must choose one or the other form of payment exclusively limit the private market for health care. All told, however, there seems to be a growing dynamic toward injecting more money into the health care system through private markets rather than addressing the more pervasive issues of effective and coherent reorganization of health care services.

Stakeholders in the Health Care System

Consumers

In Canada there has been a noticeable change in public opinion, from overwhelming satisfaction with the health care system to growing concerns about timely access to specific services and the long-term sustainability of publicly funded health care. The majority of Canadians, and in particular those who have accessed health care services, are satisfied with the care they receive, but they express a sense that the overall system is in crisis.

If we consider the identical questions posed by the Commonwealth Fund health surveys in 1988 and 1998, what becomes evident is the dramatic deterioration in Canadians' views about their health care system. In 1988, 56 percent of Canadians agreed with the positive spin that "on the whole the system works pretty well and only minor changes are needed"; by 1998 this figure had declined to 20 percent. While 5 percent of Canadians in 1988 agreed with the negative spin that the health care system had to be completely rebuilt, 10 years later 23 percent thought that was the case. New data tend to suggest that the opinion trends have stabilized, but they do not point to a reaffirmation of confidence in the existing system. Other data suggest that even though most Canadians are satisfied with their own personal care, they are anxious in terms of their perception of the long-term viability of the public system. And while they support the existing model in principle, they are also becoming "tuned into" the existence of alternative solutions that may be at odds with the existing system.

The results of a recent Environics poll confirm this trend and bring the sense of crisis into sharp focus. In asking the direct question, "Is the health care system in crisis?" two-thirds of Canadians agree that it is. What is interesting is that this trend holds across age, gender, and socioeconomic status. Although there is no real consensus on reform options, private sector remedies are gaining currency as alternatives to the existing public model. In the United States, *public* regulation in some form or another may be seen as a cure for ills of the *private* system; in Canada, increasingly, the opposite seems to be the case.

Private Industry

In Canada, where the insurance industry in most provinces has been shut out of the health care market except for supplementary care, the Supreme Court ruling in the *Chaoulli* case opened the door to a larger role for private insurance. The only province to do so has been Quebec, in a modest effort for non-urgent surgical services, although both Alberta and British Columbia are in the process of designing similar types of legislation.

Because of the limitations on private insurance, private health care providers have also been limited in Canada. In the past decade, however, cuts in the public system and impatience with waiting lists for non-urgent care have opened up an important window of

opportunity for private providers. They have expanded their markets, particularly in larger urban areas, in diagnostic testing, physical exams, specific non-urgent surgery, home-care services, and long-term care provision.

Pharmaceutical Industry

Price controls in Canada, a political tradeoff struck in the early 1990s to protect big pharma patents and to stimulate biotech development, have led to considerably lower prices for many popular drugs. But outpatient prescription drugs remain one of the principal gaps in public insurance, and consumers are concerned about the availability of new and more costly drug therapies. A national pharmacare program was one of the recommendations of the Romanow Commission, championed by both Liberal governments and consumer groups. Only one province, Quebec, has a pharmacare program in place, a public-private hybrid that is expensive and essentially mandates universal coverage while allowing private supplementary insurance to remain in place. Although provincial governments are cognizant of the growing pressure of drug costs on public coffers, the importance of the biotech and pharmaceutical industries, particularly in Toronto and Montreal, make it unlikely that any sweeping reform will take place in the near future.

Canada's health care system has been based on the socialization of financing, but not the socialization of delivery.

Health Care Providers

In Canada, where both nurses and physicians are dependent on adequate public funding for their livelihoods, a divide is emerging between the two groups. The Canadian Nurses Association continues to be vocal about the accessibility of quality health services and the need for more government funding to ensure nursing provision. Physicians, meanwhile, have begun to change their official positions. The Canadian Medical Association served as an intervener in the Supreme Court case on private insurance, and a majority of the CMA's members specifically cited the case in a landmark motion in 2007 that supported private insurance and private health care when such care was not available in a timely manner in the public system. And, as the debate over the role of private insurance and for-profit medical services deepens in Canada, last year's tenure of Dr. Brian Day, one of the country's pioneering entrepreneurs in the provision of private surgical care and one of the most outspoken advocates for private medicine, as head of the CMA signals a pivotal moment in the development of the Canadian health care system.

What Is Driving Health Care Reform?

The pressures for change in both the United States and Canada are grounded in very different contexts of existing health care systems. In Canada, when we talk about the "crisis in health care financing," we are referring to the challenges that governments face in restricting public-sector spending and in intergovernmental squabbles over fiscal balance and imbalances. Despite the debate over the extent to which health care costs are soaring out of control in this country, most of the available evidence suggests that these costs have stabilized to some extent over the past few years. What has changed is the fiscal capacity—and/or political will—of governments to foot the bills for health care and the increased reliance on non-public spending for certain services.

There is a perception that the stabilization of costs over the past three to five years may have happened at another expense: timely access to quality care. Canada's health care system has been based on the socialization of financing, but not the socialization of delivery. Because health care in the public system is—in theory—supposed to be provided on the

basis of need, rather than ability to pay, some people will be waiting longer for certain services, depending on the prioritizing of medical need. In practice, this selection has led to the perception that there are serious problems in access to certain types of care. A recent Statistics Canada study, based on a survey of 14,000 respondents, shows that 18 percent of the 23 million Canadians who used health services in 2001 experienced difficulties with access. As a proportion of the whole population, 11 percent claimed that some of their needs had remained unfulfilled, mostly because of the length of waiting lists or the unavailability of some services in some places. At the level of individual Canadians, the most important concerns expressed are basically about how care is rationed as a public good—the problems associated with equity based on needs-based prioritizing.

Optimists rightly point out that Canada's universal medicare system produces enviable outcomes in terms of the overall health of the population, including a slightly higher life expectancy and lower infant mortality rates—all at a fraction of the cost of the U.S. system. In Canada, unlike many other public systems in Europe, provincial health care systems have so far resisted the use of market incentives, parallel private markets, and user fees and co-payments on certain services. There remains a consensus around the idea of health care as a social right in Canada, around the principle of universality and the need for public involvement—both in determining regulation and in financing—to guarantee this right. But, clearly, satisfaction about existing health care arrangements is eroding within the general public, the policy elites that influence public opinion, and the political leadership itself. A review of newspaper coverage of health care issues over the last decade, for example, shows two trends. The first is the simple yet significant fact that the volume and depth of coverage and analysis of health care issues has increased. The second, and perhaps more portentous, trend is the way in which private-sector and for-profit alternatives are covered and legitimized. For the last decade, the Canadian health care model has been subjected to a barrage of criticism by opinion leaders. This onslaught has stirred groups in the health care sector to feed a growing perception of crisis and to relentlessly push for solutions or alternative models in line with their interests.

Conclusion

Since Canada and the United States are situated at such different starting points in health reform, it is unlikely that the two systems will converge any time soon. The direction of future reform in both countries will be marked by a continued ideological battle over the sustainability of health care funding and the best ways of guaranteeing access to care. To different degrees, right-wing messages about the benefits of private market solutions and decentralization toward subnational initiatives are gaining prominence in both countries.

These observations make a cautionary tale: however much one believes in the effectiveness and viability of the Canadian public model, health care can no longer be considered an immutable "sacred trust" that the Canadian public will continue to support at any cost. Basically, if provincial health care systems do not deliver on promises and address dissatisfaction about the quality of care, and if policy leaders, including the federal government, do not succeed in establishing confidence in the ability of the public model to meet future needs, then supporters of alternative visions are likely to become much more vocal and powerful in advocating change—however far from existing principles such change may seem.

Ted Marmor's Response

Antonia Maioni's essay prompts two kinds of reactions in my case. One is admiration for her clear portrait of Canadian medical circumstances, public opinion, recent medicare controversies, and the uneasy contemporary state of affairs. By "contemporary state of affairs," I mean the combination of increased funding for medicare, contentious federal-provincial relations, and continuing controversy over the role of private medicine in Canada's publicly funded form of universal health insurance. My second reaction is that such a portrait—a focus on one country, as with my own essay on the United States—has the effect of initially blocking a comparative perspective on our North American medical care arrangements. My remedy will therefore be to address the Maioni portrait briefly, but to concentrate on the second, comparative perspective.

There is little substantive to add to Maioni's "internal" representation of Canada's medical care arrangements, developments, and issues. It is in my estimation accurate, balanced, and comprehensive, leaving out nothing crucial. We learn from this essay that, although Canada's basic medicare structure has not changed fundamentally over the past 20 years, Canadian confidence in its future has dropped sharply. In addition, Maioni emphasizes that, even though the 2005 *Chaoulli* decision has so far had a limited impact on Quebec's policies, it has opened up the issue of whether private medicine has a role to play, especially in legal or political challenges arising in Alberta, British Columbia, and, obviously, Quebec. We also learn from Maioni that the infusion of public funds in the last few years has certainly not brought quiet confidence back to this sector of Canadian public life. Quite the contrary, in fact.

How different it all appears from the perspective of a health policy analyst looking north from the United States. Many of us eye with envy the remarkable Canadian modes of financing medical care for its citizens. With decades now of comparative experience, the record is clear (to us): Canada has managed to arrange broad health insurance coverage of its entire population; to deliver, in general, quite decent care; and to pay considerably less (some 40 percent less) of its GNP for the bargain. Tell an American business or labor leader now that the United States has the best medical care arrangements in the world, and you will get a laugh or a pie in your eye. The United States spends nearly 16 percent of its GNP on care and, as I noted in my essay, has nearly 46 million citizens completely uninsured at any one time, with millions more under-insured from the serious financial consequences of illness or injury. The United States spends more than any other nation on health care and, as I also noted, is hardly celebrating that statistic.

No one would suspect this scenario from recent rounds of Canadian commentary about Medicare in the United States and the refrain of enthusiasm, particularly from physician groups, for American levels of spending and adoption of new technology. In Canada, as Maioni observes, people complain that too little money is spent on the public health care system, not that the United States—or Switzerland or wherever—spends too much. "Under-funding" has become a predictable slogan, reiterated without the slightest appreciation that it is common to claim that spending more is always better in any professional enterprise. Someone has a bad medical experience, and the language of crisis erupts. To many informed American observers, this reaction seems quite batty. Getting good value for money in medical care is a task that is never completely finished.

But the idea that Canada faces a comparatively serious set of problems seems, from my perspective, myopic.

There is, I would argue, much confusion about the significance of managing medical care finances under public auspices and through public budgets. Some Canadians believe that everything would be better if only there were private arrangements—private augmentation, so to speak, of squeezed governmental budgets. The relevance of the U.S. experience is precisely that it offers an object lesson in the failure of privately based controls on medical inflation. For the last two decades, the United States has taken seriously the vaunted advantages of the private market model of medicine. Rightly or wrongly, the country has pursued a bewildering mix of private solutions—business coalitions at the local level, self-insurance by large firms, experiments in group practice, increases in consumer payments (deductibles, co-insurance, co-payments), and all sorts of rearrangements of who can tell the doctor or the hospital what and what not to do. The result has been twofold: a staggering growth of organizational innovations (preferred provider organizations or PPOs, HMOs, disease managers, etc.) and total failure to restrain the relentless rise in U.S. health expenditures. It is worth remembering that, in 1970, the United States and Canada spent the same proportion of GNP on medical care (about 7 percent). Thirty-five years later, the United States spends at least 50 percent more than Canada and, at the same time, faces its patients with the highest out-of-pocket charges in the world. Those who claim "under-funding" in Canada hardly celebrate the American result, but it is worth noticing.

The comparative portrait leaves the observer with both ironies and unanswered questions. Crisis talk in Canada leads to suggestions of privatization along American lines at the very time when observers like me look to Canada for models of how to steer a system financially to bring spending under control. If Canadians accept the under-funding and privatization option, they will move Canada toward the United States, not Europe, which spends on average no more than Canada. The result would be even greater Canadian difficulty in freeing up resources for other purposes.

The final irony involves myopic views of the connection between economic progress and social programs. Many Canadian business figures—like their counterparts elsewhere—regard generously funded social programs as an economic disadvantage, burdens that hold Canada back in international competition. In the case of medicare, at least,

Canada has managed to arrange broad health insurance coverage of its entire population; to deliver, in general, quite decent care; and to pay considerably less (some 40 percent less) of its GNP for the bargain.

On this night at San Francisco General Hospital, there were 13 people waiting for in-patient beds. The wait can be as long as 24 hours. Since SF General is a county hospital, it serves all segments of the community, regardless of financial and insurance status. For the uninsured, a county hospital emergency room is often the first and last resort for treatment.

this view is precisely backwards. Were medical care changed in the ways advocated by the "under-fundists," the costs of illness would become more, not less, of an economic burden, and, ironically, in precise proportion to drawing more funding to medicine.

The unanswered question is simple: What price is being paid for the undeniable fact that Canadian medicare is both a relative bargain and a competitive business advantage? Is Canada failing to meet some fundamental medical needs? Are Canadians needlessly suffering (or even dying) for want of appropriate access to care? Never mind what the United States is doing, should Canada be spending more in some areas of medicine and less in others? If the answer to this last question is yes, the American experience suggests that the extra spending should be done through the public sector. And much research suggests that the largest payoffs lie not in traditional medical care, but in social investments that improve the average person's capacity to cope and stay well. There is more to the story here than the debate over funding levels has revealed, but the central message is to beware of selective and misleading glances across our borders.

Antonia Maioni's Response

Then and Now

As Ted Marmor reminds us, health care reform has been a perennial feature on the American political stage. In that respect, the Canadian version of the story seems quite different. When I began to publish my comparative work on the health care systems in the two countries, the first reaction in Canada was "So what?" Sure, people said, Canada and the United States have different health care systems—end of story. As it turns out, of course, that is only the beginning of the story. Much inspired by Marmor's own political analyses of Medicare in the United States, I take the position that the portrait of health care development in Canada as the value-driven proof of Canadians' quasi-genetic difference from Americans is highly suspect—just as it is also misplaced and overdrawn. The emergence of universal health insurance in Canada has as much to do with politics as does its absence in the United States. And the same can be said for all the pressures in health reform in the two countries today.

From the vantage point of a Canadian who has lived in the United States, I recognize that one of the most impressive feats is the way the United States has managed to build such an astonishing welfare state despite all the political odds against it. Medicare and Medicaid are huge public programs, the likes of which Canadians can only imagine. Yet, at the same time, the political analysis of this feat—which began much earlier than anything Canadian governments managed to do—begs the question of why there is no national health insurance in the United States today, and why the quest for universal coverage is still making front-page headlines in the 2008 presidential contest.

Marmor's analysis tells us that story with great power and persuasion. It is the existence of Medicare and Medicaid, and the co-existence of these programs within a "medical game" dominated by private interests, that have made the twin problems of cost and access the huge political challenges they are today. Marmor also reminds us that the United States is a large and complex place, and that these complications are reflected in the way that health care reform plays out differently among a wide variety of programs, stakeholders, and individual Americans. Although Americans are deeply divided about health care reform, they are not ambivalent about its importance. We Canadians would do well to remember this intensity, in regard not only to health reform debates in the United States but even more so in Canada.

Again, flowing from Marmor is the realization that things change over time, affected by institutional contours and political timing. This potential for change has been an important lesson for observers and scholars of Canadian health care debates. Barely more than a decade ago, hardly any political actor could raise even the whisper of privatization; today, it is being seriously discussed—albeit not yet implemented—in policy forums across the country. Canada is not immune from such discussion, and it is crucial to recognize that confidence in the health care system has been eroded not only because of system performance but also because of ideological division.

Us and Them

I used to ask my students in Canadian politics what made us "distinct" as Canadians; over the years, the top three reasons turned out to be hockey, Tim Horton's, and health care.

The real burden, as the U.S. example shows, remains the total cost of health care, and that total cost is unquestionably inflated because of the presence of private markets for these profitable—and scarce—goods that do not conform to simple consumer analyses.

While the first two tended to stand alone, health care was usually qualified by the phrase "unlike the United States." Well, like it or not, for Canadians the U.S. experience is important and, in so many respects, instructive.

From Marmor's analysis, we can also draw comparative lessons about similarities and differences. While the principles of funding and access differ considerably, the health care system itself, including physician training and medical protocols, makes Canada the most similar comparison to the United States. It is precisely because there have always been so many similarities in challenges, coupled with crucial differences in responses, that the comparison is compelling. Canadians are wont to insist that the best comparisons for health reform are with European nations, but Marmor reminds us that our two countries—and their health care systems—share a common continent with highly interdependent social, economic, and cultural spaces. In this sense, their future paths must have an impact on each other.

Marmor raises several points that should make Canadians, particularly policy makers, sit up and take note. For example, his analysis of the cost crisis of health care in the United States should be required reading for anyone on the northern side of the border who continues to harp on about the "burden" of health care spending on provincial budgets. Here is the obvious economics lesson: The real burden, as the U.S. example shows, remains the total cost of health care, and that total cost is unquestionably inflated because of the presence of private markets for these profitable—and scarce—goods that do not conform to simple consumer analyses.

The political lessons are also worth noting. Politicians play political football with health care at their own peril—and at the peril of their constituents. Even a cursory glance at the 1990s federal-provincial showdowns over health care reform in Canada—and the blatant posturing of the federal government in this regard—reveals much about how public confidence can be eroded and public goods devalued.

Marmor also raises the question of rationing. He points out—and rightly so—that every health care system imposes some form of rationing. In Canada, health care systems are designed to ration care on the basis of medical need; in the United States, access to care

is associated with being properly insured, on the one hand, and, on the other, being able to pay for that insurance or for the other non-insured associated costs of care. In Canada, anxiety has increased over access to certain kinds of non-urgent care; in other words, Canadians have concerns about how care is rationed as a public good and how equity is achieved amid needs-based prioritizing. In the United States, meanwhile, the concerns are more basically about paying for health care; in other words, Americans are worried about the problems associated with health care as a commodity rather than as a public good, and about the lack of equity in the U.S. health care system.

Conclusion

Overall, Marmor's analysis reflects how similar pressures in the United States and in Canada are grounded in very different political realities and different contexts of existing health care systems. In many respects, these distinctions have endured, and health care in Canada and the United States still remains quite different. But I am becoming more pessimistic—or perhaps less sanguine—about the patterns of political change that point toward a kink in the health policy path for Canada. From the past two decades I've spent observing the health care politics and policy in Canada, it is obvious that satisfaction is eroding and that the old saw about Canadians being kinder, gentler, or whatever does not and will not inoculate them against change. What matters is whether the system is living up to needs and, increasingly, how the system can respond to expectations, both of which have been sorely tested by the machinations of political and social actors. The U.S. example, well drawn by Marmor, reminds us that politics and policy are equally important in health care reform.

Theodore R. **Marmor** is professor emeritus of politics, public policy, and law at Yale University. He is co-author of *America's Misunderstood Welfare State* (1992), and author of *Understanding Health Care Reform* (1994) and *Fads, Fallacies, and Foolishness in Medical Care Management and Policy* (1994). His most widely acclaimed book is *The Politics of Medicare*, 2nd edition (2000).

Antonia **Maioni** is associate professor of political science at McGill University and director of the McGill Institute for the Study of Canada (on leave 2007-2008). She is currently a visiting scholar at the McGill Institute for Health and Social Policy. She is the author of *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (1998).

The Canada Institute is an integral program of the Woodrow Wilson International Center for Scholars. The Center is a nonpartisan institution, supported by public and private funds and engaged in the study of national and world affairs.

The aim of the Canada Institute is to increase knowledge about Canada in the policy-making community, to focus on current U.S.-Canada issues and common challenges, and to keep an eye on the future, looking ahead to long-term policy issues facing the two countries in a variety of areas. The Canada Institute brings together top academics, government officials, and corporate leaders to explore key questions in the bilateral relationship through seminars, conferences, research projects, and publications.

The Canada Institute on North American Issues, incorporated in 2002 and affiliated with Operation Dialogue, was founded to conduct research on cross-border topics and encourage dialogue among key government, corporate, and academic institutions in Canada, the United States, and Mexico. CINAI, based in Toronto, is chaired by C. Warren Goldring.

Woodrow Wilson International Center for Scholars
Canada Institute

One Woodrow Wilson Plaza
1300 Pennsylvania Avenue, NW
Washington, DC 20004-3027
www.wilsoncenter.org/canada
canada@wilsoncenter.org
T (202) 691-4301
F (202) 691-4001

Canada Institute on North American Issues

33rd Floor, TD Tower
66 Wellington St. W.
Toronto, Ontario M5K 1E9
www.thecanadainstitute.ca
T (416) 815-6272