

# The Health-Care Battle Is On

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**A**s early as October 10, 1992, the *New York Times* declared that "the debate over health-care reform is over. Managed competition has won" (editorial, "The Bush-Clin-ton Health Reform"). However, with many Americans continuing to campaign for a universal, single-payer, Canadian-type system, the issue is far from settled. Dismissing them as "the guerrilla fighters of the health-care debate," the May 4, 1993, *Times* described single-payer supporters as "outfinanced by the industry groups, outmuscled by the policy gurus in the White House, viewed by most of the pundits as hopeless idealists" (Robin Toner, p. A22). Marginalized by the politicians and the media alike, these advocates still constitute "a force to be reckoned with in the coming struggle on Capitol Hill," the *Times* nevertheless warned.

## Managed Competition Untried Anywhere

Despite many months of promotion by the *Times* and others, the campaign for managed competition is stalling and proving to be a hard sell with the public. Part of the reason for this is that managed competition is many things to many people, as the daily updates and trial balloons from the health-care reform task force indicate. Far from the "blueprint" that simply required Congress to "dot the i's and send [to] the President," as the *Times* claimed in October 1992, managed competition has not been

## U.S. Public Is Being Hustled

In order to sell managed competition—a proposal clearly inferior to and more expensive than a publicly administered single-payer system—it has been presented by the *Times* and others as "the only reform that has a realistic chance to control costs as coverage is extended to millions of uninsured Americans" (October 10). Americans need to be convinced that no other solution is possible. This requires a two-pronged attack on the single-payer model.

The first, and the most frequent, attack simply dismisses it by declaring it "utterly unrealistic" and "too radical for American politics to digest" (May 4). But increasingly, as the single-payer "guerrilla fighters" continue their campaign with the grass roots, it has become necessary to use a second prong of attack—to write "exposés" of the Canadian single-payer system to show that it, too, is in crisis and that adopting a similar system in the U.S. would not solve the health-care problem. Indeed, it might simply result in introducing an additional set of problems.

This second line of attack was ably pursued by Clyde H. Farnsworth in his March 7, 1993, front-page *Times* feature story "The Bill Comes Due: Canada's Health Care Costs." The main point of this story

was that "like the United States, Canada, with a radically different system ... faces exploding medical costs" and spending outstrips government's ability to pay. Farnsworth contended that while "no one wants to dismantle the most popular Canadian social program ... there is talk of changing some of the ground rules." He then detailed some cost-cutting measures under consideration by a few provincial governments, including the possible introduction of user fees, a reduction in some of the services covered, a cap on overall government spending in health care, and a reduction in the increase of doctors by limiting enrollments in medical schools.

## Times Withholding Essential Information

in one province is recognized in all other provinces); and public administration (in each province it must be run by a public, non-profit agency). Doctors, as in the U.S., are private entrepreneurs and are reimbursed on a fee-for-service basis according to periodically negotiated fee schedules. Hospitals, which are private, non-profit corporations overseen by community trustees, receive an annual global budget. (This is rather like the method used in the U.S. to finance police and fire departments. Few would argue that these essential services should be provided on either a fee-for-service basis or only to those who can afford to pay.)

### Powerful Groups Besiege the Canadian System

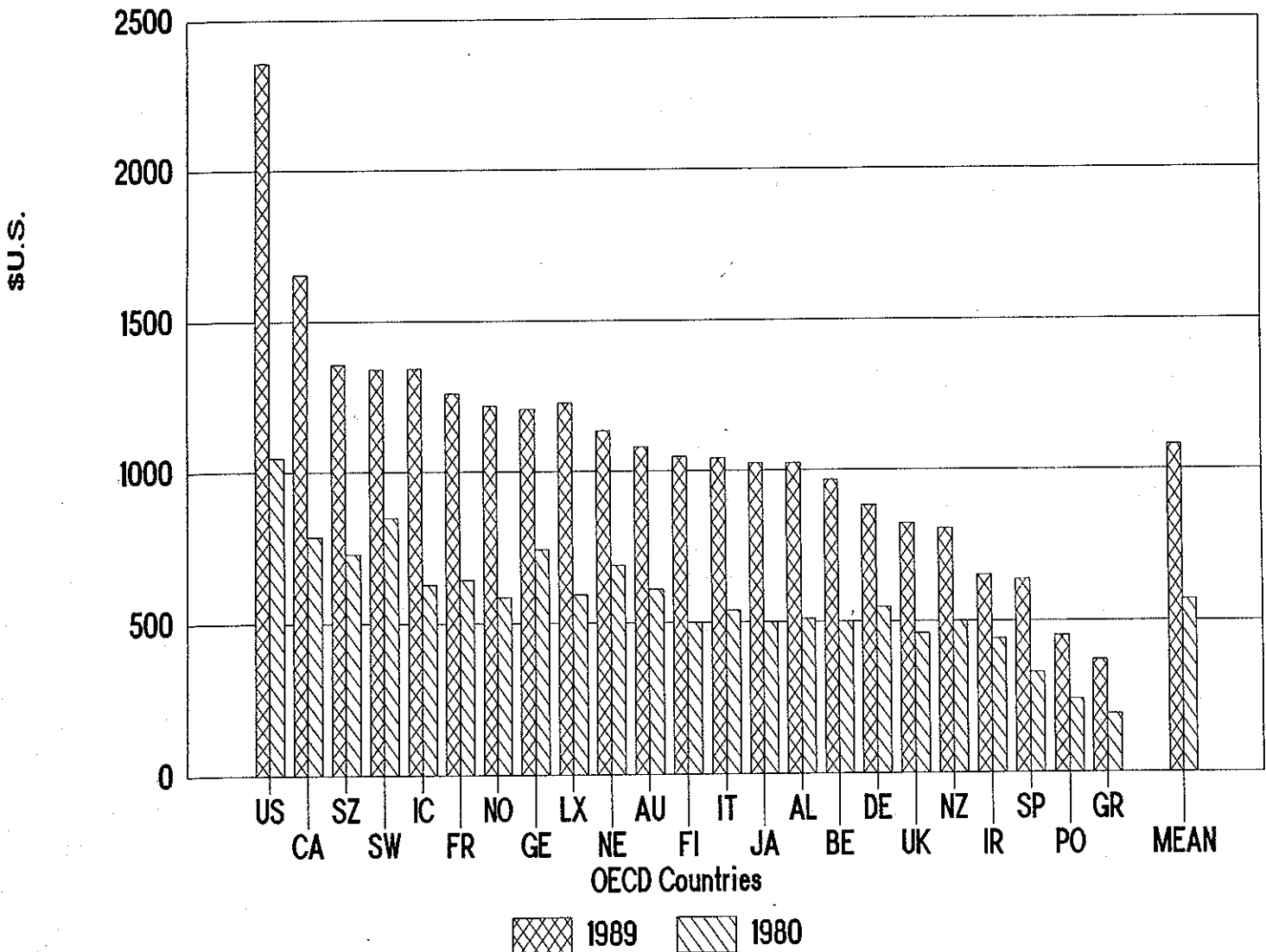
Despite the success of the Canadian system in providing quality health care for all, it has not completely eliminated pressures from powerful groups, including hospital administra-

tors, physicians, health-care worker unions, and to a lesser extent, even private insurance companies (these are permitted to offer insurance for services and items that are not covered by the public plans), which are all jockeying for greater power, resources, and control within the system. And it is widely recognized that an important part of a publicly administered system is open and ongoing public debate over allocation of resources and level of service. Farnsworth noted, for example, that "despite the financial constraints," Ontario and British Columbia have both rather quickly expanded their open-heart surgery capacity—in response to public pressure over delays.

Farnsworth admits that the Canadian system "provides good medical care to all its citizens at a lower cost than in the United States—averaging 1,915 American dollars per person in 1991 ... compared with \$2,868 in the United States" (March 7). Nevertheless, he maintains that it is a system in crisis, where "spending

## Health Care Expenditure Per Capita International Comparison, 1980 and 1989

Robert G. Evans and Maureen Law, *The Canadian Health Care System* (Health Policy Research Unit, University of British Columbia, 1991)



in recent years has grown nearly as fast as in the United States, and is outstripping the ability of the public sector to pay.”

As Canadians pay for their health-care system through general tax revenues, the message is clear: A public system, even if it is cheaper, will lead to increased taxes. The U.S. image of Canada is of much higher taxes. Canadians, however, pay on average only 3 percent more taxes than Americans, and in return receive not only their health care, but a far more generous overall social benefits package.

Yet, as Farnsworth noted, some cutbacks are taking place. Increasingly, provincial governments have felt squeezed on health-care costs during the current recession. Also, changes in the financing program by the federal government have reduced its share of health-care costs from 50 percent to 30 percent, leaving the provinces to make up the lost revenue and pressuring provinces to cut costs. Farnsworth did not, however, make the obvious connection between this financial restructuring that shifts cost to the provinces and its long-term role as a method of undermining the popular national health-care system, which the Tories dare not directly attack.

### Changing Drug Patenting Ominous

Another financial strain, greatly resented in Canada though ignored by Farnsworth, stems from recent changes in Canada's drug patenting laws made under pressure from the U.S. pharmaceutical industry. The laws had kept Canadian drug prices significantly below U.S. prices. Abolition of Canada's system of compulsory licensing—an effective and inexpensive method of regulating drug prices—and harmonization with U.S. drug patenting laws will force provincial health-care plans to shell out millions more dollars annually to drug companies (see sidebar).

Overall, health-care spending in Canada is not out of control as it is in the U.S., where health-care costs absorb an ever-increasing share of GNP. In Canada, health-care spending has risen over the last decade at roughly the same pace as the average income. And in the component covered by the public plans—hospitals, physicians, and administration (approximately 74 percent of the overall system)—costs have remained steady or fallen somewhat throughout the 1980s. If cost containment were the central consideration, this would tend to point to the conclusion, obvious though unacceptable to Farnsworth and the *New York Times*, that services that have remained outside the system (dentists, drugs, and “extras” such as private rooms in hospitals) should now be drawn into the public programs.

Are Canadians paying too much for health care? Not compared to the United States, though probably compared to other advanced industrial countries. Comparison of per capita costs for health care shows Canada to be on a par with some European countries, such as Germany and France, and well above the United Kingdom, Japan, and Austria. However, Farnsworth ignores this widely available data, as it would only emphasize that it is U.S. health-care costs that are out of step, not Canadian.

### Canadians Facing a Long-term Threat

In one important respect, Canadians are facing a long-term threat to their health-care system and indeed to all public services and enterprises. The neo-liberal policies of free trade, privatization, deregulation, and debt reduction followed by the federal and

most provincial governments, and promoted by the *New York Times* and Toronto's *Globe and Mail*, ultimately seek to require that all social services be dealt with simply as economic commodities to be shaped exclusively by the market.

But this campaign is proving hard to push. Canadians rejected private insurance and medicine for profit more than two decades ago, when they chose to establish their highly successful and popular universal health-care system. They again rejected it a decade ago when Parliament unanimously passed the Canada Health Act of 1984, banning “extra-billing” by doctors and reaffirming the five principles of the health-care system.

As Clyde Farnsworth noted, with polls regularly showing support for the health-care system by 85 percent to 90 percent of the population, few politicians would dare challenge the program directly.

## The U.S. Drug Lobby Strikes Again

A significant cost in any health-care system is pharmaceuticals. With 20-year patenting provisions on most drugs, the drug companies reap monopoly superprofits. In 1969, as a method of controlling drug prices, Canada amended the country's patent act to provide for compulsory licensing of pharmaceuticals. Compulsory licensing essentially negated the patent monopoly, encouraging the development of less expensive “generic” drugs and promoting competition to reduce prices.

While avoiding the large and cumbersome bureaucratic regulation associated with price controls, compulsory licensing led to a significant drop in prescription drug prices. By 1983, it was calculated that drug costs in Canada were more than \$200 million lower than they would otherwise have been.

In a sense, this legislation was an experiment in real “managed competition”—one that proved too effective for the multinational pharmaceutical companies to tolerate. They lobbied the Canadian government to repeal the legislation, but were unsuccessful until the late 1980s, when the U.S. government and its trade representative joined the fight to force Canadian compliance with the interests of the multinational pharmaceutical companies. They pressured Canada to “liberalize” its compulsory licensing provision, targeting it as an assault on “intellectual property rights.”

In 1987, after negotiating the Free Trade Agreement with the U.S., the Canadian federal government amended the compulsory licensing law, protecting monopoly patents for seven to ten years. This year, new legislation was passed extending the protection to 20 years—abolishing this inexpensive and effective method of controlling drug prices.

(For additional information, see Joel Lexchin, “Pharmaceuticals, Patents and Politics: Canada and Bill C-22,” *International Journal of Health Services*, Vol. 23, No. 1, 1993, pp. 147-60.)

—Elaine Bernard