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- 2.History of Health Care in Northern America
- 3.Health Care in the United States
- 4.Health Care in Canada
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- Boychuk, Gerard William. National Health Insurance in the United States and Canada: Race, Territory, and the Roots of Difference. Georgetown University Press, 2008.
- Fierlbeck, Katherine. Health Care in Canada: Policy and Politics. University of Toronto Press, 2011.
- Gratzer, David. Better Medicine: Reforming Canadian Health Care. ECW Press, 2002.
- Jonas, Steven. An Introduction to the U.S. Health Care System: Fifth Edition. Springer Publishing Company, 2003.
- Lipset, Seymour Martin. Continental Divide: The Values and Institutions of the United States and Canada. N.Y. Routledge, 1991.

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Introduction

Health care system is a complex area, touching on a variety of topics and disciplines. To understand its organization, we must look not only at the historical development, system of government and policy making, interest groups and health care provision and delivery, but inevitably also to the very nature of population of both countries. People living in Canada and the United States determine the health care system and shape its form.

The aim of the thesis is to compare Canadian and U.S. health care system with respect to its organization, legislature, infrastructure, as well as major entities of both systems. The emphasis is put on the differences between both systems and consequences of the organization and principles and issues respective countries have to address in order to secure the health of their population. Chapter 1 introduces Canada and the United States of America as countries occupying the North American continent and subject of interest of scholars comparing characteristics of both countries. Chapter 2 outlines both systems and history of medical and hospital care in Canada and the United States with focus on individual events which helped to shape the current form of health care. Chapter 3 consists of the description of government organization in Canada and the United States. It also includes the role of government in health care funding and provision. The emphasis is put on the legislation and policy making in both countries. Chapter 4 introduces the phenomenon of public health as different from public health care. The emphasis is put on the provisions and incentives of government health departments and agencies dealing with the health of population. Chapter 5 outlines the major issues and problems both systems try to address by introducing new implementations and policies and also includes analysis of health indicators reported by the Organization for Economic Co-operation and Development (OECD). Chapter 6 summarizes the most important aspects of both systems as well as current challenges both countries face.

1. Health Care in Northern America

Canada and the United States of America belong to the most developed countries in the world. Occupying the same continent, with English-speaking majority, they have been objects of comparison for many years. Especially Canadian scholars seem to be obsessed with the ‘other,’ trying to understand diverse qualities of southern neighbour. Robert Evans in his contribution to “*Canada and the United States: Differences that Count*” says that “the American alternative is there, the ever-present “Other” with which we compare virtually everything we do. So large, so self-absorbed, Americans implicitly assume that their own arrangements in any field are the best, the “natural” forms (possibly ordained by God) towards which the rest of the world should be guided and assisted.”¹ Evans further claims that Canadians “will always compare [themselves] to the United States because that’s what Canadians do. We cannot help it.”² Yet surprisingly, one of the revolutionary research based on comparison of Canada and the United States was carried out by an American scholar, Martin Lipset.

In his “*Continental Divide: The Values and Institutions of the United States and Canada*,” Lipset tried to understand the differences between the two countries through a comparative perspective. Being among the few American scholars fascinated by its northern neighbour, his work is considered to be a significant insight into the world of both nations. As he claims, “[I]ocated on the same continent, with the majority of their populations speaking the same language (although important minorities do not), they are probably as alike as any other peoples on earth. But (...) they are also somewhat dissimilar in political and religious institutions and in culture and values. They share many of the same ecological and demographic conditions, approximately the same level of economic development, and similar rates of upward and downward social mobility on a mass level. Today they are both wealthy and democratic societies, but they still march to a different drummer ...”³

Especially striking is the fascination of Canadians with the health care system in the United States. As Pat and Hugh Armstrong in “*About Canada: Health Care*” add,

¹ David Martin Thomas, *Canada and the United States: Differences that Count* (Peterborough, Ont.: Broadview press, 2000), 21.

² Thomas, *Canada and the United States*, 23.

³ Seymour Martin Lipset, *Continental Divide: The Values and Institutions of the United States and Canada* (New York: Routledge, 1991), 2.

“Canada’s focus on U.S. comparison is understandable, given our familiarity with what almost all of us reject as an unfair and expensive system.”⁴ It is true that the U.S. is considered to be a model for many countries around the world, or at least that is the impression of many. Katherine D. Fierlbeck in “*Health Care in Canada: A Citizen’s Guide to Policy and Politics*” notes that Canadians have tendency to compare their system with that of the United States because of proximity.⁵ Although many aspects of the country are worth awe and respect of the rest of the world, some are not; one of them being the health care system.

In the words of Martin Lipset, “the United States and Canada remain two nations formed around sharply different organizing principles. Their basic myths vary considerably, and national ethos and structures are determined in large part by such images. One nation’s institutions reflect effort to apply universalistic principles emphasizing competitive individualism and egalitarianism, while the other’s are an outgrowth of a particularistic compact to preserve linguistic and provincial cultures and rights and elitism.”⁶ “Canada and the U.S. have grown up with substantially different characters: group rights, public institutions, and defence to authority have abided north of the border, while individualism, private interests, and mistrust of authority have remained strong to the south.”⁷ Individuals’ beliefs and shared values, sense of responsibility, community, philanthropy, and freedom of choice all determine the present state of health care and show diversification of approaches towards health care. There have always been debates whether health is a private matter, a responsibility of every individual, or whether it is a right which needs to be protected and secured by the state.

The U.S. has one of the weakest welfare provisions among the developed countries.⁸ According to Fierlbeck, “the concept of ‘social solidarity’ is quite weak in the United States (with some regional variations), and there is frequently more emphasis on self-reliance.”⁹ Yet Americans have much greater sense of philanthropy and common good than Canadians because “the tradition of private support for worthy endeavours is far more deeply imbedded in the American psyche...Canadians appear to rely more on

⁴ Pat Armstrong and Hugh Armstrong, *About Canada: Health Care* (Black Point, Nova Scotia: Fernwood Publishing, 2008), 41.

⁵ Katherine Fierlbeck, *Health Care in Canada: A Citizen’s Guide to Policy and Politics* (Toronto: University of Toronto Press, 2012), 303.

⁶ Lipset, *Continental Divide*, 225.

⁷ Michael Adams, *Fire & Ice: the United States, Canada and The Myth of Converging Values* (Toronto, Ont: Penguin, 2009), 5.

⁸ Lipset, *Continental Divide*, 4.

⁹ Fierlbeck, *Health Care in Canada*, 284.

government than on voluntary efforts to finance such causes.”¹⁰ Why is it that Canada adopted a universal public health care system while the U.S. struggles to introduce similar system in their own country?

According to Lipset, the influence of British form of government and the smaller population relative to land mass is a major factor of Canada’s organizing principles concerning the role of government and the way it deals with social issues.¹¹ He points out that the United States is an exception among the developed countries in the lacking involvement in health care and welfare of its population.¹² The World Population Review¹³ states that the latest estimated number of population in Canada on March 20, 2014 was almost 35.2 million, the 37th most populous country in the world, occupying area of 9.9 million km².¹⁴ The United States was by March 14, 2014 the 3rd most populous with estimate of almost 320.6 million population with approximately 4.5% of total world population is spread over the area of almost 9.83 million km².¹⁵

Fierlbeck notes that there are six pillars of health care which represent desirable qualities towards which the health care is directed. Cost containment, efficiency, equity, universality, comprehensiveness, and responsiveness, those are the objectives of every successful health care system.¹⁶ Yet as she claims “any attempt to improve a health care system by focusing on one particular variable will likely have other consequences (either unintended or predictable) on other dimensions of the system.”¹⁷

“Citizens commonly seem more aware of the qualities that are lost through reforms than of the limited gains made; rarely is attempt at reform an unmitigated success. This is because the general characteristics of a desirable health care system cannot always be easily reconciled. Some principles — like universality and equity, or universality and cost control — are more constant; others — like equity and responsiveness, or equity and cost control — are less congruous.”¹⁸ The extent to which the respective health care systems succeed in reaching the desired qualities is a matter of long, complex, and

¹⁰ Lipset, *Continental Divide*, 143.

¹¹ Lipset, *Continental Divide*, 136.

¹² Lipset, *Continental Divide*, 136.

¹³ World Population Review. “World Population Review.” Accessed April 20, 2014. <http://worldpopulationreview.com/>

¹⁴ World Population Review. “Canada Population 2014.” Accessed April 20, 2014. <http://worldpopulationreview.com/countries/canada-population/>

¹⁵ World Population Review. “United States Population 2014.” Accessed April 20, 2014. <http://worldpopulationreview.com/countries/united-states-population/>

¹⁶ Fierlbeck, *Health Care in Canada*, 3.

¹⁷ Fierlbeck, *Health Care in Canada*, 301.

¹⁸ Fierlbeck, *Health Care in Canada*, 302.

deliberate study. More so that even the majority of Canadians and Americans do not understand how their health care system works, simply because they either don't use it as such, or they trust the state to do their best in protecting their health. While Canada takes part in the provision of health care through universal public health insurance system, to this date, there is no such system in the United States.

1.1. Medicare as a Symbol of Canada

Canada's national health insurance program – Medicare – has an iconic status as a major component of Canadian citizenship, a symbol of the country. As Fierlbeck notes, health care in Canada is highly political, playing a major role in federal and provincial elections, constitutional debates, and the articulation of Canadian identity, topic of debates over policy, and relationships between individual levels of government.¹⁹

Contrary to the public knowledge, Canada does not have a single national plan which would encompass universal conditions. Because of the federal organization of the country, the health insurance schema is composed of thirteen provincial and territorial health plans. Even though there are certain discrepancies among individual provinces and territories, they all share common features in order to meet the provision of the legislation stipulating health care in Canada – *Canada Health Act*. The universal public insurance program is designed to ensure health insurance coverage of medically necessary hospital and physician services for all residents irrespective of their ability to pay. General taxation is a major source of funding.

Both, the federal and provincial/territorial governments share roles and responsibilities over health care system in Canada. The federal government provides provinces and territories with cash contributions under the *Canada Health Transfer* (CHT). Federal legislation, criteria and conditions must be satisfied by the individual governments in order to qualify for financial support. Yet the management, organization and delivery of health care services available for the Canadians remain a matter of individual provincial/territorial governments.

Health insurance in Canada is provided by provincial and territorial plans and by private insurance companies. Under the *Canada Health Act*, medically necessary services are covered publicly. Approximately 60% of private health insurance is provided through

¹⁹ Fierlbeck, *Health Care in Canada*, ix.

employment benefits or purchased personally.²⁰ This form of insurance covers wide range of uninsured services such as vision and dental care, private nursing, drug prescriptions, and enhanced medical services. Third-party insurance plays an important role in coverage of the services which are not included in the plans of jurisdictions (secondary, supplementary services). Provincial and territorial governments are responsible for administering the health care insurance plan in their jurisdictions.

Health Cards

Every Canadian resident eligible for health insurance must apply for the coverage to the ministry or department of health. Specific criteria, application process and documentation may vary according to individual province and territory. Upon application for the insurance coverage, the individual will receive his or her health card which serves as a legitimation that the cardholder does not have to pay for the service he or she is seeking. In the case of loss or if the card is invalid, the procedure is paid directly by the individual and later paid back in a form of reimbursement of the ministry.

Administration

The responsibility for administering health insurance plan is autonomous to the governments in provinces/territories. They have the ability to choose specific structure of which best serves their needs. Those governments also negotiate physicians' fees and with health professionals and regional agencies approve hospital budgets.

Although according to the *Canada Health Act* medically necessary hospital and medical services are universally insured everywhere in Canada, provinces and territories may choose to provide ***supplementary health care services*** for their residents. Those are provided upon meeting the eligibility guidelines. Each province and territory issues its own list of insured services, which is reviewed periodically by the ministry of department of health and medical association. In addition, all provinces and territories provide specific services for certain population groups. The hospital and medical services to First Nations, Inuit and Innu population living in the reserves, as well as federal public service employees are provided by the federal government with the assistance of the *Noninsured Health Benefits Program*.²¹

²⁰ Most of the companies that offer insurance to their employees include also employees' families and other dependants to the health benefits.

²¹ Valerie D. Thompson, *Health and Health Care Delivery in Canada*. (Toronto, ON: Elsevier Canada, 2010), 169.

1.1. Health Care in the United States

With thousands of independent medical practices, partnerships and provider organizations; public and non-profit institutions such as hospitals, nursing homes, and other specialized care facilities; major corporations manufacturing drugs and devices, and great basis of health corporations; medical care in the United States is an enormous industry.²² It is considered to be by far the largest service industry of the country and eighth largest economy in the world.²³ With astonishing \$2.7 trillion in costs, consuming over 17% of the nation's gross domestic product, and employing workforce of over 16 million, health care is a target of attention and interest of the public, political leaders, and also all forms of media.²⁴ Health care of the United States is marked with great intensity on all levels of labour and personnel of corresponding types and functions. With the implementation of the new legislation, system of U.S. medical care becomes even greater puzzle.

The forms of health insurance in the U.S. are: (1) private plans, (2) federal Medicare for people over sixty-five, (3) state-federal Medicaid for the low-income population, and (4) none.²⁵ The insurance coverage depends on age, employment status (past and present), income, place of residence, and the nature of illness²⁶ as well as financial health of individual.²⁷

²² Harry A. Sultz and Kristina M. Young, "*Health Care USA: Understanding Its Organization and Delivery*" (Burlington, MA: Jones & Bartlett Learning, 2014), xxiii.

²³ Sultz and Young, *Health Care USA*, xxiii.

²⁴ Sultz and Young, *Health Care USA*, 1.

²⁵ Since March 31, 2014 the ACA provision of insurance exchange came to effect. Americans were to purchase health insurance coverage in the health insurance Marketplace, a website which collected all information necessary for individuals to choose preferable health insurance plan.

²⁶ Before the implementation of the ACA, in many cases pre-existent conditions were a reason why beneficiaries were dropped from the insurance coverage and were refused to be compensated for their medical expenses. Other insurance companies refused to ensure severely sick individuals as they represented high risks and it was not economical to cover their medical expenses.

²⁷ Fierlbeck, *Health Care in Canada*, 26.

2. History of Health Care in Canada and the United States

Throughout the history of Canada and the U.S., both systems have experienced significant changes in very nature of health care. From private matter of relationship between patient and physicians to modern and highly sophisticated model, the approach to health care has gone through intense transformation.

2.1. Canada: From Shamans to the Canada Health Act of 1984

After passing the *British North America Act* in 1867, the new Dominion of Canada came into being. It consisted of Ontario and Quebec (formerly Upper and Lower Canada), New Brunswick, and Nova Scotia. Each province has its representatives in government, own law-making body, as well as Lieutenant Governor who represented the Crown.²⁸ The responsibilities for health of the population of almost 3.7 million people (according to the first census in 1871) were divided between the federal and provincial governments.²⁹

2.1.1. Early Beginnings

From the very beginning, the federal government was responsible for establishment and maintenance of marine hospitals, the care of Aboriginal population, and the management of quarantine to prevent outbreaks of diseases.³⁰ Responsibilities such as social welfare were not clearly defined by the Act, however were assumed by default as a part of public health and therefore matter of provinces/territories which established and managed hospitals, asylums, charities and other charitable institutions.

2.1.2. 19th century

During the 18th and early 19th century, hospitals served primarily as caring places for poor while other patients were treated at home. First doctors came to Canada from Europe (primarily English and French civilian and military physicians) as settlers and cared for the sick in their homes.³¹ Since only the wealthiest patients could afford medical care in hospitals, the less fortunate turned to religious or other charitable organizations. Later on, patients' homes substituted hospitals with family and friends taking care of the

²⁸ Thompson, *Health and Health Care Delivery in Canada*, 73.

²⁹ Thompson, *Health and Health Care Delivery in Canada*, 73.

³⁰ Thompson, *Health and Health Care Delivery in Canada*, 73.

³¹ Thompson, *Health and Health Care Delivery in Canada*, 74.

sick and disabled.³² By the time of Confederation, the number of medical care providers (doctors, hospitals) and also medical schools has increased, allowing medical care to be more accessible to wider population.³³

2.1.3. 20th century

In 1914, due to the increasing shortage of physicians in their community, the residents of Sarnia, a small municipality in Saskatchewan, devised a plan to keep a local doctor from going to war and decided to use municipal tax money for paying him \$1500 to practice medicine in the community.³⁴ Despite government's disapproval, their action attracted attention of other doctors and with the passage of the *Rural Municipality Act* in 1916, the government allowed municipalities to collect taxes for funding local physicians and hospitals. In 1919, the Liberal election campaign was based on and attempt to introduce publicly funded health care system in Canada much to the discontent of provinces and territories which refused joint funding.³⁵

During the 20th century a demand for improving health care for the poor emerged as the Great Depression of 1929 and the World War II both proved to be essential for introduction of public care in Canada. After the economic crises of 1929, while some patients started to pay for doctors and hospitals in food and services, majority of Canadians did not get any health care at all. This led to an increase of discontent among the population and various protests were initiated throughout the country as public started to call for national health program. Government was reluctant in involvement in public health care marketplace, yet pledged to provide for the most deserving and vulnerable individuals and realized that more affordable, secure and accessible health care system was necessary.³⁶ In 1935, the *Employment and Social Insurance Act*, allowed federal government to collect taxes which would fund provision of social benefits which however the Supreme Court of Canada and the Privy Council of Great Britain declared as unconstitutional and violating authority of the provinces and territories.³⁷

When Canada entered the WWII in 1939, the economy was still in a bad shape. Nevertheless, major investments in the health-care sector, especially training and

³² Thompson, *Health and Health Care Delivery in Canada*, 74.

³³ Thompson, *Health and Health Care Delivery in Canada*, 74.

³⁴ Thompson, *Health and Health Care Delivery in Canada*, 81.

³⁵ Thompson, *Health and Health Care Delivery in Canada*, 81.

³⁶ Thompson, *Health and Health Care Delivery in Canada*, 81.

³⁷ Thompson, *Health and Health Care Delivery in Canada*, 81-2.

employment, were to improve health of Canadian population.³⁸ Also the invention of new modern technologies and forms of treatment led to need for hospitals which would effectively utilize modern and innovative equipment. The war also emphasizes and strengthened feeling of solidarity among Canadians and the legacy of war left Canadians with an expectation that government should intervene in most matters of population, especially those in need.³⁹ In 1940, the provincial and territorial government agreed to amend the *British North America Act* which led to the introduction of a national unemployment insurance program and in 1946 another legislation, concerning family allowances for children aged 16 or under, was successfully passed.⁴⁰

WWII was followed by major changes in political landscape and major shift in the thinking of Canadians. Provinces and territories took responsibilities over social and economic lives of their populations, the federal government was to provide for reasonable standard of living and acceptable access to basic services, including health care.⁴¹ This was a step towards emerging of new social programs with the modification of the existing ones and formalizing of health insurance. Inventions in medicine and shift from home to hospital-based care demanded a greater need for organized health care. It was believed that involvement of the federal government would result in more equitable and stable funding, supporting medical discoveries. In following years the government together with the provinces set up a number of grants to fund the development of health care services. Through the National Health Grants Program, the government offered a total of \$30 million to improve and modernize hospitals, provide training for professionals, and fund research in various medical fields.⁴² These programs resulted in a massive hospital building across the country.

Despite continuous request for a nationally funded health care system, the federal government, provinces and territories continued to struggle over the implementation of the system. In 1957, the federal government introduced the *Hospital Insurance and Diagnostic Services Act*, offering every province or territory in Canada (willing to implement a comprehensive insurance plan) a federal assistance in the form of 50 cents for every dollar spent on the plan.⁴³ After some deliberation, all provinces agreed and

³⁸ Armstrong and Armstrong, *About Canada*, 12.

³⁹ Armstrong and Armstrong, *About Canada*, 13.

⁴⁰ Thompson, *Health and Health Care Delivery in Canada*, 82.

⁴¹ Thompson, *Health and Health Care Delivery in Canada*, 82.

⁴² Thompson, *Health and Health Care Delivery in Canada*, 83.

⁴³ Thompson, *Health and Health Care Delivery in Canada*, 83.

became part of the scheme. But not all provinces (primarily due to population distribution) were able to meet the needs for comprehensive services and the equalization payment system was introduced. Yet the struggle for national health insurance plan was not over.

Tommy Douglas, the premier of Saskatchewan, argued that health care is not only part of human dignity, but also basis for economic efficiency. He is often called a father of Medicare and significant figure of Canadian history. Douglas was the first political figure to introduce public health system. In 1961, he declared that “the time is surely past when people should have to depend on proving need in order to get services that should be the inalienable right of every citizen of a good society. It is all very well for some people to say that there is no stigma or humiliation connected with having to prove need. This is always said by people who know that they are in no danger of having to prove need.”⁴⁴ His popularity can be seen also in the fact that in 2005 he was voted the greatest Canadian ever in a CBC television poll.⁴⁵

The province of Saskatchewan under Douglas enacted the *Municipal and Medical Hospital Services Act* in 1939, allowing municipalities to collect a land or a personal tax to finance hospital and medical services and in 1947 the government passed the *Hospital Insurance Act*, guaranteeing the residents of Saskatchewan hospital care in exchange for a modest insurance premium payment.⁴⁶ Further attempts to provide citizens with comprehensive and publicly funded medical care met with a strong opposition of Saskatchewan doctors, who worried that they would be controlled by the province and the tradition of private and independent practice would be lost. The government was forced to modify its proposal and the new legislation ensured that doctors could practice independently, yet with fees paid and negotiated by the government.⁴⁷ Services provided were covered by taxes and hospital care was available for everyone in the province irrespective of their ability to pay. Even though in the beginning there was a strong opposition of those who saw the plan as a way to expensive care of questionable quality, the predictions did not come true and the success of Saskatchewan model attracted attention of other provinces who implemented similar models. The call for universal health care system across Canada was however still undermined by those who feared the

⁴⁴ Fierlbeck, *Health Care in Canada*, 18.

⁴⁵ Armstrong and Armstrong, *About Canada*, 15.

⁴⁶ Thompson, *Health and Health Care Delivery in Canada*, 84.

⁴⁷ Armstrong and Armstrong, *About Canada*, 17.

intervention of federal government. The provinces anticipated loss of autonomy granted by the *British North America Act*. The federal government reacted by offering funds for hospital construction and education of health care personnel which led to an enormous expansion of hospitals, yet left provinces, insurance companies and individuals with the bills for services.⁴⁸

In 1960, the federal government authorized the Royal Commission on Health Service (known also as the Hall Report), a committee investigating the state of health care in Canada and possible alternatives to already well-established Saskatchewan model. It was headed by the Honourable Justice Emmett Hall who noted that free health care is an economic investment in the country and urged the federal government to retain strong control over health care financing while the provincial and territorial governments keep a degree of authority over the implementation of their own health care services.⁴⁹ The commission suggested constructions of new medical schools and hospitals and provision of scholarships to doctors and dentists in preparation for caring of the growing and aging Canadian population. After long deliberation, the committee agreed that the single system was the most efficient and effective one.⁵⁰ The *Medical Care Act* was introduced by the Parliament in December 1966 and implemented on July 1, 1968.⁵¹ Each province and territory was free to administer the plan in its own way with the condition that it met the criteria outlined by the Act – universality, portability, comprehensive coverage, and public administration. As a result, the position of physicians as primary health care professionals was reinforced. The funding from the federal government was restricted to hospital-based and physician-oriented services. The need for community-based services outside the hospital and the alternative funding arrangements became evident.⁵² The expenditures of government increased rapidly and provincial and territorial spending was to be reduced by a new system of funding. Under this new provision, provinces and territories gained greater freedom how they could spend money. EPF based the cash transfers on number of residents in each province/territory and the rate of economic growth.⁵³ This led to major cuts in government funds and individual jurisdiction had to reduce the services provided, much to the dislike of residents. Doctors used extra-billing

⁴⁸ Armstrong and Armstrong, *About Canada*, 17.

⁴⁹ Thompson, *Health and Health Care Delivery in Canada*, 84-5.

⁵⁰ Armstrong and Armstrong, *About Canada*, 19-20.

⁵¹ Thompson, *Health and Health Care Delivery in Canada*, 86.

⁵² Thompson, *Health and Health Care Delivery in Canada*, 86.

⁵³ Armstrong and Armstrong, *About Canada*, 22.

and hospitals decided to reduce staff and hospital beds, as public health care came under a threat. A second royal commission lead by Emmett Hall was called into action and in 1980 recommended that in order to put an end on extra billing which violated the *Medical Care Act*, it was necessary to allow doctors to practice outside the Act.⁵⁴ A new piece of legislation was to be introduced in 1984, probably the most famous one in Canadian history – the *Canada Health Act*.

2.2. The U.S. & the Road towards the Affordable Care Act of 2010

The transformation of health care from a simple professional service to an immense and complex corporation-dominated industry was influenced by various factors. Legislative, political, economic, organizational as well as professional just to mention a few. Changing population demographics, aging of Americans caused by technological and scientific advances, rising costs and the effects of medical education all played an important role in the development of American health care system.⁵⁵

Since early 19th century, the United States has been trying to introduce a campaign for universal healthcare, which was becoming a common practice in developed countries of Europe. Some started with compulsory sickness insurance for workers as early as the end of 18th century, other countries (including Sweden, Denmark, France or Switzerland) subsidized the benefit societies formed by workers themselves.⁵⁶

2.2.1. Early Beginnings

Hospitals in the early era of America were founded to serve as shelters for older adults, the dying, orphans and the vagrants and especially to protect the rest of the community from the sick and mentally ill.⁵⁷ The first hospitals, pest houses, or quarantine stations were established in isolation as a prevention from spreading the disease to the rest of the population. Medical care was practiced solely at patient's home as hospitals became houses of horror, accommodating the individuals posing a risk to the ordinary people.

⁵⁴ Thompson, *Health and Health Care Delivery in Canada*, 88.

⁵⁵ Sultz and Young, *Health Care USA*, 33.

⁵⁶ Physicians for A National Health Program, "A Brief History: Universal Health Care Efforts in the US" Accessed April 21, 2014. <http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us/>

⁵⁷ Sultz and Young, *Health Care USA*, 110.

2.2.2. 19th century

During the 19th century, a group of professional healers came to dominate the field of health care in the United States and established a powerful and unified organization of physicians. Various medical societies, including the American Medical Association,⁵⁸ were in charge of licencing process, allowing the physicians to practice medicine and provide health care. Medical practice was considered simple and often involved long-standing relationships between patients and their physicians who had complete control over their own practice and gained a freedom as to where, when, and how they practiced it without any interference from outside. The fees were confidential between the two parties. As practitioners endowed medical practice with mystery, patients were willing to pay any amount of money that would secure them adequate care. Physicians, upon having the privilege to collect the bills themselves, usually estimated the fees according to individual patients' ability to pay.⁵⁹

2.2.3. 20th century

Reformers (being aware of their own as well as community's social welfare) began to call for improvement in social conditions of powerful working class.⁶⁰ Americans started to turn to their employers, as well as various fraternal orders, guilds, trade unions or even individual commercial insurance companies in order to get a compensation for their lost income during sickness or injury.⁶¹ These compensations later extended to their dependents and marked a beginning of social insurance programs uniformly targeted against the risks of an income loss caused by accident, sickness, or disability of the workers. Driven by the prospect of prosperous business, some commercial life insurance companies introduced lump-sum payments at death which compensated for final medical expenses and funeral costs, other companies gained popularity due to premium payments required by industrial policies. The 1920s witnessed a major backlash to the health care reform plans as the campaign for compulsory health insurance was interrupted in 1917 by World War I and 'anti-German fever' which considered 'socialist' insurance program inconsistent with the American values of

⁵⁸ The AMA which noted that "no third party [must] be permitted to come between the patient and his physician in any medical matter" and warned against alteration of "the old relations of perfect freedom between physicians and patients." (Sultz and Young, *Health Care USA*, 34.)

⁵⁹ Sultz and Young, *Health Care USA*, 33-4.

⁶⁰ *A Brief History*.

⁶¹ Sultz and Young, *Health Care USA*, 34.

freedom.⁶² Resistance towards health care reforms appeared also in the post-war, anti-Communist, era and the call for public insurance was in 1919 condemned by the resolution of the AMA House of Delegates, much welcomed by the physicians afraid of loss of freedom over own medical practice.⁶³ Yet it did not take long before the financial security of physicians and hospitals came at stake again, this time due to the Great Depression of 1929 when nation's inability to pay for medical services was enormous and resulted in drops in incomes of physicians and hospital admission rates.⁶⁴ In order to save their existence, medical service providers started experimenting with insurance plans.

The Baylor University Hospital Plan included enrolment of 1,250 public school teachers at a monthly payment of 50 cents which guaranteed 21 days of hospital care⁶⁵ and later served as a model for the genesis of Blue Cross hospital insurance. A trend of multihospital plans followed and brought about increased availability to hospital care and strengthened cooperation between physicians and hospitals. By 1937, there were 26 plans with more than 600,000 members.⁶⁶

The AMA, being a major stakeholder in the organized medicine system, was continuously antagonistic to the concept of universal health insurance and invested large amount of money in lobbying against it. Various attempts of introducing voluntary health insurance by a group of prominent Americans (from medical, public health, and social science fields) met with rejection from members of the Committee on the Costs of Medical Care (a formation of self-created, privately funded group), responsible for solving the long-standing issue of U.S. public health care.⁶⁷ The AMA experts expressed concern over increased medical expenses. Some projected health insurance as a cause of possible “destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession.”⁶⁸ The AMA once again called the plans “economically unsound, unethical, and inimical to public interest,” expressing a concern for people who were forced into “saving for sickness.”⁶⁹ Slowly but surely, the government realized that it was necessary

⁶² *A Brief History*.

⁶³ Sultz and Young, *Health Care USA*, 34.

⁶⁴ Sultz and Young, *Health Care USA*, 35-6.

⁶⁵ Sultz and Young, *Health Care USA*, 35-6.

⁶⁶ Sultz and Young, *Health Care USA*, 35.

⁶⁷ Sultz and Young, *Health Care USA*, 35-6.

⁶⁸ Sultz and Young, *Health Care USA*, 36.

⁶⁹ Sultz and Young, *Health Care USA*, 35.

to become part of health care legislation, as the most significant social initiative ever passed by Congress, the *Social Security Act of 1935*, came to effect.⁷⁰

Following World War II, the federal government started to invest in building new hospitals and facilities and medical research, which led to increase in costs. Instead of putting pressure on hospitals and physicians to contain their costs, private insurance companies raised premiums. A prominent role in raising costs of health care in the decades after World War II played also federal government's coverage of health care for special populations (in the forms of categorical or disease-specific programs designed to address needs not otherwise met by state or local administrations or the private sector).⁷¹ Much less was allocated to other activities, like research, development, and public health activities.

Finally in 1965, the proponents of government-sponsored insurance to older adults and low-income population enabled the passing of Medicaid and Medicare legislation in 1965 as a part of *Great Society Legislation (Social Security Act)*.⁷² Voluntary health insurance against hospital care costs became dominant product of insurance companies in the United States. In the 1970s government started to invest in medical programs which led to major improvement in medical care and treatment of previously life-threatening diseases, yet consequently also to enormous increase in government costs.⁷³ Due to technologic revolution, Medicare and Medicaid costs were also constantly increasing with U.S. health care expenditures exceeding \$2.7 trillion (over 17% of the gross domestic product).⁷⁴

Although the main concern of the government became the reduction of costs, no effort was put in controlling access and often questionable quality of provided care. The main problem proved to be the legislation process. Providers of health care wanted to take control over the change of system but first had to face powerful medical and hospital lobbies, physicians, hospital administrators, and other health professionals focusing on their own interests.

During the 1980s, the situation remained tense as the interest groups were fighting for their own profit, ignoring the needs of population. In 1973, the *Health Maintenance Organization Act* advocated development of health maintenance organizations

⁷⁰ Sultz and Young, *Health Care USA*, 37.

⁷¹ Sultz and Young, *Health Care USA*, 37.

⁷² *A Brief History*.

⁷³ Sultz and Young, *Health Care USA*, 38.

⁷⁴ Sultz and Young, *Health Care USA*, 39.

responsible for the financing and delivery of comprehensive health services to population for a prepaid, fixed fee.⁷⁵ The HMOs were expected to promote health and prevent illness, and therefore hold the costs of the health services down. In the beginning of 1990s, a significant reduction in expenditures for social programs was made by the government; a step previously rejected. Prospective payment for Medicare based on diagnosis-related groups substituted the retrospective payment of hospital charges in order to contain health care costs.⁷⁶ The issue of uninsured population grew stronger as the number of Americans without adequate or any health insurance was estimated at 37 million as the *Health Insurance Portability and Accountability Act* signed into law in 1996.⁷⁷ It permitted individuals to continue insurance coverage after a loss or change of employment and regulated the circumstances in which an insurance plan limited benefits due to pre-existing conditions.

2.2.4. 21th century

On November 12, 2008, days after the election of Barack Obama, “*A Call to Action: Health Reform 2009*” was released by Senator Max Baucus in which he outlined intention to improve access to quality, affordable health care, and to control costs in the U.S. health care system.⁷⁸ It was the time of economic crises which led to numerous political pledges concerning economic stimulus, education reform, and bailouts for banks and automobile industry, all of which required significant financial resources. Analyses and assessments crafted by the most prestigious academic research and industry experts noted that U.S. health care system focused on providing care for individuals with acute conditions, completely ignoring the needs of wider population, which could benefit from primary preventive care.⁷⁹ The system rewarded reimbursement to providers for services delivered rather than with financial aid which would ensure improvement or at least maintaining of health status among populations.

⁷⁵ Sultz and Young, *Health Care USA*, 41.

⁷⁶ Sultz and Young, *Health Care USA*, 42.

⁷⁷ Sultz and Young, *Health Care USA*, 51.

⁷⁸ Sultz and Young, *Health Care USA*, 55.

⁷⁹ Sultz and Young, *Health Care USA*, 55-6.

3. Health Care Systems in Canada and the United States

Both countries adopted different approaches to the development of health care programs. Canada started with hospital constructions due to heavy government investments which led to expansion of hospital services. The United States on the other hand, through their Medicare and Medicaid and other public programs focused on particular population groups: the poor, the elderly, the disabled, and also the military. Today, national systems of health care differ not only in the complexity of their organization and financing, but also in the extent to which health care as such is a problem for individual user. It is therefore no wonder that majority of Canadians and Americans become lost when it comes to system of health care.

3.1. Role of Government and Funding

As Lipset notes, “the cross border differences in North American values, reflecting the varying organizing principles of the two polities, show up in the disparate roles assigned to government and voluntary initiative in dealing with social issues. North of the border, the Tory orientation and the smaller population relative to land mass have meant a larger number of functions for the state. The United States, set in a classically liberal-Whig mold, stands out among developed countries in the relative lack of involvement of its governments in fields such as ownership of industry, welfare, health care, and urban amenities.”⁸⁰ Differences between Canada and the United States are particularly striking with respect to the role government has in medical care.

The American system is one in which “the government pays most of the cost of health care for the elderly, the poor and the disabled. Most others either have health insurance paid for by their employers or have to buy it from an insurance company. Some have no insurance. Conversely, the Canadian system is one in which the government pays most of the cost of health care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals.”⁸¹

⁸⁰ Lipset, *Continental Divide*, 136.

⁸¹ Lipset, *Continental Divide*, 138.

Lipset also notes that whereas in Canada there is a consensus between Canadian politicians about the commitment to public payment for medical costs and control of prices paid to physicians and hospitals, the medical profession in the United States retains more power even in the publicly funded sector.⁸² Fierlbeck agrees by saying that “[d]iscussions over health care funding are not simply about allocation of money and the regulation of services, but rather about the interplay of human relations, the resolution of political struggles, and the kinds of values that democratic societies reflect through their public policies.”⁸³

3.1.1. Canadian Federalism of Health Care

Canada is a federal parliamentary democracy and a constitutional monarchy, Queen Elizabeth II being the head of state. Canada comprises of four main regions (composed of ten provinces and three territories: Western Canada, Central Canada, Atlantic Canada, and Northern Canada).

Being a constitutional monarchy, employs federalism as its system of government. The power is divided between the federal, provincial/territorial and also local governments. This organizational structure applies also to the health care policy. Provinces execute more autonomy over the territories which are situated in remote areas of the continent. Because territories are usually less-populated than provinces, the federal government is responsible for their social programs (such as welfare, education and welfare). Territories also obtain equalization payments to substitute for the revenues collected by larger and wealthier provinces.

Health care system of Canada is a *fragmented system*, controlled by provinces but coordinated by the federal government. “The dynamics of Canadian health care – including pressures for change and options for implementing change – are to a large extent determined by legal institutions.”⁸⁴ The framework of health care federalism is embedded in the *Canadian Constitution* (originally the *British North America Act*). By the time the constitution was negotiated in 1867, health care was considered a private matter. Most of the care was provided privately at home with family members taking care of the sick or disabled and hospitals were voluntarily run by churches or charitable organizations. Health care was seen as rather minor matter of public interest suited for provincial regulation. Yet since then, the nature of health care has gone through a

⁸² Lipset, *Continental Divide*, 139.

⁸³ Fierlbeck, *Health Care in Canada*, 17.

⁸⁴ Fierlbeck, *Health Care in Canada*, 20.

significant change and transformed from private matter to highly sophisticated and expensive system difficult to be provided solely by small jurisdictions. While the provinces and territories are responsible for delivering health care to the majority of Canadians, the federal government also has an array of roles and responsibilities that affect health and health care in the whole country.

In the era of complex and expensive health care of technological advances and the need for innovations, the ability to experiment and test new ideas is facilitated within federal structure of Canada. The provinces claim regulatory powers, but the federal government has essential expenditure power. The federal government also enjoys influence through its residual powers in discussion over issues of public health and is also responsible for the federal health plans, securing care for specific groups of Canadians (First Nations, etc.), provincial/territorial governments remain their own autonomy over health care delivery.

Yet as Fierlbeck argues, the federal government uses financial support as a means of controlling the provinces/territories actions in health care matters.⁸⁵ It bases allocation of federal money on provinces' compliance with the provisions set out by the *Canada Health Act*. Although the provisions are not legally binding, meaning that their breaching is not against the law, provinces and territories adhere to the provision voluntarily.

Transfer Payments of the Federal Government

The amount of money allocated to provincial and territorial governments through transfer payments are calculated and distributed through five main transfer models.⁸⁶

1. The Territorial Financing Formula

Money allotted to the territorial governments in Yukon, the Northwest Territories and Nunavut are based on their unique geography, population distribution, and high cost of delivering health care and other public services to these remote locations. Because such areas are not popular among practitioners, there are incentives (in the form of recruitment and retention bonuses) from the federal government to attract the attention of physicians in order to secure the health care for their residents.

⁸⁵ Fierlbeck, *Health Care in Canada*, 20-1.

⁸⁶ Thompson, *Health and Health Care Delivery in Canada*, 186-9.

2. Equalization Payments

The difference between wealthy and poor provinces and territories play an important role in the allocation of federal funds. Equalization payments are embedded in the *Canadian Constitution* and ensure that ‘provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.’⁸⁷ Provinces which are better well-of can afford to provide more public services to their residents. Equalization payments prevent poor territories from raising taxes to meet the medical needs of their residents. Money received equals difference between fiscal capacity (ability to generate income) and the 10-province standard (i.e. the national average).⁸⁸ The provinces and territories have complete control over the way they spend the equalization payments and it is not limited only to the health care.

Provinces eligible for equalization payments in 2010 were: Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario, and Manitoba (source: Department of Finance Canada).⁸⁹

3. The Canada Health Transfer

The transfer from federal to provincial and territorial governments consist of tax points and cash. (Tax points are a reduction in amount the federal government taxes the provinces and territories. In turn, provinces and territories can increase their taxes by the amount of tax points and use the money earned from their taxes to pay for medical services.)

4. The Canada Social Transfer

These funds are directed towards social programs, child care, as well as postsecondary education. Contrary to the equalization payments, they must be used in concrete areas stated above. Until 2014, the money transferred through the Canada Social Transfer will be annually increased by 3% (‘automatic escalator’) until the legislation will be renewed.⁹⁰

⁸⁷ Thompson, *Health and Health Care Delivery in Canada*, 188.

⁸⁸ Thompson, *Health and Health Care Delivery in Canada*, 187.

⁸⁹ Thompson, *Health and Health Care Delivery in Canada*, 188.

⁹⁰ Thompson, *Health and Health Care Delivery in Canada*, 189.

5. The Health Reform Transfer

Through the HRT, additional funds are provided for reform in primary care, home care services and also the drug cost coverage.

The funding of provincial and territorial health care is preceded by long and complicated process of analysis, proposals, agreements and bargaining over health care expenditures and needs of individual jurisdictions.⁹¹ Once the agreement is met and signed (in form of an Accord), the provinces and territories are obliged (although not through legislation) to meet the five provision of the Canada Health Act in order to get financial support from the federal government. The health care spending among provinces and territories varies considerably. This is caused by several factors (demographics, population distribution, age and health of population). As mentioned earlier, jurisdictions are able to choose their own health care insurance plan as well as services they provide, depending on which it regards as medically necessary.

The role of federalism in Canadian system of health care is subject of controversy among individuals. Fierlbeck discusses two major questions⁹² which arise: first, does a health care system function better governed at a national or a regional level? Second, what is the best way to facilitate a working relationship between individual levels of government in health care?

As she notes, national-level government has much more economic and administrative capacity to establish such expensive and complicated service as health care. There are discrepancies between individual provinces in their fiscal ability as well as expertise required for establishment of highly sophisticated modern health care systems. Moreover, larger and wealthier provinces are able to invest great capital into modern technology and infrastructure (e.g., electronic health records) while the rest is left with outdated equipment. Disparities among provinces can lead to differences in the quality of services as well as distribution of health professionals within provinces and territories.⁹³ The federal government provides the remote territories with payments which serve as means to diminish the difference between individual areas. Also, doctors are offered bonuses when they decide to practice in remote locations. Another subject of disputes is the issue of accountability and responsibility. With the large number of

⁹¹ Thompson, *Health and Health Care Delivery in Canada*, 189.

⁹² Fierlbeck, *Health Care in Canada*, 44.

⁹³ Fierlbeck, *Health Care in Canada*, 45.

jurisdictions, it is difficult to determine who is responsible for the failures of the system.⁹⁴ Such fragmented system is inefficient in addressing global issues and react to sudden events (terrorist attacks, epidemics) or those which occur on an international basis. It takes too much time for individual provinces and territories to get involved in actions crucial for securing the health of Canadians.

The fragmentation of health care has also significant advantage. Because there is no universal health plan in Canada, the federal government gives provinces and territories relative freedom about their own health plans. Therefore, “regional governments are more responsive and accountable to local populations, and smaller government in smaller jurisdictions have the capacity to be more flexible and innovative.”⁹⁵ Provincial governments better understand the local political culture, better comprehend the needs and limitations of the territory they have control of, and can take into consideration public opinion. “Effective health care is complex, expensive, and wide-ranging, requiring collaboration, coordination, and communication.”⁹⁶ The question of autonomy often causes tension between the federal and provincial/territorial governments. The federal government is not only a provider of financial support through Canada Health Transfer, but it also offers leadership, advice and direction on health care issues of the country, thus expanding its influence in the matters of individual jurisdictions. The role of financing is fundamental for provinces’ ability to establish public insurance systems. The research and evaluation role comprises funding of other governmental bodies. The federal government also monitors health infrastructure, as well as health human resources and health technologies. Disputes between governments harm the system. With personal interests being above those of the Canadians, policy making can become a quarrel of egos rather than sophisticated opinions and ideas how to secure health of Canadians. Yet the situation is nowhere as bad as in the United States.

3.1.2. The U.S. as a Source of Payment

The United States of America, referred to as the United States (U.S.) is a federal republic, consisting of 50 states and a federal district of Washington D.C. In the past, the federal and state governments concentrated solely on funding services for specific population groups; people in government service and their dependents, Native Americans, etc. Today, a combination of public programs constitutes nearly 40% of total

⁹⁴ Fierlbeck, *Health Care in Canada*, 46.

⁹⁵ Fierlbeck, *Health Care in Canada*, 46.

⁹⁶ Fierlbeck, *Health Care in Canada*, 48.

national care expenditures.⁹⁷ The most essential are the federal Medicare and joint federal-state Medicaid programs. Other programs supported by federal government are: U.S. Public Health Service hospitals, the Indian Health Service, state and local inpatient psychiatric and long-term care facilities, the Veterans Affairs hospital and health services, the Department Defence services, public health activities, as well as various grants and initiatives.⁹⁸

However as Sultz and Young note, “in the absence of a comprehensive national health and social services policy, government’s role in financing health care services can be described as a system only in the loosest interpretation of the term”⁹⁹ – health care financing is a matter of individual programs of reimbursement, direct payments, grants, matching funds and subsidies. The government – rather than providing services directly – serves as a link between health care providers and purchasers which Sultz and Young describe as a ‘vendor-purchaser relationship.’¹⁰⁰

3.1.2.1. *Medicare*

Medicare, or the “Health Insurance for the Aged,” Title XVIII of the Social Security Act of 1965 signalled government’s entry to personal health care financing and meant a breakthrough in the system of health insurance in the United States.¹⁰¹ Currently, it covers approximately 50 million Americans, including elderly, younger disabled individuals and others eligible for the coverage. In 2012, the expenditures of Medicare were \$550 billion and it is projected that by the year 2022 they will reach \$1.1 trillion.¹⁰²

The proposition of the *Social Security Act* was preceded by various discussions over social legislation. There has been a significant resistance from the private sector and also organized and voluntary medicine (the AMA) which has prevented the enactment of comprehensive national health care system.

Originally, Medicare was composed of two parts, based on the resources for funding and benefits.¹⁰³ The mandatory **Part A** coverage was funded by Social Security payroll taxes and provided benefits for hospital care, limited nursing care, short-term home health care after hospitalization, and hospice care. **Part B**, supplementary medical

⁹⁷ Sultz and Young, *Health Care USA*, 313.

⁹⁸ Sultz and Young, *Health Care USA*, 313.

⁹⁹ Sultz and Young, *Health Care USA*, 313.

¹⁰⁰ Sultz and Young, *Health Care USA*, 313.

¹⁰¹ Sultz and Young, *Health Care USA*, 314.

¹⁰² Sultz and Young, *Health Care USA*, 314-16.

¹⁰³ Sultz and Young, *Health Care USA*, 313-16.

insurance, was a voluntary program, funded by beneficiary premium payments and federal general revenues. This plan covered physician services and outpatient diagnostic tests, medical equipment and supplies, as well as home health services. Based on a voluntary enrolment, **Part C** or Medicare + Choice, was added by the *Balanced Budget Act of 1997* and allowed private health plans to administer Medicare contracts. The *Medicare Prescription Drug, Improvement, and Modernization Act* added **Part D** for prescription drug coverage.

Despite the effort to reduce spending of Medicare, it is projected that Medicare will account for 5.7% of the nation's GDP by 2035.¹⁰⁴ To control the spending of Medicare for each beneficiary, the ACA established the **Independent Payment Advisory Board** (IPAB) which is required to produce annual health care report, submit recommendations and propose legislation to slow growth in national expenditures to health care since 2015.¹⁰⁵

As Sultz notes, in spite of efforts to introduce a public health insurance which would help the elderly and less fortunate Americans bare medical care costs, the system poses various limitations (e.g., deductibles, co-insurance, and limited compensated days of hospital care).¹⁰⁶ So-called 'Medi-gap' policies offered commercial insurers to enter into the system.

3.1.2.2. *Medicaid*

Medicaid legislation was enacted together with Medicare as a part of the *Social Security Act* in 1965. The state through Medicaid provides health care for over 62 million of economically needy, low-income Americans; including children, adult, elderly and those with disabilities.¹⁰⁷ This number will however rise due to the ACA and Medicaid eligibility expansion. It is one of the most funded health care programs and a third largest source of health insurance in America. Approximately two thirds of Americans enrolled in Medicaid receive their benefits through managed care as an effective way of health care delivery.¹⁰⁸ Funded by personal income and corporate and excise taxes, Medicaid represent a transformation of funds from economically affluent individuals to those in need.¹⁰⁹

¹⁰⁴ Sultz and Young, *Health Care USA*, 335.

¹⁰⁵ Sultz and Young, *Health Care USA*, 335.

¹⁰⁶ Sultz and Young, *Health Care USA*, 316.

¹⁰⁷ Sultz and Young, *Health Care USA*, 325.

¹⁰⁸ Sultz and Young, *Health Care USA*, 326.

¹⁰⁹ Sultz and Young, *Health Care USA*, 326.

Medicaid is a joint federal-state program, the sharing of expenses based on per capita income of individual state.¹¹⁰ As in Canada, individual plans and policies vary across states. There are no directives from federal government as to what exactly the states should provide for their residents. The government however issues guidelines outlining specific individuals and groups that must be covered under federal Medicaid plans.

The three main coverage programs include:¹¹¹

1. Health insurance for **low-income** families with children;
2. Long-term care for **older** Americans and individuals with **disabilities**;
3. Supplemental coverage for low-income Medicare beneficiaries for services not covered by Medicare, including Medicare premiums, deductibles, and coinsurance.

3.1.2.3. Children's Health Insurance Program (CHIP) 1998

The most recent public health insurance program is targeted at uninsured children living in low-income families. The *Balanced Budget Act* of 1997 included an initiative of State Children's Insurance Program (later evolved into Children's Insurance Program (CHIP)). The eligibility for CHIP was based on the family income which was too high for the enrolment to Medicaid, yet too low to purchase insurance privately.¹¹² Beginning in 1998, it targeted enrolment of 10 million children, yet by 2010 the number of insured children was 'just' 8 million and in 2010-2011 approximately 9.8% of American children under the age of 18 remain uninsured.¹¹³

3.2. Policy Making

Policy making processes played an important role in the development of health care systems in Canada and the United States. As Fierlbeck notes, "policy decisions are constrained by the institutional environment within which they are articulated."¹¹⁴ Policy making processes prove to be essential in determining specific roles of governments and individuals in political field.

¹¹⁰ Sultz and Young, *Health Care USA*, 325.

¹¹¹ Sultz and Young, *Health Care USA*, 325.

¹¹² Sultz and Young, *Health Care USA*, 327-8.

¹¹³ Sultz and Young, *Health Care USA*, 328.

¹¹⁴ Fierlbeck, *Health Care in Canada*, xii.

3.2.1. Canada

“Health care in Canada is constrained by a federal system, in which sustained political agreement must be achieved by numerous political actors, often with competing interests, before any significant political change can occur” (Fierlbeck: xii). Canadian policy making process is divided into three levels (stages), each of which is set out under the *Canadian Constitution*. The stages of law-making process are: the **Cabinet** stage; the *parliamentary* stage; and the *coming into force* stage.

The Cabinet’s decision to address a matter through a bill of regulation is based on an information developed by the Minister’ departmental office. The primary purposed of the Cabinet stage is to decide which options the government wants to implement through new legislation. Government policy is the origin for the majority of government legislation. These policies are reviewed by appropriate federal departments and if they decide that respective legislation is needed to implement a policy, the policy consultations proceed. This allows stakeholders, other departments, provincial governments and others to provide input into the legislation before its draft. Upon these consultations, a Memorandum to Cabinet is prepared and must be approved and authorized by the Department of Justice in order to begin drafting the legislation. Often the sponsoring department hosts interdepartmental consultation prior or the completion of the Memorandum.

The Memorandum is then revised by the Cabinet and submitted to appropriate Cabinet policy committee which prepares a Committee report and presents it to the Cabinet. The report of the Committee must be ratified by the Cabinet in order for the policy to proceed. The Department of Justice then prepares a bill upon consultation with the sponsoring departments and legal services. The draft bill must be approved by the sponsoring minister and the Government House Leader. He or she then seeks delegated authority from Cabinet to approve the bill for introduction in Parliament.

The legislation which involves spending or taxation measures must be introduced in the House of Commons before the Senate and require a royal recommendation beforehand.

The bill, once introduced, must pass through both the House of Commons and the Senate after which the bill receives Royal Assent at which point the bill becomes an Act. Yet the legislation is not automatically in effect. An Act may even not be proclaimed in force despite being granted Royal Assent. The process of transition from policy to enforceable law is complete.

3.2.2. The United States

The process of policy making is a combination of intense discussions, negotiations, and hearings leading to the final implementation. Every policy making process begins with debate within relevant committees. Those are groups of powerful senior politicians formed in the House of Representative and the Senate. Because the Senate is comprised of representatives of the individual states irrespective of its size, a considerable portion of representatives come from small, rural, and highly conservative states. The committees responsible for the matters of health care evaluate the form of the reform and its impact. Being the first true link in the policy making process, various interest groups try to influence committees' dealings; either through lobbying or campaign contributions. Immense amount of money is invested by various interest groups which try to influence the process leading to the new law. Each committee with the relevance of health care (three for the House and two for the Senate) presents its own bill which is submitted to the Congressional Budget Office which estimates the costs. If the committee passes the bill, it is forwarded to the full House (or Senate) for consideration and each bill is further debated. Each arm of Congress addresses its bill differently and separately. In the House, the Rules Committee sets the terms for debate voted on by the full House. After the time of debate has passed, the House votes on the bill. Simple majority is required for the bill to pass. The legislative process in the Senate is different. When the bill is presented as 'regular,' the senators are allowed to discuss the bill as long as they please and can present indefinite amendments, thus prolonging the discussion and even altogether obstructing passage of the bill. If the senators want to prevent the filibuster, they may do so by 'cloture,' which requires the support of a supermajority of sixty votes. This procedure imposes limits on the discussion and speeds up the whole process, leading to the voting on the bill. There is also a possibility of 'reconciliation' bill which restricts filibuster altogether (e.g., if the bill is of a much narrower focus). After the House and the Senate agree on a bill, it is passed to the joined House-Senate conference committee which writes a 'conference report' and produces a final single bill which goes back to both houses of the Congress to be further debated. If this final bill is passed by both, it goes to the President. He either signs the bill or vetoes it.

Because of this prolonged and complicated system of policy making, it is no wonder that the final bill hardly resembles the original piece of legislation. Changes made by both houses as well as joint committee can result in completely new bill. Majority of the proposals do not make it through the process at all. Interest groups play a major role in

the health care system in the U.S. and have numerous opportunities to influence decision making processes at various levels and in different phases. Major interest groups in the health care in the United States which engage in any attempts to introduce new legislation into the system. Many problems of U.S. health care result from a system shared among federal and state governments and the private health care industry.¹¹⁵ Federal and state executives and legislators face intense pressure from supporters and opponents of health care system changes with varying lobbying efforts of interest groups which become increasingly sophisticated and well financed.¹¹⁶ Among the major groups who have played key roles in the debates on tax-funded health services are: providers, insurers, consumers, business, and labour. The strong connection between politicians and lobbyists also plays an important role in the debates on health care reform plans.

The American Medical Association

The AMA founded in 1847, is the largest medical lobby of 217,000 individuals. This number however includes only 17% percent of the medical professionals and medical students. The significant role of the AMA was most evident between the 1940s and 1970s, when it opposed almost every government-provided insurance plan. In the 1980s it even opposed cuts in the Medicare and in 1989 it became included in the Congress and later even publicly supported by the Obama plan.¹¹⁷

Insurance Companies

The efforts of insurance companies to exclude high-risk consumers from the insurance pools and their frequent premium rate hikes contributed to the focus on cost containment and the plight of the uninsured and underinsured in the debate.

It is evident that both countries engage in long and rigorous legislative processes when introducing a new policy. It is no wonder why especially in the United States the fate of majority of health care reforms was determined long before even the introduction and first discussions appear. The strong political and social pressure put on individual representatives plays a major role in policy making, especially concerning such fatal subject as health care. Although the presidents of the U.S. have long before strived for universal public health system and no doubt were elected because of their proposals of

¹¹⁵ Sultz and Young, *Health Care USA*, 46.

¹¹⁶ Sultz and Young, *Health Care USA*, 46.

¹¹⁷ Sultz and Young, *Health Care USA*, 46-47.

health care reform, every one of them, except Barack Obama, failed. Yet it is still very early to talk about success of Obama administration and its care.

3.3. Legislation

3.3.1. The Canada Health Act

The *Canada Health Act* became a law under Prime Minister Pierre Trudeau's Liberal government in 1984 and received royal assent in June 1985. It is a legislation that governs and guides delivery of equal, prepaid, and accessible health care to Canadians.¹¹⁸ The *Canada Health Act* orders 100% coverage and sets out the criteria and conditions which represent principles and values of the Medicare policy for Canadians and guide funding of health plans across the country. The goal of the Act is to meet the primary objective and "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."¹¹⁹ In order to qualify for federal payments, individual provincial and territorial governments must meet **five principles**: public administration, comprehensiveness, universality, portability, and accessibility.¹²⁰

1. **Public administration**: each plan must be 'administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision making on benefit levels and services, and whose records and accounts are publicly audited.'

The health insurance plan must not be governed by a private enterprise and must not be in a business of making a profit. Public authority answers to the provincial or territorial government regarding its decisions about benefit levels and services, with publicly audited records and accounts. The Ministry of Health, the Department of Health, or the equivalent provincial or territorial government department must oversee all health plans.

2. **Comprehensiveness**: every plan must 'cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services that require

¹¹⁸ Thompson, *Health and Health Care Delivery in Canada*, 89.

¹¹⁹ Thompson, *Health and Health Care Delivery in Canada*, 90.

¹²⁰ Fierlbeck, *Health Care in Canada*, 21.

a hospital setting) and, where the law of province so permits, similar or additional services rendered by other health care practitioners’

Eligible person with a medical need is allowed to access prepaid services which are provided by physicians and hospitals through provincial or territorial health insurance plans. Services included under the plan must be available to all resident of the province or territory irrespective of their income or current financial situation. There must be no barriers to access and all insured individuals must be given equal opportunity to seek insured services.

Each province or territory is allowed to select which services will be covered under its specific plan. Every eligible resident must be offered comprehensive coverage of provincially or territorially tailored services (including components of home care or nursing home care, chiropractic care, eye care under specific conditions, and Pharmacare for designated population groups). This gives the provinces/territories a freedom to react to the specific needs of their residents.

3. **Universality:** ensures that ‘all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health insurance plan on uniform terms and conditions.’

To be eligible for health care in Canada, a person must be a lawful resident of a province or territory. A resident is defined as “a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province.”¹²¹ This excludes tourists, transients or visitors to the province. The minimum residence requirements vary across provinces and territories.

The federal government also allows the jurisdictions to choose whether or not they charge insurance premiums their residents. However the inability to pay does not prevent the treatment of resident and there are no barriers and discriminations based on factors such as previous health records, current health status, race, or age.

4. **Portability:** Canadians are allowed to transfer their health coverage between provinces and are covered for non-elective services when visiting other provinces.

¹²¹ Thompson, *Health and Health Care Delivery in Canada*, 91.

“Canadians moving from one province or territory to another are covered for insured health services by their province of origin during any waiting period in the province or territory to which they have moved.”¹²² The waiting period cannot under the *Canada Health Act* exceed three months.

“Although Canadian residents are covered for necessary care while absent from their home province, they are not permitted to seek elective surgeries or other planned care in another province or territory.”¹²³ However in some cases, they may be granted approval for elective nonemergency surgery dependent on individual jurisdiction.

5. **Accessibility:** provinces must ensure that their citizens ‘have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means’

Because ‘*reasonable access*’ means ‘access to services when and where they are available, as they are available,’ individuals seeking services which is not available in their living area are granted permission to the closest location where this services is offered.¹²⁴ The interpretation of the term is however highly controversial because of the inequalities between individual provinces and territories, and does not guarantee equality of services. Another subject of debates is the term ‘medically necessary’ which denotes services covered by the public insurance. Since the *Canada Health Act* leaves the doctors to determine which services are medically necessary, there is no uniformity among insured services within individual provinces and territories. Because the consideration of ‘medically necessary’ is to a large extent for individual doctors subjective, physicians collaborate on the lists of insured services with their governing body or other government officials.¹²⁵

In addition to the five criteria stated above, there are also two conditions which provinces and territories have to follow: **information** and **recognition**. Each province and territory must inform the federal government about their individual health plans and at

¹²² Thompson, *Health and Health Care Delivery in Canada*, 91.

¹²³ Thompson, *Health and Health Care Delivery in Canada*, 92.

¹²⁴ Thompson, *Health and Health Care Delivery in Canada*, 93.

¹²⁵ Thompson, *Health and Health Care Delivery in Canada*, 95.

the same time they must publicly recognize the contribution of the federal government to health care services.¹²⁶

Provinces and territories adhere to the provision voluntarily, as they are not binding on them and by violating the CHA they cannot be charged in court of law. The federal government does not have legitimate authority to enforce the compliance of provinces and territories in the matters of health care. The exact way of accommodation of the provision vary across the provinces and territories. Each province and territory chooses optional services which will be covered by its plan. There are however pressures on provinces to maintain their compliance to these principles: the threat of federal claw backs and pressure of the public.¹²⁷ Because the *Canada Health Act* permits extra-billing of patients, the federal government may take back the total amount of collected money from the next fund transfer of those who charge additional fees. As Fierlbeck notes, “since the enactment of the Canada Health Act, from April 1984 to March 2008, deductions totalling \$9,019,499 have been applied against provincial cash contributions in respect of extra-billing and user charges provisions of the Act.”¹²⁸ Provinces are however permitted to establish any blend of private and public insurance they choose (or even eliminate the public insurance as a whole). Private insurance can on some instances even coexist with the CHA by certain conditions. Each province accommodates the principles of CHA in its own terms and this in many cases depends on politics and specific population structure. Some provinces which are not able to support private sector generally employ a combination of mechanisms to discourage private health care altogether.

The *Canada Health Act* does not mandate the coverage of pharmaceuticals. Medically necessary drugs are provided free at point of delivery to patients only within hospitals. However provinces and territories provide some kind of drug insurance for specific population groups (presumably elderly and those who cannot afford necessary medications). There may also be a contribution from the patients in the form of *deductibles* or *co-payments*. In case of *catastrophic drug costs* (highly expensive drugs used for specific health conditions), the governments will assume the cost if the family is not able to provide for them on its own.¹²⁹

¹²⁶ Thompson, *Health and Health Care Delivery in Canada*, 94.

¹²⁷ Fierlbeck, *Health Care in Canada*, 21.

¹²⁸ Fierlbeck, *Health Care in Canada*, 21.

¹²⁹ Thompson, *Health and Health Care Delivery in Canada*, 204.

Each drug falls within one of the two categories. *Over-the-counter medications* can be purchased without a prescription and are rarely covered by public insurance plans. *Prescription drugs*, which are to be purchased only with a prescription from physician (family doctor or specialist) may be covered by insurance. Approximately about a third of Canadians is publicly insured for pharmaceuticals, one-half of working-age Canadians have employment-based private drug insurance.¹³⁰ Sixty-two per cent of therapeutic drugs are bought through the private sector which is for many scholars, including Fierlbeck, a sign of ‘privatization’ of health care.¹³¹

As Fierlbeck notes, by the time the *Canada Health Act* was implemented, focus was on hospitals as the front line of medical treatment, with extensive surgeries and institutionalized segregation of inpatients being part of the treatment.¹³² This is in fact articulated by the Act which ensures that hospital services are publicly insured, while the pharmaceuticals are not. However during later period, the health care becomes defined by the use of therapeutic drugs to avoid long stays in hospitals and introduce treatment on an outpatient basis. Because the pharmaceuticals are not included in the Act and therefore have to be covered privately (depending on the provincial and territorial plans, as well as third-party insurance coverage), the shift of costs from public to private sectors took place. Sixty-two per cent of therapeutic drugs are bought through the private sector which is for many scholars, including Fierlbeck, a sign of ‘privatization’ of health care.¹³³ Although there have been many attempt to enlarge the provision of *Canada Health Act* and include Pharmacare to medically necessary services covered under public insurance, major political barriers prevented such step. More so that global pharmaceutical companies hold political power over new legislation. It is solely in the hands of government whether they decide to remove specific drug from a prescription list, allowing the residents purchase without restrictions. Another obstacle in the reform of Pharmacare is the issue of costs connected with the provision of drugs with estimates ranging from \$7 to \$19 billion per year.¹³⁴

¹³⁰ Fierlbeck, *Health Care in Canada*, 154-5.

¹³¹ Fierlbeck, *Health Care in Canada*, 153.

¹³² Fierlbeck, *Health Care in Canada*, 153.

¹³³ Fierlbeck, *Health Care in Canada*, 153.

¹³⁴ Fierlbeck, *Health Care in Canada*, 155.

3.3.2. The Patient Protection and Affordable Care Act

The enactment of the Patient Protection and Affordable Care Act (ACA) is “a historic achievement in expanding access to health care, promoting population health, and attempting to control short- and long-term costs. The ACA reaches into virtually every dimension of the health care delivery system with monumental changes that are unprecedented in the system’s history.”¹³⁵ The lines above represent the notion of most Americans (and even Canadians) that the enactment of the ACA is a milestone in the history of the United States. As Sultz and Young point out, “the ACA holds out much hope for achieving meaningful change that will improve U.S. citizens’ health status, but only if system changes succeed in replacing existing volume-driven system with one driven by values that have consumer health outcomes as the primary focus.”¹³⁶ The U.S. attempt to provide a form of national health insurance can be traced back into 1912 and the administration of Ronald Reagan.¹³⁷

The *Patient Protection and Affordable Care Act*, also known as the ACA or ‘*Obamacare*’ signed into law on March 23, 2010 and represents significant regulatory legislation of the U.S. health system critical in shaping health policy in the United States.¹³⁸ Because of the economic and banking crisis in 2008-9, the debate over new legislation turned into a struggle. The legislation had gone through much of tailoring and its final form became result of compromise between individual levels of political and public scene.

The intentions of the ACA – addressing the ever-standing problems of American health care system – represent a historical milestone and give into public discontent with the old system. According to Fierlbeck, one of the reasons was the election of Barack Obama and consequent Democratic majority in houses of Congress as well as unprecedented strategy of Obama administration.¹³⁹ Clinton’s ill-fated plan proved to be a lesson for following administration which decided to engage in completely different strategy.

“Obama tried to push legislation through Congress quickly, did not release a fully elaborated plan allowing the Congress to contribute to it, he also forced Senate leaders to

¹³⁵ Sultz and Young, *Health Care USA*, 493.

¹³⁶ Sultz and Young, *Health Care USA*, 336.

¹³⁷ Fierlbeck, *Health Care in Canada*, 267.

¹³⁸ Fierlbeck, *Health Care in Canada*, xxii.

¹³⁹ Fierlbeck, *Health Care in Canada*, 286-7.

put reconciliation instructions for health reform into the budget resolution, leaving no space for filibuster. The Democrats were able to pass the health care legislation without any Republican support.” “The Obama administration touted incremental, friendly sounding reforms such as electronic health records, prevention, and medical homes...”¹⁴⁰ The legislation also addressed the need of cost containment as the skyrocketing expenditures affected recipients of health care as well as providers and major stakeholders.

The *Affordable Care Act* introduces a journey towards extensive health care coverage of uninsured Americans. The major goal of the ACA is to significantly reduce the number of uninsured population through an expansion of insurance coverage on public and private level. Two mechanism are to be used in order to increase the number of covered population – state-based insurance exchanges with individuals and small companies purchasing health insurance, and expansion of eligibility for Medicaid support.

3.4.2.1. Medicaid Expansion

By 2014 the Act requires most Americans to carry health insurance coverage by ‘individual mandate’ or by expansion of Medicaid eligibility levels.¹⁴¹ Individuals without coverage must pay a penalty. Those for whom the costs of insurance would exceed 8% of their income, people with incomes below the federal requirement for tax filling, people whose religious beliefs are opposed health insurance and members of Indian tribes.¹⁴² The goal is to provide coverage for the 32 million uninsured Americans (about 17% of total population). The expansion of Medicaid is targeted at non-elderly, low-income parents, and childless adults with incomes up to 133% of the federal poverty line.¹⁴³ The number of enrollees to Medicaid is expected to increase by almost 15 million in 2014 and by 26 million by 2019 with individuals having freedom to choose between employer-provided, Medicaid, or personally purchased insurance.¹⁴⁴ Despite the effort to reduce spending of Medicare, it is projected that Medicare will account for 5.7% of the nation’s GDP by 2035.¹⁴⁵ To control the spending of Medicare for each beneficiary, the ACA established the **Independent Payment Advisory Board (IPAB)** which is required

¹⁴⁰ Fierlbeck, *Health Care in Canada*, 287.

¹⁴¹ Sultz and Young, *Health Care USA*, 330.

¹⁴² Sultz and Young, *Health Care USA*, 330.

¹⁴³ Sultz and Young, *Health Care USA*, 330.

¹⁴⁴ Sultz and Young, *Health Care USA*, 331.

¹⁴⁵ Sultz and Young, *Health Care USA*, 335.

to produce annual health care report, submit recommendations and propose legislation to slow growth in national expenditures to health care since 2015.¹⁴⁶

A 2012 U.S. Supreme Court decision stated that the participation of individual states is optional and those who decide to implement the Medicaid expansion will be provided with federal expansion funding (ibid. 331). By March 2014, 27 states have agreed to participate, 19 states rejected, and 5 remained in an open debate.¹⁴⁷

3.4.2.2. Health Insurance Exchanges

The ACA also requires states to establish health benefit exchanges and create separate exchanges for small employers.¹⁴⁸ The intention is to create a competitive health insurance market and provide customers with relevant information (web-based, understandable, and comparative) on insurance plans which they can choose and to standardize rules of pricing of insurance plans which must meet federal requirements for minimum coverage, known as ‘**essential health benefits**’¹⁴⁹ covering ten categories as listed below:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and new-born care;
5. Mental health and substance use disorder services, including behavioural health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Paediatric services, including oral and vision care.

¹⁴⁶ Sultz and Young, *Health Care USA*, 335.

¹⁴⁷ Kaiser Family Foundation, “*Status of State Action on the Medicaid Expansion Decision, 2014*” Accessed April 25, 2014 <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>

¹⁴⁸ Sultz and Young, *Health Care USA*, 331.

¹⁴⁹ Sultz and Young, *Health Care USA*, 331.

Federal support is available for the states until their financial self-sustaining (predicted in 2015).¹⁵⁰ Furthermore, the governments provide levels of premium and cost-sharing subsidies in the form of advance or refundable tax credits based on a personal income (between 100% and 400% of FPL).¹⁵¹

Because the insurance expansion means a great increase in government expenditures, it had to secure compensation in forms of financial implications and mechanisms to generate new federal revenues through penalties, fees and taxes levied on firms and individuals to offset expenses.¹⁵² Although employers are not required to offer health insurance under the ACA, those with more than 50 employees will be assessed a fee of \$2,000 per full-time employee if they do not offer coverage and if they have at least one employee who receives a premium credit through a health insurance exchange.¹⁵³ To reduce the expenditures, the implementations of the ACA have introduced pivotal programs of reimbursement and organizations within the system of health care. One of the goals is to improve patient care and provide valuable information for individuals and to shape the future of payments methods.¹⁵⁴

Accountable Care Organization (ACO)

Groups of providers and suppliers engaged in ACO model in order to coordinate the care and health-related services for Medicare patients. Intended to address the costly fragmentation of system (duplication of services, medical emergencies, and costly hospitalizations), they ensure care coordination with reimbursement structure for combining fee-for-service payments with shared savings and bonus payments with specific quality performance standards.

Hospital Value-Based Purchasing Program (VBP)

The goal of VBP model is to discourage inappropriate, unnecessary and costly care of acute care Medicare hospitals and allows them to earn payment based on patient satisfaction and clinical outcomes. Projects of VBP became implemented by the CMS

¹⁵⁰ Sultz and Young, *Health Care USA*, 332.

¹⁵¹ Sultz and Young, *Health Care USA*, 332.

¹⁵² Sultz and Young, *Health Care USA*, 330.

¹⁵³ Sultz and Young, *Health Care USA*, 332.

¹⁵⁴ Sultz and Young, *Health Care USA*, 333-5.

(Centres for Medicare & Medicaid Services) already have been replicated by many private insurers.¹⁵⁵

Bundled Payments for Care Improvement Initiative

The BPCI is designed to encourage health care personnel to work closely together to achieve improved patient outcomes at lower costs. It again reacts to fragmentation of the system and minimal coordination between individual providers. Instead of separate Medicare fee-for-service payments for individual services, the patient pays for all services provided during his or her illness, reducing the costs and improving final outcomes.

3.4. Departments of Health Care

The federal governments in both countries operate federal agencies which deal with health care and welfare of the population. In Canada, the major federal agency is **Health Canada**, federal department of health. In the United States, the **Department of Health and Human Services** is its equivalent. Yet as is evident from its name, the DHHS deals not only with health and health care, but also with welfare and social services for those who are the least able to help themselves.

3.4.1. Canadian Health Portfolio

Health Portfolio supports the Minister of Health in maintaining and improving health of Canadians. It comprises Health Canada, the Public Health Agency of Canada, the Canadian Institutes of Health Research, the Hazardous Materials Information Review Commission, the Patented Medicine Prices Review Board and Assisted Human Reproduction Canada.¹⁵⁶

As Fierlbeck points out, the “effective service delivery depends on the development of seamless service between sectors (e.g., primary care, surgical care, postoperative care, rehabilitation, and follow-up care) but also potentially between departments (e.g., between health care, mental health care, social services, justice, and police services).”¹⁵⁷

¹⁵⁵ Sultz and Young, *Health Care USA*, 334.

¹⁵⁶ Health Canada, “About Health Canada: Health Portfolio,” Accessed April 14, 2014 (last modified: 2013-10-31) <http://www.hc-sc.gc.ca/ahc-asc/minist/portfolio/index-eng.php>

¹⁵⁷ Fierlbeck, *Health Care in Canada*, 115.

3.4.1.1. *Health Canada*

Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances.¹⁵⁸ The goal of Health Canada is “to be among the countries with the healthiest people in the world as measured by longevity, lifestyle and effective use of public health care system.”¹⁵⁹

Formerly known as the *Department of Health and Welfare*, **Health Canada** is the federal government department established in 1996, headed by a minister of health, responsible for federal health matters.¹⁶⁰ The organizational structure of Health Canada comprises sub-departments organized into branches, agencies, offices, and sub-organizations. Health Canada is a science-based department and encompasses role of leader/partner, funder, guardian/regulator, service provider and information provider.

Health Canada “believes that prevention and health promotion can hold health care costs down and improve quality life in the long term. To this end, the Department is committed to meeting the challenges of tomorrow by supporting research and fostering partnerships with researchers across the country and the world. We also work collaboratively with the provinces and territories to test ways in which the Canadian health care system can be improved and ensure its sustainability for the future.”¹⁶¹ The Government of Canada recognizes that Canadians identify health care as a high priority. Health Canada tries to manage accountability of the department, conducts internal audits, evaluation studies and performance measurement frameworks and prepares estimates of resources required for upcoming fiscal year.¹⁶² Health Canada protects Canadians from unsafe food, health and consumer products; supports delivery of healthcare to First Nations and Inuit; promotes innovation in healthcare; and also informs Canadians to make healthy choices.¹⁶³

Health Canada regularly issues its main goals under ‘Mission and Vision’ with annual program activities, strategic outcomes and planned expenditures issued in the

¹⁵⁸ Health Canada, “About Health Canada,” Accessed April 14, 2014 (last modified: 2014-02-27) <http://www.hc-sc.gc.ca/ahc-asc/index-eng.php>

¹⁵⁹ Health Canada, “About Health Canada: About Mission, Values, Activities,” Accessed April 14, 2014 (last modified: 2011-10-12) <http://www.hc-sc.gc.ca/ahc-asc/activit/about-apropos/index-eng.php>

¹⁶⁰ Thompson, *Health and Health Care Delivery in Canada*, 115.

¹⁶¹ Health Canada, “About Health Canada.”

¹⁶² Health Canada, “About Health Canada: Accountability, Performance & Financial Reporting,” Accessed April 14, 2014. (last modified: 2007-10-17) <http://www.hc-sc.gc.ca/ahc-asc/performance/index-eng.php>

¹⁶³ Health Canada, “Health Canada – a partner in health for all Canadians,” Accessed April 14, 2014. (last modified: 2014-02-27) <http://www.hc-sc.gc.ca/ahc-asc/activit/partner-partenaire-eng.php>

Health Canada Reports on Plans and Priorities.¹⁶⁴ One of the interest of the department is to make Canadian population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.¹⁶⁵ It also identifies core values: personal integrity, healthy working environment, and democratic values.

The organizational structure of Health Canada features an internal (i.e., the one which provides services for other groups under federal jurisdiction) and an external arm (i.e., that which provides leadership for health care in the provinces and territories).¹⁶⁶ The prime minister appoints an elected representative to head Health Canada as minister of health responsible for matters of Parliament, including promotion and preservation of health of Canadian population. This means overseeing health-related laws and regulations. The key function of the minister of health is controlling the Public Health Agency of Canada (another federal department concerning health care). The deputy minister is appointed from the civil services and collaborates with the minister of health and may even assume his or her duties.¹⁶⁷ The associate deputy minister and other assistant deputy ministers of health are also appointed from the civil service. Other organizational health offices and agencies provide leadership to the PHAC.

3.4.1.2. Public Health Agency of Canada

The *Naylor Report*, (the National Advisory Committee on SARS and Public Health) issued in 2003, emphasized the disadvantages of Canadian fragmented system which was unable to determine the accountability for the outcomes, lack of effective communication between individual jurisdictions, differences in resources and capacity of individual regions.¹⁶⁸ This critical document led to a change of system in 2006 and the passage of *Bill C-5* which established the federal **Public Health Agency of Canada** (PHAC) and a national chief public health officer.¹⁶⁹ It is an agency of the Government of Canada responsible for public health, emergency preparedness, response to and infectious and chronic disease control and prevention. As mentioned above, the PHAC is a member of the Federal **Health Portfolio** and together with Health Canada shares fairly the same agenda which can cause tensions between the two departments.

¹⁶⁴ Health Canada, "About Health Canada: Health Canada Report on Plans and Priorities," Accessed April 14, 2014 (last modified: 2014-03-06) <http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/plans-prior/index-eng.php>

¹⁶⁵ Health Canada, "About Health Canada: About Mission, Values, Activities."

¹⁶⁶ Thompson, *Health and Health Care Delivery in Canada*, 117.

¹⁶⁷ Thompson, *Health and Health Care Delivery in Canada*, 116-17.

¹⁶⁸ Thompson, *Health and Health Care Delivery in Canada*, 108-9.

¹⁶⁹ Thompson, *Health and Health Care Delivery in Canada*, 109.

The main figure of the organization is Chief Public Health Officer of Canada, responsible for the PHAC. He or she reports to and provides advice for the Minister of Health as well as the federal government on issues concerning the health of Canadians. The advantage of this arrangements is by Fierlbeck seen in the fact that the CPHO is well established within government and informed about the developments regarding administration and policy, communication of information, coordination and collaboration.¹⁷⁰ Yet the power of the CPHO is limited because it would be unreasonable to speak against the federal government and in many occasions he or she does not use its position as a figure accountable for people and does not address the issues pronounced by the public health community. The CPHO finds oneself torn between the interest of the public and government and is often found in self-censuring position.¹⁷¹

The organization of PHAC is based on a principle of collaborative federalism which assumes equality between federal and provincial governments. The Pan-Canadian Public Health Network, governed by a council of representatives (either assistant deputy ministers or medical health officers) from each jurisdiction and co-chaired by provincial and territorial representatives and supports the notion of indifference.¹⁷² There are six 'expert groups' which specialize in individual issues of public health, as well as standing and temporary issue groups which provide support. Public health is also a significant component on the regional level with regional centres connected with local academics, policy makers, stakeholders, and provincial governments. Individual National Collaborating Centres address priorities set by the government by which they are also funded.

In addition, Health Canada is active also on an international level, collaborating with international agencies and governments, including the World Health Organization (WHO), the Pan-American Health Organization (PAHO), and also the Organisation for Economic Cooperation and Development (OECD).¹⁷³

¹⁷⁰ Thompson, *Health and Health Care Delivery in Canada*, 116.

¹⁷¹ Thompson, *Health and Health Care Delivery in Canada*, 117.

¹⁷² Thompson, *Health and Health Care Delivery in Canada*, 116-18.

¹⁷³ Thompson, *Health and Health Care Delivery in Canada*, 135-46.

3.4.2. The United States Department of Health and Human Services

The U.S. department of health corresponding to Canadians is the **Department of Health and Human Services** (DHHS). The DHHS is federal government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS is headed by the Secretary who is the chief managing officer for agencies which include 11 operating divisions, 10 regional offices, and the Office of the Secretary.

The Office of the Secretary provides leadership through staff division of offices which oversee operations and provides guidance, ensuring wise fund spending and following of laws. Operating divisions administer wide variety of health and human services in order to serve and protect American population. The DHHS works closely with state and local governments. Many services funded by the DHHS are provided at local level by state or county agencies, or through private sector grantees.¹⁷⁴

“The mission of the Department of Health and Human Services is to help provide the building blocks that Americans need to live healthy, successful lives,”¹⁷⁵ such as health protection, promotion, provision of health and other human services for vulnerable population. The major role of the DHHS is administering the federal programs of Medicare and Medicaid. In addition, the department also organizes programs which carry out activities through its divisions.

The mission of the DHHS is to secure the healthy and successful lives of Americans through access to health care, controlling the quality of food, and preventing spread of infectious diseases which threaten the Americans. The head of the DHHS is the Secretary, the chief managing officer of family of agencies, which provide the HHS-funded services at the local level. The organization of the DHHS is depicted below.

¹⁷⁴ U.S. Department of Health & Human Services, “About HSS: HSS Family of Agencies,” Accessed April 14, 2014 <http://www.hhs.gov/about/foa/index.html>

¹⁷⁵ U.S. Department of Health & Human Services, “About HHS,” Accessed April 14, 2014 <http://www.hhs.gov/about/>

4. Public Health

The term '*public health*' is often defined as "efforts made by communities to cope with the health problems that arise when people live in groups."¹⁷⁶ Fierlbeck goes even further, citing Health Canada and noting that it is "the health of the population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services."¹⁷⁷

Although public health has come to an attention of the public as early as in the fourteenth century Europe,¹⁷⁸ just recently it has become a phenomenon of government in Canada and the United States. Realizing that health of the public is not just a matter of treating diseases and curing sick, individual governmental institutions and organizations started to focus on prevention and promotion of health and healthy living. By various campaigns and activities, they try to change the approach from expensive high technology treatments to preventive care. Emphasizing the need to take care of oneself long before any health problem occurs. The origins of public health can be traced back to efforts for better sanitation which in many caused spread of plagues around the urbanized and often overcrowded cities. Sick individuals (as well as those who possessed threat for the population) were kept isolated from the rest of the 'healthy' people, usually in segregated places far from the cities. Nonetheless it was difficult to maintain desirable health status of the people. Public health is inevitably linked with government and political structure of public health has always been reactive. Because of the globalization and modernization, the public health has become a worldwide phenomenon. Modern pathogens have tendency to spread across countries by human travel or the way in which food supply is designed and managed.¹⁷⁹ Another factor in politicization of the public health is system's complexity. It is simply much more efficient to address the monitoring of spreading diseases as well as make an effective response towards them. Individual governments are forced to co-operate also on an international level.

Public health is often grounded in the principals of social justice, being a right of every individual. The need to identify and secure positive health status of population and

¹⁷⁶ Sultz and Young, *Health Care USA*, 427.

¹⁷⁷ Fierlbeck, *Health Care in Canada*, 104.

¹⁷⁸ Fierlbeck, *Health Care in Canada*, 105.

¹⁷⁹ Fierlbeck, *Health Care in Canada*, 106.

quality life, is a matter of governments' efforts and various activities which are essential for keeping the population satisfied and in a good health. It is an interdisciplinary phenomenon, applying principles of medicine, epidemiology, statistics, social and behavioural sciences, environmental sciences, and other disciplines. Attempts to deal with various forces contributing to the problems of morbidity and mortality, as well as with the unfortunate individuals handicapped by illness, disability, or even poverty comprise part of the agenda. As the major representatives realized that healthy people mean prosperous economy and wealthy country, protection of the health of the population increasingly became one of the major interests.

As Fierlbeck notes, "clear causal relationships remain the foundation of thinking about the provision of health care; and there are reinforced by bureaucratic cultures that emphasize accountability, efficiency, and outcomes. But this approach cannot easily be reconciled with increasing evidence that both broad social and physical factors and very subjective psychological states of mind (including self-esteem and a sense of control over one's life) also play an undeniable role in the overall state of one's physical health."¹⁸⁰

4.1. Canada

According to Fierlbeck, there are two political institutions which influence the character of public health in Canada – liberalism and federalism.¹⁸¹ She notes that the approach to public health and the role of government is based on two opposite liberal views. There are often tensions between those who see health as primarily an individual responsibility and those who consider health as a consequence of social organization.

Federalism in Canada plays also an important role in the sphere of public health. The division of power and control over health matters between the federal and provincial/territorial governments is at once an efficient system which leaves individual jurisdictions a freedom of choice. Yet because of the interdisciplinary nature of health care which encompasses wide range of social determinants of health (income and social status, social support networks, education, employment, social a physical environments, personal health practices and coping skills, healthy child development, gender, culture, and access to health services),¹⁸² there is also a need for interventions among individual governmental departments.

¹⁸⁰ Fierlbeck, *Health Care in Canada*, 300.

¹⁸¹ Fierlbeck, *Health Care in Canada*, 105.

¹⁸² Fierlbeck, *Health Care in Canada*, 107.

The milestone in the organization and management of the public health in Canada was sudden appearance of the SARS virus in 2003.¹⁸³ The efficiency of public health system was questioned by the public, emphasizing the inability of governments to manage preceding high-profile outbreaks of viruses. Public discontent was supported as various critical reports on Canada's public health system were issued. The *Naylor Report*, (the National Advisory Committee on SARS and Public Health) issued in 2003, emphasized the disadvantages of Canadian fragmented system which was unable to determine the accountability for the outcomes, lack of effective communication between individual jurisdictions, differences in resources and capacity of individual regions. This critical document led to a change of system in 2006 and the passage of *Bill C-5* which established the federal Public Health Agency of Canada (PHAC) and a national chief public health officer.¹⁸⁴

4.2. The United States

Public health in early America was heavily influenced by the medical and administrative experience of the British who founded the General Board of Health as early as in 1848 together with the legislation of Public Health Act, becoming a world leader in public health philosophy and practice.¹⁸⁵ The epidemics of common diseases led to sanitary reforms as the early cities and towns recognized responsibilities over the health of their citizens and as part of "Poor Law" legacy began to establish alms-houses and town-employed physicians to provide care for the sick.¹⁸⁶ Despite the effort to facilitate the sick, the condition of the alms-houses and the cities were often unsanitary, contributing to the deterioration of public health. As various surveys had shown, the creation of board of health in cities was inevitable, with New York City being the first to create appropriate administrative structure by passing first-ever public health law.¹⁸⁷ Nevertheless even in the early era of public health, the initiatives were motivated by economic and commercial concerns, rather than solidarity of humanitarian values.

In 1933, the *Federal Emergency Relief Act* was passed as a reaction to the local and state governments' need for welfare assistance.¹⁸⁸ Yet the participation was optional

¹⁸³ Fierlbeck, *Health Care in Canada*, 108.

¹⁸⁴ Fierlbeck, *Health Care in Canada*, 108-9.

¹⁸⁵ Sultz and Young, *Health Care USA*, 431.

¹⁸⁶ Sultz and Young, *Health Care USA*, 432.

¹⁸⁷ Sultz and Young, *Health Care USA*, 432.

¹⁸⁸ Sultz and Young, *Health Care USA*, 433.

and many parts of the country did not implement the act. Then in 1935 and the passing of the *Social Security Act* helped to develop a more sophisticated system of federal assistance in the matter of public health services. All political jurisdiction were obliged to create public health services and agencies, with the authority of the Public Health Service which later became a part of Federal Security Agency (created in 1939). These agencies provided the Americans with significant services (health, welfare, educational).

The Public Health Service also played an important role during the World War II, when it carried out emergency health and sanitation programs. It later became implemented into the Department of Health, Education and Welfare (HEW). During the following years, various agencies and national institutes had to address the emerging issues of rising population as well as occurrence of severe diseases such as cancer, heart and lung diseases. Various initiatives were established in the early 1970s, as health awareness of the public increased. But the dissatisfaction with the federal public health agencies and their failure to improve the access to health care led to an end in federal health policy. Consequently, the responsibilities for creating a uniform and cooperative national public health system was transferred to the states. Upon the study of public health in the United States in the 1980s, the committee appointed by the Institute of Medicine reported that public health is in trouble because of its instability, disorganization, inadequate financial support, inefficient data gathering, and lack of links between the public and private sectors and especially lack of clear delineation of the responsibilities between levels of government, just to mention a few.¹⁸⁹ Yet the recommendation were not followed through as they required strong financial as well as public support.

4.2.1. DHHS and Healthy People

The *Department of Health and Human Services* is federal government's agency which concentrates on protection, promotion and provision of health and other human services.¹⁹⁰ It administers Medicare and Medicaid programs for vulnerable American population and carries out activities of operating divisions. Because the DHHS encompasses numerous activities requiring federal grants, the range of programs supported has been reduced in recent years with proposed budget of the DHHS in 2013 of 941 billion.¹⁹¹

¹⁸⁹ Sultz and Young, *Health Care USA*, 440.

¹⁹⁰ Sultz and Young, *Health Care USA*, 434.

¹⁹¹ Sultz and Young, *Health Care USA*, 434-7.

The DHHS continuously tries to improve the situation of public health in the United States. In order to outline the most important responsibilities of the health department, it started to publish documents dealing with public health outlining major challenges of the system. *Healthy People* provides science-based, 10-year national objectives for improving the health of Americans – encourage collaborations across communities and sectors; empower individuals toward making informed health decisions; and measure the impact of prevention activities.

The DHHS' collecting of data concerning public health and its analysis serve to define the health status of population and recognize existing and emerging health problems. Policy development is one of the most essential function of public health. It involves the analysis of problems, recommendations for optimal solutions and mobilizing public and community organizations.

Unsurprisingly, about 85% of challenging goals of Healthy People 2000 failed to be met.¹⁹² Despite efforts to address the issues of public health and introduce a sophisticated system of health care delivery among population, the goals of Healthy People 2010 fell even shorter. Health disparities between individuals increased and some of the health indicators even worsen despite the collaboration of experts, professionals and public which was allowed to contribute with own comments on the draft of Healthy People initiative.¹⁹³ Most recent documentation, Healthy People 2020 seems to be much more ambitious, crafted with expert and public input. It includes not only those objectives and goals which failed to be met by its predecessors but also adds several topics addressing newly occurred issues.

In the United States, the role of philanthropy, volunteerism, and charitable organization has a long history. From the very beginning of health care, the voluntary organizations provided services to the public and play an important role in the development of health care delivery and provision. Yet this changed throughout the years, with era of modern technological inventions which lead to transformation of medical services and treatments. As Fierlbeck notes, “clear causal relationships remain the foundation of thinking about the provision of health care; and are reinforced by bureaucratic cultures that emphasize accountability, efficiency, and outcomes” and continues that “broad social and physical factors and very subjective psychological states of mind (including self-esteem and a sense of control over one’s life) also play an

¹⁹² Sultz and Young, *Health Care USA*, 443.

¹⁹³ Sultz and Young, *Health Care USA*, 443.

undeniable role in the overall state of one's physical health."¹⁹⁴ It is important to realize that the preventative care is often much more economical than the actual curing of patients. Yet public health remains in the background of government and public interest from number of reasons. Firstly, the results of public health are often indirect and invisible for the ordinary people. Unlike numbers of cured patients, the statistical data concerning health promotion among communities remain unpersuasive and it is hard to determine the efficiency of preventative care. Because of its interdisciplinary character, also the responsibility for the health status of population is not easily determined.

According to statistics, the health indicators of Canada and the United States were similar fifty years ago; until the end of the twentieth century when severe health inequalities in the U.S. exceeded those in Canada.¹⁹⁵ The very poorest 20 per cent of Canadians enjoyed the same life expectancy as average-income Americans. This is surprising considering that Canada spend far less on health care than the United States but still produces much better health indicators, as is evident also in recent OECD reports. The reason for such disparities is not only a social and economic situation of individual countries, far more essential are inequalities in the distribution of wealth among the society.¹⁹⁶ Americans rank among the most productive countries, creating difference between incomes of Canadians and Americans, but also between individual classes. Moreover, "...the two countries have evolved different hierarchies of values in which relatively greater numbers of Canadians have a sense of autonomy and personal control, including control over their own bodies."¹⁹⁷

Yet both countries face a challenge of the future of public health. It is inevitable that a transformation of the system from biomedical model to a population health model requires considerable change towards preventive health approach. The majority of financial resources comes to the treatments and provision of health care services, and only a small portion is allocated to the prevention and promotion of health (2% in Canada and 3% in the U.S.). This is true in the United States and also Canada. What are the obstacles towards preventive health approach?

According to Sultz, the different emphasis of population-based orientation of public health professionals and the individual-centred focus of private health providers,

¹⁹⁴ Fierlbeck, *Health Care in Canada*, 300.

¹⁹⁵ Fierlbeck, *Health Care in Canada*, 122.

¹⁹⁶ Fierlbeck, *Health Care in Canada*, 122-3.

¹⁹⁷ Adams, *Fire & Ice*, 66.

have caused a division between public and private health services.¹⁹⁸ There is a significant difference between the practitioners with a population perspective and those focused on services provided for individual patients. This is also evident from the numbers of specialist among the medical students. There is a considerable emphasis on sophisticated technologies even in the medical education which leads to the inadequate preparedness of public health employees.

¹⁹⁸ Sultz and Young, *Health Care USA*, 445.

5. Challenges of Health Care

Discussion over health care in Canada and the United States is in a strict sense discussion over public vs. private system of health care. Yet the difference between Canadian and U.S. system of health care inevitably touch upon the efficiency of both systems. Major concerns that have been central to debates over health care system are: access, quality, government expenditures, and health care costs.

As Fierlbeck argues (much in favour of U.S. system), management of private investor owned enterprise is more efficient than management of the same activity by publicly owned enterprise.¹⁹⁹ She claims that the market forces individuals to think about costs and minimize overconsumption of offered goods and agrees with experts that public health care has a significant flaw because patients bear no direct costs for the medical services offered to them. As a result, patients seek treatment for even trivial cases, use emergency rooms which are more expensive than visits of GP, demand costly tests for minor problems, and eventually prefer staying in hospital for much longer period of time over recuperating at home.²⁰⁰ Because of public system, there are hospitals open 24 hours and ready to accept patients at any time, with no incentives to cut federal expenditures by working more efficiently. Yet there is also a counterclaim that it is precisely the opposite — private system — which is the more inefficient and major flaw of U.S. system and its fragmentation. Fierlbeck claims that those who can afford it visit specialized and much more expensive physicians rather than cost-effective general practitioners.

To avoid overutilization of highly expensive specialized professionals and technologies, Canadian system uses so-called ‘gatekeeping,’ absent from the U.S.²⁰¹ ‘Gatekeeping’ is a system in which primary consultation is provided by general practitioners (usually family doctors) covered by public health insurance. The patient is then referred to the specialized physicians only if the GP gives him or her permission, reducing the unnecessary provision of specialized and highly expensive services. American patients, on the other hand, have complete freedom about the doctors and services they choose to use, as long as they are able to pay for them. And as Fierlbeck notes, Americans tend to demand choice in the range of health and medical services and

¹⁹⁹ Fierlbeck, *Health Care in Canada*, 32.

²⁰⁰ Fierlbeck, *Health Care in Canada*, 33.

²⁰¹ Fierlbeck, *Health Care in Canada*, 33.

consume as much as they want.²⁰² This is one of the reasons why gatekeeping was never introduced to the U.S. system. The criticism over limited selection of publicly funded services and goods is another topic concerning the comparison of Canadian and U.S. system. “Canadians have fewer doctors and less high-tech equipment than Americans. Canadians also have older hospitals and have access to fewer advanced medical treatments and technologies that are commonly available to Americans... Canadian patients who want to escape the delays in the public system are also prohibited from paying privately for health care services.”²⁰³

Another aspect of private system is a competition between individual providers, which is impossible in the public system. In order to attract consumers, the health care providers invest great amounts into advertising and marketing of their products (goods and services). Their strategy to acquire as much consumers as possible often leads to overcapacity, unused facilities and equipment. In order to attract the attention of potential clients, private health care providers must operate with significant number of health professionals, doctors and nurses, in order to meet the demand for delivery and provision of services. The number of patients can change dramatically and may lead to excess or shortage of health care facilities.

Also the funding of private system causes inefficiencies. Fragmentation of the payments results in high administration costs. Excessive administrative costs account for almost half of the difference in the share of GDP spent on health care expenditures between Canada and the U.S.²⁰⁴ Supporters of the private system point out to the problem of overconsumption. The RAND study on health insurance and ‘moral hazard’ studied insights about moral hazard and health insurance.²⁰⁵ Participants were divided to those who paid a fee-for-service with either co-insurance or 25 per cent, 50 per cent, or 95 per cent co-insurance; others were assigned to individual deductible plan with 95 per cent co-insurance.²⁰⁶ As the study has shown, those in cost-sharing scheme consumed less health care with no measurable effect on their health status. Individuals which bare direct costs of health care services (or medicine) are likely to be more careful about the amount of services they use. It may therefore seem that the private system is more efficient after all. Those who can afford health care support the system by their willing to pay for services

²⁰² Fierlbeck, *Health Care in Canada*, 284.

²⁰³ Fierlbeck, *Health Care in Canada*, 37.

²⁰⁴ Fierlbeck, *Health Care in Canada*, 35.

²⁰⁵ Fierlbeck, *Health Care in Canada*, 35.

²⁰⁶ Fierlbeck, *Health Care in Canada*, 36.

used, those who cannot are simply left out. Yet there comes a question of what happens to those who lack insurance altogether and are unable to bear the costs.

5.1. Access and Quality

As the *Canada Health Act* states, every Canadian resident eligible for Medicare is provided with public health insurance under which he is granted reasonable access to medically necessary services. Because ‘reasonable access’ means access to services when and where they are available, as they are available, those who require service not available in their living area are granted permission to the closest location where this services is offered.²⁰⁷ The interpretation of ‘reasonable access’ is also controversial because of the inequalities between individual provinces and territories, and does not guarantee equality of services. Yet unlike Americans, Canadians have access to primary form of medical and hospital services when and where they need to, irrespective of their ability to pay.

Despite sophisticated high-tech health care and complicated infrastructure required for its successful delivery, more than million Americans remain without access to health care. Although American population is one of the most productive in the whole world, there are significant disparities between incomes of individual social groups, with millions of Americans living within the poverty level. Although the Patient Protection and Affordable Care Act promises to insurance coverage expansion as the coverage is expected to increase for additional 32 million Americans by 2019,²⁰⁸ significant number of Americans will still be uninsured. Either because they will be too wealthy to be eligible for the Medicare or Medicaid plan, yet too poor to afford private health insurance. Although the expansion means an important step towards securing access to health care for significant portion of American population, it does little to improve the questionable quality of health care. The quality and appropriateness of medical care is major problem to the system. Not only has it impact on the health of individuals but the questionable quality and overuse of many diagnostic and therapeutic services influences the overall costs.

²⁰⁷ Thompson, *Health and Health Care Delivery in Canada*, 93.

²⁰⁸ Sultz and Young, *Health Care USA*, 56.

One of the most significant health indicators is life expectancy at birth which measures “how long, on average, people would live based on a given set of age-specific death rates.”²⁰⁹

In 2011, with 78.7 years, life expectancy in the U.S. was significantly below the OECD average (80.1 years). Canada, on the other hand, had life expectancy of 81.0 years, just slightly above the OECD average. Suggested explanations for such low rate in the U.S. are, according to the experts; highly fragmented nature of U.S. health system with relatively few resources devoted to public health and primary care, and a large share of population uninsured; others also blame health-related behaviours of Americans (higher calorie consumption and obesity rates, higher consumption of prescription and illegal drugs, higher deaths from road traffic accidents and higher homicide rates); adverse socio-economic conditions with higher rates of poverty and income equality also play a role.²¹⁰ With the increased interest at public health, prevention as well as promotion of health and various incentives in the health sector, it is possible that the situation in the U.S. may change throughout the years. The implementation of the ACA and insurance exchanges will lead to decline in the number of uninsured Americans, yet the socio-economic diversification will inevitably prevail.

One the other hand, the major factor of improvement in mortality rates is advanced medical care and reduction in risk factors (such as consumption of high-calorie food) under the government agenda. It is evident that although there are various questions of health care quality and access in the U.S., it remains one of the most advanced systems of medical care. The highly modernized and inventive methods of diagnosis and treatments help the health professionals in curing the most severe diseases.

5.2. Costs and Government Expenditures

Health spending growth has slowed significantly in Canada and also the United States since the emergence of economic crisis in 2008. It is no wonder that governments cut down their investments into the health care sector, one of the most expensive sectors among their agenda. Yet as figures show, the government spending in the U.S. is still sky high and although government continues to support public plans and other incentives, it has no impact on the health outcomes of the population.

²⁰⁹ OECD (2013), *Health at a Glance 2013: OECD Indicators*, OECD Publishing. Accessed April 4, 2014. http://dx.doi.org/10.1787/health_glance-2013-en, 24.

²¹⁰ *Health at a Glance 2013*, 24.

According to OECD Health Data 2013,²¹¹ the health spending accounted for 17.7% of GDP in the United States in 2011, by far the largest share in the OECD; more than eight percentage point higher than the OECD average of 9.3%. Canada accounted for 11.2% of GDP, exceeding average by almost two percentage points. In total, the United States spent \$8,508 USD on health per capita (the OECD average is \$3,339 USD), Canada spends \$4,522 USD, almost half of the amount in the United States. In the U.S., less than 50% of health spending is publicly financed. Yet because overall spending is much higher than in any other country, the government (public) spending is still greater than elsewhere (in Canada, the main source of health funding is the public sector, comprising 70%). Public spending increases due to the expansion in health coverage as well as the commercial insurance business in the U.S. With the implementation of the ACA and coverage expansion, it is unlikely that this trend will not prevail. The health care industry is predicted to account for 20% of total U.S. economy in 2021.²¹² The results of the ACA provisions are far-reaching and their impact on the system of health care funding is a matter of years to follow.

Despite the great amounts of government funds allocated to the health care sector, considerably more than in any other country of the world, there has been a question of efficiency of the system. The costs in U.S. health care sector are much higher than in other countries, yet those are experiencing much better outcomes from much cheaper services. Sultz and Young point out that about 30-40% of U.S. health spending is a ‘waste’ because the U.S. health care provides services deprived of value and inefficiently produces valuable service.²¹³ “The U.S. approach [to health care system] brings with it high government costs, while the actual delivery of insurance and care is driven by quilt of private insurers, for-profit hospitals, and other players adding cost without value.”²¹⁴ The often pronounced inefficiency of the U.S. health care system is presented in the unnecessary use of modern medical technologies. The total number of MRI units was in 2011 31.5 per million population with 102.7 MRI exams per 1,000 population. The same can apply to the CT scanners, with 40.9 per million and 273.8 CT exams per 1,000. Canada, on the other hand, manipulated with ‘only’ 8.5 MRI units per million population

²¹¹ OECD, “*Health Status*.” Accessed April 4, 2014.

http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

²¹² Sultz and Young, *Health Care USA*, 286.

²¹³ Sultz and Young, *Health Care USA*, 295.

²¹⁴ Armstrong and Armstrong, *Health Care*, 97.

and the number of 49.8 MRI exams per 1,000. The CT scanners (14.6 per million) processed 127.0 CT exams.²¹⁵

New equipment and computerized technologies have changed the system of health care delivery and required specially trained personnel. The reimbursement system did not require documentation of the necessity for the use of technologic innovations, not even analysis of their benefit for the patients.²¹⁶ American Medicare and Medicaid caused an increase in access to wide variety of prescription drugs. Direct marketing via television and radio advertisement has driven the consumers to (often unnecessary) use of prescription drugs.²¹⁷ Aging of population is also considered to influence the costs of health care in the U.S. with persons over the age of 65 as be major consumers of inpatient hospital care accounting for more than one-third of all hospital stays and predicted to grow to 19.3% by 2030.²¹⁸ The specialization of health care has also been a driver of health care costs. As medical science and technology advanced, the preference for specialty care increased. Work of specialists became more valuable for the individuals demanding the best care possible. Nowadays, nearly 60% of practicing physicians in the United States are specialists.²¹⁹

In Canada on the other hand, all publicly funded services are paid for out of general revenues. Currently, Ottawa (the Federal Government) provides about 17 per cent of the public spending on health care, the remaining 83 per cent are provided by the provinces and territories tax bases.²²⁰ Each province and territory has specific method of financing health care services not covered by federal funding. Because the consultation with doctor belongs in Canada to the primary services provided freely to the residents, it is not surprising that the number of doctor consultations per capita is far above the OECD average (approximately 6.8) with almost 8 consultations. In the U.S. the number is only slightly above 4 consultations. Americans try to avoid the consultations as much as possible as a basic doctor visit may be a significant expense for them. Canadian public health system is also projected into the number of consultations per doctor with more than 3,000 consultation per year. In the U.S. each doctor provides slightly less than 2,000 consultations.²²¹

²¹⁵ *Health at Glance 2013*, 87.

²¹⁶ Sultz and Young, *Health Care USA*, 297.

²¹⁷ Sultz and Young, *Health Care USA*, 297.

²¹⁸ Sultz and Young, *Health Care USA*, 297.

²¹⁹ Sultz and Young, *Health Care USA*, 298.

²²⁰ Fierlbeck, *Health Care in Canada*, 22.

²²¹ *Health at Glance 2013*, 85.

Almost all hospitals in Canada are private not-for-profit institutions funded through a global budget by provincial departments of health and governed by boards of trustees. Provincial and territorial governments' spending account for 90% of hospital income.²²² The remaining 10% come from insurance companies or private sector. There is a wide range of hospital facilities, funded solely or in part publicly. Other hospitals are covered only partially by provincial or territorial insurance and clients are obliged to pay additional services they use. Hospitals are operating on a business basis, meaning that they are expected to conclude a fiscal year with a balanced budget.²²³ Hospitals are therefore trying to find ways of reducing their expenditures, leading to cuts to services, reduction in hospital beds, merging or complete closure of hospitals, insufficient staff, long wait lists for surgery, tests and admission to hospitals and so on.²²⁴

Drugs represent the second largest health care expenditure. Total spending on drugs in Canada reached \$29.8 billion (\$897 per Canadian) in 2008 and accounted for 17.4% of total health care spending.²²⁵ The reason of high expenditures is not only increase in the consumption of pharmaceutical drugs, but also increased costs, aging population, health care system factors and the introduction of new drugs to the market.

Majority of Canadians rank shortage of doctors among the top problems of health care.²²⁶ There is a combination of factors which support the common belief. Although the number of doctors and medical staff has increased in the past years, it is still insufficient to meet the needs of population and replace those who retire from the occupation. Number of physicians in U.S. per capita is far below the OECD average (with only 2.5 practising physicians per 1,000 population in the U.S.), yet the number of nurses per 1,000 exceeds the OECD average (U.S. 11.1 nurses). Canada has slightly fewer figures in both cases with 2.4 physicians per 1,000 and 9.3 nurses per 1,000.²²⁷ The proponents of reform in Canadian health care emphasize the shortage of doctors and call for government measures which would secure adequate distribution of physicians across the country. But the issue of insufficient workforce on the health care prevails also south of the border, where majority of health professionals transfer to more profitable and prosperous specialized practices, leaving gaps in the system of prevention, primary and long-term care. Trend of

²²² Thompson, *Health and Health Care Delivery in Canada*, 193.

²²³ Thompson, *Health and Health Care Delivery in Canada*, 193.

²²⁴ Thompson, *Health and Health Care Delivery in Canada*, 193.

²²⁵ Thompson, *Health and Health Care Delivery in Canada*, 203.

²²⁶ Fierlbeck, *Health Care in Canada*, 132.

²²⁷ *Health at Glance 2013*, 56.

decrease in number of hospital beds can coincide with the increase of procedures performed on ambulatory (or same-day basis) and conversely decrease in the length of stays in hospitals. Because the emphasis is placed on procedures which do not require hospital stays, rather are performed evasively or in an ambulatory care, there is not as much need for greater capacity of hospital facilities. Also, the advanced drugs are in many cases used instead of a complicated surgery which was in the preceding times the only option of treatment.

There is a strict line between services provided publicly and those provided on a private basis, not covered by public insurance. Canada is therefore unique in its ability to restrict growth of two parallel private insurance system which would compromise this one-tier system. As a result of said restriction, 'medically necessary services' are freely accessible to all despite the income. Services covered publicly include only primary care of GPs and hospital services and there is whole range of procedures, treatments and services which fall to the second category and are not covered under universal public insurance. Insurance plans of individual provinces may differ in order to meet the needs of their residents. Although there have been many attempt to enlarge the provision of Canada Health Act and include Pharmacare to medically necessary services covered under public insurance, major political barriers prevented such step. More so that global pharmaceutical companies hold political power over new legislation. It is solely in the hands of government whether they decide to remove specific drug from a prescription list, allowing the residents purchase without restrictions. Another obstacle in the reform of Pharmacare is the issue of costs connected with the provision of drugs with estimates ranging from \$7 to \$19 billion per year.²²⁸

Because of the growing population of elderly people and aging of those born during post-war baby boom, it is presumed that elderly Canadians consumes significantly more than the rest of the population. Some argue that although care for elderly people is costly especially during the last days of their lives, the young ones often engage in dangerous activities which lead to serious accidents. Also the health status of current generation is much better than in the previous one and this trend is likely to continue because of major inventions, change of lifestyle and other provision of public health. Canada is projected to have 20 per cent of its residents over 65 in 2024.²²⁹

²²⁸ Fierlbeck, *Health Care in Canada*, 155.

²²⁹ Armstrong and Armstrong, *About Canada*, 90.

Wait times have become a major preoccupation of governments and the general public and are always among the priority issues of politicians.²³⁰ The agreement between the federal/provincial/territorial governments in 2004 established five priority areas concerning wait time – cardiac surgery and catheterization, cancer surgery, cataract surgery, hip and knee replacement, and MRI and CT imagery.²³¹ Surveys carried out by the interest groups which seek a privatization of system, especially delivery of services, often exaggerate the problem in hand with reports being in many cases about subjective opinions rather than clear data.²³² The federally funded Canadian Institute for Health Information (CIHI) counts wait time in terms of “how long it takes from when the booking form is received until elective surgery happens.”²³³ The surgeries included on the priority list are now getting more attention and resources, while other areas of health care are put aside, rising the expenditures for public hospitals repairing the damage done by “butchers” from private clinics.²³⁴

The critics of Canadian system also emphasize that in other countries, especially the United States, people do not have to wait for such procedures as knee and hip replacements. This assumption is true only in the case of so-called quick care paid directly by patients. “The data that do exists suggest that wait times in the United States are increasing, particularly in hospital emergency departments, and that many people never get on a waiting list at all.”²³⁵ The Canadian government is pressed into belief that the cause of the crisis are wait times and many provinces and territories attempt to introduce so-called wait time guarantees. If the provincial Medicare system is not able to make particular procedure available within a certain time (pre-established and reasonable) it would guarantee to pay for the procedure performed by private provider, in other province, or even in the United States.²³⁶ Public system proves to be more efficient in reducing wait times and at the same time, prevailing the quality of care. Unlike in private payment or for-profit delivery, the government can implement manners reducing wait times also because of more coordinated system and administration.

Despite the problems and challenges of health care systems in both countries, there seems to be a consent with the current situation. The OECD conducted polls

²³⁰ Armstrong and Armstrong, *About Canada*, 91-2.

²³¹ Armstrong and Armstrong, *About Canada*, 97.

²³² Armstrong and Armstrong, *About Canada*, 92.

²³³ Armstrong and Armstrong, *About Canada*, 94.

²³⁴ Armstrong and Armstrong, *About Canada*, 97.

²³⁵ Armstrong and Armstrong, *About Canada*, 94.

²³⁶ Armstrong and Armstrong, *About Canada*, 99.

concerning perceived health status of population of member states. Perceived health status reflects people's perception of physical and psychological health. The international comparisons are difficult to interpret because of the subjectivity, formulation of survey questions and other social and cultural factors. Self-reported health status inevitably reflects subjective assessment of health and can be affected by factors such as cultural background and national traits.

The response scale used in Canada and the U.S. is asymmetric (skewed on the positive side), including response categories: "excellent, very good, good, fair, poor." Both, Canada and the United States are (together with Brazil) among the three leading countries, with about nine of ten people reporting to be in good health.²³⁷ Percentage of Canadian adults reported to be in good health in 2011 was 88.2 per cent, while in the U.S. it was 89.5 of total population with men more satisfied than women in both countries.²³⁸ The income level also plays a significant role in the perception of health among individuals. Those with highest income (fifth quintile) are in general more satisfied with their health due to different living and working conditions, and health-related lifestyles.

Although throughout the years, the condition of public health in the U.S. has improved as indicated by the decline in morbidity and mortality rates, the situation is far from ideal. Importance of health prevention and promotion of healthy way of living is often competing with other values of health care. In the country where even primary and minimal adequate health care is inaccessible for some individuals, it is understandable why public health activities are put to a side. Spending great amount of money in the area of health care which does not produce direct and visible results is also a reason why public health is unpopular among the government and also public. As in the whole system of health care, there is a lack of knowledge among the population. Information asymmetry touches upon the subjects of mission of public health programs and plans.

That the situation of public health sector in both countries is less than optimistic is evident. Canada with its federal system lacks proper management and administering of public health campaigns and activities. The United States on the other hand try to improve the organization of individual institutions. Yet even more problematic is the opinion on public health by common people. There are differences between those who consider health their own matter, their right and also freedom to do what they want with it. Others put pressure on governments to take care of them and are not willing to actively

²³⁷ *Health at Glance 2013*, 40.

²³⁸ *Health at Glance 2013*, 41.

participate in their own health matters. The values and cultural differences between individual Canadians and Americans play a role in the sphere of public health. While Canadian sense of responsibility for health of others is strong even concerning health care, American strive for freedom is an obstacle hard to overcome. The government intervention into personal lives of individuals is strongly opposed by those who are afraid to lose their freedom of choice. A choice whether to live in a healthy way and self-consciously take care of own body, or become ill and die prematurely.

Interest groups claim that public health programs represent social change and an unjustified intrusion from the government to the private lives of common people.²³⁹ Health professionals may fear that the activities of public health will expand to their own activities. The essential point in the public health is recognition that prevention is much more important than actual treatment of already sick people. The United States is well-known for their modern technologies of treatment and diagnosis. As Shultz points out, curative medicine is in favour over preventive care even in a matter of resource allocations with just about 3% of government funds allocated to public health.²⁴⁰

The unpopularity of public health is also seen among professionals who are not willing to participate in public health. Preventative care is not a favourable field of study of medicine students and even scarcity of nurses and other health care personnel is evident.

²³⁹ Sultz and Young, *Health Care USA*, 446.

²⁴⁰ Sultz and Young, *Health Care USA*, 445-7.

6. Conclusion

Debates over health care system and its policy, once grounded within economics and interest-group politics, have now become involved in the public administration, sociology, comparative politics, law, philosophy, and other disciplines.²⁴¹ Health care is a complex area, touching on a variety of topics. It is a system shaped by political, social, professional and economic forces. The health care system is an ongoing and dynamic process, encompassing number of legislations, provisions, and other objectives.

There have always been debates whether health is an intimate matter, a private responsibility of every individual, or a right which should be secured by the state. Because health and health care has become one of the most politicized subjects of public interest, the role of governments in provision of health care has increased. Even though they are trying to improve health and care for their population, significant issues still remain to be addressed.

The United States, despite being a world dominance, major economic power and important player on international level, is well-known for its inefficient and expensive system of health care. Stories of Americans dying because they cannot afford even basic form of health care are circulating around the world, shedding the image of perfect nation and emphasizing its failure concerning health care. American system of health care is one in which the interests and profits of certain groups are more prominent than the health of individuals. Even more striking is the fact that great majority of Americans are satisfied with their system which causes distress among other countries. Those who can afford health care, use it with no visible barriers. As long as they can pay for it, they can be provided with high range of medical and hospital care. Yet there are millions of individuals who have to choose whether to see a doctor or provide for their family. Although health is among the priority values of every individual, it seems as if profits of powerful interest groups play much more important role in the system. Some may argue that the role of government in health care is sufficient. Medicare, Medicaid and other state/federal programs help to transfer economic burden for provision of health and medical care into the more capable and fortunate individuals. Yet the astonishing number

²⁴¹ Fierlbeck, *Health Care in Canada*, xiii.

of individuals left with their own resources to pay for immensely high medical bills is hard to overlook. Throughout the history, there have been many efforts to enact various forms of compulsory health insurance in the United States. The pressure of opposing interest groups and the AMA prevented the legislative health care plans to become part of government's agenda, concentrating on the aging population of Americans as well as those with low income who could not afford any kind of health insurance. Powerful medical and hospital lobbies exerted great influence over the legislation which would change the existing system of health care services. Therefore even a slight idea of any alteration in the legislation was doomed from the very beginning.

Americans are well-known for their high expertise in health sector and health professionals filling headlines with ground-breaking technological advancements and innovations. The fascination for treating "lost causes" and miraculous improvement in the most desperate cases is another aspect of the system. More money is invested into treatment of terminal disease than into prevention and promotion of health and healthy lifestyles. Billions of dollars are spent on researches and studies securing longevity of people, yet some of the Americans die prematurely because of basic illness which could be remedied by aspirin. Yet the major investment into health care sector do not correspond to the outcomes. American health care is the most expensive, yet most inefficient system in the world.

Although in comparison to the U.S., the Canadian system proves to be much more efficient and successful, even there can be found individuals who are calling for a change. In the era of economic contraction, the questions of sustainability of public system become much clearer and the need for fundamental reform is evident. More so when Canadians see the efforts of Americans to improve their abysmal health care system.

Canadians are concerned that public system is no longer sustainable and becoming a luxury which only a handful of Canadians can afford. The healthy and wealthy cover most of the bills for health care instead of those unhealthy and poor. Yet Medicare is still considered Canada's best-loved social program and a defining feature of the country. "[L]osing [Medicare] would mean losing a symbol that is the essence of the Canada that emerged from World War II committed to democratic and solidaristic means of achieving our right to care."²⁴² Some proponents of privatization of medicare in Canada claim that public system fails in allocation of financial resources. Yet as Armstrong & Armstrong

²⁴² Armstrong and Armstrong, *About Canada*, 8-9.

argue, “the evidence and the values of most Canadians are both on the side of keeping medicare public; indeed, they are both on the side of expanding its public scope and character.”²⁴³ Necessary health care services should not be a source of profit. Majority of Canadians consider health care as a source of national pride, others are critical of the system pointing to its shortcomings and calling for major reform. They believe that the parallel private system would address the problems of wait times and economic sustainability, much to discontent of scholars and other professionals. In words of Eric Reguly, columnist of *Globe and Mail Report on Business* “[c]ritics of government-run health care are either rich hypochondriacs who want to buy mode medical services than the state will allow them, or lousy economists.”²⁴⁴

But there is much disagreement about the form the reform should have and what should be done in order to ‘save’ the health care. The discussions over health care reform cannot be narrowed down to the choice between public and private option. It is more about the combination of both in a way which will be the most efficient for both countries. All health care systems focus on achieving the ideal model, one in which several factors interplay. “No matter what shape a health care system takes, someone will be able to argue that it could be doing a better job in some respect (and that there *is* another country that is doing a better in job in this area).”²⁴⁵

One of the arguments the opponents (and the one which is emphasized the most) of any change in health care system is the issue of costs. Indeed, “[m]ajor health insurance reforms mean a significant redistribution of wealth, and where there is economic redistribution there is always a political struggle.”²⁴⁶ Yet as Canadians realized during the economic depression in 1930s, government intervention can have positive effects on the productivity and economic situation of individual residents and also country as a whole. Only individuals with good health can contribute to prosperity of the country. Although the enactment of the ACA and consequent insurance coverage expansion in the U.S. means immense additional expenditures of the government, it is an inevitable step towards (hopefully successful) transformation of health care system.

²⁴⁷Looking at the differences between individual countries, one may suggest that the U.S. should adopt the system of Canadian public system, which is obviously much

²⁴³ Armstrong and Armstrong, *About Canada*, 10.

²⁴⁴ Armstrong and Armstrong, *About Canada*, 11.

²⁴⁵ Fierlbeck, *Health Care in Canada*, 302.

²⁴⁶ Fierlbeck, *Health Care in Canada*, 285.

²⁴⁷ Thomas, *Canada and the United States*, 44.

more successful. Yet “[a]s a number of thoughtful American commentators (as distinguished from the professionally mendacious) have pointed out, the United States is different in a number of important respects, not least in its form of government. An attempt to graft Canadian institutions onto American traditions might come out very differently—and much worse—in both structure and functioning.”²⁴⁸ Even Fierlbeck admits that “there may be a certain efficiency in constructing health policy in one country that may not exist in another.”²⁴⁹

²⁴⁸ Thomas, *Canada and the United States*, 44.

²⁴⁹ Fierlbeck, *Health Care in Canada*, 300.

Résumé

Hlavním cílem práce je pospat a porovnat systémy zdravotnictví a zdravotní péče v Kanadě a Americe. Součástí práce je tak popis a analýza organizace jednotlivých systému, stejně jako nástin nejvýznamnějších problémů, jimiž oba státy čelí. Historický vývoj, politické a legislativní uspořádání, infrastruktura, to jsou jen některé složky ovlivňující podobu systému zdravotní péče, jenž je předmětem zájmu nejen politiků, ale především veřejnosti. Ke zdraví jako jedné ze základních lidských hodnot je v obou zemích přístupováno odlišně. Vzhledem k tomu, že zdravotní systém do jisté míry vypovídá o samotném charakteru jednotlivých zemí a lidí, jež v nich žijí, důraz je kladen také na tento aspekt, stejně jako pohled odborníků na současný stav zdravotní péče Kanady a Spojených států.

V úvodu své práce se zabývám porovnáním Kanady a Spojených států jakožto světových velmocí, jenž pojí vysoké postavení v mezinárodní politice. Jakožto země obývající značnou část Amerického kontinentu, se oba státy nachází v hledáčku předních odborníků a vědců, zkoumajících rozdíly (a podobnosti) mezi oběma státy a jejich obyvateli. Fascinace porovnáváním obou států je evidentní zejména u kanadských odborníků. Najdeme však i hrstku Američanů, věnující se Kanadě. Bezesporu nejvýraznější osobností je v tomto případě Martin Lipset, jenž do své práce zahrnul průlomovou studii obou zemí. I když se oba státy pyšní shodnými ekologickými a demografickými podmínkami, obdobným přístupem k politickým a náboženským institucím, stále přetrvávají důležité rozdíly. Obecné povědomí o Spojených státech jako nadřazené, ideální zemi nadále přetrvává ve většině Kanadčanů. Není tedy divu, že nejpalčivějším tématem je rozdíl v systémech zdravotní péče v Kanadě a Americe a jsou to právě kanadští vědci, jež se touto problematikou zabývají a poukazují zejména na jeho nedostatky.

Druhá kapitola obecně představuje systémy zdravotní péče a poukazuje na nejdůležitější aspekty, jež odlišují kanadský systém od toho amerického. Systém zdravotní péče, tzv. Medicare, je pro mnohé Kanadany symbolem země a národa, poukazujícím na solidaritu a smysl pro společné dobro. Jako takový se kanadský systém, jenž je ukotven v zákoně o zdravotní péči (Canada Health Act), vyznačuje rozdělením pravomocí a zodpovědností týkajících se zdraví a poskytování zdravotní péče mezi

federální a provinční/teritoriální vlády. Díky CHA mají všichni obyvatelé Kanady volný přístup ke zdravotní péči, a to bez ohledu na svůj věk, pohlaví, zdravotní stav, či finanční situaci. Veškeré úkony spjaté s poskytováním základní péče jsou pokryty z veřejného pojištění, s nímž na základě vystavení zdravotní karty disponuje každý Kanadčan, splňující podmínky pro poskytování služeb zdravotní péče. Vlády jednotlivých provincií a teritorií si volí podobu svých programů a služeb, krytých ze svých vlastních finančních prostředků. Federální vláda na základě dodržování pěti základních předpisů CHA poskytuje finanční podporu jednotlivých provinciím/teritoriím tak, aby byly schopny zajistit adekvátní péči pro své obyvatele. Jelikož však veřejný CHA nezahrnuje širokou skupinu služeb zdravotní péče, je nezbytné, aby si obyvatelé Kanady zajistili dodatečné pojištění (nejčastěji ve formě zaměstnaneckých benefitů), nebo za služby poskytované mimo plány oblasti, jež obývají, platili hotově.

Zdravotní systém ve Spojených státech je na druhou stranu čistě privátním systémem, jež se často stává subjektem četných debat a zájmu veřejnosti a médií. Zdravotní péče v USA je označována za nejdražší, ale také jeden z nejméně efektivních systémů v celosvětovém měřítku. Jelikož USA nedisponuje žádnou formou veřejného zdravotního systému, veškerá péče je poskytována pouze těm jedincům, jež si ji mohou vzhledem ke své finanční či sociální situaci dovolit. Je tedy zřejmé, že na rozdíl od systému kanadského dochází k diskriminaci celé řady obyvatelstva. Zdravotní pojištění ve Spojených státech má z největší části podobu privátních smluv mezi pojišťovacími firmami a jednotlivci, či jejich zaměstnavateli. Pojištění jako forma zaměstnaneckého benefitu tvoří stejně jako v Kanadě největší podíl pokrytí nákladů spjatých s poskytováním zdravotní péče. Na rozdíl od Kanadského systému, ceny a formy pojištění závisí na věku, zaměstnání, stejně jako zdravotním stavu, místě bydliště a finanční situaci jednotlivce. Federální vláda poskytuje zdravotní pojištění v rámci svých vládních sociálních programů Medicaid a Medicare. Tyto se však zaměřují pouze na specifickou část populace (lidé starší šedesáti pěti let, lidé s nízkými příjmy a jejich děti, hendikepovaní). Ti, jež nejsou oprávněni k využívání ani jednoho programu, zůstávají v mnoha případech bez pojištění a tedy přístupu k jakékoliv zdravotní péči. V současnosti je to zhruba sedmnáct procent všech Američanů.

Třetí kapitola se zabývá historickým vývojem jednotlivých systémů zdravotnictví, stejně jako nejdůležitějšími událostmi, jež přispěl k současné podobě zdravotního systému v Kanadě a Spojených státech. Až donedávna se oba státy mohly pyšnit do jisté míry stejným systémem. To se však změnilo v šedesátých letech a

prvotních pokusech provincie Saskatchewan o návrh jednotného systému zdravotního pojištění. Nejvýraznější postavou v celé historii kanadského CHA byl Tommy Douglas, který se zasadil o vznik veřejného zdravotního systému, když prohlásil, že udržení zdraví obyvatel je nezbytné k celkové prosperitě země. Na rozdíl od USA tak Kanada postavila základy systému, jenž v relativně nezměněné podobě funguje dodnes. Zatímco vláda Spojených států se obávala ekonomických zásahů do veřejné sféry, Kanada začala investovat do celé řady sociálních programů, jenž měly napomáhat v utužování vztahů mezi vládou a lidem, a do jisté míry zabránit veřejnému odporu proti federálnímu systému. Zároveň se zasadila o zachování autonomie jednotlivých provincií a teritorií. Jediným vyslyšením Američanů po univerzální zdravotní péči pro všechny obyvatele se stal vznik federálních programů Medicare a Medicaid v sedmdesátých letech. Zatímco se tyto programy zasloužily o umožnění přístupu ke zdravotní péči pro značnou část obyvatel, byly spojeny s nebývalým nárůstem federálních výdajů a spolu s nimi přispěly k navýšení cen za poskytované zboží a služby. Obyvatelé Spojených států po celou dobu usilovali o jednotný systém veřejného poskytování zdravotní péče. Celá řada prezidentů přicházela s návrhy na reformu zdravotnictví, jejíž součástí byly také návrhy na změnu systému. Jejich prosby však nebyly až do roku 2010 vyslyšeny.

Třetí kapitola se zabývá rolí vlády ve zdravotním systému, zejména otázkou jeho financování a legislativního uspořádání. Kanadský federální systém je často označován za nejdůležitější faktor, jenž ovlivnil současnou podobu systému zdravotní péče. Zatímco zodpovědnost za poskytování adekvátní péče je přisouzena provinčním/teritoriálním vládám, je to právě federální vláda, jenž tuto péči finančně zabezpečuje. K tomu mu slouží celá řada metod a mechanismů, jenž mají zaručit co možná nejspravedlivější rozdělení prostředků mezi jednotlivé jurisdikce. Vzhledem ke skutečnosti, že se jednotlivé provincie a teritoria liší ve své velikosti, rozloze, zalidněnosti, ale také v množství vlastních prostředků, je nezbytné, aby pomocí federálních příspěvků zajistily kvalitní a dostatečnou péči svým obyvatelům, tak jak jim to uděluje CHA. Spolu s finanční pomocí se federální vláda také stará o poskytování péče specifickým skupinám obyvatel.

Role vlády Spojených států spočívá zejména ve zprostředkování zdravotní péče pro skupiny Američanů, oprávněných k využívání služeb Medicare a Medicaid. Tyto federální programy představují značné finanční náklady zejména proto, že Amerika se vyznačuje vysokým počtem chudých obyvatel, jenž jsou zahrnuti v Medicaid, stejně jako stále rostoucím počtem obyvatel starších šedesáti pěti let. Právě tato část populace patří mezi nejčastější klienty lékařských a nemocničních zařízení, stejně jaké konzumenty

služeb zdravotní péče. Programy nezahrnují pouze zdravotní péči, ale také nemocniční služby, vyšetření mimo nemocniční zařízení, zdravotnické pomůcky a vybavení, či léky.

Legislativní proces je dalším faktorem ovlivňujícím podobu systému zdravotní péče v obou zemích. Zatímco v Kanadě je v rámci parlamentního systému omezený prostor na ovlivňování jednotlivců politických stran reprezentujících veřejné zájmy a zastupujících lid, ve Spojených státech je vyvíjen obrovský tlak na jednotlivé politiky rozhodující o podobě a implementaci nových zákonů o zdravotní péči. Není tedy divu, že jakýkoliv návrh na reformu zdravotnictví se ve Spojených státech střetává s odporem ze strany řady zájmových skupin, v čele se zdravotnickými organizacemi a pojišťovny, jakožto významnými složkami celého systému. Zatímco v Kanadě se v rámci tzv. Health Portfolia setkávají hned dvě federální organizace, zabývající se do jisté míry totožnými záležitostmi ohledně zdraví a zdravotní péče, ve Spojených státech je touto rolí pověřena pouze jedna federální organizace. Ve Spojených státech tuto funkci zastává ministerstvo zdravotnictví a sociálních služeb. Jak již z názvů vyplývá, je toto ministerstvo zodpovědné nejen za zdravotní péči, ale také sociální služby jako je zajištění bydlení pro nejvíce potřebné. Spolu s tím se DHHS zabývá administrací programů Medicare a Medicaid. V Kanadě však dochází k rozkolům mezi oběma federálními institucemi, jelikož není zcela zřejmé, jakými pravomocemi jedna či druhá disponuje.

Čtvrtá kapitola zahrnuje otázku veřejného zdraví, jakožto předmětu zájmu veřejnosti, ale i jednotlivých ministerstev zdravotnictví v obou státech. Jelikož je veřejné zdraví pojmem relativně novým, jeho pojetí v rámci politiky obou zemí se stále formuje. Zatímco Kanada pro toto odvětví zdravotní péče zřídila zcela novou organizaci, Spojené státy zahrnuly aktivity spojené s veřejným zdravím do pravomocí DHHS, jakožto jediného ministerstva zabývajícího se zdravotní péčí. Obě země se však vyznačují povědomím o potřebě poskytování řady aktivit, jež mají zlepšit vnímání obyvatel o potřebě zdravého životního stylu, stejně jako poskytování potřebných informací, jež mají zaručit dlouhý a spokojený život jak Kanadčanům, tak Američanům. Důraz je v obou zemích kladen na preventivní péči a propagaci zdravého životního stylu, jakožto jednoho z faktorů, mající vliv na zdraví obyvatelstva. Bohužel veřejné zdraví je na okraji veřejného zájmu, jelikož výsledky kampaní a akcí, které jednotlivé instituce podnikají, nepřinášejí zcela viditelné a okamžité výsledky. Zároveň přetrvává názor, že jsou tyto aktivity podřadné léčení pacientů, o čemž svědčí také malý zájem ze strany lékařů a zdravotního personálu.

Pátá kapitola se zabývá problémy, s nimiž se jednotlivé systémy potýkají, stejně jako výzvami, jimiž čelí. Zdravotní systém jakožto komplexní a komplikovaný soubor nejrůznějších složek tvoří nezanedbatelnou část státních výdajů, a to jak ve Spojených státech, tak Kanadě. Vzhledem k této skutečnosti se proto vlády snaží o co největší minimalizaci nákladů, což však mnohdy vede ke zhoršení zdravotní péče. Stejně tak je tomu i v Kanadě. Přesto, že Kanada zavedla tzv. gatekeeping systém, jenž umožňuje pacientům navštívit specializovaného doktora pouze na popud a povolení praktického lékaře, soukromé kliniky se předhánějí v poskytování služeb, jenž vyžadují nemalé finanční náklady, stejně tak jako velkou poptávku pro specializovaných lékařích a zdravotnickém personálu, který tedy opouští veřejný sektor. Skutečnost, že dochází k plýtvání finančních prostředků, je patrna také z počtu drahých zařízení, jež zůstávají nevyužitá. Spojené státy patří mezi zemi s největším počtem MRI a CT vyšetření, jenž jsou v mnoha případech provedena zbytečně i při zanedbatelných zdravotních potížích. Nemocnice však vzhledem k systému financování svých aktivit zájem na tom, aby neprováděly zbytečné úkony. I když je velkým problémem kvalita poskytované péče a služeb, jak však vyplývá ze studií OECD, Kanadčané i Američané jsou spokojeni se svým zdravím.

Závěrečná kapitola se zabývá současným stavem jednotlivých zdravotních systémů a nastiňuje směr, jimž se jednotlivé státy v otázce zdravotnictví a zdravotní péče, ubírají. Mnoho odpůrců veřejného kanadského systému poukazuje na skutečnost, že je tento systém z hlediska nákladovosti neudržitelný a je tedy potřeba radikální změna, a to ve formě privatizace zdravotnictví. Podíváme-li se však do Spojených států a důsledků této formy poskytování zdravotní péče, je jasné, že privatizace by byla špatným krokem. Navíc je velice nepravděpodobné, že by se Kanadčané vzdali systému, jenž je symbolem jejich země a jenž je právě s hrdostí odlišuje od Spojených států. Ba právě naopak, objevují se i tací, jenž volají po rozšíření Medicare také na jiné služby, jako je poskytování léků. Vezmeme-li v úvahu skutečnost, že v době vzniku CHA se většina nemocí léčila operativně, nebyla potřeba léků tak velká, jako je tomu nyní v době sofistikovaných léčebných postupů, jež již mnohdy nevyžadují zákrok lékaře. Ve Spojených státech dochází čím dál tím více k odlivu lékařů do sektoru specializace, jenž je atraktivnější nejen z hlediska oboru jako takového, ale i finančního ohodnocení. To, že se američtí lékaři soustředí na léčbu těžkých případů vyžadujících moderní přístupy a technologie, je patrné také na počtu studentů medicíny, zejména obecného lékařství. Rovněž zdravotní personál se soustřeďuje v lépe placených odvětvích a dochází tak k nedostatku lékařů

v sektoru preventivní a dlouhodobé péče. V obou zemích se objevují názory, že změna je nezvratná. Liší se však pohledy na to, jakou podobu zdravotního systému by měly Kanada a Spojené státy implementovat do svého legislativního systému. Oba systémy (privátní i veřejný) se vyznačují klady a zápory a volba mezi dvěma alternativami je tedy otázka volby menšího zla. Zatímco Kanadčané vítají veřejný systém, jenž zaručuje potřebnou zdravotní péči komukoliv, kdykoliv a kdekoliv, obyvatelé Spojených států mají obavu ze ztráty svobody, jež si tak pracně vydobyli. Je velice nepravděpodobné, že se tento přístup v nejbližší době změní.

Bibliography

Adams, Michael. *Fire & Ice: the United States, Canada and The Myth of Converging Values*. Toronto, Ont: Penguin, 2009.

Armstrong, Pat, and Hugh Armstrong. *Health Care*. Black Point, Nova Scotia: Fernwood Publishing, 2008.

Fierlbeck, Katherine. *Health Care in Canada: A Citizen's Guide to Policy and Politics*. Toronto: University of Toronto Press, 2012.

Lipset, Seymour Martin. *Continental Divide: The Values and Institutions of the United States and Canada*. London: Routledge, 1991.

Sultz, Harry A., and Kristina M. Young. *Health Care USA: Understanding Its Organization and Delivery*, Eight Edition. Burlington, MA: Jones & Bartlett Learning, 2014.

Thomas, David Martin. *Canada and the United States: Differences That Count*. Peterborough, Ont.: Broadview press, 2000.

Thompson, Valerie D. *Health and Health Care Delivery in Canada*. Toronto. ON: Elsevier Canada, 2010.

Electronic Sources

Health Canada, “About Health Canada,” (last modified: 2014-02-27) <http://www.hc-sc.gc.ca/ahc-asc/index-eng.php>

Health Canada, “About Health Canada: About Mission, Values, Activities,” (last modified: 2011-10-12) <http://www.hc-sc.gc.ca/ahc-asc/activit/about-apropos/index-eng.php>

Health Canada, “About Health Canada: Accountability, Performance & Financial Reporting,” (last modified: 2007-10-17) <http://www.hc-sc.gc.ca/ahc-asc/performance/index-eng.php>

Health Canada, “About Health Canada: Health Canada Report on Plans and Priorities,” (last modified: 2014-03-06) <http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/plans-prior/index-eng.php>

Health Canada, “About Health Canada: Health Portfolio,” (last modified: 2013-10-31) <http://www.hc-sc.gc.ca/ahc-asc/minist/portfolio/index-eng.php>

Health Canada, “*Health Canada – a partner in health for all Canadians*,” (last modified: 2014-02-27) <http://www.hc-sc.gc.ca/ahc-asc/activit/partner-partenaire-eng.php>

Kaiser Family Foundation, “*Status of State Action on the Medicaid Expansion Decision, 2014*” <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Physicians for A National Health Program, “*A Brief History: Universal Health Care Efforts in the US*” <http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us/>

The OECD, “*Health at a Glance 2013: OECD Indicators*,” OECD Publishing. http://dx.doi.org/10.1787/health_glance-2013-en

The OECD, “*Health Data 2013: How Does Canada Compare*,” <http://www.oecd.org/els/health-systems/Briefing-Note-CANADA-2013.pdf>

The OECD, “*Health Data 2013: How Does the United States Compare*,” <http://www.oecd.org/unitedstates/Briefing-Note-USA-2013.pdf>

U.S. Department of Health & Human Services, “About HHS,” <http://www.hhs.gov/about/>

U.S. Department of Health & Human Services, “About HSS: HSS Family of Agencies,”
<http://www.hhs.gov/about/foa/index.html>

World Population Review. “World Population Review.”
<http://worldpopulationreview.com/>

World Population Review. “Canada Population 2014.”
<http://worldpopulationreview.com/countries/canada-population/>

World Population Review. “United States Population 2014.”
<http://worldpopulationreview.com/countries/united-states-population/>

List of Abbreviations

ACA – The Affordable Care Act

ACO – Accountable Care Organization

AMA – American Medical Association

CHA – Canada Health Act

CHIP – Children’s Health Insurance Program

CHT – Canada Health Transfer CPHO – Chief Public Health Officer

DHHS – Department of Health and Human Services

FPL – Federal Poverty Level

GDP – Gross Domestic Product

HEW – Health, Education and Welfare

HMO – Health Maintenance Organization

HRT – Health Reform Transfer

IPAB – Independent Payment Advisory Board

OECD – Organisation for Economic Co-operation and Development

PAHO – Pan-American Health Organization

PHAC – Public Health Agency of Canada

VBP – Value-Based Purchase

WHO – World Health Organization

Anotace

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Tato diplomová práce se zabývá systémy zdravotní péče v Kanadě a Spojených státech Amerických, zejména z hlediska historie, organizace a legislativního a institucionálního členění jednotlivých systémů. Cílem je analýza a porovnání systému, jejich efektivity a také problémů, jimiž oba státy v rámci zdraví a zdravotnictví čelí. V závěru je nastolena diskuze ohledně reform, které jsou předmětem debat odborníků, ale i široké veřejnosti v obou zemích.

Klíčová slova: zdravotní péče, zdravotní systém, zdravotnictví, Kanada, USA

Annotation

The diploma thesis deals with health care systems in Canada and the United States, their history, organizational and legislative structure, as well as their institutional organization within each state. The aim is analysis and comparison of both systems, evaluation of their efficiency, and also presentation of issues and challenges concerning health and health care which are being addressed by respective states. The discussion over health care reforms as subjects of public and government debates is outlined in the conclusion.

Keywords: health care, health care system, health, Canada, USA