Prepared Testimony of Dr. Danielle Martin
Vice President, Medical Affairs & Health System Solutions
Women's College Hospital, Toronto, Canada

Before the United States Senate Committee on Health, Education, Labor and Pensions
Subcommittee on Primary Health and Aging

"Access and Cost: What the US Health Care System Can Learn from Other Countries"

March 11, 2014

Chairman Sanders, Ranking Member Burr, distinguished members of the HELP Committee, and my fellow panelists, I deeply appreciate the opportunity to come before you today to discuss the common challenges faced by the health systems of the United States and Canada, and to shed light on some policy solutions offered by a comparative examination of both.

My name is Dr. Danielle Martin. I am a primary care family physician working in the Family Practice Health Centre at Women's College Hospital, an ambulatory care hospital located in downtown Toronto, Ontario. I have practiced family medicine in Canada for 9 years in a variety of settings, including remote rural communities as well as in the heart of our biggest city. My practice has included office-based comprehensive care family medicine, obstetrics, minor surgical procedures, and rural emergency and inpatient medicine. I also serve in an administrative leadership position at Women's College Hospital as Vice President Medical Affairs and Health System Solutions. Women's College is a unique organization - a hospital without inpatient beds that focuses on advancing the health of women, improving ambulatory care for people living with complex chronic conditions, and health system solutions. Being an outpatient hospital means that we deliver treatments, diagnostic procedures and perform complex surgeries for patients who do not require overnight stays.

In addition to my clinical training I also hold a Masters in Public Policy from the University of Toronto where I am currently an Assistant Professor in the Department of Family and Community Medicine and in the Institute of Health Policy, Management and Evaluation at the Dalla Lana School of Public Health.

Prior to becoming a physician I worked in health care policy and I have held a wide variety of leadership roles throughout my clinical training and practice. From 2005 to 2011 I was

privileged to sit on the Health Council of Canada, the national organization responsible for monitoring progress on health care reform across Canada and reporting to the public. My longstanding interest in promoting a Canadian health system that is equitable, sustainable, and that delivers quality care led me in 2006 to help found Canadian Doctors for Medicare, a national advocacy group dedicated to strengthening our public system. I continue to sit on the board of directors of CDM.

My writings on our health system have appeared in a variety of peer-reviewed publications including the Canadian Medical Association Journal, Canadian Family Physician, and HealthcarePapers. I have also published articles and op-eds on health care in major Canadian newspapers such as the National Post, Globe and Mail, Toronto Star and I am regularly cited as an expert in news reports related to health reform and the Canadian health system. I continue to speak and write about the future of health care in Canada.

Health system thinkers face many of the same health policy challenges and share many of the same goals regardless of the disparate systems in which we work. It is my strongly held belief that we have much to learn from each other. In the brief time available to me this morning, I hope to help you understand how and why we have developed and maintained a single payer health care system in Canada, and what I think American policymakers can learn from our experience.

To that end, I will begin by providing some background on the structural elements of the Canadian single payer system that I think are especially relevant to the American context. I will also outline the advantages the single payer structure affords us as we tackle the significant challenges we face: namely, the ability to ensure equity of access to services; the ability to control administrative costs; and the ability to jointly pursue shared policy goals in a coordinated manner. Finally, I will speak briefly on the issue of access to care in the Canadian system, a topic which I know frequently receives media attention in American markets.

The Canadian Single Payer System: Key Elements

I do not presume to claim that the Canadian system is perfect or that we do not face difficult systemic challenges. However I will put forth the argument that our challenges do not stem from the single payer nature of our system, nor are they insurmountable within that essential structure. Quite the contrary, working within a single payer insurance structure helps us to better address and tackle many of the health care challenges shared by all developed nations, including rising costs, variation in quality, and inequities of access.

1. *Health insurance is provided at the level of the provinces*

Although media coverage on both sides of the border often talks about the "Canadian" health care system as a single monolithic entity, it will be of interest to the committee to learn that in

fact the Canadian system is actually 13 separate provincial and territorial systems, each quite independent from the other, in large measure because the Canadian constitution clearly puts most health care matters in provincial jurisdiction. We have learned, as I think you are also experiencing, that different provinces have different appetites and needs when it comes to public health care insurance and what, or more to the point who, it should cover. Our system finds its origin in reform in a single province that gained popularity and caught on over decades across the country.

Prior to the 1940's, access to health care in Canada was based on the ability to pay – and quite often, losing one's health meant losing the farm. In 1947, the Province of Saskatchewan introduced a public insurance plan to pay for hospital services. In 1962, at roughly the same time the United States was beginning to debate the creation of the Medicare and Medicaid programs, Saskatchewan extended public insurance to cover physician services as well. Public insurance became popular very quickly and other Provinces soon followed suit with similar reforms.

As the Committee is now aware, the Canadian single payer health system is actually a consortium of thirteen systems (one for each province and territory) that together provide coverage for all Canadians. That is, each province mostly controls the provision of health insurance, with minimum standards set at the Federal level. These standards do not speak to the details of health service provision; rather, they dictate that in order to receive federal funding support, health insurance plans within the provinces must be (1) Universal, (2) Accessible, (3) Comprehensive, (4) Portable and (5) Publicly administered.[i] Beyond a federal requirement that insurance plans must provide coverage for medically necessary physician and hospital services, the provinces and territories enjoy quite a lot of flexibility in determining the "basket of services" covered.

2. *Insurance is public, but health services delivery is private*

When discussing health system structures, it is critical to distinguish between who pays for services and who delivers them. Contrary to what many Americans may believe, Canada does not have "socialized medicine" in the strict sense, since in spite of being paid for through public insurance, almost all services are delivered by private entities. This includes not only our hospitals, which are mostly independent private not-for-profit entities, but also our providers, most notably physicians, who are not employees of the state. In Canada medically necessary physician services are covered by provincial insurance for which all residents are eligible, but physicians are independent contractors. Speaking as a practicing family doctor, this is a key feature of our system well worth highlighting; and given the current structures in American health care I think it is of some salience to your deliberations.

WCH

WOMEN'S COLLEGE HOSPITAL

Health care for women | REVOLUTIONIZED

Benefits of the Single Payer Insurance Model in the Canadian Context

It is my view that the single payer structure of our provincial health insurance systems, while far from a panacea for all that ails us, is the best possible structure within which to address our challenges. Single payer promotes equity of access to services; it enables coordinated pursuit of shared health policy goals; and it allows us to deliver quality care at far lower costs than those seen in the United States. I will address each of these benefits in turn.

1. *Equity*

Poll after poll has demonstrated the enduring popularity of the single payer model among Canadians.[ii] When asked what features of our system are most salient, Canadians from all walks of life answer that it is this aspect of our system that gives them particular pride. There is a strong consensus across Canada that access to health care should be based on need rather than the ability to pay.[iii] This is a fundamental principle of our system, and pooling risk by having everyone in the system makes it possible. While of course we continue to struggle with inequity across other aspects of health care, we do not have significant equity problems with respect to insurance. We do not have uninsured or underinsured residents. We do not have different qualities of insurance depending on a person's employment. We do not have an industry working to try to carve out different niches within the risk pool. At substantially lower cost than in the U.S., all Canadians have health insurance and need rather than wealth is what drives access to care. This is a very significant accomplishment and as we watch the debate unfold in the US as to how to address the challenges you face, we are reminded of its significance daily.

2. *Achieving Consensus Policy Goals*

One of the big challenges in a multi-payer system is the question of how to achieve policy reform with so many players in the game. In a single payer framework there is a place where the providers and insurers can go to address challenges together, namely the bargaining table. This is as beneficial to providers as it is to insurers since it affords all groups a policy lever beyond legislation or self-regulation that is open and accountable. If government and providers identify a significant challenge in the health system that needs to be addressed, they can work together to try to align financial incentives to advance those shared policy objectives.

For example, across the political spectrum and between countries with disparate health systems, there is a shared consensus among both government and physicians that the provision of quality primary care should be a key policy goal. The evidence on the importance of primary care as a determinant of population health is widespread from the work of Barbara Starfield and others.[iv] We all want to see a well-developed primary care system and enough primary care physicians to serve the needs of the population. But it has been difficult over the last several decades to convince medical students to choose primary care when the compensation has lagged behind that of our specialist colleagues and the greatest needs are in remote or underserved urban areas. Single payer allows for a consolidated voice at the bargaining table to have this conversation. Without jeopardizing physician autonomy, Canadian provincial

governments have been able to work with the provincial medical associations to negotiate aligning financial incentives to promote primary care – from higher compensation for primary care doctors to programs that help reduce medical school loans for young doctors who choose to work in underserved areas.[v]

Furthermore, this system affords the patient a voice at the table through their democratically elected representatives. This stands in contrast to a multi-payer private system where private insurance companies are not accountable to their enrollees but rather to their shareholders.

3. *Lower Administrative Costs*

On a practical level, having one payer for health services requires a far smaller administrative footprint than that under a multi-payer system. Canadian doctors save time on paperwork and Canada's overall administrative spending is far lower than our neighbor to the south. In fact, a comparative study published in *Health Affairs* found that if US physicians were to curtail administrative costs to the level of those in my home province of Ontario, the total estimated savings would be $27.6 billion per year. [vi] Looking at overall costs, a 2003 study found that after exclusions, administration accounted for 31.0 percent of health care expenditures in the United States and 16.7 percent of health care expenditures in Canada.[vii] Even this figure can be deceptive, as the Canadian system includes private supplemental health insurance that often covers services that are not covered by the public plans. Total administrative costs include those for private plans, but when only the public single payer insurance program is considered, the overhead shrinks to just 1.3 percent.[viii]

The far lower administrative costs in the Canadian system are one factor in explaining our relatively lower overall costs. Canada's spending on health care as of 2011 is 11.2% of GDP placing it roughly within the middle of the pack of similarly developed countries, compared to the U.S.' 17.9%.[ix] One key factor in this disparity is the distinction between the mix of multiple private, for-profit insurance companies which work alongside a patchwork of public providers in the United States in contrast to the Canadian system which relies mostly on public financing and not-for-profit deliver. It is not the distinctly Canadian system that produces these savings so much as the underlying principle of publicly accountable universal health care, a principle shared by all OCED countries excluding the United States.[x]

Access and Quality in the Canadian Model

A concern has been raised that cost savings, though laudable, are indicative of poorer quality of care, whether in terms of health outcomes or in access to care. On both points, this concern is unfounded. First, Canadians enjoy the same or better outcomes of healthcare as Americans. We see this in terms of overall health outcomes such as life expectancy and infant mortality[xi], though as others have pointed out these outcomes are tied to larger social determinants of health and are not necessarily a proxy for understanding the outputs of a health system.

When we turn to outcomes that are more directly attributable to provision of health care services we see the same pattern of equal or better outcomes for Canadians.[xii] And a recent systematic review of Canada's single payer system found that Canada achieved health outcomes that are at least equal to those in the U.S. at two-thirds the cost.[xiii] Examples of comparative health outcomes between Canada and the States may be found in the Appendix to this testimony.

Addressing Wait Lists

While socio-economic barriers to care regrettably exist in both countries, access to health insurance is unencumbered in Canada regardless of income. But what of wait lists for care? When it comes to urgent, necessary care, Canadians are not waiting substantially longer than our peers in other countries, including the United States. However, unfortunately this has not been the case for elective medical care, particularly diagnostic imaging, non-urgent specialist appointments and elective surgeries such as cataract surgery, and hip and knee replacement. In response to this challenge we have seen governments doing much work to reduce wait times in the past decade. The key to success has been to change the way that we deliver service, for example, through single common wait lists rather multiple queues. It is also important to bear in mind that Americans also face the problem of wait times to see specialists. Of the 40 percent of Americans who report difficulties in seeing a specialist, 40 percent cite long waiting times, 31 percent cite a denied referral, and 17 percent say they cannot afford private insurance.[xiv] The Canadian system, which allows patients to see specialists on referral as well as directly, and in which private insurance is not tied to the ability to pay, does not burden patients with either of these problems.

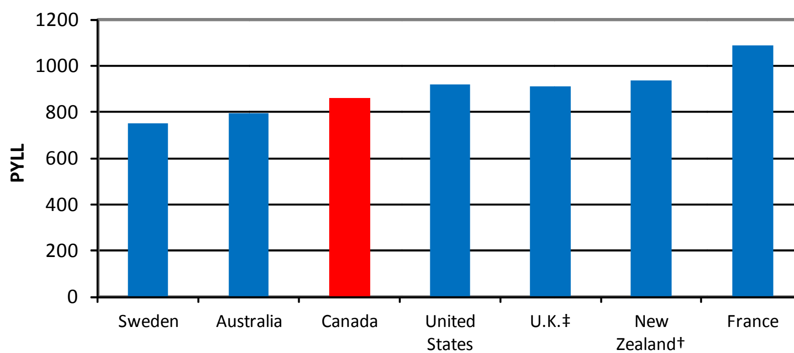
One proposal that absolutely has not shown success has been to move from a public system such as the one in Canada to a two-tiered system where patients with the means are able to jump the queue. A study conducted before and after the move from single-payer to multi-payer insurance in Australia found that median waiting times were inversely related to the proportion of public patients.[xv] In other words, in those parts of the country where there was more privately insured care, waits in the public system were longer. Why was this the case? Because our health human resources are not infinite, and the doctors, nurses and others providing care have to come from somewhere. The drain on the public system from doctors exiting to the private sector creates longer waiting lists in public healthcare. Instead, our focus should be on reducing wait times in a way that is equitable for all. That has been the imperative of the reforms in Canada, and while the battle is not yet over, it is in my view an exemplary example of how Canadian health policy thinkers work to improve our system while upholding our values.

Conclusion

I want to reiterate my thanks to this Committee and to Chairman Sanders and ranking member Burr for giving me the opportunity to present this testimony today. It is truly an honor to exchange ideas about health system solutions on both sides of the border. I look forward to answering your questions and engaging in dialogue, as well as learning from my fellow presenters.

Outcomes

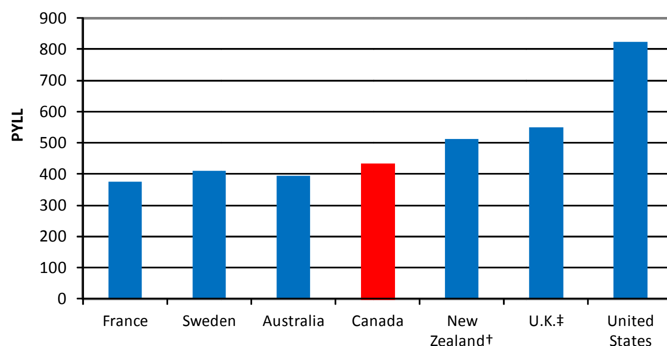
Cancer PYLL Comparison with OECD Countries, 2009



Outcomes

ystems/oecdhealthdata.htm

Heart Disease PYLL Comparison with OECD Countries, 2009



Source: OECD Health Statistics 2013, www.oecd.org/health/health-systems/oecdhealthdata.htm

WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

---

[i] Canada Health Act (R.S.C., 1985, c. C-6) http://laws-lois.justice.gc.ca/eng/acts/C-6/FullText.html

[ii] A November 2012 ACS-Leger Marketing web panel of 2200 Canadians found that Universal Health Care topped the list when it came to overall importance of sources of Canadian pride, with 95% of respondents deeming it important, and with the highest proportion of respondents citing Universal Health Care as "very important" relative to other Canadian institutions or sources of pride: http://www.acs-aec.ca/pdf/polls/Pride%20in%20Canadian%20Symbols%20and%20Institutions.ppt. And in a 2004 national program of the Canadian Broadcast Corporation (CBC), Canadians chose Tommy Douglas, the father of Medicare, as the Greatest Canadian of All Time, beating out other popular nominees such as Terry Fox: http://www.cbc.ca/archives/categories/arts-entertainment/media/media-general/and-the-greatest-canadian-of-all-time-is.html

[iii] See Canadian Nurses Association. http://www.cna-nurses.ca/CNA/documents/pdf/publications/Social_Justice_2010_e.pdf. Ottawa, 2010, and also Commission on the Future of Health Care in Canada's "Building on Values: The Future of Health Care in Canada" 2002 Report by Commissioner Roy Romanow, which states at the outset that "Canadians have been clear that they still strongly support the core values on which our health system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship." (p. xvi)

[iv] See Starfield B, "New Paradigms for Quality in Primary Care." British Journal of General Practice, April 2001.

[v] For examples see http://www.health.gov.on.ca/en/pro/programs/northernhealth/nrrr.aspx And http://actionplan.gc.ca/en/news/government-canada-announces-student-loan-forgiveness-family-doctors-and-nurses-rural

[vi] Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP, "US Physician Practices versus Canadians: Spending Nearly Four Times as Much Money Interacting with Payers." *Health Affairs.*2011;30(8):1443–1450.

[vii]Costs of Health Care Administration in the United States and Canada Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D.N Engl J Med 2003; 349:768-775August 21, 2003DOI: 10.1056/NEJMsa022033 http://www.nejm.org/doi/full/10.1056/NEJMsa022033

[viii] Costs of Health Care Administration in the United States and Canada Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D.N Engl J Med 2003; 349:768-775August 21, 2003DOI: 10.1056/NEJMsa022033 http://www.nejm.org/doi/full/10.1056/NEJMsa022033

[ix] See OECD World Bank Health Indicators, http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

[x] Starfield B. "Reinventing Primary Care: Lessons from Canada for the United States. Health Affairs. 29, No. 5 (2010) 1030-1036.

[xi] See OECD World Bank Health Indicators, http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

[xii] Coleman MP et al. "Cancer Survival in Five Continents: A Worldwide Population-based study (CONCORD). The Lancet Oncology. 2008 Aug; 9(8): 730-56. Canada ranked near the top of the 31 countries studied with an estimated five-year survival rate of 82.5%, well above the European average of 57.1% and trailing and only slightly lower than the U.S. rate.

[xiii] Guyatt G et al. *"*A Systematic Review of Studies Comparing Health Outcomes in Canada and the United States*."* Open Medicine, April 18, 2007. Vol. 1 (1), pp. 27-36.

[xiv] Ross JS, Detsky AS. Health care choices and decisions in the UnitedStates and Canada. JAMA. 2009;302(16):1803–4 cited in Starfield B. "Reinventing Primary Care: Lessons from Canada for the United States. Health Affairs. 29, No. 5 (2010) 1030-1036.

[xv] Duckett. (2005). Australian Health Review 29. 87.