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EDITORIAL

Oh, Canada: Comparing single-payer health care with practice in the United States

I recently moved to Canada after 20 years of practice in the United States in both private and academic sectors. Many of my new patients were surprised that an American physician would willingly move to Canada when the reverse is the norm. After a year of weighing the differences, my impression crystallized when a colleague with international practice experience posed the question: "Do you miss the US system?" My immediate answer was "NO." Surprisingly, I was favoring the practice of medicine in Canada. What follows is a personal commentary on the defining features of Canadian health care from my perspective as a university-based dermatologist in Toronto.

Patient access to health care

The promise of the Canadian system is universal access. The populace generally takes pride in its 1 tier, single-payer, comprehensive health care system and is willing to pay high taxes to preserve it.[1,2]

In Ontario, after 3 months of residency, the Ministry of Health[3] issues a card that entitles holders to all covered services. Physician visits, laboratory tests, imaging, surgeries, emergency room visits, and hospitalizations are covered at no added cost to patients. Home nursing, physical therapy, and transportation of disabled are routinely covered or subsidized.

Patients choose a primary care physician from the entire pool of Ontario family physicians. Specialist consultations (including internists) require a referral from any physician. Without a referral, specialists may see patients, but the fee is reduced, so most specialists have exclusively referral practices.

Universal access has many advantages for patients. The number of uninsured patients is negligible compared with that in the United States.[4] Admissions screening is minimal. One-tier health care eliminates inequitable patient selection by doctors or insurers. Patients have full access to any doctor in the province; there are no exclusive provider panels. Referrals to specialists in Canada are not based on financial incentives but are made for best patient care.

There are problems, however, in patient access. A growing shortage of doctors has severely limited access. Medical school class sizes were reduced 10 years ago for fear of oversupply, and now more doctors are lost to retirement annually than can be trained. The shortage especially affects family physicians; fewer medical graduates are choosing family practice because of low earning potential. Entire communities are understaffed, patients are increasingly using emergency departments for primary care, and patients who relocate sometimes travel long distances to keep established family doctors. Wait times can be lengthy for routine visits, specialist appointments, and treatments. Across Canada, wait times were 77% higher in 2001 and 2002 than in 1993.[5] Median wait time from general practitioner referral to specialist consultation is now 7.3 weeks, with the longest wait times 12.7 weeks for orthopedic surgery. From specialist appointment to treatment is an additional 9.2 weeks for all specialties, 19.3 weeks for orthopedic surgery, and 10.3 weeks for elective cardiovascular surgery.[5] Medical school sizes are now increasing, but many believe that universal access is not being realized given current delays.[5] There is growing public sentiment in favor of some privatization of health care.

Physician autonomy

Physicians in Canada manage patients without corporate or governmental restrictions, that is, it is assumed that patient management decisions are made on the basis of scientific evidence and are limited to those necessary for good patient care. Physician sovereignty in the United States has been seriously eroded in recent years. Medicare and private insurers require preauthorization for even minor management decisions, and many indicated treatments are denied. Doctors who trained in Canada may take for granted this autonomy, but for me, it was the primary determinant of my preferring practicing in the Canadian system over that of the United States.

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Documentation

In teaching hospitals and clinics, attending physicians may use residents' chart notes, adding appropriate documentation as needed for patient care or teaching purposes. Being able to cosign the consult note is liberating. Fees for medical services are fixed, eliminating complex documentation requirements (also eliminating higher fee for more effort!) In contrast, documentation requirements have been increasing in the United States and have had negative effects on teaching.[6,7] Fixed fees in Canada also reduce the fear of getting audited for fraudulent billing, a recent problem in several medical institutions in the United States. If Canadian doctors have significant billing irregularities, they can be audited and charged if there is insufficient documentation to justify fees billed.

Diagnosis

All tests ordered by physicians are covered at no cost to patients. Absent are the frustrations of convincing patients to have tests done that are not covered or lobbying insurance carriers to pay for testing. With appropriate documentation, even highly specialized testing is covered.

Problems with diagnostics are at least twofold. Long wait times for diagnostic procedures create management difficulties, and low reimbursements may result in under-investigation. For magnetic resonance imaging, computed tomography scans, and bone densitometry, wait times can be more than 4 months.[8] Independent health facilities[9] are starting to appear, and existing centers are expanding hours of operation, but doctors and patients continue to be frustrated with the delays.

For some diagnostics performed by physicians, low reimbursement may be a disincentive. Coronary angiography (2 angiograms maximum) reimburses $107.50; gastroscopy pays $90.30; colonoscopy to splenic flexure pays $113.10 (to cecum, add $68.40); and bronchoscopy with or without biopsy pays $110.35. Skin biopsy pays $14.50. Wet preparation for fungus pays $1.82, so few dermatologists perform this, and residents no longer learn the procedure. Diagnostic mycology and bacteriology are no longer in the jurisdiction of physicians in Canada.

Therapy

All medically necessary services are covered, including critical care. Patients receive no bill for hospitalizations except for luxuries like private rooms. Benefits for doctors and hospitals are less obvious. Treatment fees are fixed, regardless of case complexity (Table 1) and are low compared with US reimbursement schedules. Examples include $248.80 for an appendectomy, $338.95 for normal obstetrical care and vaginal delivery, and $1044.38 for craniotomy and resection of an intracranial tumor. Low reimbursement in Canada may prevent overtreatment, but it may also cause substandard care of patients and certainly contributes to doctors leaving Canada.

Table 1 Selected fees from the Ministry of Health, Schedule of Benefits[13]

Consultations:	
Dermatology (referral required)	$ 53.45
Family practice	$ 54.75
Cardiology, and all internal medicine specialties	$ 112.35
General surgery	$ 59.55
Neurosurgery	$ 89.70
Skin biopsy	$ 14.50
Excision, malignant lesion, face or neck	$ 69.50
Excision, melanoma, >1-cm margins, layered closure, any site	$ 121.65
Appendectomy	$ 248.80
Obstetrical care and normal vaginal delivery	$ 338.95
Renal biopsy, needle	$ 98.70
Kidney transplant	$1522.70
Craniotomy plus excision intracranial tumor, supratentorial	$1044.30

Noncovered service

Only services deemed medically necessary are covered. Although not always agreed on, the clear distinction between covered and noncovered services in Canada simplifies discussions with patients. In the United States I perceived a higher sense of entitlement to treatments. A recent survey showed that 26% of patients sanctioned physician deception to get medically necessary services covered.[10] In another survey of 857 US physicians, although 77% chose to appeal restrictions on medically necessary services, 11% chose misrepresentation to obtain necessary services.[11] I recall numerous instances in the United States of patients asking me to manipulate codes to justify treatments that were not medically necessary.

Physician billing and reimbursement

Physician fees in Ontario, established by the Ministry of Health (Table 1), are submitted to one office and paid within 6 weeks.[12] Patients do not receive statements and do not usually see physician fees.

Despite low reimbursement, the simplicity, predictability, and prompt payment of a single payer have merit. My former US office (2 physicians and 200 visits weekly) dealt with more than 200 separate insurance companies, each with different restrictions and reimbursement schedules. Rejected claims and delays were commonplace. A minimum of one full-time employee was necessary to process

the billing. In my present practice with 6 doctors and higher volume, registration time is minimal and billing effort is 15 to 20 hours weekly for the whole clinic. Underpayment or nonpayment is a rarity. In the United States it is common to receive 50% or less of what is submitted, and many insurers routinely deny or delay claims.

Prescription drugs

Drug coverage facilitates patient care in Canada. Most employer plans cover all prescription medications with no copayment. For patients (>65 years) receiving Medicare, there is full coverage through the Ontario Drug Benefits formulary, which substitutes generic drugs, and may not cover newer drugs. Noncovered drugs can be obtained for patients through applications for limited or special use. In the United States, the lack of prescription drug coverage is a rapidly expanding problem, especially for seniors.

Malpractice insurance

Malpractice insurance is through the Canadian Medical Protective Association,[13] and premiums are lower than in the United States. For most medicine subspecialties the annual premium in Ontario is $3912 ($2448 in other provinces). By contractual agreement, the province returns a variable portion of the premium annually. Specialties with the highest annual premiums in Ontario (in Canadian dollars) are orthopedic surgery ($27 900), neurosurgery ($45 744), and obstetrics ($75 084).[13]

Malpractice issues are complex and go beyond the scope of this article. However, premiums and the risk of being sued are lower than in the United States, and Canada has not yet experienced doctor "walkouts" like those that have occurred recently in the United States.

Conclusion

This overview is largely personal and based on my experience in Canada and the United States. Clearly, there are pros and cons to each system, and the challenge of encouraging high-quality health care while discouraging overuse will likely continue indefinitely on both sides of the border. Current limitations of the Canadian system seem mostly to affect wait times and physician supply. Whether long wait times adversely affect overall societal health or merely patient satisfaction remains to be seen. A shortage of well-trained physicians will likely become the main threat to good care in Canada. Despite the shortcomings, I am impressed with the high level of care I have witnessed in Canada and find it agreeable to work in a system that strives to provide health care to all.

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