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LESSONS FROM THE CANADIAN AND AMERICAN HEALTH CARE SYSTEMS

Jennifer Horester

Introduction

Both President Clinton and Congress are under pressure to adopt reforms to the current health care system in order to improve patient access and allow more equitable delivery of essential medical and hospital services. Various opinion polls suggest that a majority of Americans do favor some form of national health insurance (NHI) plan, but there is no consensus on the direction a new health care plan should take to accomplish these goals. (Hyclak, p. 25) Many critics of the current system are looking toward the Canadian universal health care system for the solution to the “health care crisis” present in the United States. Canada’s single-payer approach to health care, with the government as the single source of payment for health care, is admittedly a radical one. As one observer has noted, “The idea of turning over one-seventh of the U.S. economy to the federal government seems about as politically palatable as eliminating the tax breaks for home-mortgage interest.” (Symonds, p. 82) But those in favor of adopting Canada’s single-payer system stress the system’s advantages of providing a comprehensive health insurance system that covers medically necessary hospital and doctor services for all residents. The thought that all Americans, regardless of ability to pay, would have access to well-trained doctors and well-equipped hospitals is certainly an attractive one. However, there are also many Americans who feel there is no “health care crisis” in the United States. They feel the current system may need a few reforms, but nothing as radical as the imposition of a Canadian-style single-payer system.

In order to determine whether any new American health care plan should take the direction of Canada’s single-payer system, it is important to understand the evolution and principles of the Canadian universal health care system. It is also helpful to realize that Canada is facing several current problems with its universal health insurance program, including the possibility of rationing, long waiting lists, and limited availability of new medical technology.
These problems have steered President Clinton away from proposing a single-payer system to Congress and the American people. Rather, his Health Security Act relies on a blend of regulatory and market forces to provide universal coverage. Before embracing the Clinton plan, however, it is important that Americans understand the status of the current American health care system and whether there really is a "health care crisis" in the United States.

My intention in this paper is to provide the reader with a better understanding of both the Canadian and American health care systems as they exist today. A better understanding of the two systems will allow the American people to make a more informed decision on the direction the American health care system should take to provide quality health care to those in need.

**Evolution of Canada's Health Insurance Program**

Canada's first pre-paid health insurance plan arose from an agreement made in 1665 between surgeon Etienne Bouchard and the settlers of Montreal. For a premium of 100 sous a year, Etienne Bouchard would provide any treatment a settler and his family needed, without any further charges. After the Second World War, the federal and provincial governments began to discuss several reconstruction measures for the provinces, including health insurance. The federal government desired every province to establish its own health plan in order to provide every Canadian with health insurance coverage. The federal government offered to share the provinces' costs that would result from this comprehensive coverage. However, these discussions ended without an agreement being reached; therefore some of the provinces decided to act without the support of federal funds. (Canadian Embassy [n.d.], p. 1)

In 1947, Saskatchewan became the first province to establish universal public hospital insurance. British Columbia established a similar program in 1949, and Alberta and Newfoundland began hospital plans that provided partial coverage. Parliament passed legislation in 1957 to allow the federal government to share in the cost of provincial hospital insurance plans that met minimum eligibility and coverage standards. By 1961 all ten provinces and two territories had public insurance plans that provided comprehensive coverage for the cost of hospital care for 99 percent of the population. Beginning in 1962, Saskatchewan again was the first to provide insurance for physician services outside hospitals. The federal government enacted medical care legislation in 1968, and by 1972 all of the provincial plans had been extended to include services provided by doctors who were chosen freely by individuals. (Canadian Embassy, 1993, p. 2)

For the first twenty years, the federal government's financial contribution to the provincial plans was linked to the actual cost of insured health services. These contributions were approximately 50 percent of actual provincial expenditures on insured health services. (Canadian Embassy, 1993, p. 2) This financing agreement presented the provinces with a significant problem. Because the federal contribution was linked to insured services, the provinces were unable to allocate these funds to areas such as extended health care services. Therefore, in 1977 this arrangement was replaced by per capita block funding. (Canadian Embassy, 1993, p. 2) Federal contributions were no longer directly related to provincial costs, but rather were now based on a three-year moving average of the gross national product. The contribution to insured hospital and doctor services now took the form of block grants and the transfer of personal and corporate income tax points to the provinces. (Canadian Embassy [n.d.], p. 2) In other words, the federal tax was cut and the provincial tax was raised by an equivalent amount. (Canadian Embassy, 1993, p. 3) A further annual grant, based on a per capita amount indexed to the growth of the GNP, was made toward extended care provided outside the hospitals. (Canadian Embassy [n.d.], p. 2) Because the transfer of funds from the federal government to the provincial level was no longer tied to provincial spending, the provinces gained the flexibility to invest in other approaches to deliver health care to Canadian residents. These included community health centers and expanded coverage for supplementary health benefits such as extended care services, prescription drugs for seniors, and dental care for children. (Canadian Embassy, 1993, p. 2)
In 1979, the federal government appointed the Hall Commission to review the provision of health services in Canada. The Commission reported that Canadian health care ranked among the best in the world, but it warned the federal government of two practices that were threatening the accessibility of care to Canadians. The practice of extra billing, whereby doctors required patients to pay them more than the amount stipulated by the provincial plan, and hospital user fees, a flat fee charged for merely entering a hospital, were creating a two-tiered system that threatened the accessibility of care to Canadians. (Canadian Embassy, 1993, p. 2)

In 1984, Parliament passed the Canadian Health Act, which established the criteria the provinces must meet in order to qualify for their full share of federal funding for medically necessary hospital and physician services. (Canadian Embassy [n.d.], p. 1) Again, with the advent of block funding, the provinces' entitlement to the federal contribution became conditional solely on their compliance with the five criteria set out in the Canadian Health Act. The five criteria stipulated in this legislation are public administration, comprehensiveness, universality, accessibility, and portability. The public administration criterion requires that the insurance plan must be administered on a non-profit basis by a public authority responsible to the provincial government. The comprehensiveness criterion means that all medically necessary services performed by doctors or in hospitals must be covered by universal health insurance. According to the universality criterion, each health plan must cover all legal residents of the province, who become eligible for coverage after a minimum period of residency of not more than three months. By accessibility is meant that provincial health insurance plans must provide reasonable access to necessary hospital and physician care without financial or other barriers, and that no one may be discriminated against on the basis of income, age, or health status. The portability criterion, finally, means that residents are still entitled to coverage even when they are temporarily absent from their home province or when moving to another one. The Canadian Health Act also provides for an automatic dollar-for-dollar penalty if any province permits user charges or extra billing for insured health services. The federal contribution is now based on a uniform per capita entitlement which takes the form of a tax transfer and cash payments. (Canadian Embassy, 1993, p. 2)

Canada’s Health Care System Today

Canada’s system today, popularly called “medicare,” consists of twelve interlocking health plans administered by the provinces and territories, which have constitutional authority for health care. As noted above, federal legislation sets out the basic principles and conditions for payment of federal contributions to the operation of the provincial plans. The basis of “medicare” in Canada is that medical care is a basic right that should be available to all, regardless of economic circumstances, and that the presence, or lack thereof, of money should not be a factor in the decision to see a physician. (Ulbrich, p. A12) Contrary to some reports, Canada does not have “socialized medicine,” with doctors employed by the government, but rather socialized insurance. Most doctors within the system are in private practice and are paid on a fee-for-service basis. The fee schedule which determines the fee for a particular service is negotiated between the provincial medical association and the provincial government. (Canadian Embassy, 1993, p. 1)

Canada's health care system relies extensively on primary care physicians who provide medical care and make referrals to specialists. In fact, primary care physicians account for approximately 63 percent of all practicing physicians in Canada compared to 45 percent in the United States. Many Americans immediately see a specialist without receiving a referral from their general practitioner. About eight out of ten primary care physicians in Canada are family physicians and general practitioners, compared to approximately one in three in the United States. (Canadian Embassy, 1993, p. 1) A Canadian who needs medical care goes to his doctor or clinic and presents the health insurance card issued to him by his province. Any services the doctor performs are billed to the province; the patient does not pay his doctor directly for the medical services received. The
patient is also not required to fill out any forms for the insured services. There are no deductibles, co-payments or dollar limits on coverage inherent in the Canadian health insurance system. Under provincial laws, private insurers are restricted from offering coverage which duplicates that of the governmental programs, but they may compete in the supplementary benefits market. (Canadian Embassy, 1993, p. 1)

Although Canada’s health care system does provide universal comprehensive medical coverage for all Canadian residents, there are some criticisms of the system. One of the most common is the supposed overwhelming presence of rationing inherent in the system. As noted by Paul Craig Roberts:

Government programs have a knack for producing more problems than solutions. Government health programs notoriously do so because they increase demand while curtailing supply. The result is rationing, which means either a deterioration in the quality and timeliness of care, or denial of treatment in cases where the patient’s prospects are deemed not good or the cost is reckoned to exceed the value of the person’s life. (Roberts, p. 14)

In November, 1993, Ron Winslow in the Wall Street Journal discussed a study which compared one particular type of medical care in the United States and in Canada. The study claimed that Canadians receive less aggressive treatment for heart attacks and suffer more pain and disability during recovery than U.S. patients. Based on detailed interviews with patients conducted one year after their heart attacks, the researchers found that 35 percent of the Canadians interviewed had recently suffered chest pain, compared with 21 percent of the Americans. Also about 35 percent of Canadians but only 26 percent of Americans said that their health was so impaired that it restricted their ability to perform many of their routine daily activities. Some researchers state that this study is a warning about the Canadian health care system’s strategy for containing costs by strictly limiting use of high-technology services. (Winslow, p. B1)

Expensive high-tech equipment in Canada is frequently distributed among a region’s hospitals, unlike the situation in the U.S. where most hospitals acquire their own high-tech equipment. Canadian surgeons frequently complain about the scarcity of advanced diagnostic equipment such as magnetic resonance imaging (M.R.I.) devices. There are currently only fifteen M.R.I. scanners in all of Canada, compared to some 2,000 in the United States. Furthermore, the Canadian system is very hesitant to invest in an abundance of expensive new machines and procedures until their medical value is solidly proved — and, critics say, proved again. Therefore, the price of universal access is a degree of inconvenience and delay and, in quickly-developing fields, sometimes settling for last year’s treatment. (Rosenthal, p. A16)

In addition to complaints about the limited availability of new medical technology, critics of the Canadian system are quick to point out the long waiting lists for medical services. The American Medical Association reports that an individual could on average wait anywhere from six to nine months for a cataract extraction in Vancouver and one to three months for a psychiatric, neurosurgical, or routine orthopaedic opinion. In Quebec, patients can wait six months for an angiogram and eight to nine months for coronary artery bypass surgery. (Ulbrich, p. A12) As Dr. David Peachey, director of professional affairs for the Ontario Medical Association, states, “Americans ration by price; we ration by waiting lists.” According to one woman who moved to Montreal from Nevada in 1988 so her native Canadian husband could be treated for a lethal form of skin cancer:

There are long waits [in Canada] for elective surgery and other elective procedures, but if you have to cut down the waits by excluding people who don’t have money, I’d rather wait. In the States, you don’t have long waiting lines because most people don’t have the money, and if you don’t have the money you don’t go to the doctor. (Ulbrich, p. A12)

Even though Canadians do have to wait for elective and nonemergency procedures and also have far less high-tech equipment, the Canadian system “has served society, and the average citizen, better than the U.S. system,” argues Vickery Stoughton, an American who has worked as CEO of both Toronto Hospital and Duke University Medical Center. (Symonds,
Canadians regard health care as a basic right, and they value their health system highly. In 1992 the American medical magazine *Physician's Management* surveyed Canadian health consumers and physicians on satisfaction with their health care system. The results showed that 84 percent of Canadian doctors and more than 90 percent of consumers rated the quality of care provided by the system as “good to excellent.” (Canadian Embassy, 1993, p. 3)

**Does a Health Care Crisis Exist in the U.S.?**

While the debate in the United States continues over what changes must be made to the current health care system in order to provide comprehensive coverage to every American, there are many people who feel there is no “health care crisis” in the United States today. Although they agree that the current system may need a few reforms, they do not believe the imposition of a Canadian-style single-payer system would improve the system. What evidence is there to support or counter this claim? The most widely published statistics on the issue include the following:

- In 1991 the United States spent $2,817 per capita for health care, approximately 34 percent more than Canada's US$2,110 per capita. (Canadian Embassy, 1993, p. 2)
- The life expectancy of a person born in the United States in 1990 is 75 years whereas in Canada the life expectancy is 77 years.
- The infant mortality rate was 11 per 10,000 births in the United States in 1990 compared to 7 per 10,000 births in Canada. (Reeves, p. A4)
- In 1993, the United States devoted 14 percent, approximately $940 billion, of its gross national product to health care which was 47 percent more than Canada's spending of 9.5 percent of its gross national product.
- At some point in 1991, the last year for which comprehensive data is available, 37 million people lacked medical insurance in the United States. (Stelzer, p. A14)

Do these statistics signify a health care crisis in the United States? Those who are skeptical argue that the “crisis” characterization has arisen because of four circumstances: the most recent recession; the continual rise in health care costs; the notion that everyone should have health insurance as a matter of right; and the liberal bias of the major media. (Stelzer, p. A14)

The insecurity generated by the most recent recession is certainly one of the major circumstances behind the charge that a severe health care crisis exists in the United States. With most Americans' health insurance linked to their jobs, there is the worry that the loss of one's job will lead to the loss of one's health insurance. And if an individual with an existing major health problem secures a new job, the likelihood of his or her receiving coverage is lowered. These are clearly justifiable worries for many Americans, considering the fact that employers pay about 86 percent of the total costs of employee medical insurance coverage.

Costs for health care are now claiming 14 percent of the U.S. gross national product — a high figure by international standards — and are still rising. This has caused many people to fear that soaring health care costs will eventually lead to the impoverishment of America. (Stelzer, p. A14)

Additional pressure for health care reform comes from the notion that everyone should have health insurance as a matter of right. Many argue that a system in which at least 37 million Americans today are without coverage is a system seriously in need of reform.

Finally, many critics argue that the “crisis” characterization has resulted from the alleged liberal bias of the major media. The following statistic, which has been widely published and broadcast by the major media, portrays one of the great inconsistencies present in this debate of whether a crisis really exists: “Although 75 percent of Americans have been convinced that there is a crisis, 80 percent simultaneously report themselves as 'very' or 'somewhat' satisfied with their own health care.” (Stelzer, p. A14)

The push for health care reform thus rests on the charge that a health care crisis exists in the United States. But how solid is the case that the situation is truly of crisis proportions? One
of the most frequently cited statistics in the debate is that 14 percent of the United State's GNP is being spent on health care. But, as some critics ask, by what standard is spending that much on health care excessive? If the United States prefers to devote a larger portion of its income on health care than do other nations, is that not its choice? Critics contend further that the international comparisons of percentages of GNP spent on health care do not consider several aspects of the current health care system and American society. Such comparisons do not, for example, consider or measure the quality of service that a given health care system provides for the people living within a particular country. International cost comparisons also ignore queuing and other forms of rationing that reduce recorded costs by forcibly limiting the availability of medical service. Moreover, societal attitudes are not considered by international comparisons. As one observer notes, "The high expenditures in the U.S. reflect a basic American value: Damn the costs, save lives, and use expensive technologies whenever necessary." (Stelzer, p. A14)

The high costs of health care in the United States reflect yet another distinctive feature of American society — the social pathology of the lower class. As President Clinton recently pointed out to an assembly of doctors at Johns Hopkins, "We'll never get the cost of health care down to where it is in other countries as long as we have higher rates of teen pregnancies and higher rates of low birth-weight births and higher rates of AIDS, and, most important of all, higher rates of violence." (Stelzer, p. A14)

The other major statistic that is driving the health care debate today is the fact that 37 million people in the U.S. today are without medical insurance. If this were all there were to this statistic, then 15 percent of our population must live with the constant anxiety of not being able to pay for medical care. However, there are several factors that this particular statistic happens to ignore. Some of the uninsured are between jobs and therefore would probably not be currently covered even under an employer-provided plan. Also, many of the uninsured are former students who are entering the labor market for the first time and who are no longer covered by their parents' plans. Those under the age of 25 who are uninsured are also a generally healthy group for whom health insurance is often not a cost-effective purchase. Estimates show that the number of consistently uninsured Americans in our society is actually closer to 5.5 million rather than 37 million people. (Stelzer, p. A14)

Nonetheless, although many critics proclaim that there is no health care crisis in the United States, most agree that certain reforms are necessary within the present system. Some suggest, for example, subsidizing insurance for the truly poor and compelling payment by the voluntarily uninsured. But probably the most important reform suggested by these critics is making coverage portable, so that the loss of a job does not deprive a worker of health insurance. As one such critic states, "Such tweaks to the system would avoid the disaster in store for us if we follow the Clintons down the path to a health care system presided over by the same people already doing such a wonderful job delivering our mail." (Stelzer, p. A14)

The Clinton Health Plan

In September, 1993, President Clinton unveiled his 1,364 page proposal to reorganize radically the United States health care system. Since the unveiling of this proposal, however, he has experienced several setbacks in his desire to implement comprehensive, universal health insurance for every American. And as of the time of this writing (July, 1994), he has challenged Congress to ensure that whatever plan emerges accomplishes the following goals: provides comprehensive coverage for every American; guarantees the freedom to choose one's physician; and will not dramatically increase the deficit with exorbitant costs. Even though the President's original plan will probably not be implemented in its entirety, the following overview will perhaps point out some lessons the United States might learn from Canada and its single-payer health insurance system.

First of all, the imposition of President Clinton's Health Security Act would cause many Americans to enter into less expensive group medical practices such as health-maintenance organizations (HMOs) while leaving their private doctors. The income of many doctors,
pitals, insurers, and drug manufacturers, through stringent federal cost controls, would be forced down. This aspect of the plan resembles the single-payer system in Canada where predetermined amounts are set by the provinces on how much a provider may receive for performing a particular service. The current health care costs for many large, high-wage companies (such as automobile manufacturers) would thus be dramatically cut. But on the other hand health care costs would increase for many mom-and-pop businesses that now pay nothing toward their workers' health insurance and would be forced to do so under Clinton's proposal. Overall, some estimates point out that the President's plan would cost $700 billion over five years, half of which would represent new spending. Clinton proposes to cover the cost mainly through a new $1-a-pack tax on cigarettes and through savings in existing federal health care programs, with $91 billion left over to reduce the federal budget deficit. (Goodgame, pp. 54-55)

President Clinton's plan does promise, though, to guarantee a generous minimum package of health insurance to all Americans. Hospital stays, doctor visits, ambulance trips, drugs, lab tests, preventive dental care for children, and pregnancy-related services would all be covered under the new plan, just as they are in Canada's single-payer system. However, private-duty nursing, cosmetic surgery, hearing aids, adult eyeglasses and contact lenses, in vitro fertilization, private hospital rooms, and sex-change operations would not be covered under the President's plan. (Goodgame, p. 57) The plan also promises to guarantee portability of health insurance even for workers who change jobs, become laid off, or develop a health condition — also a feature of the Canadian single-payer system. The fact that the U.S. is the only industrial democracy that does not provide universal health insurance coverage (which President Clinton has described as a "national disgrace") has more than anything else pushed him to reform the present system. (Goodgame, p. 55)

The concept of "managed competition" seems to be the word of choice today to describe the President's plan. Under a system of managed competition, health insurance buyers would unite together in large "alliances" to bargain with competing networks of doctors, hospitals, and other health care providers for the best service at the best price. The theory behind these large alliances is that greater bargaining power will result in lower costs and greater efficiency within the system. Limits on health care spending would be accomplished through strict enforcement by a powerful new National Health Board that would decide when health care providers were charging "too much." (Goodgame, p. 55) The structure comprised by these alliances and the National Health Board is very similar to that of the Canadian system, where provinces and the medical associations set controls on health care costs. Some medical providers in the U.S. are concerned that cost controls would hinder the development of new drugs and result in the rationing of care, both problems which have resulted in Canada.

The Clinton plan would require all employers to contribute 80 percent of the cost of an average health insurance plan. Each employee would be responsible for paying the remaining 20 percent of this cost. Estimates from the White House claim that in 1994 these policies would cost an individual $1800 a year and a two-parent family $4200 a year. (Goodgame, p. 55) The amount that an employer would contribute to workers' health insurance plans would be capped at 7.9 percent of payroll to provide financial relief for companies who spend a substantial amount on health care.

The Clinton plan also proposes to rid the system of medical billing and insurance claim forms. Before a patient would leave the doctor's office or the hospital, instant electronic billing would occur, serving to cut down the large amount of costly paperwork inherent in today's system. All plans would also adopt a standard claim form by January of 1995. The plan also allows each state the flexibility to choose the health care plan which would be the most suitable for its region. (Goodgame, p. 56)

Although the Clinton plan has many attractive features for certain individuals and groups, such as high-wage companies and the involuntary uninsured, there is serious concern as to how the government plans to pay for this new American health care system without increasing the deficit dramatically. The bravest proposal is to cut spending on the Medicaid pro-
gram for the poor by $114 billion over five years. The Medicare program for the elderly and disabled would be cut by $124 billion. The plan’s proposal of placing a $1-a-pack tax on cigarettes will create “sin taxes” of $105 billion over five years, which will be a source of funds for the new system as well. (Goodgame, p. 57)

Congress, special interest groups, the media and many other individuals have been scrutinizing the President’s proposal since its unveiling in September 1993. During the months that have passed since then, several criticisms have come to light concerning various aspects of the plan. One criticism of the plan is the fear that health care provided under the new plan will be limited. A National Health Board, consisting of seven people appointed by the President, will make the decision on how much the nation can spend on health care beginning in 1996. After 1996, increases in health plan premiums will be limited by an “inflation factor” based on the consumer price index. The presence of these price controls on premiums will of course limit the amount of money in the health care system. Therefore, the less money there is in the system, the more likely rationing will occur and the quality of health care may eventually suffer. Other critics fear that the deficit will increase with the Clinton plan because U.S. health care costs will continue to be more expensive than other nations as long as there are higher rates of violence, teen pregnancies, and low birth-weight babies. (McCaughey, p. 21)

The ability to continue to receive care under one’s current doctor will also be difficult under the new plan. Decisions such as when to see a specialist or obtain a second opinion or what hospital is best for a particular condition will be less subject to individual control. Critics feel the plan’s design will force most people into HMOs, which restrict the choice of physicians and hospitals and use gatekeepers to curb the use of specialists, expensive tests, and costly high-tech treatments. Fee-for-service insurance, the current system, will be difficult to buy. Price controls on doctors’ fees and other regulations will push doctors away from independent practice and into HMOs. The Clinton plan also limits the amount health plans can pay physicians and prohibits patients from paying their doctors directly. Alliance officials instead will post a schedule of fees, and it will be illegal for doctors to accept more than that amount. (McCaughey, p. 22)

Under the President’s plan, Americans would receive more primary care than specialized, high-tech care, just as is the case in Canada. This prospect may not be comforting to many with heart disease, AIDS, or cancer. The study reported earlier in the Wall Street Journal, comparing U.S. and Canadian heart disease patients, presents strong evidence that low-tech care is often not sufficient for these health conditions. The study found, for example, that American heart attack patients who tended to be treated with three costly, high-tech procedures recovered much better than Canadian heart attack patients, who had less access to the procedures. American patients also tended to have a better quality of life after a heart attack than Canadian patients. Canadians were reported to suffer more recurring pain, feel more depressed, and less able to perform many of their routine daily activities. (McCaughey, p. 24)

The Clinton plan, in the short run, depends on HMOs to limit the access for Americans to specialist and high-tech care. But in order to achieve this in the long run, the Clinton plan has proposed restrictions on medical education by allowing that no more than 45 percent of young doctors be permitted to go on to advanced training in a specialty by 1998. (McCaughey, p. 24) Undoubtedly, government restrictions on medical education will reduce the consumption of expensive, “cutting-edge” care; doctors who are not knowledgeable in sophisticated technology cannot, of course, use it. But preventing doctors from learning about the most advanced medical procedures is to some a Draconian way of reducing the consumption of health care. (McCaughey, p. 24)

Some critics have sent out a warning to Americans over the age of 65 that the Clinton plan will have serious effects on this age group. The new plan would empower the Secretary of Health and Human Services to set a controlled price for every new drug, and require drug manufacturers to pay a rebate to the federal government on each unit sold to Medicare patients at market price instead of the controlled price.
If a producer of these drugs balks at paying the rebate, the secretary can "blacklist" the drug, striking it from the list of medications eligible for Medicare reimbursement. (McCaughey, p. 25) The elderly have been told that the new plan will cover their prescriptions, but they have not been told that this proposal threatens to keep new drugs from older patients.

Critics of President Clinton's Health Security Act want the American people to know and remember the following key points of the bill before settling for a low-budget health plan. The Clinton plan will prevent people from buying the medical care they need. With the advent of price controls on premiums, Americans will be forced into HMOs and pressure will exist on HMOs to sharply cut access to specialists and effective, high-tech cures. Price controls on doctors' fees and regulations tying doctors' hands will curb the care physicians can afford to give patients. Price controls on new drugs will keep people over the age of 65 from getting the medications that can help them. Most important, government restrictions on medical education will limit what future doctors know, costing the lives of many Americans and an amount of suffering no one can possibly calculate. (McCaughey, p. 25)

Conclusion

At the time of this writing, no one is certain of the path the American health care system will take. Today there exist supporters for the Canadian single-payer system, President Clinton's Health Security Act, and other suggested reforms that would improve the current health care system but not radically change it. Representative Jim McDermott (D-Wash.) and 92 other House Democrats have sponsored the leading single-payer proposal in the United States today. These sponsors claim that "no other plan would do more to preserve the two traditional bedrocks of American medicine: the freedom to choose your own doctor and the autonomy of physicians to order care as they see fit." (Symonds, p. 82) There are others, though, who feel the Canadian single-payer system is not the answer to the "health care crisis" in the United States today. As Dr. Donald Wigle, a Toronto cardiologist, states: "Canadians are used to peace, order and good government—we probably seem like a dull lot. Americans go for life, liberty and the pursuit of happiness. I don't think they would put up with the wait." (Rosenthal, p. A16) And finally, there are those who feel the current system only needs a few reforms, not a complete overhaul. Dr. Robert Califf, a researcher at Duke University Medical Center, acknowledges that the U.S. health care system may use too many resources. "The Americans might not have needed all the technology they got to achieve that same quality of life [as compared to Canadians]. I think we would all agree that somewhere between Canada and the U.S. would probably be about right." (Winslow, p. B1)

There are still no clear-cut answers as to the direction a new health care system should take in order to provide every American with comprehensive medical care of the highest quality. But, the first step to solving any problem, regardless of its magnitude, is to identify and understand the causes of that particular problem. And the President's proposal, the scrutinizing of his proposal by its many critics, and the lessons which the U.S. can learn from the Canadian system have all helped the American people to identify and understand the weaknesses and strengths present within the current U.S. health care system.
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