Universal, Affordable, Quality Health Care: Ideas from Other Countries

Luncheon Speech with CYNTHIA RAMSAY, health economist and consultant, on September 26, 2002, at the University Club in Montreal

MICHEL KELLY-GAGNON (MEI'S PRESIDENT): Après une rançon de dix millions qui sera payée à même les profits de la soirée, on a réussi à libérer la conférencière.

Donc, bonsoir à tous, good evening. Mon nom est Michel Kelly-Gagnon. Je suis directeur exécutif de l'Institut économique de Montréal.

D'abord, bienvenue à notre première conférence de la saison. Encore plus de gens que prévu ont répondu positivement à notre invitation, et j'en suis très heureux. C'est peut-être une preuve supplémentaire de l'intérêt grandissant des Québécois et des Canadiens pour des alternatives au système de santé actuel.

L'Institut économique de Montréal est un organisme indépendant et non partisan. Notre principale mission est l'éducation économique des Québécois.

Un de nos objectifs est d'attirer l'attention des décideurs québécois sur les expériences étrangères positives en matière de politiques gouvernementales et notamment en terme de partenariat privé-public.

D'ailleurs, plus tôt aujourd'hui, madame Ramsay a rencontré des représentants du Parti libéral du Québec et rencontrera demain matin des représentants de l'Action démocratique. Des invitations ont également été envoyées au Parti québécois, mais nous n'avons pas eu le plaisir d'avoir de leurs nouvelles.

Notre dernière conférence sur la santé remonte à avril dernier, mais nous avons été, dans l'intervalle, très actifs sur d'autres tribunes.

Notre chercheur associé en santé, le Dr Edwin Coffey, qui est avec nous ce soir, a continué, comme il le fait régulièrement, à publier des textes d'opinion dans les quotidiens ainsi que dans les magazines spécialisés. Il a aussi rédigé un chapitre du livre de mon bon ami David Gratzer (orth.) intitulé *Better Medicine: Reforming Canadian Health Care*. Et sincèrement, I would highly recommend his book, *Better Medicine*, edited by David Gratzer. And as I said, Dr. Coffey, our senior policy analyst for health care matters at the Montreal Economic Institute, did a chapter. And Miss Ramsay also did a chapter in this book. That's actually why, that's actually how I heard about Cynthia. And sthere are a whole range of other interesting articles by people like William Watson from McGill University, and so on. So it's a very interesting book.

Et le Dr Coffey et moi avons été invités d'ailleurs à faire une présentation devant la Chambre de commerce du Canada. Nous avions auparavant témoigné auprès de diverses commissions, dont la Commission Romanow et celle du Sénat canadien, entretiens qui furent fort intéressants et qui me permirent notamment de faire connaissance avec la Sagouine qui, pour ceux qui ne le savent pas, est maintenant une sénatrice.

Notre dernière conférence sur la santé portait sur les réformes du système de santé en Suède. Je suis d'ailleurs heureux de souligner que nous sommes la première organisation au Canada à avoir mis l'accent sur ces réformes.

Notre conférencière d'aujourd'hui, madame Ramsay, a elle aussi étudié l'expérience suédoise, mais aussi celle de plusieurs autres pays. Son étude, intitulée *Beyond Private Debate, Beyond the Private Debate, an Examination of Quality, Access, Cost in Health Care Systems in Eight Countries*. Donc, comme le titre très explicite le dit, madame Ramsay, pendant un an, en fait une année complète, a étudié huit systèmes de santé à travers le monde, dont celui du Canada, et a évalué ça à partir de critères très précis dont elle vous parlera tout à l'heure.

Avant de lui céder la parole, permettez-moi de vous la présenter brièvement. Cynthia Ramsay est une économiste dont le champ de spécialité est la santé. Elle a d'abord travaillé comme analyste à Statistique Canada. Ensuite, elle a oeuvré pendant cinq ans à titre d'économiste senior de la santé à l'Institut Fraser. Madame Ramsay est toujours basée à Vancouver, mais elle poursuit maintenant ses recherches sur la performance des systèmes de santé à titre de consultante indépendante. Elle a aussi produit une étude cet été qui en fait a été commandée par la Commission sur l'avenir des soins de santé au Canada, connue sous le nom de Commission Romanow.

Sans plus tarder, without further ado, please welcome miss Cynthia Ramsay.

CYNTHIA RAMSAY (HEALTH ECONOMIST AND CONSULTANT): Sorry about that. I also apologize for not addressing you in French. I do understand it very well, but learned it in Winnipeg and, therefore, have a horrible Western Canadian accent, and will not make you listen to it. And also, with health care, when you get to a more definitive subject, it's harder to speak in another language. So…

But I have, I would like to thank Michel Kelly-Gagnon and the Montreal Economic Institute, because it's very nice to come out here for a few reasons, mainly because my family is here, but also it's always nice to find like-minded people. I'm a colleague and friend of David Gratzer's, and he's sort of been one of the people who I've been able to talk about issues with. But there is, in my mind, an intellectual vacuum in the health policy area in Canada, and a lack of real dialogue in Canada about health care and the potential to change it in I would hope positive ways, and that was one of the reasons I actually decided I wanted to do this study.

The Marigold Foundation is based in Calgary. They usually fund smaller things such as a community park or a program for teen mothers or things like… they usually… policy is not their issue, and Canada certainly isn't, they really do focus on Calgary, but when they talked to me and we were discussing what I wanted to do, they were really open to the idea of broadening the debate, and the best way I thought of broadening the debate was to get more countries involved and to look at it, because it's been, it's incredibly frustrating to talk about health care because it's such a political and gut topic, and it's always, you mention the word private, and the leap is directly towards, oh, you want to Americanize the system, I don't want to talk to you anymore. Like it's just that's the end of the conversation, and despite the fact that we've got, you know, a strong private sector here for uninsured services already, some 30 per cent of health spending is private already, it's not necessarily an evil thing. And so I wanted to look at other countries and so that's what I did, and beyond the private/public debate.

And I looked at Australia, Canada, Germany, Singapore, South Africa, Switzerland, the United Kingdom and the United States. And I chose these countries sort of ad hoc, but part of it was shared United Kingdom history with Australia, South Africa, Canada, we all came from the same health system. As far as others, Germany, Singapore, they rely quite heavily on the private sector and yet are also very much private sector, I mean, the government controls things in Singapore. Yes, there's a large private sector, but it's heavily regulated. And there is very much of an involvement of the government in every aspect of a Singaporeans' life. So it's an interesting mix and almost a contradiction that there is so much private sector there and choice in health care. And yet we can't talk about it here.

I also wanted to include the United States because I didn't want to leave the boogie man out, I wanted to see where it placed. I'm not a fan of it necessarily, the system per se, but I thought, Let's see what it does.

And also, all of the countries, and I don't think you'll ever find a purely private system, and so, when people talk about adding private sector or private… never assume that they're talking about getting rid of the government. I mean, I don't know why that's an assumption. I mean, it's ludicrous to think that you could have a purely private system or a purely public one. No country in the world does that.

So I looked at a few things. I looked at what I thought Canada was trying to achieve. I figured, or any health care system for that matter. You would want your health care system to be high quality, because you want people to get better, you want to treat them. You definitely don't want to make them sicker anyway. You want to look at access, especially in Canada, since that's the whole rationale for our system. We have to protect lower-income people so that they can always get care whenever they need it. And you also look at cost, because as much as we would like the system to be free, as much as we would like everybody to get health care regardless of any ability to pay from anybody, that's just not logical.

For the purposes of the study though, just to show you how unbiased I am, I took low-cost as being better, when I was comparing countries, I took it as a low-cost system, because that seems to be the rationale. If you spend less on health care, somehow that's related to the fact that you have a better health care system. If anyone could point that out to me as to why that's necessarily the case, I don't know. So… but I did assume for this study that low-cost is better.

So when I looked at quality, I looked at things like health status, life expectancy, perceived health status, mortality rates, preventable illnesses like tuberculosis, appropriateness of services, I looked at C-sections and things like that which have been used before as an indication of if you've got too many, then maybe there's something wrong. And I also looked at some patient satisfaction measures, mainly from a Commonwealth fund survey which I've given you part of, an updated survey, and also the World Health Organization is the only organization that has done a comprehensive review of the world and their health systems, the countries' health care systems, and so they had an index looking at patient satisfaction and responsiveness of the system to patients' needs. So I included that in what I was looking at.

As far as access goes, I looked at insurance coverage in a population, and I also looked at immunization rates and things like that as kind of a really pseudo-measure of availability of primary care and things like that.

I looked, tried to look at equity in health outcomes. So I tried to get life expectancies/mortality rates from a low-income region of the country and high-income region. I looked at the majority population in a country and looked at one of its more prominent minorities. So, in Canada, it would be… looked at Canada's mortality/life expectancy figures and compared it to the First Nations numbers on those accounts. And in the United States, it was the Black population with the White population, and tried to get some gauge of this whole idea. In Canada, we want equity of outcome, whereas I hate to say it, but we usually end up getting equity of input rather than equity of output. And also looking at the availability of health care services, because if we don't have a hospital, the doctor or whatever, you don't have access to it.

And then cost, I looked at efficiency, total health spending and sustainability, I tried to figure in how many medical students they were training, what the age breakdown of population was and things like that, because older patients tend to require more and expensive care.

And so that actually brings me to Table 1, which, you know, I wasn't going to do numbers and stuff, but I'm an economist, so I have to at least bore you with a few tables, and I'm just going to move this back a bit, because it's easier to pronounce.

I did the index the same way that the United Nations does its human development index, in the same way the Fraser Institute did its contrary index to that, and basically, when you look at the scores, it's just like in school, 100 is the best, zero, you know, thanks for coming out, but this is all relative too, so this isn't like an absolute score, this is how these eight countries compared to each other. So if I picked another seven countries, Canada might end up first. So that is a caveat of this.

Now, I didn't include in the overall score at the bottom such stuff like demographics and socio-economic status, because I thought it would unfairly penalize something, a place like South Africa

that's dealing with obviously a lot of social problems that doesn't mean anything about their health care system.

So I looked at health status, mortality rates, as I already mentioned. Canada is the winner in health status. For example, with an 82.7 out of 100. And so it does fairly well, we're pretty healthy. So that was good news.

And we fare okay on health coverage, which you would expect given than we supposedly have a universal system. It's a bit of a surprise that we didn't, we're third, Switzerland beats us, insurance is mandatory in Switzerland, it's dealt out by private companies, but it is mandatory. And then the United Kingdom has a mix, a bit of a parallel private system as well, but it's mainly public, so it obviously does well in coverage as well.

And on the equality measure, there is unfortunately not a lot, and this is what I would like more research actually to be done in this area, specifically because I think if we're defending Canada's health care system on the basis of equality arguments, then we should know how we fare on those measurements compared to other countries that do it differently. Unfortunately, there weren't a lot of data, and in the small amount of data I could find, Singapore came out number 1. Probably more due to its smallness and homogeneous population, relatively homogeneous. And Canada did okay on that as well. If you look at something like technology though, Canada scored a 6.2, and so there is maybe some cause for concern there.

So you can look through that, and at the bottom is the overall score where I actually included spending, but only total spending, and didn't include whether public or private necessarily.

So that brings me to the Table 2, which is basically an overall ranking done a few different ways, because I was trying to see if you liked just ideologically public versus private spending, or private versus public, how much the order of the countries changed in how you ranked them. And so, in the overall ranking, the initial one, I came out with Singapore as the best health care system, United Kingdom, Switzerland, Germany, Australia, Canada, United States and South Africa. But even if you say private sector funding is bad and if you have a high level of private-sector funding, I give you a zero or lower to zero, and public sector is good, so it gets more than 100, Canada still only came out fourth. So it sort of made me question anyway the whole idea of whether or not public or private funding puts you near, anywhere in the list in specific.

I'm going to focus on the overall ranking, because that's the main one, and that was, I did this completely a bit in… I didn't know how to rank, because basically what I did was take I think 100 variables or something like that, and tried to find data on them all, I had to rule out some of them that I wanted to compare, but there weren't enough data, but took just a broad approach, I didn't want to exclude anything necessarily and then, in the appendix of the study, there's huge tables, very small print of all the raw data, because one of the things I hate is when people do indices and they don't include the raw data. So, what are you basing this on? And so I put in all the raw data that people can make their own indices, they could check that I did mine right, and actually it's kind of funny because I got my paper reviewed initially by a couple of paper, and they were like, I got a different answer for this, and oops!

So I want people in there to be basically in an approach of openness as far as critiquing it because it is just one opinion, but what was interesting about it is the World Health Organization ranked all these countries, hundreds of them, the order of my countries came out the same. So I was ranking them completely differently than what the World Health Organization was doing, but we came out with basically the same conclusion as to rank. The only difference was that in their study, Canada beat out Australia. But just, it was a flipping of them. Singapore was sixth on their whole thing, and you go down, United Kingdom I think was 18th, and… So it was, it kind of gave me a bit of, of relief that I'd perhaps done this in a coherent way.

And also, what I did as part of the study that's unrelated to the index was I wanted to prove to myself, you often hear people talking about the socio-economic factors that are more important than health, or… and I kind of believed it, and there are enough studies out there that, you know, justify that. But what I wanted to do was prove it to myself, basically. I was talking to someone earlier today, and more or less I can throw any numbers at you and I could draw completely different conclusions than you from the same data.

And so I always caution people to, you know, if you don't like mine, go and find somebody else's, go see if there's a preponderance of evidence in one area or another, and so I wanted to prove to myself about the whole socio-economic thing, I took World Bank data for more than 200 countries, did regression analysis, and lo and behold, I found out that when you're looking at what determines, the determinants of health, such as number of physicians perhaps, or hospital beds, immunization, expenditure in health, if you spend more, do you get better health, all these types of things, and if I saw if there was a correlation with life expectancy, mortality and fertility rates and things like that.

Where did I come out? Basically, what I found out, not reading this, (inaudible) to anybody here, basically what you find out is that gross domestic product per capita, or income, and the illiteracy rate, or the literacy rate, depending if you're a positive or negative person, is correlated with health status, much more so, and immunization rates actually I found to be too, much more so than the number of physicians, hospital beds, you know, as far as population health status, it doesn't matter. What I take from this is not that those things are not important, but in my head anyway, it means that they're not sacrosanct, that we can change the acute care system, or toy with it or whatever we want to do, if we want to try things out with it to make it better, it's not necessarily going to mean, Oh, my God, Canadians are going to be in a horrible health position because we made changes to the acute care system. I think we overvalue it as far as its place in our health status. And so that's what I took from that.

The other thing I took from the study as a whole, and the ranking, especially if you look at Singapore, it's 62 or something out of 100, not, I mean, that's pretty bad, I mean, I would… my parents at least wouldn't have been happy if I'd done that in school, so it says to me that to go blindly and find another health care system and just implement in Canada, you're not going to get it. Like, too bad, it's not going to be that easy. You're going to have to look at different elements, maybe pick and choose a bit. No one health care system is way better than another at performing on cost, access and quality.

I also concluded from it that, really, given who beat out Canada, that either a publicly or privately funded, or a mix, I mean, everybody's got a mix and everybody does it differently, and they're all equally capable, they all have, especially noteworthy is they all have measures in place that try to make sure that everybody gets health care they need regardless of ability to pay. Even the horrible bastion of private medicine down south, there are laws that state that you have to treat a patient that comes into your emergency room, you can't turn them away. Not only that, but you've got to stabilize them before you transfer them and dump them somewhere else, you've got to get permission from another hospital, you've got to go through a whole procedure, and if you don't do that, you get fined, and there are provisions in place. How well it works will vary, but they do try to make sure that people are getting the care that they need regardless of their ability to pay for it.

And, again, as I said, the income per capita and literacy had the strongest relationships, and one of the biggest things that I also found was that we need, before we're going to be doing these things, we need a lot more data and a higher quality of data, because a lot of times, you think you're comparing the same thing about somebody's health care, well, that includes data - oh, well, ours doesn't. Well, you know. So there are these things that you have to make sure you're talking about.

Since I did this study, the… this is Exhibit 1 and 2 I think I've given you the next, this comes from… published in The Health Affairs magazine May/June 2002, and it's a follow-up study, one of the satisfaction measures I used was of how Canadians liked their health care system, and how satisfied they are with it, and if you look at Exhibit 1, it basically looks, they looked at five countries over the space of 1988, 1990, 1998 and 2001, and it's interesting, if you look at only "minor changes are needed," 56 per cent of Canadians in 1988, 1990, figured it was fine, minor changes would, would be no problem. By 2001, that number had gone down to 21 per cent.

So there is an increasing dissatisfaction in the Canadian health care system, and I have to say, I, when I was in Vancouver, the Kirby Commission came along, and they were very (inaudible), it was great, they actually grilled the guy next to me who was for the status quo a lot more than they grilled me, I got off very easy, which I don't usually do, and… but one of the Senators actually asked me, and I think this epitomizes part of the problem with organizing our health care system,

Why did I include, why did I include patient satisfaction measure? So, anyway, that's my experience with the Kirby Commission.

And just if you look at the next one, I think, I don't know if anybody has them or not, I can either get the Institute to make photocopies or… but I, in the next one, it's basically citizens' views on their health care system and general access problems. So it goes from everything from "There is so much wrong in the system that it should be completely rebuilt", "Access is worse than it was a couple of years ago", "It's very hard to see a specialist", or "It's kind of hard to get into, get care in the evenings or weekends", or it's sometimes not able to get care because of where you live. So if you're in a rural area, chances are you're not going to be able to walk into the emergency room and get the level of care that you're going to get if you walk into downtown Montreal.

So if you look at Canada, what's interesting about this is this goes, the interview is below-average income and above-average. So your lower- and higher-income people. And if you look at Canada, which is supposedly doing a great job helping the lower-income people, the whole system is based on making sure those people get access, if you look at "There is so much wrong in the system", 23 per cent of the people thought there is so much, you need major changes, that have low income, versus 13 per cent higher-income. If you look at something like "It's very… or extremely hard to see a specialist", below-average is 20 per cent, whereas above-average is 14. So you see, first of all, the differences within Canada, between how low- and high-income perceive their access to the system. But you also see, sort of relative to other countries, that Canada, in the low-income category, has some of the highest percentages of people who are having trouble accessing the system in the lower-income. And if you look at the high-income, you've got quite… we're the highest in some of those. So not only are we not achieving our goal of making it necessarily easier for lower-income to access the system, also the people who could be paying, or could be contributing more or could be, you know, the rich, who we are so worried about giving more access, they are also having trouble. So we're all kind of in the middle somewhere unhappy, which, you know, where you go with that is your own choice, but to me, it's sort of, at least, I question what we're doing as far as… and why we are doing it.

And the last thing I'm just going to quickly point out is a couple of tables from a recent Fraser Institute publication that you can look, mull over the data at home, it's the August Fraser Forum, which I think you could probably get on-line, at www.fraserinstitute.ca. And it's just a couple of tables I found interesting. One is sort of where Canada ranks internationally, and there's more to the table than this, I only took one of the pages, for technology, remember my index, we were awful low, and they're using OECD data as well, so it's not surprising that Canada, for example, for MRIs per capita, is at 18th out of 23 countries. CT scans, they're 17th out of 22.

But what's more unsettling to me than the fact that we're way down these lists is that we also don't seem to be performing very well on disability-free life expectancies, potentially years of life lost, and also on breast cancer mortality and things like this, we're doing not very well. And that is probably more of a concern to me than the fact that we don't have enough MRIs. And another reason to question what we're doing and how we're doing it.

And then the last thing is just to show that Canada, and this sheet, these are all countries with socialized, social insurance, health care systems, it's not free market wheeling and dealing systems, these are systems that are similar to Canada's in their mindset, and Canada, you know, it's one of only seven of these types of countries that does not allow cost sharing. It's one of only 11 countries out of 24 that doesn't allow for hospital co-payments and things like that. And so we're unique, but I don't know if it's necessarily a good thing in this case, and that we should look at countries like… just because we're next door to the United States doesn't mean they're the be-all and end-all. And it doesn't mean that that's the only way to privatize, and the fact that they're in our market or they're our neighbours, I mean, our system was based on that of the United Kingdom, we've looked abroad before, and I think we should do it again, and I want to leave you a good 20 minutes or so for questions. So thank you.

MICHEL KELLY-GAGNON: Thank you Cynthia for this excellent presentation. Donc, nous allons effectivement passer à la période de questions. Si c'est possible pour vous, ce serait bien de formuler la question en anglais. Par contre, si c'est impossible pour vous de le faire, on se fera un plaisir de tenter de jouer aux interprètes on the spot.

Je pense que nos invités apprécieraient si vos questions étaient les plus brèves et les plus précises possible et si vous pouviez également vous identifier avant de poser votre question. Mon collègue Patrick Leblanc va prendre le micro à la Phil Donahue et va être disponible pour prendre vos questions. Voilà.

ANNABEL SOUTAR (DIRECTRICE ARTISTIQUE, PROJET PORTE-PAROLE): Hi, my name is Annabel Soutar, I'm a playwright. That finding that you had about illiteracy and income is very interesting to me, and I'm wondering if, given that… it seems to be a pretty strong argument in favour of preventative versus curative medicine, and I'm wondering if you're finding that there is a trend in that direction, towards preventative, investing more in preventative programs in health care.

CYNTHIA RAMSAY: I think there are. I do sometimes worry about that investment though, because for example, setting up a wellness centre which ostensibly will educate people on how to eat properly or do something, whether or not, I mean, if you're going to do that with public funding, I would want real measures in place to make sure that that money is being well spent and that there's outcomes that you expect from that wellness centre, because, otherwise, it could be such a void, such a money pit and such… I mean, ultimately, you know, like I go to my doctor, and they tell me, Yes, you've got lose weight, yes, okay, well, whatever, you know, like, you, so what, you could pay him a million dollars to tell me that, I'm still not necessarily going to do it. So, ultimately, yes, and I know, I mean, I'm an educated person on what I should eat and what I shouldn't, you know, and we should exercise, and often more often I end up watching television.

But now, if there were something, and it's funny that health isn't enough of a reward in and of itself. And this is, as an economist, I guess, I could be proud, but I find it kind of depressing, I think that if you went more along a system of a bonus or something, if you didn't go to the doctor more than just your physical or… you know, if you actually attached some of the money to preventative care to the actual people who are doing it, like if I got a bit of a rebate on my… we have to… even for public, yes, a rebate on your taxes, or in British Columbia, we… our free health care system not only costs our taxes, but we have to pay premiums on top of that. And we don't have the choice of being uninsured because they passed a law saying it was illegal to be uninsured. So basically, and unless you have a low enough income, you have to pay them, there's no ifs, ands and buts. If you arrive into a hospital, they'll treat you probably, but they'll hit you up for the premium after, I'm sure.

If I got a break on that, or if they gave me a little bit of a discount, I'm not saying penalize even people who smoke or things, but just can I get a break if I do good things, like I'd rather see those types of things that make it more immediately tangible that I did something good, and I can see it.

ANDRÉ CÔTÉ (CHEF DES AFFAIRES GOUVERNEMENTALES ET PROFESSIONNMELLES, ELI LILLY CANADA): Hello, I'm André Côté, I'm government affairs manager for Eli Lilly, we're a research-based pharmaceutical company, so you may have an idea of what, what type of question I'm going to ask. In looking at some of your health index scores, I was wondering if pharmaceuticals per se were evaluated, and also I was wondering if, in that respect, if increased spending in pharmaceuticals could tend to lead to overall health care savings and elsewhere.

CYNTHIA RAMSAY: I guess you've read the Fraser Institute study that says it does, oh, says that spending in pharmaceuticals was one of the areas that actually is correlated positively with health standard. That's the only study I know of that has found that. So I haven't done that personally, but there is a study at least out there that says that of all health spending on system-type elements, which the pharmaceuticals are one, that is the one element that if you do increase spending in it, you see a positive correlation with health status, it's a good thing. What was the other part? Sorry.

ANDRÉ CÔTÉ: Are pharmaceuticals evaluated…

CYNTHIA RAMSAY: Yes. And I'm just finding the table at the back, they were evaluated in a couple of instances. One was I didn't want to assume necessarily, although I ended up… it's mainly a study of acute care, but I did try to make it broader than that, and one of the ways I did it was to look at the distribution of health spending, and how it's broken up between things like pharmaceuticals, acute-care facilities, prevention, administration, all these types of things, and the countries that had a more diverse spread or more equal spread fared better in the study. So it's in there, but it's also on an indication that's used, I used it in service appropriateness. So I actually used it as an, not necessarily a positive, I think, actually, if you had higher medicines consumed per capita, I said you were doing a worse job, which is open to interpretation, because if it is indeed the case that it's beneficial, but for the purposes of this study, it was a negative use of the pharmaceutical industry. Sorry.

IAN MacDONALD (PRIVATE CITIZEN): My name is Ian MacDonald, I'm just a retired, a member of the general public who's interested in the subject. And I may be reading far too much between the lines, but basically, on the excerpt that you probably saw that was published in The Gazette a couple of days ago, I was left with the impression that the U. K., which is a mixed system, as you point out, is ranking somewhat higher than I probably would have expected. And certainly, if you read the U. K. press, you see all sorts of expressions of dissatisfaction with at least the national health service…

CYNTHIA RAMSAY: Yes.

IAN MacDONALD: … component, and, of course, the… our government is pumping massive amounts of new money into this, I just wondered if you can comment somehow on that.

CYNTHIA RAMSAY: I think that one thing, part of the lesson is, is don't trust what you read in the paper, because they, yes, I mean, I actually, besides being a health economist, I co-own the Jewish Western Bulletin, which is the Jewish community newspaper in British Columbia, and even us, we have to serve our community, and you want positive stories, I mean, you want the fact that so and so… but the bigger news story is the bad thing that happened unfortunately, and that's the way you communicate. So I think in health care, I mean, I don't think a crisis is imminent, I mean, I think we've got big problems and I think we've got some of them I'm sceptical we'll be able to overcome, but I don't think that we're all going to be out on the street in five years, I think that we'll manage.

So even if you read our press, I think you would get an overly negative view of the health care system, because even if you read surveys of people who have had contact with the system, another table, which I didn't give you, of the five-country one in health affairs, asked people how your encounter with your hospital or your GP was, and it was pretty reasonably positive in all five countries, including the United Kingdom.

So one of the problems in the U.K. I think is they have more I think than almost any other country, the tabloid-type press. The other thing is they actually are, have a lot more measurements. I mean, you can go there and you can see the hospital waiting list for every hospital and every procedure, and you can get a much more of an idea, so you have more knowledge, so you have more to be upset about, because you know more I think is, is part of the irony of it. If you keep people ignorant, they're more or less, yes, whatever, so I waited six months, and see, it's not a big deal. But when you realize, Oh man, that hospital over there, I could have only waited a month, then you start getting annoyed and angry. And I think that they have tried some major reforms that haven't worked. And I think personally, it's my personal opinion, they haven't worked because they're not patient-focused, they're more trying to, like the GP fund holding, or now it's called the primary care groups or whatever, it's all directed at the providers of care, whether it be hospitals or doctors, it's all at these people above the level of the person receiving the care, and I think, to me, that's one of the pitfalls. But overall, they seem to have an okay system, (inaudible) the data, so I mean…

DAVID ANBER (PRESIDENT, McGILL UNIVERSITY CANADIAN ALLIANCE CLUB): I'm David Anber, I'm representing the Canadian Alliance Party of Canada (sic). I have a question about your Table 1, especially the variables, which I find all the variables particularly fascinating. In particular I'm looking at one variable, that patient satisfaction, and I was wondering if you had drawn any conclusions to how to patient satisfaction relates to other variables, in particular maybe even the overall score, because there seems to be interesting results that, in some scores, might be high, yet the patient satisfaction might be low, or vice versa. And I think that that's a little bit interesting to look at, and I was wondering if you had anything to say about that.

CYNTHIA RAMSAY: Well, it is interesting actually because, again, it's, it's hard to know because a lot of, there's actually I think been studies that show that there's always a question on self-perception of health, and there have been studies that have actually shown it's not a good measure. I mean, you might think you're really healthy, but you are the sickest person, you know. So your own perception of your own health is not always good, and I'm not saying that that's, I think if you feel healthy, that says something, and that your opinion matters and your satisfaction matters. But when you're looking at actual outcomes of health, I think it has to be taken quite different from how you feel it went. I mean, a lot of people, if you just manage to get into the doctor and you got your treatment or you got whatever he told you to do or she told you to do, you go home feeling a bit better, and whether or not though you are getting better is a question. And there's also issues of placebo effects, whether or not you take a sugar pill and you think it's doing something, that you get better on your own. There's all these elements that are so unknown as far as patient satisfaction in the actual outcomes. So I think that you might feel fine, but the X-ray might show otherwise. And I think that's why you'll get discrepancies in people's happiness with the system versus what it's actually producing, its outcomes in cancer survival rates and things like that.

UNIDENTIFIED MAN: But that could be true of all outcome.

CYNTHIA RAMSAY: Yes.

UNIDENTIFIED MAN: The actual number is not as relevant as the comparative…

CYNTHIA RAMSAY: And that's why I did it.

UNIDENTIFIED MAN: Is it the same question everywhere or (inaudible)?

CYNTHIA RAMSAY: Yes, there were two. There was one in the five-country study that you have some there, it was… this was an earlier version of the five-country study because this one came out. So yes, the same question every country, same formulation, same groups that they're looking at. And the other measure was the World Health Organization, which looked at patient dignity, respect of privacy, and included all these types of things in their interviews. So the measure is the same across countries, but there are two different measures within that component.

LUCIE BÉLANGER (AVOCATE, HEENAN BLAIKIE): Hi, Lucie Bélanger from Heenan Blaikie. I would like your comments about low scores of obtained by Canada and the U. K. on technology.

CYNTHIA RAMSAY: We don't have much. I mean, if you look at just pure OECD countries, so you're looking at countries of comparable wealth and status, the Fraser Institute, that I do recommend in getting, because whether or not you like the Fraser Institute or don't, it just, in a lot of things, it's just comparing OECD data, and a table is a table, and you can interpret it how you want, but they've got a lot of handy tables, and one of them is just looking at technology, and here we are table… looking at MRI per million, CT scanners per million, radiation therapy machines per million, you don't have this, sorry, this is one I kept to myself, it is part of the page 44 table, but

this is just a bit more specific on technology, lithotripters per million inhabitants as well, and Canada just ranks dismally. I mean, they looked at 23 countries with respect to MRIs, and Canada is 18th rank.

And what's frustrating actually, in the United Kingdom, they don't actually spend that much, so you kind of think, Okay, fine, they don't spend it, so they don't have it. Canada is one of the most expensive health care systems in the world, and if you adjusted for age some calculations, you'd get… it's the most expensive health care system in the world, and yet, we're 18th of 23 on MRIs, 17 of 22 on CT scanners, eight out of 22 on radiation therapy, and 13 out of 14 on lithotripters. I mean, and I'm not saying necessarily you want to spend all your money, because, I mean, these are expensive things, you… but there are choices that have to be made, and I sometimes worry we're making them by default. Like I want to know that someone chose, instead of spending a million dollars on an MRI, they've spent a million dollars on something else that was necessary, or something that affected more people in the end, helped the health of 500 people rather than help the health of 100 people, and so you've got a bit of a bang for your buck. But I don't trust the way the system is organized now that you're getting those kinds of measurements of trade-offs. And that's I think what concerns me more. I'm not saying that we rank 18 out of 23, so we should go buy a bunch of MRIs, I think we have to look at where this technology places in our health care system, and at least make the decision consciously to be 18th. I don't think we're doing that now.

JEAN DUPRIEZ (PLANIFICATEUR FINANCIER, VALIMAX): My name is Jean Dupriez, I'm a financial planner. And by the way, my youngest daughter is a doctor. I read in La Presse a few days ago that in Quebec, we have 35,000 bureaucrats in our systems, while we have 14,000 doctors. Did you ever study that ratio of the number of bureaucrats in various countries to the number of doctors, comparing that with the degree of satisfaction of people?

CYNTHIA RAMSAY: No, I…

JEAN DUPRIEZ: And this would mean, could we be more satisfied with a highly "Sovietized" system as the one we have here in Quebec?

CYNTHIA RAMSAY: Well, the main concern that I have, and it's, again, a problem with the confusion I think between inputs and outputs, in Canada, we sometimes proudly say, you know, in British Columbia, we've increased health spending every year, as if that in and of itself should make me feel happy about the system.

Now the question is, is it going just to more bureaucrats or is it going to fund more doctors or is it going to fund more chiropractors, or is it going to fund somebody that I might actually want to see? And from what I've talked, I've taken quite a few tours of hospitals, mainly in Vancouver, where I live, but there's complaints from the frontline workers that, you know, we've got I don't know how many hospital administrators, and what we really need is a nurse at the entryway of the emergency room, or what we really need is not 12-hour shifts for these people, but eight-hour shifts.

And so I do, I do think there's a tendency, but I would also say that a private system is also going to have a lot of people involved in administering, and also are going to be… and that's one of the arguments often used against it, is our administrative costs would increase because now, not only do you have the 35,000 centred locally here in Quebec, but you've got 20,000 more because there are more people competing for the services.

So it's I guess the incentives facing those administrators, and if they were in the private sector, basically, if you don't make it fly, you're, you know, you're bankrupt, you're out of there. If you don't make your hospital some place that's pleasing for patients and staff is happy to work there, and you've got an environment, then you would go, you'd be out of business, whereas here, you can spend all the money, have the worst hospital, in Vancouver, General Hospital, there's paint peeling off the ceiling, there's mice, there's, you know, you walk down the hall of the cardiac… not intensive care, but one step down, and you've got people's diapers sitting on the floor that haven't been cleaned. I mean, it's like where is the money going? And I think that it is often, too often, to

the higher-level people, and you end up getting this burnt-out workforce who can't do any more on so little. And so I would agree. But I've never done a study, and it would actually be a fun sort of thing to do, I think, in a way, because I've heard of statistics similar to that in British Columbia, like just there's no comparison of the numbers. It's just… how it can take that many… I guess too many cooks in the kitchen is what that is.

MICHEL KELLY-GAGNON: Cynthia, Michel Kelly-Gagnon, let's suppose for a moment that you present yourself in order to become prime minister of Canada, and then the population, realizing your charm and your intelligence, you win by a landslide victory…

CYNTHIA RAMSAY: This is in Canada.

MICHEL KELLY-GAGNON: … yes, and you have, you know, a supreme popular support, the polls are at 95 per cent in your favour…

CYNTHIA RAMSAY: So I've lied about my health care campaign…

MICHEL KELLY-GAGNON: What kind of two or three kind of main, you know, not in the specifics because we don't have the time, but what are the two or three main changes or directions for changes that you would tell your minister of health to engage in?

CYNTHIA RAMSAY: Well, basically, I would do it right away, because I need three years for people to realize that it's not going to kill them. One is I think that the Clair Commission was actually on the right track, and then was wrong, on the idea of saving now for retire… for long-term care. Eventually, I would like medical savings account, but I think the first thing I would do in office is, okay, part of your taxes is actually being earmarked for you, and we're making you a little health care RRSP, and that's one of the things I would start with. And that would be a thing you wouldn't see until the population got older, and it wouldn't really have much impact, but I would decrease some funding of other things to give people money to have in a health care account to start them off.

The second thing I would do is, if I had the ultimate power of the supreme universe behind me, I would break up some of the unions in turf battles. Because I think that the legislation right now on scopes of practice is way too specific, and you can't get, you can't have a fluid system because doctors only can do this, registered nurses can only do that, LPNs can only do that. And then you've got all the unions, the hospital employees unions, who only can do that. And all these people, because there's restricted access into their professions, commands a premium. So we're paying them basically I would say most of them more than they're worth, some of them are not getting paid enough because they're excellent, but sorry, you're a union number, you're number 6, you've only been here six years, it's all you get. Who cares that you're the best person ever to walk in our door. So I would change that if I could somehow, just so they forget that, scopes of practice are gone, we're having much more wide open and we're also getting rid of union powers. That would be the second thing.

And if I was still alive and nobody had car-bombed my house, I would probably end up…

(Inaudible)

CYNTHIA RAMSAY: Especially not here I guess. The… what I would do is, is reward the better behaviour. I mean, you've got to eventually get it down to patients taking care of themselves and providers taking care of themselves, and if you're going to have fee for service, fee for service works fine if it's somebody paying you and you have to perform for them basically. And so in a market where… because if you get fee for service for doing a good job, bad job, no job, then that doesn't work, so I would also change, try to introduce not necessarily user fees, but perhaps, like I was talking about, like a break on a premium or bonuses on your taxes or something along those lines.

MICHEL KELLY-GAGNON: Three more people want to ask questions, and then we'll have to conclude.

ROBERT WEINMAN (DIRECTEUR DU SERVICE DE SANTÉ, ALCAN): My name is Robert Wagner, and I'm a physician. I just want to ask you a couple of questions and just get your views. I moved here from the United States a number of years ago, and one of the comments I made to my wife a number of years ago was that I was afraid that we would end up living in the highest taxed area of the world and end up having to pay the same educational costs as people in the United States. That tendency, outside of Quebec, is happening, the educational costs are going up and up.

So my question is, if we privatize, which is very in vogue now, and everybody talks about getting more money into the system by privatizing, and the taxes don't change, I'm not sure how the public benefits, you know. It's very nice having the highest taxes in the world, but if you also have to pay for your health care, because you can't get it with your taxes, I'm not sure what the attraction is there.

CYNTHIA RAMSAY: I would say…

ROBERT WEINMAN: I would also make the corollary comment that if you are allowed to get a reward for good behaviour, that in effect does penalize the other people because the pot is closed. So the other pot is going to go up because the other is going to go down. The government doesn't get more tax money in because they give me a break.

CYNTHIA RAMSAY: Well, no, they give you a break so you don't end up in hospital costing them 800 dollars when you could have spent 50. I mean, that's where the break comes in. You're not just giving people money for the sake of giving it to them, you're giving it to them because they'll use the preventative medicine that will keep them out of the more expensive and therefore will not be taking away from… so…

But, as far as privatizing and not decreasing taxes, I would agree with you that I think that that's why I'm hesitant to endorse something like a user-fee approach, because personally I think, basically, what I would be doing is I would be giving ten dollars to the emergency room, and I have no idea where that money goes, I don't know if it's going to go to get me better service the next time, I don't know if it's going to be… the hospital gets to keep it, or… I don't, I'm not necessarily, it doesn't reflect the true cost of the service that I got when I was there. So I'm not really feeling the impact of, oh, my God, this cost me, ooh, ten dollars, like, really, it might be enough to keep people away who can't afford it, which would be problematic, and there have been studies that show that user fees do do that, but I think you can, you can get around those problems, I think. But any recommendation that I tend to make is a tandem thing. I mean, if you're going to go along this route of a medical savings account or anything, that you've got to bring the taxes down along with it.

ROBERT WEINMAN: Are there any examples of where that's actually happened?

CYNTHIA RAMSAY: Of decreasing taxes by… I wouldn't know off the…

ROBERT WEINMAN: (Inaudible) but as a result of people paying more (inaudible).

CYNTHIA RAMSAY: I don't know off the top of my head. What I would say though is that there are a lot of systems that have more private-sector involvement that spend less on health care. Now, whether or not that generates into less general taxes, I don't know.

NANCY BONO (PHILOSOPHY STUDENT, McGILL UNIVERSITY): Hi, my name is Nancy Bono,

and I'm a philosophy student at McGill University. I have two questions. First, I'd like to apologize for raising my hand while you were talking about Exhibit 1, I just wanted to mention that I'm missing it, I don't know if anyone else is, we seemed to be shuffling. Could you remind me what Exhibit 1 was about, or what the title was? (Inaudible) distractive?

CYNTHIA RAMSAY: It had something to do with the Canadians liking their health care system in 1988 versus 2001. I think it's the citizen's overall views about their health care system, five countries.

ATTENDEE: We don't have it.

CYNTHIA RAMSAY: You don't have it. Okay. I apologize for that then.

NANCY BONO: No, it's okay. So there was a decrease in the appreciation of the system?

CYNTHIA RAMSAY: Yes. Sorry. Boy. Yes, it went from 56 per cent of Canadians who were thinking that there were only minor changes were needed, which was really high and which is a good thing, because only minor changes… in 1988 to by 2001, only 21 per cent of Canadians were of that opinion. And 59 per cent of Canadians thought that fundamental changes were needed. And it's interesting because in and of itself, if you look at the 2001 numbers, between the countries, Australia, Canada, New Zealand, United Kingdom, United States, on these, whether or not you need to rebuild the system, fundamentally change it or just tinker with it, if you look at the pure numbers of 2001, they're all pretty comparable, but the interesting thing is how Canada used to be way ahead of these other countries more than ten years ago, and I can't explain that.

I mean, it might just be perceptions or media, or it might be truly things have gotten so much worse. But it's interesting to note that the big thing is the drop, from 56 per cent thinking only little things done, more so than the 21 per cent, because in that year, people thinking only minor changes were needed, in 2001, was 25 per cent in Australia, 18 in New Zealand, 21 in U.K., 18 in the States. All pretty much in the same ballpark. But we used to have something more.

NANCY BONO: Okay. And my second question. I'd like to know if in your studies, you came across any countries that spent quite a bit of money, well, government control on personal health care education, and left medical treatment largely to the private sector? And if so, how did they fare, and if not, what do you think of such a system, or the benefits of such a system?

CYNTHIA RAMSAY: Most countries actually do focus on sort of the acute care and they're all into making sure that it's there. And I'm going to get this wrong if I just do it off the top of my head, so I just want to quickly… as far as that goes, I mean, I don't want to… I think we have to set our priorities, and I think that education is one of them. Whether it has to be public education is another question. But, for example, Singapore, which is the very government controlled, private practitioners provide about 80 per cent of the primary care, while the government only provides about 20 per cent. But it's the flip side for acute care, so it's the really expensive care, the acute care, that the government is providing 80 per cent, and the private sector only 20, which kind of almost to me went against intuitive nature, because the primary care is the… well, it's both, I mean, obviously, you want people to get it, well, no, it's not… they leave it all in private hands, so I guess people could choose not to do that, and then just end up in the more expensive acute care sector.

And you think if you wanted to encou… like Canada seems to be going the opposite way. The governments across the board, not just in Quebec, are looking at these primary care units and really focusing on primary care, or trying to, although I don't think they'll be able to do that in the end, there'll be lots of noise, but you still have to have the hospital, you close it down, I know they've closed down some several years ago, but they always cause a problem. It seems to be the reverse, and I'm not sure which is better. I mean, I just do find it interesting that in Singapore

they basically leave primary care to the people, and if, boy, if God forbid, something happens to you, then that's where they guarantee that you're going to get some treatment. I just think it's different. I don't know if I would pick one.

MICHEL KELLY-GAGNON: We now have to conclude. Again, thank you very much Cynthia for this presentation. We have here for you a small token of appreciation to thank you for flying all the way from Vancouver to be with us.

And thank you to all of you for being with us tonight. For those who were with us for the first time tonight, I hope we will have a chance to see you again. The Montreal Economic Institute holds about four public events a year.

Je profite d'ailleurs de l'occasion pour vous inviter à notre prochain événement: un déjeuner-conférence en compagnie de l'Honorable Mike Harris, premier ministre de l'Ontario de 1995 à 2002. L'événement a lieu le 4 décembre prochain à midi au Ritz-Carlton.

Encore une fois, merci d'avoir été avec nous ce soir et bonne fin de soirée à tous!