Chapter 2. Health Care as a Reflection of Underlying Cultural Values and Institutions

The Organizing Principles of the Canadian Health Care System

Since the case decided in 2005 by Canada’s Supreme Court that overturned a law in Quebec that had banned private alternatives to the public Medicare system (see pp. 31–32 of the book), there has been intense discussion and debate in Canada about permitting the development of private-sector alternatives in parallel with Medicare. The Canadian Medical Association commissioned a national poll of public opinion regarding the issue and found that only 15 percent of Canadians are in favor of allowing the development of private-sector alternatives to Medicare. Most Canadians want to maintain Canada’s single-payer system that assures the same level of care for all Canadians. However, they want a system that provides better access to care and enhanced quality of care.


The controversy over private-sector alternatives was at the center of a debate over who should be the next president of the Canadian Medical Association (CMA). In August 2006 the CMA elected Dr. Brian Day as its president-elect. Dr. Day, an orthopedic surgeon, “operates Canada’s largest private hospital in violation of the law,” as described in an article from the *New York Times*. Despite his leadership of Canada’s largest for-profit hospital (located in British Columbia), Dr. Day was quoted in the *Globe and Mail* as stating, “My support for universal health care is unequivocal. I totally reject the so-called U.S. system.” It appears that the debate over private-sector alternatives will be a major issue for the CMA to confront in coming years.

Mason C. 2006. Canadian doctors elect advocate of larger private role in medicine. *New
In a number of Canadian provinces, the issue of expanding the role of the private sector has become contentious. These include:

**British Columbia**

As described above, Cambie Surgery Centre in Vancouver, BC, of which Dr. Brian Day is president, is the largest private, for-profit hospital in Canada. On its web site, Cambie is described as “the most modern and only free-standing private hospital in Canada” ([www.csc-surgery.com/](http://www.csc-surgery.com/)). It offers a range of surgical services, such as orthopedic surgery or eye surgery. Many of these services are covered under Canadian Medicare; thus providers are prohibited from providing them in a private context. Nonetheless, the Cambie Centre enjoys quite a patient following.

The efforts of another doctor to expand private sector alternatives in British Columbia have not been quite as successful. On December 1, 2006, Dr. Mark Godley opened the False Creek Urgent Care Centre in Vancouver, at which he offered rapidly available care for injuries and illnesses, for a set fee. The standard fee for treatment was $199, with additional fees for additional services as required ([www.urgentcarecentre.com/](http://www.urgentcarecentre.com/)). Of course, the treatment of injuries and illnesses is fully covered under Medicare. Thus, in offering a private-sector alternative for these services, the Urgent Care Centre was violating both the laws of British Columbia and the national law, the Canada Health Act. In press reports, Dr. Godley is quoted as saying, “To be
straight and blunt about it, we feel we are on absolutely strong legal grounds.” In response, British Columbia Premier Gordon Campbell stated, “We’re very clear in British Columbia that the Canada Health Act will be enforced, and I can tell you that if someone is breaking the Canada Health Act they will be prosecuted to the full extent of the law.”

A news report from December 21, 2006, in the *Vancouver Sun* stated that the “controversial private urgent-care clinic in Vancouver has shut its doors just two weeks after it opened.” Subsequently, it was reported that the clinic was permitted to reopen, but only if they bill the provincial health ministry for services, without charging patients directly. It appears that there may be further legal tests coming from British Columbia regarding the extent to which private-sector alternatives to Medicare are allowed under Canadian law.


*Ontario*

Private clinics, in which patients are charged fees over and above what the provincial health plan will pay, have also begun to open in increasing numbers in Ontario. Ontario permits clinics to open once the physician has registered with the provincial health plan, but does not monitor them as to their payment policies unless it receives complaints. The provincial health ministry did act in 2005 to prevent a clinic from opening in Toronto, because the clinic planned to charge “membership fees” to its patients, a practice reminiscent of concierge practices in the United States (discussed in Chapter 7 of the book). However other clinics with similar billing practices have been able to remain open, so long as they remain “under the radar.”

**Alberta**

In March 2006, Premier Ralph Klein of Alberta proposed a change to the provincial health plan that would permit doctors to see private patients as part of their practice, charging those patients an extra fee for this extra level of service. For example, an orthopedic surgeon might provide hip replacement surgery to some patients under the provincial plan, and the same surgery to other patients willing to pay privately to obtain the procedure without waiting in the queue. (Note that this proposal is quite similar to what is permitted for some doctors under the British National Health Service.) In defending the proposal to expand private-sector options for care, Premier Klein is quoted as saying, “The health system must change to survive.” However, both Canadian Prime Minister Stephen Harper and federal Health Minister Tony Clement were opposed to the proposed changes to Alberta’s provincial health plan, and after a series of negotiations with federal officials, Premier Klein dropped his proposed changes.


**Ontario: Another Recent Court Decision**

A man in Canada was found to have liver cancer that was so advanced, he was deemed ineligible to receive a liver transplant under Ontario’s provincial health plan. With no access to a transplant in Canada, the patient traveled to England and paid for a transplant with private funds,
in the amount of about $450,000. The patient survived, and he sued the Ontario health plan to reimburse him for his care in England. The Superior Court of Ontario denied the patient’s suit, stating that he was free to obtain private care as an alternative to the public health plan, but that he had no right to obtain payment for that care from the health plan. The court is quoted as stating, “The law is clear that where the government puts in place a scheme to provide health care, that scheme must comply with the Charter. That does not entail that, having decided to provide health care, the government must do everything possible to save the lives of its citizens in every circumstance, including funding all potentially lifesaving treatments.”

The author of the news report put it this way: “In other words, governments have a right to say ‘No,’ to establish rules on what is and is not covered by the public system . . . While fair and free access to medically necessary care is the law of the land, it is perfectly legal for governments to place limits on what is covered.”


It is apparent that, in the aftermath of the 2005 Supreme Court case involving private-sector care in Quebec, there will be continuing efforts to expand the role of private-sector care within Canada’s national Medicare program. These efforts will confront consistently strong national opinion that Canada must avoid a two-tier system of care, with some patients getting care through the public health plan and some getting care through the private-sector. Government officials and the Canadian electorate appear to be firmly in opposition to efforts to add private-sector alternatives. It remains to be seen whether Canada will be able to invest additional resources in its public Medicare system such that queues for needed care are shortened and the
public regains confidence in the quality of care available in urgent situations.

The Cultural Institutions that Drive Health Care in the United States

The “Technological Imperative” and the "Technological Benefit of the Doubt"

On p. 40 of the book we learn from Victor Fuchs about the technological imperative, which he defines as “the desire of the physician to do everything that he has been trained to do, regardless of the benefit-cost ratio.” If a new, high-tech treatment is available, many patients will assume that they have not received high-quality care, and many doctors will fear that they have not provided high-quality care, unless they use the new treatment. Rarely are concerns voiced about the relationship of the marginal cost of the new treatment to its marginal benefits. As discussed above in this web supplement, the Ontario Superior Court ruled explicitly that, under the Canadian system of care, marginal cost / marginal benefit considerations do apply: “it is perfectly legal for governments to place limits on what is covered.”

In the United States, we also often follow what I refer to on p. 40 of the book as the “technological benefit of the doubt.” In comparing a new, high-tech approach to a problem with an older, low-tech alternative, we tend to expect the newer approach to be superior based on its use of advanced technology, absent empirical evidence to that effect.

In recent years, several important research papers appeared that suggest we may have paid too much attention to the technological imperative and the technological benefit of the doubt.

• Back Surgery

For many people who develop back pain due to damaged or worn-out disks in the lumbar
(i.e., lower) spine, the assumption is that surgery to repair the damage will provide much better outcomes than simply watching and waiting. (The technological benefit of the doubt: high tech is better, until proven otherwise.) Thus, rapidly invoking surgery in the face of damaged lumbar disks has become quite common—so common, in fact, that the U.S. Agency for Health Care Policy and Research (the precursor to the Agency for Health Care Research and Quality) issued a report in 1995 suggesting that many of those surgeries are unnecessary. The agency’s support so angered the surgeons who perform these operations, they lobbied Republican lawmakers and nearly got the agency that issued the report eliminated.


Thus, it was extremely interesting when, in November 2006, a team of researchers reported in *JAMA* on a large randomized study of patients with disk disease. Comparing those patients who received surgery with those who received nonsurgical treatment individualized to their specific circumstances, the authors concluded that “patients in both the surgery and the nonoperative treatment groups improved substantially over a 2-year period.” The authors were unable to say with certainty whether surgery held any advantages over a watchful waiting approach. An editorial commentator responded to the article by stating, “Several important questions remain. The cost-effectiveness of surgery for lumbar disk herniation must be established.”


**Screening for Lung Cancer with CT Scans**

It is well recognized that long-time smokers are at high risk for developing lung cancer. Many have advocated annual CT scans to screen these high-risk individuals to pick up cancers at an early stage, before they have spread. The assumption has often been that using the high-tech alternative (CT scans) will give better outcomes than the routine chest x-rays and other low-tech alternatives. Bach and colleagues reported on a study of the use of CT scans in this context and concluded: “Screening for lung cancer with low-dose CT may increase the rate of lung cancer diagnosis and treatment, but may not meaningfully reduce the risk of advanced lung cancer or death from lung cancer. Until more conclusive data are available, asymptomatic individuals should not be screened outside of clinical research studies that have a reasonable likelihood of further clarifying the potential benefits and risks.”


**Using Drug-Coated Stents to Reopen Clogged Arteries to the Heart**

For years, doctors who identify clogged arteries to the heart in a patient have attempted to unclog the artery, principally through the use of balloon angioplasty—threading a small balloon through the clog, inflating the balloon to reduce the clog, then threading a fine, wire-mesh sleeve into the artery to keep the clog open. This sleeve is referred to as a stent. The problem has been that these stents often became reclogged in fairly short order. Accordingly, many doctors started
using stents that were coated with a medication intended to reduce the recurrence of clogging. By 2006, more than 1.5 million patients were receiving these stents each year, at a cost of more than $6 billion.

Unfortunately, after these drug-coated stents had become widely used, evidence started to accumulate that the stents may in fact cause potentially fatal blood clots to develop. In one news story, a heart specialist was quoted as saying, “In the past we’d say, ‘Why not?’” His response to new data suggesting potential dangers from these new, high-tech treatments was that the data represents, “a big why not.”


In March 2007, the *New England Journal of Medicine* published a series of research articles and commentaries on the use of drug-coated stents, including an excellent editorial comment:


*The Institutional Basis of Medical Malpractice*

On pp. 44–47 in the book, I discussed perceptions that there was a “malpractice crisis” in the United States, thought to be associated with rapidly rising premiums for malpractice insurance, runaway jury awards, and the decreasing availability of malpractice insurance. However further exploration and discussion in the text suggested that the perceived “crisis” may simply have been the latest iteration of cyclical problems in the market for malpractice
insurance. Recent reports from the American Medical Association appear to bear out this assessment. For 2006, 70 percent of malpractice premiums nationwide had either stayed the same or been reduced from the previous year’s level. It has been uncommon recently to hear people speak of a “malpractice crisis.”

Sorrell AL. 2006. Liability insurance rates mostly hold steady or drop this year. American Medical News, December 11.

A series of recent studies looked at the issue of “tort reform”—state laws that place caps or limits on how large malpractice awards may be. These studies all found that these types of laws are usually associated with reduced health care costs and an increase in the availability of physicians.

