S E D A P

A PROGRAM FOR RESEARCH ON

SOCIAL AND ECONOMIC DIMENSIONS OF AN AGING POPULATION

Relatively Inaccessible Abundance:
Reflections on U.S. Health Care

Ivy Lynn Bourgeault

SEDAP Research Paper No. 203

For further information about SEDAP and other papers in this series, see our web site:
http://socserv.mcmaster.ca/sedap

Requests for further information may be addressed to:
Secretary, SEDAP Research Program
Kenneth Taylor Hall, Room 426
McMaster University
Hamilton, Ontario, Canada
L8S 4M4
FAX: 905 521 8232
e-mail: sedap@mcmaster.ca

Relatively Inaccessible Abundance: Reflections on U.S. Health Care

Ivy Lynn Bourgeault

SEDAP Research Paper No. 203

June 2007

The Program for Research on Social and Economic Dimensions of an Aging Population (SEDAP) is an interdisciplinary research program centred at McMaster University with co-investigators at seventeen other universities in Canada and abroad. The SEDAP Research Paper series provides a vehicle for distributing the results of studies undertaken by those associated with the program. Authors take full responsibility for all expressions of opinion. SEDAP has been supported by the Social Sciences and Humanities Research Council since 1999, under the terms of its Major Collaborative Research Initiatives Program. Additional financial or other support is provided by the Canadian Institute for Health Information, the Canadian Institute of Actuaries, Citizenship and Immigration Canada, Indian and Northern Affairs Canada, ICES: Institute for Clinical Evaluative Sciences, IZA: Forschungsinstitut zur Zukunft der Arbeit GmbH (Institute for the Study of Labour), SFI: The Danish National Institute of Social Research, Social Development Canada, Statistics Canada, and participating universities in Canada (McMaster, Calgary, Carleton, Memorial, Montréal, New Brunswick, Queen's, Regina, Toronto, UBC, Victoria, Waterloo, Western, and York) and abroad (Copenhagen, New South Wales, University College London).

RELATIVELY INACCESSIBLE ABUNDANCE:

Reflections on U.S. Health Care

Ivy Lynn Bourgeault*

McMaster University

Abstract:

Outsiders' views of American health care – and Canadian views in particular - contains this paradox: ready access to excellent high tech services for those who can pay but unfortunately too expensive for many Americans; in essence, *inaccessible abundance*. In this paper, I embellish upon this paradox with an initial examination of the rather complicated organization of American health care as viewed by an outside observer. I then highlight the key benefits and drawbacks seen of U.S. health care, grounded in empirical data, and how despite its drawbacks it is being spread to other countries. I conclude with a discussion of the values inherent in the provision of health care – that is, whether it should be viewed as a commodity or as a right of the citizens of a nation.

JEL Classification: I18

Keywords: U.S. health care, accessibility, external views

Résumé:

Vu de l'extérieur — en particulier, par les Canadiens — le système de santé américain est hanté par ce paradoxe : un accès facile à d'excellents services à la pointe de la technologie pour ceux qui peuvent se le permettre, malheureusement beaucoup trop dispendieux pour de nombreux américains — essentiellement, une *abondance inaccessible*. Dans cette étude, je développe ce paradoxe en commençant par une présentation de l'organisation plutôt compliquée du système de santé américain tel qu'il est perçu vu de l'extérieur. Ensuite, je mets en évidence, en m'appuyant sur des données empiriques, les avantages et désavantages observés du système américain, et expose comment, malgré ses défauts, le système américain se développe dans d'autres pays. Je conclus par une discussion sur les valeurs inhérentes à l'accès aux soins de santé – c'est-à-dire, la question de savoir s'ils devraient êtres considérés comme un bien de consommation classique ou comme un droit universel.

***** Ivy Lynn Bourgeault is an Associate Professor in Health Studies and Sociology at McMaster University in Hamilton, Ontario, Canada and holds a Tier II Canada Research Chair in Comparative Health Labour Policy. She is grateful for support for this research through the SEDAP Research Program.

INTRODUCTION

I was listening to a local radio station as I made my way home one evening from work in a city in Southwestern Ontario (Canada). The announcer was retelling a story of a woman who had fallen out of an airplane somewhere in Eastern Europe and astonishingly had survived despite having broken pretty much every bone in her body. I do not recall all the details but that she was in hospital for several months enduring surgery after surgery and many hours in rehabilitation in an effort to gain back her ability to walk, which she did. He concluded this tale with the punch line that it was a good thing that she wasn't in the U.S. because the hospital bill it would have killed her. This is one of the enduring views of American health care but it is not the only.

Another view is perhaps best depicted in a recent critically acclaimed film by Canadian director Denys Arcand entitled, "*The Barbarian Invasions*." The main character of the film, Rémy, is an old man dying from cancer in a Montreal hospital. He has only a month or so to live. His son, a wealthy investment banker, is appalled to find out that there is a several months wait for a CAT scan. He decides to spend thousands to whisk away his father to Vermont where he can get one on the spot. His father dies nonetheless.

Thus, outsiders' views of American health care – and Canadian views in particular - contains this paradox: ready access to excellent high tech services for those who can pay but unfortunately too expensive for many Americans; in essence, *inaccessible abundance*. In this paper, I embellish upon this paradox with an initial examination of the rather complicated organization of American health care as viewed by an outside observer (perhaps it is not just that is seems complicated but that it actually is). I then highlight the key benefits and drawbacks seen of U.S. health care, grounded in empirical data, and how despite its drawbacks it is being spread to other countries. I

conclude with a discussion of the values inherent in the provision of health care – that is, whether it should be viewed as a commodity or as a right of the citizens of a nation.

THE (DIS)ORGANIZATION OF AMERICAN HEALTH CARE:

"Like many other observers, I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre melange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird." (Aaron, 2003, p. 801)

Okay, so it is not just from an outside observers' perspective as this is a quote from an American health care commentator in the prestigious *New England Journal of Medicine.* It is also important to point out at the outset, as many assert, that the U.S. does not really have a health care system but rather an "agglomeration of public and private health care providers functioning autonomously in myriad and often competing ways." (Weitz, 1996 p. 328). Some general descriptions, however, can be made.

First, as one often assumes, the private provision of health care is extensive in the U.S. This includes the long standing Blue Cross and Blue Shield established during the Depression by the American Hospital Association and American Medical Association respectively, which have more recently merged. The Blue Cross label may also be familiar to some outsiders as it is one of the major providers of private health insurance outside of the U.S. Another group of private providers include the numerous and ever changing commercial insurance providers, of which some operate for-profit and some not-for-profit. There are also some privately provided pre-

payment plans, such as Health Maintenance Organizations (*HMOs)*, of which Kaiser Permanente is one of the most cited examples. This latter groups differs from the former two groups of insurers in that coverage is not after the individual falls ill but rather is paid up front - hence the term pre-payment.

But the U.S. does not have an exclusively market-based system to health care as many think. Indeed there are publicly funded health care insurance programs and overarching government regulation, some of which can vary by state. These include the two main government programs Medicare and Medicaid established in the late 1960s to cover those over 65 and those on financial assistance respectively. In addition to Medicare and Medicaid, there are also public funds going into public hospitals and Department of Veterans Affairs (VA) hospitals. Indeed, the U.S. spends almost as much public funds on health care as measured by gross domestic product (GDP) as a country like Canada (6.6 percent versus 6.7 percent respectively) and more per capita - $2,364 compared to $2,048, based on OECD data (Kozhaya, 2005).

Across both public and private sectors of health care provision in the U.S. there has been the application – and some might argue *infiltration* – of Managed Care policies. Managed Care is a specific set of practices around the management of care adopted from the private sector to make the provision of care more efficient and cost effective. Simply stated, it is a system of health care decision-making that controls costs through closely monitoring and controlling the decisions of health care providers. It gained popularity during the 1990s as it was seen as a way to control rising costs but Managed Care policies have more recently been in retreat due to a variety of pressures, not the least of which has been negative public opinion (Mechanic 2004). Many

outside observers became familiar with Managed Care through the numerous derisive accounts in the movies, such as *As Good As It Gets,* and other media.

WHAT ARE SEEN AS THE BENEFITS OF AMERICAN HEALTH CARE

The advantages noted of American health care are those largely equated with a private or market-driven approach (though as we have just described, the health care system in the U.S. does have public involvement). In general, it is regarded that one can get quick access to a wide variety of state-of-the-art technical services (Rublee 1994), that is of course if one is willing or able to pay the associated costs. It is true that in the U.S., there is a greater capacity of high technology care by and large because American doctors and hospitals are more likely to purchase the latest and often expensive medical equipment and devices (Kozhaya, 2005). For example, it was found in the Joint Canada/United States Survey of Health, 2002/03 that American women aged 50-69 were more likely than Canadian women of the same age to have had a mammogram in the last 2 years (82 percent vs. 74 percent). But there were no reported differences in the proportion of women in this age group who had never had a mammogram. Further, it is also true that patients in the U.S. are seen more quickly by a medical specialist (Kozhaya, 2005). Some argue that it is for these reasons that many Canadians cross the border to get care in the U.S. (see Box 1).

Box 1 Are Canadians flocking to the U.S. for health care?

This is a highly contentious question with a relatively unknown answer for reasons that become a little clearer from this excerpt from Alberta physician, Karen Palmer (1999) who happens to also work in the U.S. from time to time:

> *"There are no solid data on cross-border health care traffic where the care is paid out-of-pocket and not reimbursed by the provincial payers. If someone goes to the US for care and it isn't paid for by the province, there is no way to track that care. There are anecdotal reports of Canadians coming to the US for care, as there are in the other direction, but to date there are no solid studies of how much this goes on. Sometimes, we send patients to the US because we have had periodic capacity glitches in some provinces, and since there are US facilities that are grossly underutilized with empty beds and unused equipment, we are able to negotiate very competitive rates and it makes sense to send a few patients for care while we retool and improve capacity. This makes more sense for some patients than waiting. If you go out of country for specialty services that are not available in Canada, and if those services are deemed not experimental and are medically necessary, then the provinces will fully fund your care. Sometimes, people come to the US for care because they perceive that their problems are more urgent than they are. I can cite one case where an 80-year-old man decided that he had to have his prostate removed even though his doctor thought it prudent not to do this. The man insisted on coming to the US for the surgery where money will buy just about anything. The press loves these stories."*

A systematic examination of the extent to which Canadian residents seek medical care across the border was, however, undertaken by Katz et al. (2002). They collected data between 1994 and 1998 of Canadians' use of services from ambulatory care facilities and hospitals located in key border states of Michigan, New York State, and Washington State. They also supplemented these data from the U.S. with several Canadian sources, including the 1996 National Population Health Survey, the provincial Ministries of Health, and the Canadian Life and Health Insurance Association. What these data revealed was that despite the widespread perception that Canadian residents seek care extensively in the United States, the numbers they found were so small as to be barely detectible relative to the use of care by Canadians at home. As the authors summarized, "*The anecdotal reports of Medicare refugees from Canada are not the tip of a southbound iceberg but a few scattered cubes*." (p. 27)

In the U.S., there are also a greater number of health care providers per population, particularly physicians (see Box 2), and they in general are paid much higher than they are elsewhere (Oberlander 2002). Registered nurses, for example, are more likely to have full-time work in the

U.S. than in Canada largely as a result of the extensive cutbacks in the hospital sector in many Canadian provinces. Indeed, because of the wages and working conditions in the U.S., some Canadian trained health care providers, like some of their patients, head south to practice. Whether they or their U.S. counterparts enjoy greater professional freedom is an issue of contention (*c.f.*, Bourgeault et al., 2004). Moreover, a sizeable and growing number do return.

Market-based health care as it exists in the U.S. is also seen as helping to stimulate innovation and further is seen as being better able to respond to changing conditions (i.e., it is considered to be more flexible). Strongly held public values such as consumer choice, autonomy, and technical progress are also mutually reinforced by popular conceptions of the market (Mechanic 2004). Some data supports this view. For example, in the aforementioned Joint Canada/United States Survey of Health, 2002/03, it was found that American citizens were more likely to report being "very satisfied" with their health care services, including physician services, whereas Canadians were more likely to report being "somewhat satisfied" (53 percent vs. 44 percent). This, however, should not necessarily be equated with their opinion about their respective health care systems.

Box 2 Health Care in the U.S. as compared to Canada

	U.S.	Canada
Government spending (2001)	$2168 USD per person	$1533 USD per person
Private spending	$2719 USD per person	$630 USD per person
Total spending as a percent of GDP[i]	13.9 percent	9.7 percent
# of physicians per 1000 (2001) [ii]	2.7	2.1
# of nurses per 1000 (2001) [ii]	8.1	9.9 (2000 data)
# of hospital beds per 1000 (2001) [ii]	2.9	3.2
Administrative costs (1999) [iii]	$1059 USD per person	$307 USD per person

WHAT ARE SEEN AS THE MAJOR DRAWBACKS OF AMERICAN HEALTH CARE

By far, outsider's views of American health care focus on its drawbacks. The major drawbacks that those outside of the U.S. see of American health care are its excesses in terms of cost and its deficits in terms of coverage – the paradox of inaccessible abundance.

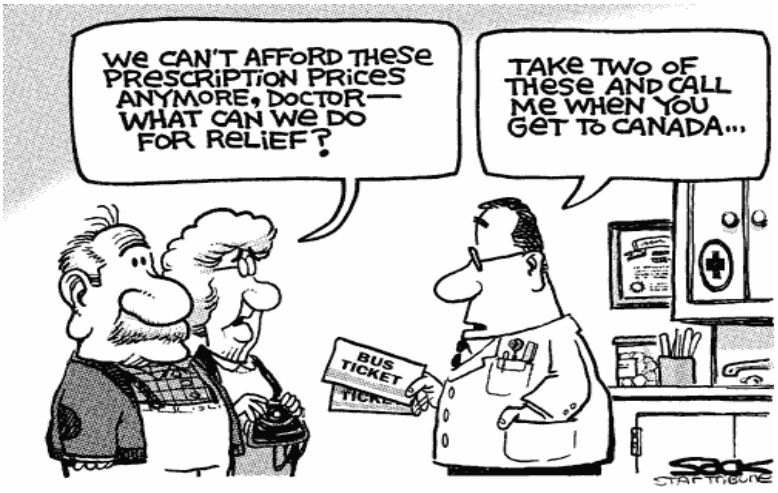
Excessive Health Care Costs

First, as is noted in Box 2, the U.S. total spending on health care is much higher than it is in Canada and elsewhere for that matter. It is in the range of 14 percent of gross domestic product whereas the average for OECD countries is around 8.5 percent (Kozhaya, 2005). Although some might argue that this is what enables them to have the best access to the latest technology, others argue that these costs do not yield the consequent expected outcomes in terms of health status. Indeed, many studies highlight the relatively poor position of the U.S. in health worldwide across a variety of indicators (Starfield 2000). This perplexing situation is as Blendon et al (2003)

describe, “The most expensive and technologically advanced health care system in the world yields health outcomes comparable to those of countries with much lower health spending.” (p. 106).

The higher costs are particularly salient in the case of pharmaceuticals. Drugs represent the fastest growing component of health care costs, with Americans paying the highest prices in the world (Light & Lexchin, 2005). This is particularly difficult for American seniors of whom 35 percent cut back on their food purchases so they can afford their medications (Navarro, 2003). According to Light (2001), the percentage savings in drug costs based on a trip to Canada in January 2000 ranged from 30 to 358 percent (see Box 3). It is clear to see why the issue of ‘importing’ pharmaceuticals from Canada was salient enough to mention during the 2004 presidential debates.

Box 3 Some of the Consequences of Higher Drug Prices in the U.S.



Many equate these higher costs in the U.S. with its fragmented organization of care. Reinhardt et al. (2004), for example, argue that "multiple purchasers of care allow U.S. prices to rise above the level attained in other industrialized countries that either endow the demand side of their health systems with strong, monopsonistic (single-buyer) market power (such as the Canadian provincial health plans)" (p. 13). As has been succinctly summarized by Blendon et al. (2003), "Researchers worldwide have exhaustively chronicled the inefficiency of the U.S. health care system" (p. 106). Indeed, a sizable portion of U.S. health care spending actually has very little to do with health care.

For example, researchers at Harvard Medical School, Woolhandler, Campbell & Himmelstein (2003) found that in 1999 U.S. health administration costs totalled almost $300 billion, or $1,059 per capita, as compared with $307 per capita in Canada. Viewed in a different way, health care administration accounted for 31 percent of health care expenditures in the U.S. as compared to 16.7 percent in Canada (of which its publicly provided health insurance program accounted for only 1.3 percent). It is for these reasons that these researchers concluded that, "A large sum might be saved in the United States if administrative costs could be trimmed by implementing a Canadian-style health care system." (p. 768).

Some have also commented on how the litigious nature of U.S. society pushes health care costs up. According to this argument, health care providers drive up costs by practicing 'defensive medicine' whereby additional, and in many cases unnecessary, tests and procedures are ordered so as to avoid litigation. Others, however, argue that this represents a relatively minor contribution to U.S. health care costs in comparison to the heavy administrative burden (Weitz,

1994 – see Box 4). Moreover, these practices have been curbed by Managed Care policies briefly discussed above.

Box 4 Four Popular Myths to Explain Rising Health Care Costs in the U.S.
(derived from Weitz, 1994, p. 341)

Myth #1

- U.S. health care costs are high because U.S. citizens expect more care than do citizens of other countries.
  - Actually, in many ways, such as number of visits to physicians, the opposite is true.

Myth #2

- U.S. health care costs are high because U.S. citizens have a unique propensity for filing malpractice suits, driving health care costs up.
  - Actually, this accounts for less than 1 percent of total U.S. health care costs

Myth #3

- U.S. health care costs are high because of its aging population.
  - Actually, in contrast to other industrialized nation, the U.S. population is comparatively young.

Myth #4

- U.S. health care costs are high because of its extensive use of new and expensive health care technologies.
  - Actually, such technologies represent a fraction of the costs attributed to hospital care which collectively accounts for one third of overall health care costs in the U.S.

The Uninsured, the Underinsured, and the Precariously Insured

Perhaps what outsiders view as being the most offensive side effect of U.S. health care is that its fragmentation and disorganization leaves a great many of its citizens uninsured or precariously insured. In fact, the U.S. is the only industrialized nation that does not provide at least basic medical services for its citizens. To put this in perspective, there are more uninsured citizens in the United States than the entire Canadian population (i.e., all those that are covered under its

universal program of health care). Specifically, According to the U.S. Census Bureau, 46 million people did not have health insurance in 2003. In addition, 82 million people went without health insurance for at least part of 2003.

It is true that for some this may be an individual choice, but for most this is a 'choice' thrust upon them. As Navarro (2003) describes, "The majority of them are working people, and their children, who cannot afford to pay the health insurance premium that would enable them to get care in time of need. Many of them work for small companies that cannot or will not pay their part of the health insurance premium." (no pagination on website). Indeed, over half of those without health insurance coverage work full-time throughout the year and an additional third work either part-time or full-time for part of the year; nonworkers make up less than 20 percent of uninsured Americans (Weitz, 1994, p. 347). This is in stark contrast to what many assume.

A more invisible problem is the issue of the under insured and the precariously insured. Being under insured has been linked to required deductibles and copayments, long waiting periods or exemptions for coverage of pre-existing conditions, lack of coverage for certain kinds of care and ceilings on coverage (Light 1992). Again the movies have been most helpful in dramatizing this situation: recall the desperation of a young father, played by Denzel Washington, in *John Q* who holds a hospital department hostage when he finds out that the treatment of his son's life-threatening condition is not covered by his health insurance. As Navarro (2003) details, "Most people find, at a crucial moment in their lives when they really need care, that their health insurance coverage does not include the type of medical problem they have, the type of intervention they need, or the type of tests or pharmaceuticals they require—or, that it covers

only a minute portion of what must be paid for the services. … But where the cruelty of the system reaches its utmost is among those who are dying. Among the terminally ill, 39 percent indicate that they have "moderate to severe problems" in paying their medical bills. No other major capitalist country comes even close to this level of inhumanity." (no pagination on website).

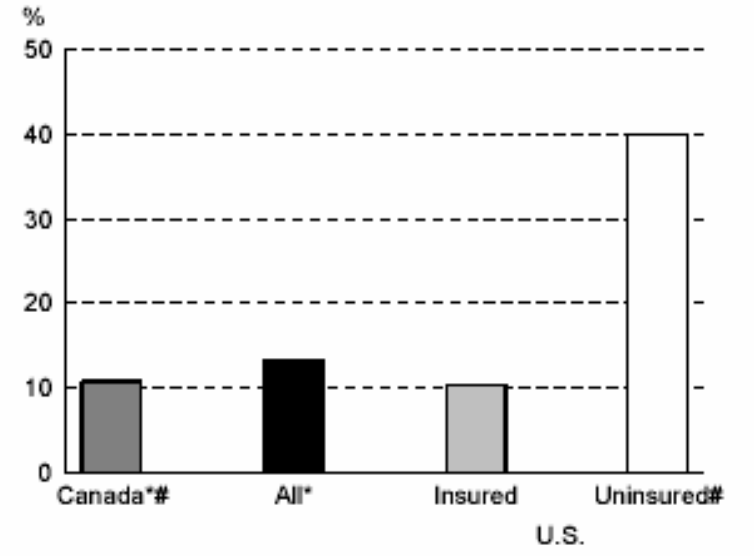
Just by way of contrast, the more innocuous of these practices – such as extra billing by physicians and user fees charged by hospitals – have been banned in Canada since 1984 due to the argument that point of entry charges would have the unfortunate consequence of limiting access – one of the key principles of Canadian health care (Barer et al., 1994). Indeed, I can recall distinctly the shocked faces of Canadian university students in my classes when I showed them the PBS film, *Borderline Medicine,* where they listen to the account of a young woman who survived cancer but is now uninsurable because she poses an excessive risk to health care insurance companies.

So addition to the indictment of poorer health outcomes in the U.S. despite the world's highest health care costs, all that money also does not extend to covering all of its citizens. But it is not just that they do not have coverage but what the lack of coverage means. In the aforementioned Joint Canada/United States Survey of Health, 2002/03 a statistically significant difference was found in the experience of an unmet health care need between uninsured Americans and insured Americans and Canadians (see Figure 1). Such unmet needs translate into the poor health outcomes including death. As Navarro (2003) further describes, "Because these individuals cannot pay for insurance, they do not get needed care, and many die as a consequence. The most

credible estimate of the number of people in the United States who have died because of lack of medical care was provided by a study carried out by Professors David Himmelstein and Steffie Woolhandler (*New England Journal of Medicine* 336, no. 11 [1997]). They concluded that almost 100,000 people died in the United States each year because of lack of needed care—three times the number of people who died of AIDs. … [and] while the media express concern about AIDs, they remain almost silent on the topic of deaths due to lack of medical care. Any decent person should be outraged by this situation." (no pagination on website).

Figure 1

Individuals Reporting An Unmet Health Care Need, Canada and the United States, 2003/03



Data source: *Joint Canada/United States Survey of Health, 2002/03.*
Notes: *Household population aged 18 and over.*
Missing data ("I don't know", "not stated", "refusal") have been excluded from the analysis.
‡ Age-adjusted percents calculated using the projected 2000 U.S. standard population.
** Statistically significant difference between Canada and U.S. All (p <0.05).*
 # Statistically significant difference between Canada and U.S. Uninsured (p <0.05).

Although unmet health needs have translated into poorer health indicators for U.S. citizens, so too has too much care. Starfield (2000), for example, highlighted how medical errors and adverse outcomes from unnecessary surgery resulted in over 12,000 deaths per year in the U.S. So to sum up in the words of Jonathan Oberlander (2002): "The health care system in the United States remains a "paradox of excess and deprivation."[iv] … Americans with insurance have access

to the latest in sophisticated medical technology and innovative medical procedures…Indeed, the availability of these resources is so widespread that some analysts believe that well-insured Americans are receiving too many medical services. At the same time, millions of Americans receive too little medical care. … The United States the only democratic country in the world with a substantial uninsured population." (p. 164).

THE SPREAD OF AMERICAN HEALTH CARE

Realizing these major drawbacks of American health care, it is perplexing why it would be seen as a model to export to other countries – particularly those with comparatively efficient systems of administration, such as Canada and the U.K. Indeed, many have questioned why policies with such a lack of evidence to support them have been translated into other health care contexts (e.g., Armstrong et al., 2003, Bourgeault et al., 2004). As Relman (2002) describes, "Health policymakers in Canada, particularly at the provincial level where most practical decisions are made, are being told a monstrous myth. Consultants and business people, often with little professional health training or experience but with ample conflicts of financial interest, are extolling the advantages of marketplace medicine and the benefits that an American-style entrepreneurial approach would supposedly bring to the stressed Canadian system. And yet the U.S. experience of the last two decades and the evidence on the performance of for-profit health insurance and medical care tell just the opposite story: Entrepreneurial markets have made a shambles of our healthcare system. Any nation seeking to follow the U.S. example risks the same failures now plaguing the United States." (p. 1 on website).

It is not only developed nations that have been the target of U.S.-based health care organizations and consultants, but developing nations as well. It is these latter countries, particularly those with a fragile health care infrastructure that is most worrying. Waitzkin and his colleagues (Jasso-Aguilar, Waitzkin & Landwehr, 2004, Waitzkin & Iriart, 2001), for example, have examined the importation of U.S. style managed care policies – often due to the encouragement do to so by the World Bank, the International Monetary Fund, and the World Trade Organization – on Latin American countries. As a consequence, access to preventive and curative services have worsened and public sector health care institutions in these countries – seen as lucrative opportunities for for-profit companies - have come under considerable strain.

A QUESTION OF VALUES

> "*The debate over health care is less a pure macroeconomic issue than an exercise in the political economy of sharing*." (Reinhardt et al., 2004, p. 23)

When one examines the provision of health care in the U.S. and indeed the systems of any country, a question of underlying values is raised. This is true of an examination of any social system not just health care. That is, a system's core values are reflected in its organization. For example, as Aaron (2003) describes "The U.S. health care administration, weird though it may be, exists for fundamental reasons, including a pervasive popular distrust of centralized authority, a federalist governmental structure, insistence on individual choice (even when, as it appears to me, choice sometimes yields no demonstrable benefit), the continuing and unabated power of large economic interests, and the virtual impossibility … of radically restructuring the nation's largest industry - an industry as big as the entire economy of France." (p. 801).

Some have framed this question of values in terms of an ethical debate as to whether health care is a right or a privilege – or alternately in terms of individualism or collectivism. Right now health care is a right for some in the U.S. who qualify for Medicare and Medicaid, but a privilege for most others. If we take the position that health care is a right and that all members of a society are interdependent, then by extension we imply that it is the duty of all members of that society to share in the burden of its costs (Weitz, 1994). Further, we would need to have agreement on what level of health care citizens have a right to access. This has been defined – and some might argue socially constructed - in the Canadian context as 'medically necessary services'. What this entails can sometimes be debated and in some cases, hotly contested, such as the recent discussion of the coverage of in vitro fertilization.

Perhaps the more specific question is whether health care is a market commodity to be bought, sold and bargained for based on one's choices and preferences. The ability to choose based on economic factors, however, necessarily implies that such choices will be limited and indeed for the some the choice will be no choice at all – or the equally absurd choice between food, shelter and health care or between health care and almost certain death (Weitz, 1994).

CONCLUSION

To sum up, I think it accurate to say that most people who live outside of the U.S. view the way it provides health care as a bit of an oddity. It contains some elements that we recognize as being advantageous, but also many other elements that we greatly dislike. For some outsiders, it is its

system of health care or lack thereof that prevents them from wishing to move to the United States. In particular, I believe it is its tendency to commodify care thereby excluding a sizeable proportion of the population from benefiting from it that we view as its greatest anathema.

Endnotes

i It is important to note, however, as it is in the Wikipedia article, *Canadian and American health care systems compared*: "Some analysts do not feel the straight GDP numbers give a wholly accurate picture. The difference in cost might have more to do with societal differences than approaches to health care. Drug abuse, obesity, and violence are all more common in the United States than in Canada, and all place a burden on the health care system. Recent history has meant that the United States has far more veterans and war wounded, also somewhat increasing cost. Accounting practices also differ and in Canada fewer capital investments are included in health care costs. Another important caveat is that research and development spending in Canada is lower, but Canada still benefits from the research done in the United States. This leads some scholars, such as David Gratzer, to argue the actual cost difference, while still real, is much smaller than the straight GDP numbers would indicate."

http://en.wikipedia.org/wiki/Canadian_and_American_health_care_systems_compared

ii Reinhardt, Uwe E., Peter S. Hussey, and Gerard F. Anderson (2004). U.S. Health Care Spending In An International Context: Why is U.S. spending so high, and can we afford it? *Health Affairs*, 23(3), 10-25.

iii Woolhandler, Steffie, Terry Campbell, & David Himmelstein. (2003). Costs of health care administration in the United States and Canada. *The New England Journal of Medicine*, 349(8); 768.

iv. Enthoven A., & Kronick R. (1989). A consumer choice health plan for the 1990s. *The New England Journal of Medicine*;320: 29.

Further Readings/Relevant Web Sites

Canadian Health Care Technology. U.S. healthcare system in a shambles. http://www.canhealth.com/News072.html

Centre for Disease Control/Statistics Canada (2002-03) *Joint Canada/United States Survey of Health, 2002-03.* http://www.cdc.gov/nchs/data/nhis/jcush_analyticalreport.pdf

Chernomas, R., & Sepehri, Ardeshir (Eds.) (1998). *How to Choose? A Comparison of the U.S. and Canadian Health Care Systems.* Baywood Publishing Co.: Amityville, New York.

Starfield, Barbara (2000). Is US Health Really the Best in the World? *JAMA.* 2000;284: 483-485.

Wikipedia, *Canadian and American health care systems compared.* http://en.wikipedia.org/wiki/Canadian_and_American_health_care_systems_compared

References

Aaron, Henry J. (2003). The costs of health care administration in the United States and Canada - questionable answers to a questionable question**.** *The New England Journal of Medicine*, 349(8); pg. 801.

Armstrong, P., Armstrong, H., Bourgeault, I.L., Choiniere, J., Lexchin, J., Mykhalovskiy, E., Peters, S., & White, J. (2003). Market principles, business practices and health care: comparing the U.S. and Canadian experiences. *International Journal of Canadian Studies*, 28, 13-38.

Barer, Morris L. [et al.]. (1994). The remarkable tenacity of user charges: a concise history of the participation, positions, and rationales of Canadian interest groups in the debate over "direct patient participation" in health care financing. [Toronto]: Premier's Council on Health, Well-being and Social Justice.

Blendon, R.J., Schoen, C., DesRoches, C. Osborn, R., & Zapert, K. (2003). Common concerns amid diverse systems: Health care experiences in five countries. *Health Affairs*, 22(3), p. 106.

Bourgeault, I.L., Lindsay, S. Mykahalovskiy, E. Armstrong, P., Armstrong, H., Choiniere, J., Lexchin, J., Peters, S., & White, J. (2004) At first you will not succeed: negotiating care in the context of health reform. *Research in the Sociology of Health Care*, 22, 261-276

Centre for Disease Control/Statistics Canada (2002-03) *Joint Canada/United States Survey of Health, 2002-03.* http://www.cdc.gov/nchs/data/nhis/jcush_analyticalreport.pdf

Jasso-Aguilar, Rebeca; Waitzkin, Howard; Landwehr, Angela (2004). Multinational Corporations and Health Care in the United States and Latin America: Strategies,

Actions, and Effects. *Journals of Health and Social Behavior*, Volume 45, Supplement 1, 136-157.

Katz, S.J., Cardiff, K., Pascali, M., Barer, M., & Evans, R.G. (2002). Phantoms In The Snow: Canadians' Use of Health Care Services in the United States. *Health Affairs*, 21(3), 19-31.

Kozhaya, Norma (2005). 45 million myths: Better Canada's frayed health care system than unbridled U.S. capitalism that leaves millions with no safety net, right? Well, take a closer look *Financial Post*, June 16, 2005, p. FP-21

Light, Donald (2001). Will Lowering U.S. Drug Prices Jeopardize Breakthrough Research? The Moral Crusades. Presentation to Faculty of Health Sciences, University of Western Ontario.

Light, Donald (1992). The practice and ethics of risk-rated health insurance. *Journal of the American Medical Association*, 267: 2503-8.

Light, Donald & Lexchin, Joel (2005). Foreign free riders and the high price of US medicines. *British Medical Journal*, 331: 958 - 960.

Mechanic, David. (2004). The Rise and Fall of Managed Care. *Journals of Health and Social Behavior*, Volume 45, Supplement 1, 76-86

Navarro Vicente (2003). The Inhuman State of U.S. Health Care. *Monthly Review*, 44(4). http://www.monthlyreview.org/0903navarro.htm

Oberlander, Jonathan (2002). The US health care system: On a road to nowhere? *The Canadian Medical Association Journal*, 167(2):163-8

Palmer, K.S. (1999). O Canada. Health Care Myths from the Great White North. Presentation to California Physicians Alliance, San Francisco, January 13. http://www.thirdworldtraveler.com/Health/O_Canada_KP.html

Reinhardt, Uwe E., Peter S. Hussey, and Gerard F. Anderson (2004). U.S. Health Care Spending In An International Context: Why is U.S. spending so high, and can we afford it? *Health Affairs*, 23(3), 10-25.

Relman, Arnold (2002). Canada's Romance with Market Medicine: For-profit health care has failed in the U.S. So now its sponsors hope to export it north. *The American Prospect magazine*, October 21.

Rublee D. (1994). Medical technology in Canada, Germany and the United States. *Health Affairs*, 13: 113-7.

Starfield, Barbara (2000). Is US Health Really the Best in the World? *JAMA*, 284: 483-485.

Waitzkin, Howard, and Celia Iriart (2001). How the United States Exports Managed Care to Developing Countries. *International Journal of Health Services*, 31(3) 495-505.

Weitz, Rose (1996) The Sociology of Health, Illness and Health Care: A Critical Approach. Albany: Wadsworth.

Woolhandler, Steffie, Terry Campbell, & David Himmelstein. (2003). Costs of health care administration in the United States and Canada. *The New England Journal of Medicine*, 349(8); 768.

Number	Title	Author(s)
(2005)		
No. 124:	Exploring the Use of a Nonparametrically Generated Instrumental Variable in the Estimation of a Linear Parametric Equation	F.T. Denton
No. 125:	Borrowing Constraints, The Cost of Precautionary Saving, and Unemployment Insurance	T.F. Crossley H.W. Low
No. 126:	Entry Costs and Stock Market Participation Over the Life Cycle	S. Alan
No. 127:	Income Inequality and Self-Rated Health Status: Evidence from the European Community Household Panel	V. Hildebrand P. Van Kerm
No. 128:	Where Have All The Home Care Workers Gone?	M. Denton I.U. Zeytinoglu S. Davies D. Hunter
No. 129:	Survey Results of the New Health Care Worker Study: Implications of Changing Employment Patterns	I.U. Zeytinoglu M. Denton S. Davies A. Baumann J. Blythe A. Higgins
No. 130:	Does One Size Fit All? The CPI and Canadian Seniors	M. Brzozowski
No. 131:	Unexploited Connections Between Intra- and Inter-temporal Allocation	T.F. Crossley H.W. Low
No. 132:	Grandparents Raising Grandchildren in Canada: A Profile of Skipped Generation Families	E. Fuller-Thomson
No. 133:	Measurement Errors in Recall Food Expenditure Data	N. Ahmed M. Brzozowski T.F. Crossley
No. 134:	The Effect of Health Changes and Long-term Health on the Work Activity of Older Canadians	D.W.H. Au T. F. Crossley M.. Schellhorn

SEDAP RESEARCH PAPERS: Recent Releases

Number	Title	Author(s)
No. 135:	Population Aging and the Macroeconomy: Explorations in the Use of Immigration as an Instrument of Control	F. T. Denton B. G. Spencer
No. 136:	Users and Suppliers of Physician Services: A Tale of Two Populations	F.T. Denton A. Gafni B.G. Spencer
No. 137:	MEDS-D USERS' MANUAL	F.T. Denton C.H. Feaver B.G.. Spencer
No. 138:	MEDS-E USERS' MANUAL	F.T. Denton C.H. Feaver B.G. Spencer
No. 139:	Socioeconomic Influences on the Health of Older Canadians: Estimates Based on Two Longitudinal Surveys (Revised Version of No. 112)	N.J. Buckley F.T. Denton A.L. Robb B.G. Spencer
No. 140:	Developing New Strategies to Support Future Caregivers of the Aged in Canada: Projections of Need and their Policy Implications	J. Keefe J. Légaré Y. Carrière
No. 141:	Les Premiers Baby-Boomers Québécois font-ils une Meilleure Préparation Financière à la Retraite que leurs Parents? Revenu, Patrimoine, Protection en Matière de Pensions et Facteurs Démographiques	L. Mo J. Légaré
No. 142:	Welfare Restructuring without Partisan Cooperation: The Role of Party Collusion in Blame Avoidance	M. Hering
No. 143:	Ethnicity and Health: An Analysis of Physical Health Differences across Twenty-one Ethnocultural Groups in Canada	S. Prus Z. Lin
No. 144:	The Health Behaviours of Immigrants and Native-Born People in Canada	J.T. McDonald
No. 145:	Ethnicity, Immigration and Cancer Screening: Evidence for Canadian Women	J.T. McDonald S. Kennedy
No. 146:	Population Aging in Canada: Software for Exploring the Implications for the Labour Force and the Productive Capacity of the Economy	F.T. Denton C.H. Feaver B.G. Spencer

Number	Title	Author(s)
(2006)		
No. 147:	The Portfolio Choices of Hispanic Couples	D.A. Cobb-Clark V.A. Hildebrand
No. 148:	Inter-provincial Migration of Income among Canada's Older Population:1996-2001	K.B. Newbold
No. 149:	Joint Taxation and the Labour Supply of Married Women: Evidence from the Canadian Tax Reform of 1988	T.F. Crossley S.H. Jeon
No. 150:	What Ownership Society? Debating Housing and Social Security Reform in the United States	D. Béland
No. 151:	Home Cooking, Food Consumption and Food Production among the Unemployed and Retired Households	M. Brzozowski Y. Lu
No. 152:	The Long-Run Cost of Job Loss as Measured by Consumption Changes	M. Browning T.F. Crossley
No. 153:	Do the Rich Save More in Canada?	S. Alan K. Atalay T.F. Crossley
No. 154:	Income Inequality over the Later-life Course: A Comparative Analysis of Seven OECD Countries	R.L. Brown S.G. Prus
No. 155:	The Social Cost-of-Living: Welfare Foundations and Estimation	T.F. Crossley K. Pendakur
No. 156:	The Top Shares of Older Earners in Canada	M.R. Veall
No. 157:	Le soutien aux personnes âgées en perte d'autonomie: jusqu'où les baby-boomers pourront-ils compter sur leur famille pour répondre à leurs besoins ?	J. Légaré C. Alix Y. Carrière J. Keefe
No. 158:	Les générations X et Y du Québec, vraiment différentes des précédentes ?	J. Légaré P.O. Ménard
No. 159: French	La diversification et la privatisation des sources de revenu de retraite au Canada	L. Mo J. Légaré L. Stone
No. 159: English	The Diversification and the Privatization of the Sources of Retirement Income in Canada	L. Mo J. Légaré L. Stone
No. 160:	Evaluating Pension Portability Reforms: The Tax Reform Act of 1986 as a Natural Experiment	V. Andrietti V.A. Hildebrand

SEDAP RESEARCH PAPERS: Recent Releases

Number	Title	Author(s)
No. 161:	Estimating a Collective Household Model with Survey Data on Financial Satisfaction	R. Alessie T.F. Crossley V.A. Hildebrand
No. 162:	Physician Labour Supply in Canada: A Cohort Analysis	T.F. Crossley J. Hurley S.H. Jeon
No. 163:	Tax Incentives and Household Portfolios: A Panel Data Analysis	S. Alan S. Leth-Petersen
No. 164:	The Healthy Immigrant Effect and Immigrant Selection: Evidence from Four Countries	S. Kennedy J.T. McDonald N. Biddle
No. 165:	Well-Being Throughout the Senior Years: An Issues Paper on Key Events and Transitions in Later Life	M. Denton K. Kusch
No. 166:	Satisfied Workers, Retained Workers: Effects of Work and Work Environment on Homecare Workers' Job Satisfaction, Stress, Physical Health, and Retention	I.U. Zeytinoglu M. Denton
No. 167:	Contrasting Inequalities: Comparing Correlates of Health in Canada and the United States	H. Armstrong W. Clement Z. Lin S. Prus
(2007)		
No. 168:	Health human resources planning and the production of health: Development of an extended analytical framework for needs-based health human resources planning	S. Birch G. Kephart G. Tomblin-Murphy L. O'Brien-Pallas R. Alder A. MacKenzie
No. 169:	Gender Inequality in the Wealth of Older Canadians	M. Denton L. Boos
No. 170:	The Evolution of Elderly Poverty in Canada	K. Milligan
No. 171:	Return and Onwards Migration among Older Canadians: Findings from the 2001 Census	K.B. Newbold
No. 172:	Le système de retraite américain: entre fragmentation et logique financière	D. Béland

SEDAP RESEARCH PAPERS: Recent Releases

Number	Title	Author(s)
No. 173:	Entrepreneurship, Liquidity Constraints and Start-up Costs	R. Fonseca P.-C. Michaud T. Sopraseuth
No. 174:	How did the Elimination of the Earnings Test above the Normal Retirement Age affect Retirement Expectations?	P.-C. Michaud A. van Soest
No. 175:	The SES Health Gradient on Both Sides of the Atlantic	J. Banks M. Marmot Z. Oldfield J.P. Smith
No. 176:	Pension Provision and Retirement Saving: Lessons from the United Kingdom	R. Disney C. Emmerson M. Wakefield
No. 177:	Retirement Saving in Australia	G. Barrett Y.-P. Tseng
No. 178:	The Health Services Use Among Older Canadians in Rural and Urban Areas	H. Conde J.T. McDonald
No. 179:	Older Workers and On-the-Job Training in Canada: Evidence from the WES data	I.U. Zeytinoglu G.B. Cooke K. Harry
No. 180:	Private Pensions and Income Security in Old Age: An Uncertain Future – Conference Report	M. Hering M. Kpessa
No. 181:	Age, SES, and Health: A Population Level Analysis of Health Inequalitites over the Life Course	S. Prus
No. 182:	Ethnic Inequality in Canada: Economic and Health Dimensions	E.M. Gee K.M. Kobayashi S.G. Prus
No. 183:	Home and Mortgage Ownership of the Dutch Elderly: Explaining Cohort, Time and Age Effects	A. van der Schors R.J.M. Alessie M. Mastrogiacomo
No. 184:	A Comparative Analysis of the Nativity Wealth Gap	T.K. Bauer D.A. Cobb-Clark V. Hildebrand M. Sinning
No. 185:	Cross-Country Variation in Obesity Patterns among Older Americans and Europeans	P.C. Michaud A. van Soest T. Andreyeva

Number	Title	Author(s)
No. 186:	Which Canadian Seniors Are Below the Low-Income Measure?	M.R. Veall
No. 187:	Policy Areas Impinging on Elderly Transportation Mobility: An Explanation with Ontario, Canada as Example	R. Mercado A. Páez K. B. Newbold
No. 188:	The Integration of Occupational Pension Regulations: Lessons for Canada	M. Hering M. Kpessa
No. 189:	Psychosocial resources and social health inequalities in France: Exploratory findings from a general population survey	F. Jusot M. Grignon P. Dourgnon
No. 190:	Health-Care Utilization in Canada: 25 Years of Evidence	L.J. Curtis W.J. MacMinn
No. 191:	Health Status of On and Off-reserve Aboriginal Peoples: Analysis of the Aboriginal Peoples Survey	L.J. Curtis
No. 192:	On the Sensitivity of Aggregate Productivity Growth Rates to Noisy Measurement	F.T. Denton
No. 193:	Initial Destination Choices of Skilled-worker Immigrants from South Asia to Canada: Assessment of the Relative Importance of Explanatory Factors	L. Xu K.L. Liaw
No. 194:	Problematic Post-Landing Interprovincial Migration of the Immigrants in Canada: From 1980-83 through 1992-95	L. Xu K.L. Liaw
No. 195:	Inter-CMA Migration of the Immigrants in Canada: 1991-1996 and 1996-2001	L. Xu
No. 196:	Characterization and Explanation of the 1996-2001 Inter-CMA Migration of the Second Generation in Canada	L. Xu
No. 197:	Transitions out of and back to employment among older men and women in the UK	D. Haardt
No. 198:	Older couples' labour market reactions to family disruptions	D. Haardt
No. 199:	The Adequacy of Retirement Savings: Subjective Survey Reports by Retired Canadians	S. Alan K. Atalay T.F. Crossley
No. 200:	Underfunding of Defined Benefit Pension Plans and Benefit Guarantee Insurance - An Overview of Theory and Empirics	M. Jametti
No. 201:	Effects of 'authorized generics' on Canadian drug prices	P. Grootendorst

SEDAP RESEARCH PAPERS: Recent Releases

Number	Title	Author(s)
No. 202:	When Bad Things Happen to Good People: The Economic Consequences of Retiring to Caregive	P.L. McDonald T. Sussman P. Donahue
No. 203:	Relatively Inaccessible Abundance: Reflections on U.S. Health Care	I.L. Bourgeault