

January 2005

Discussion following the Speeches of Mr. Johnson and Mr. Theofrastous Session 8: Canada and U.S. Approaches to Health Care: How the Canadian and U.S. Political, Regulatory, and Legal Systems Impact Health Care

Discussion

Follow this and additional works at: <https://scholarlycommons.law.case.edu/cuslj>

 Part of the [Transnational Law Commons](#)

Recommended Citation

Discussion, *Discussion following the Speeches of Mr. Johnson and Mr. Theofrastous Session 8: Canada and U.S. Approaches to Health Care: How the Canadian and U.S. Political, Regulatory, and Legal Systems Impact Health Care*, 31 Can.-U.S. L.J. 281 (2005)

Available at: <https://scholarlycommons.law.case.edu/cuslj/vol31/iss/39>

This Speech is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Canada-United States Law Journal by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

DISCUSSION FOLLOWING THE SPEECHES OF MR. JOHNSON AND MR. THEOFRASTOUS

MR. UJCZO: Well thank you, Ted, and Jon. As we all know, the first question – we will take a couple of questions right before lunch as they are setting up upstairs.

DR. KING: I was inspired by the presentation by Ted Theofrastous and the activities The Cleveland Clinic is doing and the research that is going on. It seems as though the United States is carrying the torch for the rest of the world in terms of progress. But I'm still concerned, at the same time, about access to health care. It seemed as though Jon's presentation – Jon Johnson's presentation indicated that everybody had access to health care in Canada. So I guess what you have is a question of values. One is the quality, and the other is progress in terms of health care and remedies.

I don't know whether you have any comments on that, but as I say, I got a very clear picture of both approaches. Ted, do you have any comments on that?

MR. THEOFRASTOUS: I guess maybe just an observation that's built into the process of taking a product to market in the United States is a very thorough and sometimes still uncertain analysis as to who's going to pay for it and how much will you get paid. I can tell you that pricing structures for even a single product tend to be tiered. There is sort of a list-product price versus what, you know, you can get reimbursed at certain institutions. It varies from institution to institution as well. I know The Cleveland Clinic has a very interesting payer mix relative to some other hospitals, in part, because they have their own insurance links.

I think the problem that I see in our economy is that it is not a two-tier system; it is a three-tier system. There are those who can pay. There are those that will be paid for, and then there is everybody else. And unfortunately – I mean, frankly, the beauty of a two-tier system would be, at least, there would be some place you could go if you didn't have insurance. The reality is a lot of these products will be prescribed. They will be applied, and almost like it or not, the patient is going to be saddled with that cost, and it is going to be up to them to figure it out. Here we have collection agencies that will chase you to the end of the earth to make sure your very expensive procedure is paid for.

DR. KING: Jon, do you have any comment on that?

MR. JOHNSON: Our system is very good on accessibility in that everybody is covered. There are issues of waiting times and that sort of thing, but you don't have a vast number of people not covered. Everybody is covered. But on the innovation side, we are very weak. We are weak on innovation;

we are weak on capital expenditure. We are weak on expensive diagnostic equipment like MRIs (Magnetic Resonance Imaging). Any listing of where we stand in MRIs per whatever unit, measurement you want to take vis-à-vis any number of other countries, we are way down the list. And the lack of capital spending probably goes to that very strong bias against the private sector being involved in the health care industry.

MR. UJCZO: Jim.

MR. PHILLIPS: Jon, just a question on the Canadian side: Very impressed with the availability or accessibility for coverage. But I have spent a lot of time in Canada. I have a number of friends, and in just two instances, a friend who thought he was having a heart attack went to the hospital and spent seven hours in the emergency room; never got seen by a doctor, and finally, in despair went home; he didn't have a heart attack, thank God. And the second case was a person who had kidney stones and couldn't get the ultrasound treatment and had to go to the states to get that.

So I wonder if you might comment on the difference between accessibility, which means everybody can go to the hospital, but there seems to be a real lag in Canada and Ontario, particularly, in the service of – the ability to get attended to once you get into the facility.

MR. JOHNSON: There is absolutely no question that's a problem. There has been a series of articles in the *GLOBE & MAIL* over the last while by Christy Blanchford talking about that very issue. Waiting lists are a problem. Hospital emergency wards can be fairly grim. I got quite used to them because my mother was in her mid 90s, and we spent quite a bit of time taking her to the hospital, and we would wait for hours and hours and hours for somebody to see her. The system is stressed. There is no question about it. And the governments are trying to do something about that. As to whether they are on the right track or not, I don't know. But there is no question but that it is a problem.

MR. UJCZO: Sir.

MR. LAFLEUR: I am Michel Lafleur from Chicago. First, I would like to give you some information on that perspective in Quebec. We certainly have a lot of problems on waiting lists, but it looks like the situation is clearly improving.

For instance, can I give you two examples of that? First one is there is no more waiting list in cardiology, and actually, our cardiologists are – kind of wonder – they need some more patients right now. So that's good news. The other one is that we don't have to send any more – like we used to do for renal patients – to the U.S. for treatment. That's something that is no longer the case. But, it is true that in some other aspects we have huge problems, like for hip surgery, for instance, or ophthalmology.

These are two sectors in which we have huge problems still, but we tried to improve that, and you have to take into account the fact that health care for

Quebec is 42% of our budget. So that's probably the limit. We have increased dramatically the amount of money, but we have to find a solution, and there was also a recent, last year, agreement between the federal and the provincial governments in Canada that really I think would contribute to – maybe not to save the problem, but to face the situation.

I have a comment also for Jon and probably a question for both of you. Since I represent Quebec here, I don't know if my premier would agree that Quebec acts like an independent country, especially since he is a federalist premier, and he is a former federal member of the government. So I don't necessarily agree with what you said on that.

My question is: We have not covered the impact on the industry about the rising cost of health care. I know that more and more what we hear in Quebec, and probably throughout Canada, is the fact that the companies are insisting more and more – not insisting more – but noticing more and more the fact that health care is lower, the prices of health care are lower in Canada, and when you hear GM (General Motors) and its cost related to health care, it is something that is really irritating the companies, I guess. So I don't know if you have any kind of comment on that.

Thank you.

MR. JOHNSON: On Quebec, all provinces are very sensitive about their areas of jurisdiction. Quebec may be at the top of the list of that, but the rest of them are only a little bit behind. Basically, the extent to which we have a national health care depends on a shared cost program. Herding provinces is like herding cats. They are all very difficult as regards to matters of jurisdiction, and it is very difficult for the federal government to assert its will. Quebec is particularly sensitive about jurisdiction, but actually the rest of them are, too. There is not a whole lot of difference.

The point you mention as regards companies like General Motors is one of the advantages of the Canadian health care system. You raise the auto industry as an example. One thing that the public welfare type system does by taking the vast bulk of health care and paying for it through general taxation, is to lift a burden from companies like General Motors, Daimler Chrysler, and Ford, to provide those sorts of benefits. In the U.S., the unions negotiate very fulsome health care packages with the auto companies. In Canada, there certainly are health care packages provided by companies, but they cover things like dentistry and supplemental health insurance and that sort of thing. Companies don't have to provide coverage for core health care services. And I believe that that is a significant advantage to industry in Canada. The health care system in that sense can be seen as a benefit.

There may be problems with access, and there may be problems at least in terms of waiting lists and problems getting emergency assistance, but generally speaking, given that the health care system is free, the people use it, and that is of benefit to the industry as well.

MR. THEOFRASTOUS: I guess I would say on the U.S. side, there is so much variation in terms of, particularly, in what a third-party payer will pay, but also even the sort of core reimbursement rate on the Medicare side, that as – you know, if you are a financial analyst trying to bring a medical product to market, you almost have to take an arbitrage approach to see what your bottom line is. You want your product to be broadly accepted and used, and acknowledge that some portion of that acceptance and use may actually be unprofitable, but you sort of make it up across the rest of the payer mix.

MR. UJCZO: I am getting the “all clear” sign from Henry, so we are going to wrap it up. Thank you Jon and Ted, and stomachs are grumbling. Lunch will be served upstairs in the rotunda where we had dinner last evening.

(Session concluded.)