

# Canucks versus Yankees: the Case for Universal Health Care over Private Health Care and How Psychiatry Benefits

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## Abstract

As an American –born –raised –trained psychiatrist who has practiced in the United States and now practicing in Canada, it affords me a unique perspective on the health care debates occurring in my home country. The debate regarding health care reform in the States has been heated on both sides. Even doctors are entrenched in one of the opposing positions, with the majority of U.S. physicians supporting reform with a public option [1]. However, it is difficult to discern fact from propaganda on either side, for or against universal health care. One particular problem is the misinformation and fear-mongering that has been covered regarding Canadian universal health care. In this commentary, I will attempt to make the case for universal health care, and focus specifically on the benefits of universal health care for psychiatry. I want to make the case that corporate medicine is detrimental to psychiatry, and how psychiatry practiced within a universal health care system is substantially different from that practiced within a managed care system.

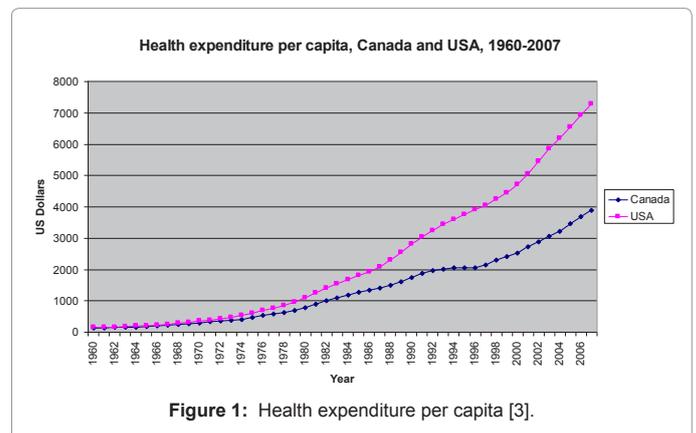
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## Canadian and American Psychiatry

When comparing Canadian and American psychiatry, many similarities exist. We have similar training and similar corresponding professional associations and journals. However, I opine that we have differing practice standards, and also believe that managed care is detrimental to psychiatry and the care of psychiatric patients. Historically, Canadian physicians have moved to the States for significant increases in salary. However, Canadian physicians are now returning to Canada for better salaries and more clinical autonomy [2], which was the case in the States before managed care. It seems that managed care is driving Canadian physicians back home. Managed care did save money and improve efficiencies when it was first rolled-out in late 1990's. But the money saved was not placed back into the actual clinical care of patients...it went to shareholders and executives of the privatized health care system in the States.

## Managed Care

In the 1990's, First Lady Hilary Clinton advocated for universal health care in the States in response to the health care crisis. As we all know, this effort to bring universal health care to the States failed. However, free market advocates took the health care baton and asserted that the market is the solution to health care crisis, hence the corporate, for-profit medicine that is now firmly established. Private coverage is now the dominant form of health coverage in the States, unlike the situation in Canada where public financing is the dominant coverage. In 2007, the States had 45.4% public expenditure on health, while Canada had 70.0% [3]. Has privatized medicine led to improved health care for Americans? I opine that it has led to worse health care (life expectancy at birth is lower in the States (78.1) than in Canada (80.7) [3], and it is expensive (the States spends nearly twice as much as Canada on health care, \$7,290 vs. \$3,895 per capita (Figure 1) [3]. One can also argue that the public sector in the States (Medicare/Medicaid) is treating the complex cases that the private sector avoids, as no profits are to be made in a capitated system when a patient actually becomes sick and needs expensive treatment. The private health care system prefers to cover healthy persons to avoid risk, leaving the sick and complex cases to the public system. The profit motive is the driving force for a private health care system, and less profit is realized with patients who actually need health care. So managing risk, denying coverage based on pre-existing



conditions and denying/restricting payment for patients who actually need care is what managed care is about increasing and preserving profit, and hence cost containment. And when care is 'authorized', there are often lifetime and/or annual limits on the coverage, with worse coverage for mental health care when compared to physical care [4]. For the working poor who do not qualify for public coverage under Medicaid/Medicare, private hospitals charge these patients anyways, often resulting in personal bankruptcy.

## Universal Health Care

Canadian medicine is a single-payer system where all Canadian

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residents are covered; costs are paid through funding from income taxes. The federal government provides funding to provinces for health care, and the provinces in turn fund regional health authorities. In other words, health care is free at the point of use, and most services are provided by regional entities [5]. Canada's regionally based health care systems are cost effective because of administrative simplicity. As there is only a single payer, there is no need for patient billing and reimbursement systems, as everyone is covered from the same payer. In addition, as private insurance is only a small part of the health care system, competitive practices such as marketing and lobbying are kept to a minimum [5]. Because of administrative simplicity, more of the health care dollars go towards actual patient care. Other benefits of the Canadian health system include: no deductibles on basic health care; no termination of coverage when individuals are sick; no restrictions on pre-existing conditions; no lifetime limits on treatment. These patient benefits are rarely seen in a privatized health care system. Although the Canadian health care system does not pay for medication, dental, and eye care, private supplemental insurance is available at a modest cost to cover these treatments. For many decades, Canadian health care was also privately financed, until politician Tommy Douglas instituted public financing in the province of Saskatchewan, which eventually was instituted at the federal level [6]. With public financing, most Canadians do not go bankrupt nor suffer from no treatment, as was the case with private financing.

### Canadian Psychiatry and Universal Health Care

It is my opinion that the psychiatry practiced in the States is significantly different from that practiced in Canada. In Canada, treatment decisions are made by the psychiatrist. Wielding clinical autonomy, Canadian psychiatrists determine which treatment modality to use: psychotherapy and/or pharmacotherapy, social interventions. No treatment authorizations are needed. On the psychiatric inpatient unit, the psychiatrist determines length of stay, and does not need authorization for the inpatient stay; the decisions are clinical, not administrative. As such, the Canadian psychiatrist can focus on a biopsychosocial formulation, which informs a comprehensive treatment plan. Canadian psychiatry does have its drawbacks. Medications are not covered and wait lists are long. Another drawback is that universal coverage is expensive. As a regional example, we will focus on the province of Nova Scotia. Almost 40% of the Nova Scotia budget is spent on healthcare (\$3.2 billion CDN) with a 6.6% annual growth rate [7]. Despite these drawbacks, Canada still spends less per capita on health care and still covers all of its citizens. As mentioned earlier, Canada spends roughly half as much as the States, \$3,895 vs. \$7,290 per capita, and year 2007 (Figure 1) [3]. More alarming is the gap is increasing as shown in (Figure 1). Explanations for this increasing gap may include: low administrative cost of the single-payer Canadian model; increasing pressure from shareholders to increase profit and produce annual growth for private American health care companies; public health measures in Canada to keep the population healthy and decrease health care costs; pharmaceutical costs in the States much higher than in Canada as the lobbyists for pharmaceutical companies in the USA are powerful in Congress and have disallowed price regulation and caps on pharmaceuticals by the U.S. government [8] the Canadian government regulates prices and places caps on pharmaceuticals; competition for the private-pay patient in the States has led to competition amongst hospitals and physician groups (with duplication of services) who utilize expensive diagnostics and treatments that drive up cost; the population-based approach in Canada where services and resources are allocated according to regional health care needs and not based on the

profit motive; defensive medicine practiced in the States can drive up health care costs due to the higher risk of malpractice litigation when compared to Canada. In addition to this increasing spending gap, life expectancy at birth for the year 2006 is higher in Canada (80.7) when compared to the States (78.1) [3]. Canadians are living longer than Americans, and Canadians spend much less on health care per capita.

### American Psychiatry and Managed Care

Managed care was originally brought into the U.S. to control spiraling health care costs in late 1990's. However, U.S. physicians have less clinical freedoms than their counterparts in Canada. In American psychiatry, managed care has led to split treatment, where the psychiatrist is trivialized and de-skilled as merely a provider and medication prescriber. The psychiatric treatment is split, as the psychiatrist is no longer able to carry out a complete treatment plan, as the psychosocial interventions are "contracted out" to allied health. As a result, the psychiatrist in a split treatment setting is not able to devise a comprehensive, biopsychosocial formulation, and in the end, the psychiatric care of the patient is compromised, as no one has a complete formulation. Thus, "split treatment" becomes such incomplete and fragmented treatment. This is akin to having no captain of a ship, with the entire seaman doing their own specialized tasks without direction and coordination. Eventually, the ship comes ashore, with no direction or purpose. Especially concerning is that new psychiatric trainees in the States have no knowledge of the psychosocial consequences of their physical interventions, as their training is geared towards diagnostic DSM-IV checklist assessments and 15-minute "med checks". Why bother with the psychosocial interventions when you can contract this out to cheaper providers? In the end, split treatment becomes expensive due to ineffectiveness. Such is the state of American psychiatry in the 21<sup>st</sup> century. American psychiatry led world psychiatric ideology over the 2<sup>nd</sup> half of the 20<sup>th</sup> century. However, managed care has eroded the expertise and value of American psychiatry, as it is too pharmacocentric and has allowed managed care to erode the patient-doctor relationship by ascribing to "split treatment". Effective psychiatrists have knowledge and skills in the psychosocial realm, and know how to integrate this with the biomedical domain. In general, Canadian psychiatrists have ascribed to the biopsychosocial model, integrated treatment, and comprehensive formulations. In psychiatry, no biological tests exist to tell us if we are right or wrong; other medical specialties are humbled by these tests. Because we have no objective tests to confirm our impressions, psychiatrists need to have complete and complex analysis to formulate a case. Split treatment and the 'medication-only-psychiatrist' leads to incomplete formulations and hence negatively impacts patient care. Managed care also erodes clinician autonomy, and treatment is determined by corporate decisions, not clinical ones.

### What Does a Graduating Canadian Psychiatry Resident See?

A graduating Canadian psychiatry resident can expect to work in an environment where he/she has clinical autonomy, and does not waste valuable clinical time dealing with authorizations. Because all of their patients have health coverage, Canadian graduates do not worry about denying treatment to a patient if they are not able to pay. In the end, the Canadian psychiatry graduate is able to practice psychiatry, and is able to utilize all the skills they were trained to do. Furthermore, the Canadian psychiatry graduate will command a generous and competitive salary. A common myth is that Canadian physicians are not adequately compensated. Table 1 shows Canadian physician compensation in the years 2004-2005 [9]. With compensation for

	N.L	P.E.I	N.S	N.B	Que	Ont	Man	Sask	Alta	B.C	Total
<b>Family Medicine</b>	<b>215,931</b>	<b>220,742</b>	<b>185,448</b>	<b>211,734</b>	<b>164,568</b>	<b>213,088</b>	<b>217,390</b>	<b>238,775</b>	<b>232,742</b>	<b>196,365</b>	<b>202,481</b>
<b>Medical Specialties</b>	<b>314,521</b>	<b>334,107</b>	<b>206,830</b>	<b>285,549</b>	<b>189,817</b>	<b>278,094</b>	<b>216,009</b>	<b>284,063</b>	<b>276,809</b>	<b>245,174</b>	<b>248,694</b>
Internal Medicine	330,869	334,107	237,613	361,263	219,434	351,826	235,867	349,879	321,970	317,202	301,450
Neurology	233,342	n/a	378,531	317,953	202,764	256,120	214,724	253,297	238,245	244,494	237,083
Psychiatry	259,752	*	149,307	195,751	119,698	184,170	159,857	236,324	234,570	170,832	175,444
Pediatrics	275,924	*	201,479	244,223	169,313	235,227	185,389	206,477	226,115	205,423	210,655
Dermatology	300,178	*	352,402	292,888	246,669	304,680	256,681	366,660	578,134	312,692	306,682
Physical Medicine	n/a	n/a	177,313	*	167,875	200,360	192,213	*	157,438	179,362	185,046
Anesthesia	344,637	*	164,175	220,956	171,798	289,396	262,026	238,935	278,630	245,030	248,994
<b>Surgical Specialties</b>	<b>367,822</b>	<b>329,280</b>	<b>321,293</b>	<b>357,199</b>	<b>240,343</b>	<b>361,045</b>	<b>337,476</b>	<b>406,161</b>	<b>427,550</b>	<b>353,479</b>	<b>334,012</b>
General Surgery	333,659	346,103	275,596	326,577	211,730	335,220	328,416	331,009	370,425	321,985	299,819
Thoracic/Cardiovascular Surgery	*	n/a	178,254	457,144	297,333	432,402	392,824	641,318	647,370	383,768	406,372
Urology	368,699	n/a	379,062	364,954	270,173	355,042	263,477	367,558	363,818	401,124	339,338
Orthopedic Surgery	383,867	*	245,606	312,339	205,013	338,152	299,419	370,649	347,606	276,376	294,965
Plastic Surgery	*	†	236,061	295,403	179,325	279,653	392,920	329,297	370,033	245,477	269,055
Neuro Surgery	*	n/a	*	*	131,620	400,764	*	*	*	348,947	297,649
Ophthalmology	411,889	333,849	466,156	507,299	313,449	457,667	469,556	632,834	608,308	546,647	455,025
Otolaryngology	475,293	*	335,502	388,563	255,892	348,880	257,072	419,487	543,338	322,564	333,392
Obstetrics/Gynecology	293,640	297,433	296,497	289,673	245,733	351,024	327,038	363,536	402,055	289,802	316,831
<b>Total Specialties</b>	<b>335,554</b>	<b>330,837</b>	<b>264,842</b>	<b>320,896</b>	<b>207,727</b>	<b>305,755</b>	<b>254,246</b>	<b>334,168</b>	<b>328,680</b>	<b>282,677</b>	<b>278,656</b>
<b>Total Physicians</b>	<b>263,996</b>	<b>252,638</b>	<b>216,778</b>	<b>259,334</b>	<b>185,751</b>	<b>258,090</b>	<b>236,695</b>	<b>277,930</b>	<b>270,328</b>	<b>232,756</b>	<b>237,492</b>

† Prince Edward Island Plastic Surgeons are included with general surgeons.

n/a= not applicable- There were no physicians for this speciality for this province

\*data have been suppressed. Please see Methodological Notes, Data Suppression section for details.

Based on gross payments.

Alternative forms of reimbursement, such as salary and sessional, are not included.

**Table 1:** Average payment per Fee-for-service physician Who Received at Least \$ 60,000 in payments by Type of Practice, 2004-2005 [9].

Canadian psychiatrists generally increasing about 5% per year and the Canadian dollar approaching par with the U.S. dollar, the compensation for Canadian psychiatrists is now especially competitive when compared to the compensation for American psychiatrists.

## What Should American Psychiatrists do to improve the U.S. Model?

This is inherently a discussion regarding how Canadians and Americans differ on political ideologies. As seen by the huge backlash by large segments of the American population to ObamaCare and Hilary Clinton's universal health care initiative as First Lady, Americans are not cohesive and many from the thriving middle and upper classes do not want to give up and dilute their own superior private health coverage so that the lower classes can in turn have adequate coverage and access to health care. Many Americans also tend to be fiercely independent, and see any form of socialism as un-American and unpatriotic. In addition, the strong lobbying from pharmaceutical and health care companies has prevented any real change to the broken health care system in the States. But American psychiatrists know what to do. We know what good psychiatric care looks like: focus on the therapeutic relationship; spending time with the patient and ascertaining the proximal determinants of the presenting symptoms; utilizing the biopsychosocial model and devising comprehensive case formulations which allows for true healing; treatment plans which includes collaboration with other health care providers and the patient's family; diligent follow-up of the patient over time and reformulating cases when hypotheses do not have good outcomes; adequate resources so that patients can have access to outpatient treatment, inpatient treatment, partial day hospital treatment,

and case management; clinical autonomy as we are the experts at psychiatric care, and hospital/mental health administration should be there to support our treatment plans and not supercede us when we make clinical decisions for our patients. American psychiatrists need to band together, break the relationships with pharmaceutical companies, and advocate as a group for what they already know how to provide good psychiatric care. And good psychiatric care occurs in a universal health care system. Either all that, or move to Canada, but not everyone can stand the fierce Canadian winters!

## So what is the Ideal Health Care System?

- I do not claim to be an expert at health care systems or economics, all I know is my own experiences as a psychiatrist in both the States and Canada. From these experiences, I have devised the following principles to follow when looking at an ideal health care system: Health care should be accessible to all citizens
- Health care should be determined by the needs of the population (not by the market)
- Health plans should be all inclusive (should not impose restrictions on pre-existing conditions, should not have lifetime caps and should not terminate coverage when individuals are sick)
- Money saved on efficiencies should be placed back into the health care system (not shareholders or administration)
- Physicians should dictate the allocation of health care resources (except for their own income)

From my experiences on both sides of the border, universal health care fits the bill for all of these principles. However, the Canadian system still has drawbacks, as it is expensive (approaching 50% of provincial budgets as the largest outlay of provinces), the wait times can be long, and at times it is not efficient. To preserve the Canadian system from the threat of managed care taking over to contain costs, Canadian doctors need to become more efficient and utilize precious resources in the best way possible to deliver good care to patients, while also containing the spiraling costs of health care. For both the USA and Canada, probably a hybrid of private and public financing and delivery will be the solution to improve health care, with special focus on accessibility, efficiency, and innovation. Also, focusing on public health and digital medicine (telemedicine, remote monitoring) can ultimately reduce reliance on hospitals and office visits, hence saving on cost. But if I had to make a choice between the two current systems, I would choose Canada's.

### Parting Words

President Obama is pushing for universal health care as it is the right thing to do. Providing coverage for 50 million uninsured fellow Americans is the right thing to do. We are not talking about providing luxury houses or fine dining; we are talking about an American's right to liberty and freedom, so how can you have liberty and freedom without good health? "I pledge allegiance to the flag of the United States of America and to the Republic for which it stands, one Nation under God, indivisible, with liberty and justice for all." Really? Is there liberty

and justice for the 50 million uninsured Americans? Or are they just selectively left out of that promise? Many of our psychiatric patients are in that mix of the 50 million uninsured Americans. Even if an American with psychiatric illness has health coverage, the insurance companies impose limits and lifetime limits on mental health treatment. As psychiatrists, we have to advocate for universal health care, especially for our psychiatric patients, as it is the right thing to do.

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