

Single payer is good for physicians



Section II: The Evidence-Based Case for Single-Payer National Health Insurance

## **Talking Point 9**

Single payer removes corporate restrictions on physicians' ability to practice medicine





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# Commentary

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## Reins Or Fences: A Physician's View Of Cost Containment

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by Kevin Grumbach and Thomas Bodenheimer

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The days when American physicians could practice medicine unfettered by concerns of cost are rapidly vanishing. The emphasis of health policy debate is no longer, "Should we attempt to contain costs?" but, "How should we control costs?" In this context, the medical profession's traditional resistance to the setting of limits in any form is unlikely to remain a credible position. Far more productive will be physicians' engagement in the selection of cost containment strategies that best preserve professional integrity and minimize disruption of patient care.

Expenditure targets and utilization review exemplify markedly different approaches to cost containment. Congress, following the recommendations of the Physician Payment Review Commission (PPRC), recently adopted expenditure targets for the Medicare program despite a highly visible campaign of opposition by organized medicine. Expenditure targets and expenditure caps are prominent cost containment strategies in other nations, most notably Canada and Germany. In contrast, strict utilization review linked to payment decisions is a singularly American approach to cost control. Nearly 60 percent of private health insurance plans in the United States, in addition to Medicare and Medicaid, now feature some form of utilization review.<sup>1</sup> Yet, compared with expenditure targets, the rapid growth of utilization review appears to have provoked far less organized opposition from American physicians.

In this Commentary, we discuss the different implications of expenditure targets and utilization review from the point of view of practicing physicians. One of our principal considerations is the extent to which these measures impinge on physicians' clinical freedom. The analogy of the medical commons provides an illustrative context for understanding how physicians may experience the growing tension between pressures to limit resources and desires for clinical freedom.

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## The Medical Commons

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The predicament of limited resources, both in health care and other areas, has been likened to a herd of cattle grazing on a common pasture of finite capacity.<sup>2</sup> Adapting the analogy of the commons to the contemporary cost containment setting, the total grazing area may be regarded as the entirety of economic resources in the United States. The smaller pasture dedicated to health comprises a portion of that grazing area. The herd represents the nation's physicians, grazing on the financial resources of the commons in the process of providing services to patients.

Physicians, guided by medicine's moral imperative to "do everything possible for the individual patient," continually attempt to extend the borders of the medical pasture.<sup>3</sup> As health care costs as a percentage of U.S. gross national product (GNP) rose from 5.2 percent in 1960 to 11.1 percent in 1988, the boundaries of the pasture dedicated to health care steadily expanded within the overall societal commons.

But communities outside the medical pasture increasingly view the herd as encroaching on resources needed for other pursuits. The organized payers-government and employers-who plant much of the "green" on the medical commons, are intent on protecting their larger commons from what they see as the relentless expansion of the medical herd. Conflict is intensifying between the contrary drives of physicians, seeking maximum care for their patients in an era of scientific breakthroughs, and the cost containment impulses of the payers planting the commons. The unencumbered open range, like the American doctrine of manifest destiny, is a thing of the past.

There are two fundamentally different manners of restraining resource use on the commons: placing individual reins on each member of the herd to control grazing on the open range (utilization review), or building a fence around the medical pasture to limit the total area of grazing available but leaving the individual cattle unharnessed (global budgetary controls such as expenditure targets). Which form of restraint, reins or fences, least threatens physicians' clinical freedom?

**Professional autonomy.** It is important to define exactly what we mean by "clinical freedom." Physicians frequently wave the banner of professional autonomy with great rhetorical flourish and lack of precision. In our view, clinical freedom is the ability of the physician to deliver medical care to a patient without the *uninvited imposition* of outside influences whose purpose is not the optimal health of the patient. Clinical freedom allows physicians to fulfill their role as the patient's agent in performing those services believed beneficial to the patient's well-being. It follows that quality-assurance peer review conducted within hospitals and group

practices should not be construed as a loss of autonomy; it is (or should be) invited by the physician, with the goal of improved patient care.

Nor is clinical autonomy linked with the fees a physician receives. Negotiation and regulation of fees by third-party payers is clearly warranted; it is the exceptional physician who expects to be paid whatever he or she chooses to bill. But to the extent that cost-control mechanisms wrest away from the physician the ability to determine the type and quantity of services, physicians' autonomy is reduced. Organized medicine frequently confuses freedom to set fees with clinical freedom. In Canada, one member of the Ontario Medical Association testified in opposition to the province's policy to prohibit extra-billing of patients above the government fee schedule: "It is our duty to ourselves, to medical students now in training, and to those yet unborn who will carry on our profession in the 21st century, to resist, in any and every possible way, this mortal attack on our professional freedom."<sup>4</sup>

The "professional freedom" defended so assiduously in this case has little to do with the notion of clinical autonomy we have proposed. In their analysis of the controversy surrounding Canada's extra-billing ban, a Canadian physician and his colleagues concluded that "the end of extra billing did nothing to interfere with clinical practice."<sup>5</sup> Unfortunately, appeals about professional autonomy, when the issue is really economic gain, simply create confusion in instances when clinical autonomy or the health of patients is genuinely at risk. True clinical freedom is important to patients as well as physicians. Patients should have the right to consult, and make decisions with, their physician under conditions of privacy, free from the interference of outside parties whose primary interest in the patient/physician interaction is to reduce the costs of that interaction.

Economic realities dictate that the era of absolute clinical autonomy is over. Whether by reins or fences, physicians will have to consider costs when making clinical decisions. Different cost containment strategies may, however, impinge on clinical freedom in very different ways.

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### Reins And Fences: Cost Control And Clinical Autonomy

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**Utilization review.** Let us now return to the medical commons and explore the impact of two contrasting cost-control methods on clinical autonomy. Utilization review ("reins") is the surveillance of and intervention in the clinical activities of physicians through such methods as preadmission authorization for hospital care, concurrent review of length-of-stay, mandatory second opinions, and retrospective claims review. Holding the reins are agents of the payers-peer review organizations (PROs) or cost management firms—who tighten them whenever physi-

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cians are perceived to be grazing outside the perimeter of practices found acceptable to the payer. The most stinging forms of utilization review employ the prod of payment denial for services received. (Total payment denial for legitimate services, in contrast to fee schedules, does have an impact on clinical freedom because it provides a 100 percent negative incentive for providing certain services.)

Supporters of utilization review might argue that this cost-control method selectively eliminates unnecessary services and is thus justified as a clinical intrusion on quality-of-care grounds. There is evidence that physicians in the United States perform large numbers of inappropriate procedures and suspicion that much of what constitutes “appropriate” standards of practice lacks proven efficacy.<sup>6</sup> But does utilization review really catch the “stray cattle” grazing unnecessarily, apart from the accepted standards of the herd, without restricting the clinical autonomy of more conscientious physicians?

Tarnishing such an ideal vision of utilization review is a pervasive uncertainty about exactly what constitutes appropriate care. In one study of the utilization review decisions of Arizona’s Medicare PRO, two community physicians conducted a blind review of hospital admissions previously evaluated by the PRO. The community physician reviewers would have denied 28 percent of the admissions approved by the PRO and would have allowed 39 percent of the admissions denied by the PRO. Worse yet, the two community reviewers disagreed with each other in 48 percent of the cases.<sup>7</sup> In another study, The RAND Corporation convened a panel of experts to review detailed medical records of Medicare patients receiving coronary angiography, upper gastrointestinal endoscopy, or carotid endarterectomy. Even among these experts, there was “substantial disagreement” about the appropriateness of 25 percent of the endoscopies and 32 percent of the endarterectomies.<sup>8</sup>

A physician writing in *The New York Times* described making daily visits to a patient terminally ill with lung cancer during the last eighteen days of her life. The patient was increasingly short of breath, weak, and unable to eat; decisions on her care had to be made daily. The physician was told by Medicare that the visits were medically unnecessary.<sup>9</sup> The 73 percent of American physicians who have experienced Medicare claims denials no doubt could add many examples of the difficulty distinguishing between appropriate and inappropriate care.<sup>10</sup> Even strict practice guidelines, currently under development, will likely be unable to eliminate the gray areas of uncertainty that color so much of what William Osler called “an art which consists largely in the balancing of possibilities.”

The harness and prod of utilization review have turned American physicians into the most “second-guessed and paperwork-laden physi-

cians in western industrialized democracies.”<sup>11</sup> Utilization review also requires a large bureaucratic force to ride the herd, holding the reins of the many individually harnessed cattle. It is no wonder that the United States has the highest ratio of health care bureaucrats to health caregivers in the developed world, causing the administrative costs of the American health system between 1980 and 1986 to grow at more than double the rate of overall health cost increases.<sup>12</sup> Proposals to expand current utilization review practices into the ambulatory sector (as currently planned by public and private payers) are daunting. Former Health Care Financing Administration head William Roper admitted that “the task of monitoring 11 million admissions from 7,000 hospitals for 475 DRGs [diagnosis-related groups] pales in comparison with that of reviewing 350 million bills from 500,000 physicians for 7,000 different procedure codes.”<sup>13</sup>

**Expenditure targets.** An alternative to the rein is the fence: a global boundary that surrounds the medical commons, setting clear limits on the amount of money budgeted for the health system. “Fences” are exemplified in expenditure targets; global budgeting of hospitals, as occurs in Canada and many European nations, is a related strategy. International experience suggests that fences are far more effective than individually placed reins in controlling costs, since they set defined budgetary limits and avoid the bureaucracy factor required by utilization review.<sup>14</sup> But what is the impact of fences on clinical autonomy?

In contrast to utilization review, global limits such as expenditure targets focus on the collective behavior of large groups of doctors and patients, rather than on individual physician/patient encounters. If physicians as a group provide so many services that budget targets are exceeded, fees are adjusted downward, creating a general incentive for more judicious use of resources. While strict global limits delineate boundaries on the common that circumscribe the ultimate clinical freedom “to do everything possible,” these boundaries distance the cost-control process from day-to-day clinical decisions. Without the constant intrusion of external utilization review, clinical autonomy is enhanced.

If the physician community finds that certain members of the herd are growing fat by consuming too much greenery at the expense of others, it becomes the responsibility of the profession to discipline such greedy members. With the development of medical practice parameters operating within global expenditure controls, collegial action against the errant individual is possible, making use of quality assurance bodies within medical societies and hospital staffs.<sup>15</sup>

Naturally, the construction of fences will create difficulties. Where to place the fence will occasion negotiation and strife.<sup>16</sup> The locus of the battle will shift from the bureaucratic conflict of utilization review to the

political conflict of global budgeting-in the words of Canadian economist Robert Evans, from “diffuse distress” to “orchestrated outrage.”<sup>17</sup> Nonetheless, global budgetary methods allow physicians to exercise internal professional review against a few outliers, while utilization review requires outside agents to scrutinize the daily decisions of all physicians.

Fences such as expenditure targets and caps also may compel physicians to recognize an additional fact: the medical commons becomes increasingly crowded as the physician-to-population ratio grows. While most industrialized nations are experiencing increases in physician supply, this trend is particularly dramatic in the United States. Global budgetary strategies may give the medical profession a greater incentive to collaborate with government and teaching institutions to exert greater “population control” over the physician herd.

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### Conclusion

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Traditionally, organized medicine in the United States has been most vigorous in lobbying against fee controls and budgetary limits and, in particular, against vesting in a publicly administered universal health care system the authority to erect fences in a global fashion. Uwe Reinhardt has commented on the irony of this political strategy:

The less tightly society controls the overall capacity of its health system and the economic freedom of providers to...price their services as they see fit, the more direct appears to be the private or public payer’s intrusion directly into the doctor-patient relationship- the less clinical freedom at the level of treatment will payers grant the providers. In fighting as tenaciously as they have for the principle of free enterprise in medicine.. .American physicians seem unwittingly to have surrendered much of their clinical freedom-a freedom still enjoyed to a much greater extent by their colleagues abroad.<sup>18</sup>

In the absence of fences around aggregate costs, payers will have no recourse but to tighten individual harnesses on physicians in an attempt to better restrain expenditures.

No cost containment approach will be entirely free of discomfort for physicians. As our nation continues to experiment with different cost containment measures, we believe physicians and policymakers should carefully consider factors such as clinical autonomy when evaluating these measures. American physicians are likely to experience continuing erosion of their clinical freedom as long as utilization review remains a prominent feature of U.S. cost containment policy. Global budgetary strategies represent a more effective and less cumbersome alternative.



## NOTES

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14. R.G. Evans et al., "Controlling Health Expenditures-The Canadian Reality," *The New England Journal of Medicine* 320 (1989): 571-577.
15. B.L. Kirkman-Liff, "Physician Payment and Cost-Containment Strategies in West Germany: Suggestions for Medicare Reform," *Journal of Health Politics, Policy and Law* 15 (1990): 69-99.
16. See J. Lomas et al., "Paying Physicians in Canada: Minding Our Ps and Qs," *Health Affairs* (Spring 1989): 80-102, for a discussion of the political conflict over physician expenditure targets and caps in Canada. Most functioning systems of expenditure targets or caps are predicated upon health care systems that either are a public monopsony (for example, Canada) or feature explicit government coordination of a multipayer universal insurance system (for example, Germany. See Kirkman-Liff, "Physician Payment and Cost-Containment Strategies"). Both the success and political volatility of America's venture into expenditure targets for Medicare may be tempered by cost shifting in response to an expenditure target instituted for only a single (though major) payer among many.
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# Physicians Who Have Practiced in Both the United States and Canada Compare the Systems

## ABSTRACT

**Objectives.** The aim of this study was to examine the US and Canadian systems from the unique perspective of physicians who have practiced in both Canada and the United States.

**Methods.** Questionnaires were sent to 355 Canadian physicians who graduated from US medical schools and 347 US physicians who graduated from Canadian medical schools.

**Results.** The overall response rate was 59% (65% of US-graduated Canadian physicians and 54% of Canadian-graduated US physicians). Thirty-six percent of the respondents were "dual experience" physicians; that is, they had practiced medicine in both countries after completing their medical training. Physicians who left Canada were more likely than those who left the United States to indicate dissatisfaction with the health care system as a reason for leaving. Respondents expressed greater professional satisfaction with their current country of practice, but overall, dual-experience physicians in the United States favored that system only slightly more than the Canadian system, whereas those in Canada rated the Canadian system significantly better than the US system.

**Conclusions.** The comparatively weak rating of the US system by dual-experience physicians underlines the need for health care reform. (*Am J Public Health.* 1993; 83:1544-1548)

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## Introduction

In the United States, interest in the Canadian health care system is widespread.<sup>1-3</sup> A large percentage of the US public favors extensive health care reform.<sup>4</sup> Proposals for reform have sometimes drawn heavily on the Canadian model,<sup>5</sup> although this model has been viewed with skepticism by others.<sup>6-8</sup> Such skepticism has been fueled by signs of increasing stress within the Canadian system in recent years. Rising costs, efforts at cost control in the face of increasing benefits, and stagnant or depressed earnings among physicians have placed the Canadian health care system in jeopardy.<sup>9-12</sup>

Analytical comparisons between the US and Canadian health care systems can sometimes exclude the human side of the equation.<sup>13-14</sup> Given the close proximity of Canada to the United States, a sizable number of health professionals have had direct experience as providers in both systems. These physicians have a unique perspective that should be of particular interest to those seeking insights into methods of health care delivery. Yet the literature on the subject to date has been limited.<sup>15-17</sup> The current study takes this inquiry a step further.

## Methods

Using the 1987 Canadian Medical Directory, we identified all Canadian physicians (488) who had graduated from US medical schools. The use of an older directory allowed for a minimum number of years of professional experience in Canada. A similar-sized group (533) of graduates of Canadian medical schools now practicing in the United States was gathered by identifying the first Canadian medical school graduate on every fifth page of

the 1988 American Medical Association Directory. (There are about 17 times more Canadian-graduated US physicians than US-graduated Canadian physicians; each group represents roughly 1% of its respective work force.) Addresses for both groups were then updated, using the 1990 directories for both countries. We sought to identify physicians who had had direct professional experience in both the United States and Canada, without a requirement as to original country of residence. The respondents thus included individuals with a variety of backgrounds and included both Canadian and US citizens who attended medical school outside their own country, some of whom stayed on to receive further medical training or to practice medicine before returning to their own country.

Questionnaires were mailed to 813 physicians so identified for whom current addresses were available. Questionnaires proved deliverable to 702 physicians (355 Canadian and 347 US) and 414 were returned, 232 (65%) from Canadian physicians and 182 (54%) from US physicians (overall response rate, 59%).

## Results

Of the 414 respondents, 256 (62%) obtained additional professional training (internships, residencies, and/or fellowships) in the same country as their medical school. Further, 147 respondents (36%)

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practiced medicine in both countries after medical training, averaging 10.43 years of experience in the Canadian system and 10.98 years in the US system. We will refer to this group as “dual experience” physicians.

Men made up 76% of the sample and women 20% (4% did not report their sex). The respondents were predominantly (88%) White. Five percent were Black, Asian, or Hispanic (7% did not report their race/ethnicity). Age was reported in 10-year increments. The predominant age group was 40 through 49 years of age, especially in the Canadian sample, where 49% of all respondents fell into this age group.

Respondents were divided into two groups. “Primary care providers” included those practicing in nonsurgical areas of medicine that traditionally provide primary care services the majority of the time: general practice, family practice, pediatrics, and internal medicine (including geriatric medicine). All others were classified as “non-primary care specialists.” The sample consisted of 166 (40%) primary care physicians and 234 (57%) non-primary care specialists (3% did not report their field of practice).

The questionnaire focused on global measures of satisfaction with the respondents’ professional experience in each country. Respondents were asked: Overall, how would you rate your level of satisfaction with your experience as a practicing physician? As a practicing physician, how satisfied are you with the financial compensation for your work? As a practicing physician, how satisfied are you with the quality of medicine you have been able to practice? Separate answers were given for each system. Additional questions addressed the impact of cost containment measures and asked each physician to compare the two systems directly, using a single overall rating. For dual-experience physicians, an additional question asked for the reasons they had left their first country of practice. Respondents were invited to expand on their responses with additional narrative.

The 147 dual-experience physicians were of greatest interest; except where noted, all results were drawn from this group, which consisted of 75 Canadian physicians and 72 US physicians. Table 1 summarizes the reasons members of this group left their first country of practice; Table 2 compares the answers of the Canadian and US dual-experience physicians to the global satisfaction questions.

**TABLE 1—Percentages of Dual-Experience Physicians Giving Reasons for Leaving Previous Country of Practice**

Reason	Physicians Who Left the United States (n = 75)	Physicians Who Left Canada (n = 72)
Generally dissatisfied with system	25	43*
Unable to practice quality of medicine desired	13	29*
Unhappy with financial rewards	5	47**
Personal reason(s) unrelated to problems with the health care system		
In addition to one or more of above	32	28
Personal reason(s) only	48*	39

*Note.* Except for those who cited personal reasons only, respondents could select more than one reason.  
\* $P < .05$  (chi-square test); \*\* $P < .001$  (chi-square test).

**TABLE 2—Satisfaction of Dual-Experience Physicians with Canadian and US Health Care Systems**

Level of Satisfaction	Primary Care Physicians		Non-Primary Care Specialists		Total Sample	
	Canada (n = 37)	United States (n = 33)	Canada (n = 38)	United States (n = 39)	Canadian Physicians (n = 75)	US Physicians (n = 72)
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Overall, Canada	5.1 (1.4)**	4.0 (2.1)	5.5 (1.0)*	3.9 (1.9)	5.3 (1.3)*	4.0 (2.0)
Overall, United States	3.4 (1.5)	4.9 (1.5)*	4.3 (1.6)	5.1 (1.4)**	3.9 (1.6)	5.0 (1.5)*
With financial compensation, Canada	4.6 (1.7)*	3.3 (1.8)	4.5 (1.6)*	3.4 (1.7)	4.6 (1.6)*	3.4 (1.8)
With financial compensation, United States	4.7 (1.6)	5.4 (1.5)	5.0 (1.0)	5.6 (1.3)**	4.8 (1.3)	5.5 (1.3)*
With quality of medicine able to practice in Canada	5.4 (1.4)**	4.5 (2.0)	5.9 (1.0)*	4.1 (1.8)	5.6 (1.3)*	4.3 (1.9)
With quality of medicine able to practice in United States	4.3 (1.6)	5.3 (1.5)**	4.8 (1.7)	5.9 (0.9)*	4.6 (1.7)	5.6 (1.2)*

\**Note.* Responses were made on a 7-point scale: 1 = completely dissatisfied, 4 = opinion neutral, 7 = completely satisfied.  
\* $P < .01$  (unpaired *t* test); \*\* $P < .05$  (unpaired *t* test).

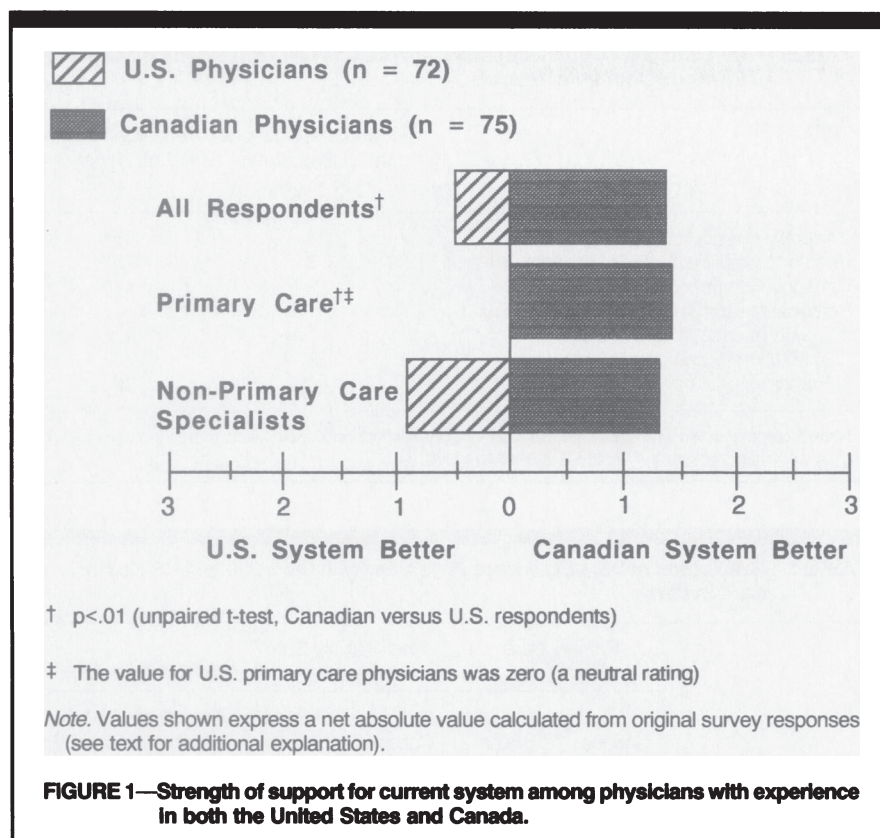
Physicians who had left Canada were significantly more likely than their US counterparts to express dissatisfaction with the health care system as a reason for leaving ( $P < .05$ ; financial compensation,  $P < .001$ ). Nearly half (48%) of those who had left the United States did so for strictly personal reasons unrelated to their experience with the US health care system (most commonly employment opportunities).

Physicians’ expressions of satisfaction with their professional experience in their current country were significantly better than ratings of that country by phy-

sicians who had left ( $P < .05$ ), with the exception of Canadian physicians’ expressions of satisfaction with the financial rewards of both systems, which were essentially equal. Further dividing the Table 2 sample into those expressing dissatisfaction with the health care system and those giving only personal reasons (unrelated to the health care system) for switching countries showed that those with strictly personal reasons rated their initial country more highly than those expressing dissatisfaction.

Specialists in both countries indicated levels of satisfaction equal to or





higher than those of primary care physicians. US physicians, both primary care physicians and specialists, were more satisfied with their earning ability in the United States than with their previous earning ability in Canada. Canadian specialists were more satisfied with levels of compensation in the United States than in Canada, but to a lesser degree than their US counterparts, whereas Canadian primary care physicians expressed essentially equal satisfaction with their income in both countries.

Regarding the effect of cost containment measures on their ability to practice, both Canadian and US physicians indicated only a slight to moderately negative impact. There was no statistically significant difference between the two groups, except that Canadian specialists viewed US efforts at cost containment more negatively than did US specialists ( $P < .05$ ).

Juxtaposed against the preceding data, the answers to the question "How would you rate the Canadian and US health systems in comparison to each other?" were unexpected. Each group again favored its current country, with the exception that US physicians who had left Canada for strictly personal reasons rated the Canadian system slightly better. The strength of response, however, was significantly different. For this question, re-

sponses given on a 7-point scale (1 = US system better, 7 = Canadian system better) were subtracted from the question's neutral rating of 4. The absolute net value of this calculation is seen in Figure 1, which demonstrates, in an overall sense, the strength of dual-experience physicians' rating of their current country over their previous one: Canadian physicians' rating of their own system was three times greater in strength than US physicians' rating of the US system ( $P < .01$ ). Among all respondents, the Canadian physicians' rating of their current system was more than four times greater in strength than the US physicians' rating of the US system ( $P < .01$ ).

It is useful to further divide the dual-experience group based on the time period in which practice experience occurred: those who, at least in part, practiced in both countries between 1970 and 1980 ( $n = 112$ ) and those whose practice experience in both countries included years after 1980 ( $n = 99$ ). The first group had the opportunity to experience the US Medicare and Medicaid programs begun in the mid-1960s as well as Canada's shift to its provincially based system, which was complete by 1972. (Most governmental programs for hospital coverage in Canada began in the late 1950s and were in place by the mid-1960s in all provinces; most

governmental outpatient programs began in the mid-1960s and were in place in all provinces by 1972.) The second group had the chance to experience the more recent strains on the Canadian system as well as the institution of diagnosis-related groups in the United States.

When results from these subgroups were compared with those of the entire dual-experience group, only two important differences were seen. Among US physicians who left Canada sometime after 1970, mean values for overall satisfaction with the Canadian system as well as for quality of care and financial compensation in that system were somewhat lower than values in the entire group of US dual-experience physicians. In the subgroup of US physicians who had left Canada after 1980, a similar drop in mean values was seen regarding the level of compensation in Canada. All other fluctuations in mean values were minimal. Overall, the differences shown in Figure 1 were not substantially altered when we focused on physicians with more up-to-date experience in both systems.

### Comment

As an important information source, physicians who have had direct professional experience in both Canada and the United States have been underutilized. These individuals have been "in the trenches" on both sides of the border and have seen how each system works on a day-to-day basis. Their input is a valuable addition to more theoretical analyses. In identifying every US-graduated Canadian physician and a similar-sized sample of Canadian-graduated US physicians, we sought to harness the real-life perspective of these unique groups.

These groups may not be representative of all Canadian or US physicians. In addition, the respondents were self-selected and may not be the same as nonrespondents. An analysis of respondents to the first and second mailings provides some information on this issue, since initial nonrespondents became part of the second group of respondents. We used simple  $t$  tests to compare all measures for these two groups. Only one of 16 comparisons was significant; this was approximately the number of differences expected on the basis of chance alone at  $P = .05$ . Respondents to the first mailing rated the US system significantly more highly than did second-mailing respondents. If such a difference is real, subsequent mailings to nonrespondents would

only be expected to strengthen the results we obtained. Thus there is little reason, based on the data themselves, to suspect that if more opinions from nonrespondents were included, different conclusions would be reached.

The evolution of Canada's single-payer system was associated with protests from physician groups who feared governmental involvement. Those less enamored of the radical changes occurring in Canadian health care may have been more likely to leave when the opportunity arose. Thus, on the one hand, we expected the results summarized in Table 1: physicians who chose to leave Canada more commonly expressed dissatisfaction with the system as a reason for leaving than did their counterparts who left the United States. Yet levels of satisfaction with their current country were essentially equal: Canadian physicians were generally as satisfied with their professional experience as were US physicians, and they were reasonably satisfied with their financial rewards (Table 2). Further, notwithstanding the knowledge that their income would be greater in the United States, Canadian specialists in our sample expressed relative contentment with their practices as measured by levels of overall satisfaction and satisfaction with the quality of medicine they are able to practice. In both cases these indicators were equivalent to those of US specialists.

The most unexpected result was the relatively weak rating of the US system by US dual-experience physicians (Figure 1). We had expected a stronger rating of the US system by these US physicians as compared with the rating of the Canadian system by Canadian physicians, both because dissatisfaction with the health care system was more commonly expressed by physicians leaving Canada for the United States and because financial remuneration in the United States is greater. In this survey, the opposite proved the case. This result is not clearly explained by the global measures of satisfaction previously described, but it is partly accounted for by the fact that among physicians who moved from one country to the other for strictly personal reasons, current US physicians rated Canada slightly better while Canadian physicians strongly favored Canada. Although both US and Canadian physicians were reasonably and equally satisfied with their current practices, a compilation of solicited comments from the current survey offers some potential clues to explain the results summarized in Figure 1.

Three issues were most often raised in the respondents' comments: access to care, administrative responsibilities, and medical malpractice. These issues were consistent with previously acknowledged strong points within the Canadian system.<sup>2,3</sup> The need for better access to care in the United States, a widely discussed issue in the current literature,<sup>18,19</sup> was by far the most common concern expressed. It appeared that once physicians had experienced the positive effects of universal access (in Canada), it was difficult to accept their absence (in the United States). Universal access was seen as a major benefit not only to the patient but to the practitioner, who no longer needed to worry about the patient's ability to pay in determining a course of action.

The inefficient paperwork jungle common to US health care<sup>20,21</sup> was contrasted with the simplified administrative tasks of the Canadian system. Although the comments indicated that administrative requirements were increasing in Canada, Canada's provincially run, single-payer system remained extraordinarily simple compared with the US system. Although respondents were often concerned with the administrative overload in the United States, there was essentially no call for a single-payer system. Rather, the overall sentiment was in favor of maintaining a public-private insurance structure but with sufficient changes to decrease the administrative burden.

Medical malpractice was seen as a serious issue in both countries. The number of lawsuits has increased in both Canada and the United States. Canadian physicians expressed concern with the trend. Yet for dual-experience physicians the problems with medical malpractice in Canada paled in comparison with those in the United States. Even today, "Canadian physicians are only one fifth as likely to be sued for malpractice as their American counterparts."<sup>22</sup>

Nevertheless, it should be emphasized that physicians who left Canada were clearly more satisfied with their practices in the United States than in Canada. Their responses should not be construed as a call for the "Canadianization" of the US health care system. Rather, the message was that the United States should seek to learn from the successes of others. Instead of being the experimenter, the US system can take what has worked elsewhere and combine it with its own many strengths. Examples of how this might be done may come from Canada, from other countries,<sup>23-25</sup> or from within our own country.<sup>26,27</sup>

The weak rating of the US system by US dual-experience physicians can reasonably be interpreted as a call for a more careful analysis and probable reform of at least certain aspects of the US system, including issues of access, administrative burdens, and malpractice costs. The data gathered in this study, especially considering the generally conservative nature of physicians as a group, emphasize the need for change in the way health care is provided in the United States. □

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## **Talking Point 10**

Medical malpractice systems can be harnessed to ensure better quality in single-payer systems. The cost and quantity of medical malpractice suits are decreasing.



## Medical Malpractice, Health Care Quality And Health Care Reform

*The discussion below is based on a presentation by Gordon Schiff, MD on May 20, 2003*

*Notes and reflections by Oliver Fein, MD, Chair, NY Metro Chapter, PNHP*

A crisis in medical malpractice is much in the news these days. The premiums that physicians pay for their malpractice insurance have been escalating in many parts of the country. **What are the causes of this crisis, and how does it relate to health care reform?**

The most important goals of a medical malpractice system are (1) to reduce preventable medical injury; and (2) to provide fair and timely compensation to injured persons. But several studies (Brennan TA, *N Engl J Med* 1991; 324:370) show:

- 98% of patients who have been negligently harmed receive no compensation.
- 83% of physicians who are sued for malpractice have not acted negligently.

Conclusion: Our present malpractice system is not working, either for patients or physicians.

**There is no consensus on the cause of the malpractice crisis or its cure:** The AMA feels the causes are: (1) increased frivolous law suits, (2) excessively high monetary settlements and jury awards, (3) greedy trial lawyers, and (4) irrationally angry patients. The AMA's solution is to cap the non-economic component of awards, given for pain and suffering, at \$250,000.

Limits on awards are not the solution. Numerous studies show that excessive awards are not the cause of the problem:

- Only two states with caps have experienced flat or declining premiums; 19 states that have implemented these limits have seen premium increases from 1991 to 2002 averaging 48.2%; 32 states without caps saw premium increases of only 35.9% over the same period (Weiss Ratings, Inc. in *Crain's Health Pulse*, June 9, 2003).

- In New Jersey, where doctors and insurers have been vociferous in blaming rising malpractice premiums on skyrocketing payouts, data on settlements, awards, and other payout for 2001-2003

shows that "the total payout declined [by 24%] even as doctors saw steep increases in their malpractice premiums." (Newark Star-Ledger, June 9, 2004)

- In Texas, where caps on non-economic damages have just been passed, one of the nation's largest medical-malpractice insurance companies told regulators they would save only 1% in total payouts. (Wall Street Journal, October 28, 2004)

- New York has more malpractice awards than any other state, but the number of such awards has remained about the same during the last decade, both in New York and nationwide. The data shows steady increases in the size of malpractice awards over this period, but these rose no faster than the overall cost of medical care. (Perez-Pena R, *NY Times*, May 21, 2003)

A more comprehensive approach is necessary. It should recognize that (1) malpractice premiums are rising because insurance companies lost investment income in the recession, not because of extravagant awards; (2) increased use of technology in medicine contributes to the higher incidence of adverse events; and (3) negligence may reflect system failures as a result of the way medical care is organized and paid for. As an example, for-profit HMOs force doctors to see more patients per hour and provide them with financial incentives to withhold care, contributing to growing distrust in the doctor-patient relationship.

Some facts are not disputed:

- The cost of malpractice premiums is less than 1% of total national health expenditures. In 2000, the average premium was \$18,400 per doctor per year, but this varies by state and specialty — some

(over)

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obstetricians and neurosurgeons pay over \$100,000/year. (AMA, *Trends in the Physician Market*, 2003)

- The total cost of “defensive medicine,” i.e., unnecessary care provided solely to look good in case of a malpractice claim, is about 2% of national health expenditures. (Bodenheimer TS, Grumbach K, *Understanding Health Policy*, Lange Medical Books, 2002)

**PNHP has not adopted a formal position on malpractice reform.** However, we must not advocate taking away patients’ legal rights, particularly when these are perceived as the only way to hold doctors, hospitals, HMOs, and other providers accountable for medical errors and negligence. We must focus our fight on equitable access to quality health care for all — that is, on a single payer national health insurance (NHI) program, recognizing that such a program promises to significantly reduce the malpractice problem:

1) Single payer NHI will reduce malpractice costs, because the costs of any medical care needed as a result of an injury will be covered within the NHI system.

2) Single payer NHI will foster a single data system, which has the potential to improve patient safety by enabling the disclosure and tracking of systems problems and thereby reducing medical errors.

3) Single payer NHI will eliminate financial barriers to access as well as any incentives for providers to avoid seeing complicated and sick patients or to withhold care. This will lead to increased trust between doctor and patient.

4) Options other than caps on non-economic damages must be explored including: (a) use of practice guidelines to help reduce negligence; (b) alternative dispute resolution mechanisms such

as mediation and arbitration; (c) no-fault reform, providing compensation to patients whether or not the injury is due to negligence; (d) enterprise liability making institutions such as hospitals, large group practices, and HMOs responsible for compensating medical injuries, thereby creating incentives for

institutions to improve the quality of care offered in their institution.

PNHP’S VISION	MARKETPLACE MEDICINE
Fair — all contribute/all benefit	Rationed by ability to pay
Generous	Mean spirited/arbitrary
Frugal	Wasteful
Inclusive	Exclusionary
<i>especially the sick</i>	<i>avoid the sick</i>
Choice/autonomy	Restrictions
Access	Barriers
Trust	Rules
Accountability	Unregulated
Commitment	Flexibility
Longer time horizons	Short-term profitability
Public/open/sharing	Trade secrets
Academic/Professional values	Commercial (near criminal) values

Chart by Gordon Schiff, MD

There are, then, two contrasting approaches to the health care system, and these lead to very different views of and approaches to the malpractice problem:

While each of these dichotomized one-word sound-bite-concepts simplifies complex issues and debates, analysts of the U.S. health system and advocates for reform are converging in a critique of those people and ideas on the right. Malpractice — both poor care and a climate generating lawsuits — is only exacerbated by market approaches to the provision of care, and they can only be fundamentally addressed by non-market professional values and approaches.

## Conclusions:

1. **The medical malpractice crisis is real:** High premiums are driving doctors to retire early, move to states with lower premiums, and limit procedures they perform. This limits patients’ access to health care.

2. **The solution must be comprehensive reform, not caps on non-economic damages.** PNHP supports increasing patients’ access to health care rather than taking away patients’ legal rights.

3. **Single payer NHI will go a long way toward solving the malpractice crisis** by removing the cost of medical care from malpractice settlements, enhancing “systems approaches” to improving patient safety, and improving trust between doctor and patient.

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# Mythbusters

A series of essays giving the research evidence  
behind Canadian healthcare debates

Busted June 2004

Revised and Updated March 2006

## Myth: Medical malpractice lawsuits plague Canada

The growing threat of a lawsuit is a handy explanation for a range of physician behaviours, including defensive medicine through excessive test ordering and avoiding certain areas of practice, types of patients, or forms of collaboration.

Healthcare professionals and the public perceive that malpractice claims in Canada are increasing dramatically. Their perception is that doctors are making more mistakes and/or that citizens are much more likely to sue than they were in the past. Ironically, this perception may be in part due to a new culture of openness and patient safety in healthcare — hospitals now go public about systemic errors, such as in 2004 when two Calgary patients died after being given potassium chloride rather than sodium chloride.<sup>i</sup>

When the Canadian Health Services Research Foundation first looked at the data in 2004, we saw that malpractice claims against doctors had actually been dropping steadily for some time. A new look at the data confirms that doctors are in fact *much* less likely to get sued than in the past.

### The tale of the tape

In Canada, most doctors receive malpractice protection from the Canadian Medical Protective Association, which tracks the number of legal actions launched and the amounts paid out to successful cases. The numbers are startling.

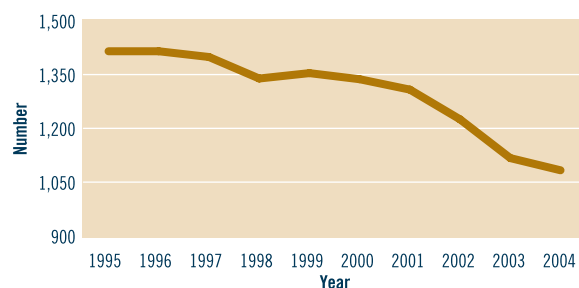
In the 1990s, the association found an increase in the number of malpractice lawsuits, peaking in 1996 when 1,415 lawsuits were filed, leading both doctors and lawyers to sound the alarm. However, the numbers have dropped steadily since 1996, to 1,083 in 2004, a 23-percent decrease.<sup>ii</sup> Moreover, an increasing proportion of lawsuits that go to trial have judgments in favour of doctors — 82 percent in 2004, up from 73 percent in 1994.<sup>ii</sup>



It's also worth noting that patients are making fewer complaints about doctors to regulatory bodies. In the province of Saskatchewan for example, the College of Physicians and Surgeons received 150 formal complaints in 2004, compared to a high of 207 in 2000, even though the number of physicians in the province remained steady.<sup>iii, iv, v</sup> Part of this shift can be attributed to the college's increasing use of alternative, informal interventions that address patient concerns more quickly than the formal system.<sup>v</sup>

People might think the number of lawsuits is going up because the amounts awarded in court decisions and settlements continue to increase. In 1995, the protective association paid an average of \$181,281 per case for lawsuits that were successful or were

Number of lawsuits filed in Canada



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settled out of court. Payments peaked in 2001, when the average was \$371,300 (mostly due to a single large class-action suit). For 2004, the last year for which data are available, the association paid an average \$300,692 per case — a 66-percent increase over 1995.<sup>ii</sup>

### The international experience

The United States is the country most often thought of as the “land of litigation.” Even there, though, the numbers aren’t skyrocketing as much as people think. The National Practitioner Data Bank reports that from 1992 to 2004, the number of successful malpractice suits against physicians went from 14,826 to 14,396 — a three-percent decrease. As in Canada, however, the average amounts paid out have increased, from \$214,332 in 1997 to \$298,460 in 2004 — a 39-percent increase.<sup>vi</sup>

### Paying the price

While the number of lawsuits against Canadian doctors is not increasing, the cost of malpractice protection is growing with the size of settlements. The Canadian Medical Protective Association’s fees for 2006 range from \$564 a year for missionary, charitable, teaching, and research work abroad to \$78,120 for obstetricians working in Ontario.<sup>vii</sup> (The association charges its fees based on both type and location of practice, with Ontario doctors generally paying the highest fees, Quebec doctors the lowest.) This represents an increase of about 12 percent over the last three and four years, respectively. However, in many provinces doctors are substantially insulated from these increases, as they are partially covered by government in their collective agreements.<sup>viii-xi</sup>

American trends are harder to track, because of the large number of private insurers offering malpractice protection there. However, fee hikes have been noted, particularly in the states of New York, Texas, and Florida, which saw fees increase 30 to 50 percent from 2001 to 2002. Many high-risk specialists like obstetricians and neurosurgeons now pay annual fees of more than \$100,000US, which is leading some of these doctors to leave their practices.<sup>xii</sup>

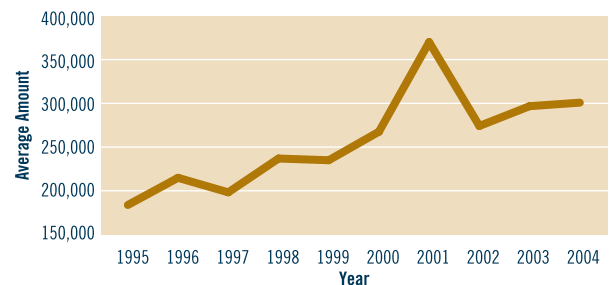
People probably believe lawsuits are on the rise because of isolated media reports about high-profile, high-cost cases. And while the data show the number of claims is a shrinking problem, even one multi-million dollar case could be enough to skew not only our perception of the problem, but the dollar figures as well.

Mythbusters are prepared by knowledge transfer and exchange staff at the Canadian Health Services Research Foundation and published only after review by researcher experts on the topic.  
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Average payments by CMPA\*



\* While the average amount awarded in 2001 is the largest ever, it was strongly affected by a single class-action lawsuit. This class-action suit accounted for 86 percent of the increase over 2000. The average is found by dividing the total amount paid by the CMPA by the number of lawsuits that were successful for the patient plus the number of cases settled out of court. Canadian Medical Protective Association 2002 Annual Report.

# The Swedish Patient Compensation System:

## A viable alternative to the U.S. tort system?

by

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and

Li Westerlund, JD, Stockholm, Sweden

A no-fault compensation system is a possible alternative to our current tort-based professional liability system. This concept has been under discussion in the U.S. for a number of years, and it has a certain appeal. While most physicians would be happy to see our present lottery system replaced, there always has been a concern that a no-fault system would result in a rapid escalation in the number of cases brought and, as a result, in overall costs.

To understand how such a system might work we might look to Sweden. The Michigan State Medical Society did just that in 1989, when it organized a trip to Sweden. Joining the medical society were representatives of the Michigan Hospital Association, the two Michigan physician-owned insurance companies, the trial lawyers association, and the Michigan legislature. The trip was led by Marilyn M. Rosenthal, professor of sociology at the University of Michigan, Dearborn, and author of *Dealing with Medical Malpractice: The British and Swedish Experience*.<sup>\*</sup> There, the delegation studied the earlier Swedish Patient Insurance Fund, the Medical Responsibility Board ("MRB") and the Swedish health care system.

Embedded within the Swedish social system, the earlier Patient Insurance Fund was the no-fault alternative to the tort system until 1996, when the Patient Torts Act (PTA) replaced it. In reality, however, the PTA also is a no-fault system, even though

<sup>\*</sup>Durham, NC: Duke University Press, 1988.

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it does require all medical and health providers to obtain liability insurance. The question we pose in this article is whether a similar no-fault system for compensating injured patients could be adapted to meet the needs of patients in the U.S. The answer will depend on whether we in the U.S. can replicate the elements of the Swedish social and legal system that underpin the success of this alternative.

### **The Swedish insurance system**

Sweden's earlier Patient Insurance Fund operated in the context of a public health care system that is part of an extensive welfare state. Sweden guarantees full employment, extensive entitlement programs, and legislated social programs. The state funds all hospitals, and all but 5 percent of the physicians are employees of the state. Financial responsibility for health care services is distributed among the national government, 23 county councils, and three large municipalities. The municipalities take primary responsibility for social welfare services. Health care accounts for more than two-thirds of each county's budget. County councils operate hospitals and outpatient services.

Other social insurance systems also compensate certain medical injuries. These include public insurance, workers' compensation, collective agreement sick-leave insurance, security insurance, no-fault traffic insurance, no-fault medical drug insurance, the General Torts Act, and compensation for victims of crime.

### **First no-fault system**

Sweden first introduced the country's no-fault Patient Insurance System in 1975. Within this system, a Patient Insurance Fund was established, funded by county tax revenue and by organizations representing private practice doctors, dentists, and physiotherapists. A consortium of private Swedish insurance companies administered the system. Three years later, a similar insurance system was introduced for injuries caused by, or clearly related to, pharmaceuticals.

The Patient Insurance System did not require a showing of fault or malpractice in order to compensate a claim against a health care practitioner. The Medical Responsibility Board processed com-

plaints alleging physician incompetence. This function was and still is entirely separate from the system that compensates patients for injuries. In 1997, it became a legal obligation for every health care authority to provide compensation for injuries sustained in the course of clinical procedures, regardless of fault.

In a 1983 study of the Patient Insurance System, Carl Oldertz, vice-president of Skandia, showed that 60 percent of the injuries were considered eligible for compensation. Of these, about 75 percent of the claims involved procedures. Mr. Oldertz said, "Our philosophy is compensation should be paid if it's possible to have avoided a particular medical injury. And that fault is an irrelevant factor."

The Patient Insurance Fund provided compensation according to a predetermined schedule, adjusted by percentage of full or partial disability and by expected duration. It covered most injuries due to diagnostic errors, new or unproved methods of treatment or their complications, hazardous interventions performed in order to avoid a threat to life or permanent disability, injuries that could have been avoided by choosing a different treatment, and most mistakes in diagnosis.

Exclusions included minor injuries requiring 30 days of sick leave from work and a minimum of 10 days in the hospital, cases of psychological or "unavoidable" injury, or "accidental" injury. It only covered infections in clean cases, excluding infection of the respiratory or gastrointestinal tract. If an expert medical advisor held that "accepted" medical treatment was used, the injury was not compensated. Injuries due to pharmaceuticals were covered through a separate program. Fault, except in rare instances, was not a necessary factor.

Loss of income was paid when the child's future opportunities could be assessed. Pain and suffering were paid with strict limitations. Economic damages were paid in a structured settlement. The statute of limitations was three years, with the equivalent of the collateral source rule, taking into account other types of insurance payments. In the case of a death no payments were made for non-economic damages. Experienced claims adjusters used objective criteria to determine awards.

The only lawyers involved in the procedures under the Patient Insurance System were the insur-



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ance company staff or individuals who assisted patients in writing out claims. The system had an 18 percent overhead, and the whole award went to the patient. Compensation was 100 percent for economic losses, with noneconomic losses paid according to a fee schedule. Noneconomic losses accounted for two-thirds of the payments. The average claim was settled within two months and most of the rest in less than six months, although some took up to two years.

Appeals went to a government-appointed claims panel with six permanent members, including one medical expert from the government. These appeals were free of charge. Approximately 20 cases could be heard in a month. The panel reversed about 10 percent of the cases.

Arbitration was available but rarely used. The chair of the arbitration panel was a governmental appointee, usually a judge, and medical experts advised the panel. In 1989, only a handful of cases had been taken to court. In general, these were in cases where the Patient Insurance Fund had excluded payment, and the lawyers argued that the case should be covered. A series of cost-cutting maneuvers had reduced the schedule of awards, strengthening those arguments.

The American trial lawyers with us who looked at this system predicted that Swedish lawyers would soon bring more of these cases to court, but the Swedes explained that American trial lawyers should recognize that the mentality of U.S. and Swedish lawyers are poles apart. Swedes generally do not believe in "a right" to economic compensation for all imperfections or defects, and Swedish case law provides very low damage awards. Indeed, the lawyers who had brought cases to court found the damage awards under the general Torts Act to be lower than the fixed benefit schedule the Patient Insurance Fund used.

Feedback from the Patient Insurance System was returned to hospitals, physicians, and the chief of the hospital clinical service. The physician could not be fired for this reason alone, but he or she could be either reassigned or sent for additional training. All case reports went to a risk management/quality assurance database. Complaints of physician fault or malpractice also could, and still can, be filed with the Medical Responsibility Board.

## Medical Responsibility Board

The Medical Responsibility Board (MRB) is a government agency resembling a court. A patient, close relative, or legal representative may claim malpractice or allege that medical practitioners have acted incorrectly. The remedies include disciplinary warning, admonition, or removal of the practitioner from the health register.

Medical practitioners are thus held responsible for their actions in a process that is separate from the system for compensating injured patients.

Although the number of complaints filed annually has varied, it has been fairly consistent. In 1994, 2,417 complaints were filed, and this number grew slowly to 3,250 in 2001. In 1994, the board judged 2,053 cases, increasing to 3,132 cases in 2001. Thus, the board clears its dockets fairly efficiently, avoiding undue procedural delay.

The MRB decides all matters associated with disciplinary sanctions. This body consists of a chair and eight government-appointed members. In 1989, they included members of parliament, representatives from each of the three large health occupation unions, and a representative from the Federation of City Councils. The chairman must be a lawyer and should have experience as a practicing judge. In certain situations, the chair may decide cases independently of the panel.

In 1994, the chairman independently judged 684 cases, and the panel judged 902. This ratio has gradually reversed, until 2001, when the chair independently judged 1,733 cases and the panel 723 cases.

Patients, health care professionals, hospitals, a parliamentary entity, or the National Board of Health and Welfare may submit complaints in writing, using forms that are widely available in all hospitals. If a plaintiff cannot file a complaint personally, a proxy may do so. Administrative staff reviews all submitted complaints, screening out 30 to 40 percent as frivolous.

The MRB assigns investigation of the complaint to a physician in the same discipline. The physician considers written testimony from the named physician, the complaining patient, and other interested parties, as well as the hospital records. A staff lawyer writes up the physician's summary, and the physician presents it to the MRB.

The opinions and recommendations of this physi-

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cian are granted considerable weight in the MRB's discussion, but the MRB's ruling typically is unanimous. The MRB's nonphysician majority gives the public confidence that physicians are not covering up for each other, and the physician experts give the panel credibility and validity. The MRB normally accords these physicians great deference.

The proceedings are conducted in writing, though portions may be verbal. The MRB thoroughly examines the factual findings of all complaints, considering all relevant records and associated documents. The practitioner under investigation must respond within a set time limit, indicating whether he or she accepts or rejects the allegations, and giving the basis for this position.

The appropriate city or district administrative court does have subject matter jurisdiction to order a hearing or issue an injunction.

Disciplinary sanctions may be imposed on health and medical practitioners who, intentionally or negligently, fail to discharge their duties or other obligations in accordance with Swedish law. The 1994 Health and Medical Personal (Duties) Act (replaced in 1999 by a new law with essentially the same content on this subject) is the controlling law. A complaint must be filed within five years of the alleged offense.

MRB sanctions may include warnings, admonitions, restriction of prescribing authority, or withdrawal of licensure, which latter must be requested by the National Board of Health and Welfare. Warnings are issued in some 20 percent of the cases. These admonishments are taken extremely seriously. The Michigan delegation was told that one admonished physician committed suicide.

Investigations usually last 18 months, but for license revocations they usually are completed in five to six months. The MRB usually issues a sanction for substance abuse or for mental incapacity, less often for professional incompetence. The MRB has complained of inadequate funding and insufficient staff.

The total number of warnings or admonitions varies. In 1994, the MRB warned 150 practitioners and admonished 112 practitioners. This rose to 226 warnings and 184 admonitions in 1996. In 2001, the MRB warned 120 practitioners and admonished 157.

A license to practice medicine may be revoked for incompetence, when a practitioner is shown to

be clearly unfit to continue in practice, or because of illness. A practitioner may receive an injunction requiring a medical examination. A license to practice may be temporarily withdrawn pending the final outcome of the examination or if the practitioner has failed to comply with the injunction within one year. In the European Union, revocation of a license to practice in any other member state also bars that person from practicing in Sweden.

License revocations are uncommon for doctors, dentists, or nurses, and only a few have been issued for other health care personnel. In 1994, of 48 filed complaints, the MRB revoked 20 licenses from seven doctors, two dentists, and 11 nurses. Number of complaints filed increased to 80 in 1998, with the MRB revoking 26 licenses from 16 physicians, one dentist, seven nurses, and two other personnel. In 2002, of 60 filed complaints, the MRB revoked 19 licenses from six physicians, one dentist, and 12 nurses.

Final decisions of the Medical Responsibility Board may be appealed to an administrative court within three weeks. In addition to the plaintiff and defendant, the National Board of Health and Welfare may appeal. The parliamentary ombudsman and the Chancellor of Justice may also appeal certain decisions. All parties are entitled to legal counsel. Few judgments have been appealed to the administrative court since July 1995, averaging 23 to 29 per year.

## Patient Torts Act

The 1996 Patient Torts Act requires that patients take their liability claims to court and that health care providers carry liability insurance. Whether the bill was passed because of perceived deficiencies in the previous Swedish Compensation Fund or primarily in response to pressure from the European Convention on Human Rights is a matter of conjecture. We do know that Article 6 of the Convention states, "In the determination of his civil rights and obligations...everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law." We also know that Sweden's governmental and quasi-governmental administrative systems have been criticized in Europe on this basis.



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The PTA compensates injuries caused by health care practitioners, including conditions that are the result of the diagnosis and treatment of disease, medical research, organ or tissue donations, transportation of patients, and dental care.

The burden of proof is lower than it is under the general Torts Act in Sweden. The plaintiff must show "by a reasonable certainty" that the health care practitioner's conduct caused the alleged injury. There is no need to prove proximate cause; that is to say, that the injury was within the scope of foreseeable risk.

Under the PTA, the "but for" test may be used, meaning that the injury would not have occurred "but for" the physician's act or omission. Also, the defendant's conduct is considered the cause if it was a "substantial factor" in causing the injury.

Claims under the PTA may involve procedures, medical devices, diagnoses, infections, accidents, and pharmaceuticals. Compensation is paid if a different procedure or method could have prevented the injury or if the injury resulted from defective devices or products or from their incorrect use. Injuries are compensated if they result from transmission of infection, from accidents in the course of diagnosis or treatment, or from pharmaceuticals prescribed or given contrary to directions. The standard of care is that of a skilled specialist or any other skilled professional within the field.

Compensation is not offered for injuries that are unavoidable, for injuries resulting from a procedure that is necessary to diagnose or treat a disease, for life-threatening injuries, or for treatments without which there would be severe disability. This includes emergency care. If the only available treatment was provided, an injury is not compensated. Under the PTA, a claim must be filed within three years from the time that the patient recognized the injury and within 10 years from the time of injury.

Calculation of medical expenses, other expenses, loss of income, funeral costs, loss of services, and damages for pain and suffering usually are the same under the PTA as under the general Torts Act. Because the public health care system funds the hospitals and employs most physicians, actual medical expenses tend to be low.

The PTA compensates only necessary expenses, not so-called comfort expenses. There is compensation for loss of future income when an injury leads

to permanent harm. The general Torts Act provides the following criteria for these calculations: type of work, previous education and occupation, retraining requirements, age, and residence.

Compensation for acute and permanent pain and suffering take into account the length of hospitalization or sick leave, and it is generally very low in Sweden. The courts usually rely on the Traffic Injury National Board tables as a template for these calculations.

Under the PTA, approximately \$180 is deducted from patient compensation. A cap on patient compensation for economic and noneconomic damages is set at an amount that presently is about \$730,000. If several patients are injured through the same conduct, the total amount paid is capped at about \$3.6 million. If this amount does not fully compensate patients for their respective injuries, payment for each individual is reduced.

When negligence can be proven, a plaintiff may file under the general Torts Act, thus avoiding the PTA deductible and the cap on compensation. The burden of proof in the no-fault PTA system requires "reasonable certainty," a lower burden of proof of causation in comparison with the general Torts Act, which requires "probable cause."

Damage awards under the general Torts Law generally would not exceed those under the PTA. Courts usually are very unwilling to award high noneconomic damages to any plaintiffs. In criminal law, for example, awards to victims of serious crimes are very low in comparison to those in the U.S. This appears to be a cultural difference, rather than a legal difference.

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## Applicability to the U.S.

To evaluate whether the U.S. should change to a no-fault patient compensation system, we need to consider whether the key elements of the Swedish system could be applied under the current U.S. health care system. The questions are whether the U.S. public would accept restrictions on the types of events that are compensated, and whether they would accept a limited compensation schedule. In Sweden, these two points explain why the number of cases and overall costs remain under control.

In legal terms, the obstacle is that compensation in Swedish medical liability cases is determined in the same way as it is in all other types of cases under Sweden's general tort law, and all these awards are low. In the U.S., awards in all types of tort cases are much higher, and this has caused the American public to expect correspondingly high levels of compensation for medical liability cases.

We also need to recognize major cultural differences between the Swedish legal system and the American system. Sweden does not have jury trials. At the district court level, a judge and three laymen decide the case, and they all have an equal vote. The crucial difference in comparison to the U.S. is that Swedish case law allows judges and laymen to decide on patient compensation, including noneconomic damages, in accord with strict guidelines. Again, this is a cultural difference. Case law has been able to develop in this way because the public is satisfied with these lower levels of patient compensation and noneconomic damages. The Swedish public does not believe that any plaintiff would have the right to \$20 million in damages for any injury. The PTA cap of approximately \$730,000 sounds high enough to them. Of course, because Sweden's social system subsidizes many of the plaintiff's costs, their lower awards reflect in part a lower need.

Although the Swedish system of socialized medicine is markedly different from our U.S. system, these differences may be less relevant to this discussion than are the differences in legal environment. Medicine is virtually free of cost within the public system in Sweden, but there is a small private system that provides a significant amount of care in some fields. In contrast, although we have

a primarily private system, we too have a large public system. Medicaid now covers 47 million Americans, and Medicare is not far behind.

To build a case for change to a no-fault system, we would have to answer the trial lawyers' charge that the tort system protects the public from "bad doctors." In Sweden, the system is clearly bifurcated, and patient compensation is entirely separate from disciplinary actions against doctors who perform poorly or are unqualified. If we were to have a no-fault compensation system in the U.S., the public would likely demand something like the Swedish Medical Responsibility Board, to feel that their interests were being protected. Although we do have boards of medicine in each state, these bodies have come under attack, and they have not maintained the credibility with the public that the Medical Responsibility Board has in Sweden. We would need to carefully study this trade-off.

In summary, the Swedish system is ideally suited to Sweden. Any attempt to adopt it, in whole or in part, in the U.S. would encounter a number of problems. The trial lawyers would oppose it, and the political climate would be problematic. If awards were to be markedly higher here than they are in Sweden, overall costs might be too high, and we would have to figure out who should bear these costs. These questions demand rigorous legal and economic analysis. □

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Section II: The Evidence-Based Case for Single-Payer National Health Insurance

## **Talking Point 11**

It is a myth that doctors practicing under national health insurance are compensated significantly worse than their American colleagues.





## How does national health insurance affect physicians' income?

**Myth: Doctors are poorly paid in single-payer systems.**

**Fact:** While some international comparisons of raw physician incomes portray U.S. physicians as staggeringly better off, a more careful analysis reveals otherwise. When compared to average national wages, American doctors don't fare significantly better than their colleagues in countries with single payer systems, such as Canada and the United Kingdom.

American general practitioners (GPs) earn 3.4 times the average U.S. wage, while Canadian and Icelandic GPs earn 3.2 to 3.5 times their national averages.

If you're a specialist seeking high pay, you're better off in The Netherlands: Dutch specialists make 7.5 times the average national wage, versus 5.5 in for American specialists.

American physician pay isn't keeping up with inflation, either. While average U.S. inflation-adjusted wages increased between 1995 and 2004, physician income *decreased*. In contrast, doctors in Canada and the Britain received pay increases similar to or exceeding average wages. Thanks to a new contract in 2004, British GPs gained a 23 percent salary boost.

Additional factors for medical practices: in single payer systems such as Canada's, administrative costs in physician offices and malpractice premiums are much lower, freeing up money for patient care and physician reimbursement.

**Myth: Doctors in countries with national health insurance work more.**

**Fact:** Doctors in countries with national health insurance work comparable (or fewer) hours to doctors in the U.S. In an average of seven OECD nations, GPs worked 49.9 hours per week and specialists work 51.6 hours per week. In the U.S., GPs worked 51.4 hours and specialists 54.3 hours.

**Myth: Canadian doctors are flocking to the United States.**

**Fact:** Since 2004 Canada has received a net gain of physicians due to migration: between 2004 and 2006, 177 more doctors moved to Canada than left.

Between 2002 and 2006, the total number of physicians in Canada increased 5 percent, slightly more than population growth over the same period.

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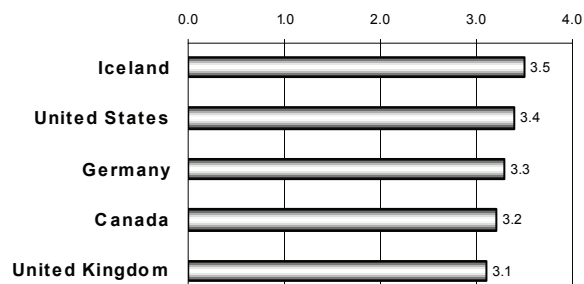
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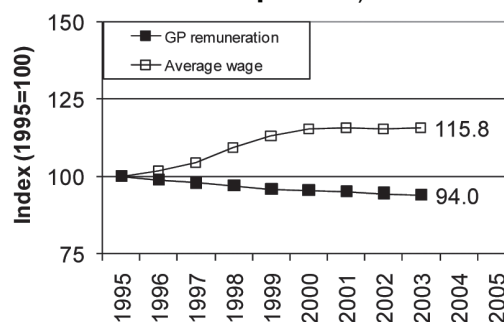
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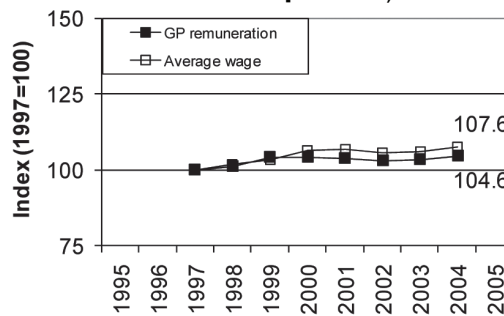
**GP Compensation as Ratio to Average Wage**



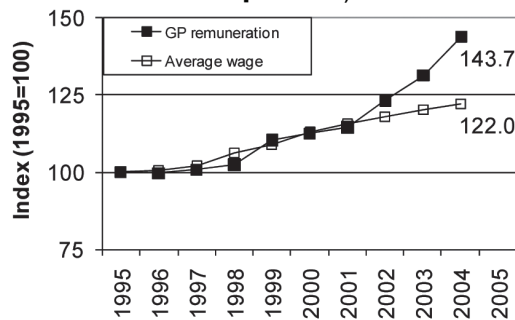
**U.S. GP Compensation, 1995-2004**



**Canadian GP Compensation, 1997-2004**



**U.K. GP Compensation, 1995-2004**



# The Impact of Single-Payer Health Care on Physician Income in Canada, 1850–2005

Jacalyn Duffin, MD, PhD

This study traces the average net income of Canadian physicians over 150 years to determine the impact of medicare. It also compares medical income in Canada to that in the United States. Sources include academic studies, government reports, Census data, taxation statistics, and surveys. The results show that Canadian doctors enjoyed a windfall in earnings during the early years of medicare and that, after a period of adjustment, medicare enhanced physician income. Except during the windfall boom, Canadian physicians have earned less than their American counterparts. Until at least 2005, however, the medical profession was the top-earning trade in Canada relative to all other professions. (*Am J Public Health*. 2011;101:1198–1208. doi:10.2105/AJPH.2010.300093)

## AS THE UNITED STATES STRUGGLES WITH HEALTH REFORM,

Canadians observe with a mix of fascination and horror as the lies about their health care system swirl in the US media. The discussion was particularly intense in the months leading up to passage of the Patient Protection and Affordable Care Act on March 23, 2010.<sup>1,2</sup> Many of these myths have been exposed. Canadians do have free choice and good access; public administration does not add to cost, rigidity, or complexity of services, nor does it exclude private-sector involvement.<sup>3</sup> The majority of Canadians who receive health care in the United States did not seek it deliberately; rather, they fell ill while traveling. Furthermore, their out-of-country costs are covered by the Canadian system.<sup>4</sup> Nevertheless, the supposed faults and flaws of the Canadian system are used in US political arguments about the merits and demerits of a single-payer system.

Among the persistent myths is one about physician income and freedoms. Increasingly, US doctors are committed to the concept of coverage for all citizens.<sup>5</sup> But some are concerned about what might be at stake for them personally. Others who oppose the changes worry about their incomes and their freedom as professionals should the president succeed with “Canadian-style,” “government-run,” single-payer health care. In speaking to the media immediately after President Obama’s speech to the Joint Session of Congress in September 2009, physician–Congressman Charles Boustany of Louisiana characterized the proposals as having the potential to destroy jobs, explode the deficit, ration care, and take away “the freedom American families cherish.”<sup>6</sup> Even proponents of health care reform think that medical income will decline.<sup>7</sup> Indeed, evidence for better Canadian health care delivery to marginalized groups has been related to the lower fees commanded by physician services in that country. This argument relies on the idea that lower fees mean that relatively fewer tax dollars go to medical practitioners and more to services for health promotion and disease prevention.<sup>8</sup> But fees are only tangentially indicative

of earnings. For instance, Canadian physicians have lower practice expenses for a variety of reasons, including the lesser costs of billing, administration, and malpractice coverage. For both policymakers and historians, reliable information on physician net income (after expenses, before taxes) in both Canada and the United States is difficult to find. Impressionistic evidence documents disparities in earnings that typify both nations—disparities between family doctors and specialists, women and men, rural and urban practices. But it is generally acknowledged that “detailed and accurate comparative physician income studies are lacking.”<sup>9</sup>

This article addresses that information gap by tracing the long view of the average Canadian physician’s net income—after expenses and before taxes—in three distinct periods: before, during, and after the advent of Canadian medicare. Sources include the Canada Census, government statistics, academic surveys, and special reports that were prepared during the advent of the current Canadian system. It will show that Canadian physicians are well paid and that medicare did not diminish their earnings. Rather medicare resulted in an initial, brief windfall of high earnings, even when compared with US data. The windfall was followed by a period of readjustment. Subsequently, Canadian medicare has maintained physicians as the top-earning professional group in that country.

## A CAPSULE HISTORY OF MEDICARE IN CANADA

Taxpayer-funded medicare in Canada did not appear at a single point in time: it emerged over a quarter century from 1962, when physician services were covered

across Saskatchewan, to 1987, when the demise of optional “full billing” in Ontario began. It continues to evolve in addressing new technologies and changing needs. More information about this history, with images, timelines, and links to reports and legislation can be found at the government Web site for Health Canada, the CBC Digital Archives, and the new Online Exhibition of the Canadian Museum of Civilization.<sup>10</sup>

## Saskatchewan Came First, 1944–1962

Canadian medicare did not begin on a fixed date; nor was it a project of a single political party.<sup>11</sup> The first experiment began in a single province with the Saskatchewan election of June 1944. As the Second World War dragged on, many jurisdictions in Canada had begun planning for social programs to avoid another postwar economic depression. The leader of Saskatchewan’s left-leaning Cooperative Commonwealth Federation party was Tommy C. Douglas, a Baptist preacher and a gifted orator. In his youth, Douglas suffered from severe osteomyelitis; the gratis services of a kind surgeon led to his recovery. Douglas said that “no boy should have to depend either for his leg or his life upon the ability of his parents to raise enough money to bring a first-class surgeon to his bedside.”<sup>12</sup>

In 1944, Douglas and his team campaigned on a platform that promised free access to health care for all citizens. Their sweeping electoral victory made Douglas premier of what was frequently called “the first socialist government in North America.” He immediately ordered a survey on health care needs, and he invited Henry E. Sigerist, the eminent, Swiss-born physician

and historian of medicine from Johns Hopkins University, to chair the health care reform. Sigerist’s survey found that Saskatchewan needed exactly what Douglas had promised: government-funded hospital, medical, nursing, and physiotherapy care; physicians on salary; more clinical facilities; and a medical school.<sup>13</sup>

Hospital coverage was implemented throughout the province in 1947. A pilot project for medical care was launched in the town of Swift Current, and lengthy negotiations began with the provincial medical profession. Immensely popular, Douglas went on to win four straight elections. Eventually his team made concessions to the wary physicians, the most significant of which was fee-for-service payment for medical services rather than the proposed salary. Legislation for province-wide medical coverage was finally passed in 1962. A bitter, three-week doctors’ strike followed this new law, but the doctors lost.<sup>14</sup> Within a year and despite their initial opposition, Saskatchewan doctors were earning more than they had in the past. One reason was that all their bills were paid and paid in full.

## The Rest of Canada Came Next

While Douglas worked toward medical coverage in the 1940s and 1950s, public hospital insurance was becoming the norm in many other provinces. In 1950, 50% of Canadians had some form of private or nonprofit insurance for hospital care. A mere six years later, 99% of the population in all 10 provinces enjoyed government plans for hospital care. The following year, federal legislation, called the Hospital Insurance and Diagnostic Services Act (1957),<sup>15</sup> promised

that half the costs of hospital care would be covered by the federal government. Since that time, transfers of funding from the federal government to the provinces, where the programs are administered, has provided more (or less) national leverage in health care policy.

In 1961, a national Royal Commission on Health Care Services was ordered by the Canadian Prime Minister, John Diefenbaker, the Conservative leader from Saskatchewan. The mandate was to survey all health-service needs, not only hospital care ones. It was chaired by Diefenbaker's law school classmate, the Saskatchewan judge, Emmett Hall. The Commission toured the country and met with more than 400 different groups to gather information. Hall's 1964 report recommended universal medicare for the entire country and adequate remuneration for doctors.<sup>16</sup> An old-school Tory, Hall expected citizens to accept certain responsibilities for maintaining their health and to tolerate taxation for such a worthy cause; in exchange, the state should provide education for health professionals, as well as free doctoring and hospital coverage for its citizens. Hall was confident that the physicians and the elected officials could negotiate fees without costly third parties.<sup>16</sup>

In 1966, the Canadian Medical Care Act<sup>17</sup> was introduced by the Liberal government of Lester Pearson and was passed almost unanimously by parliament. But health care is a provincial matter, and this legislation was federal. Once again, large transfer payments were the carrot incentive to induce provincial buy-in. Physicians were suspicious of the cumbersome system, and implementation took place

slowly in the various provinces. By 1972, all 10 provinces had enacted plans for both hospital and medical services. Revisions to the plans were made in 1977, and Hall conducted another national review in 1980.

The 1984 Canada Health Act<sup>18</sup> clarified general principles and specified terms of federal transfers. Physicians were paid—sometimes wholly, sometimes in part—from the public purse depending on their location. In Ontario for example, the province would cover 80% of the negotiated fee, and physicians were entitled to bill patients privately for the remaining 20%. Three years later, to remain eligible for the federal transfer payments, Ontario required elimination of “full billing,” which the media had successfully labeled “extra billing.” Only a minority of physicians used this symbolic remnant of discretionary fees, but most of the province's doctors went on strike over the issue. Again, the doctors lost, and some scholars suggest that public reaction to this strike cost the profession credibility and respect.<sup>19</sup>

In times of economic stress during the 1990s, federal transfer payments dwindled. Wealthier provinces, such as Alberta, took this change as a cue to allow more private services.<sup>20</sup> Nevertheless, most jurisdictions had already implemented the medicare plans.

### Medicare in the Recent Past

Canadians may complain about wait times, but health care is the country's most popular social program. Every major political party was involved in its implementation, and a publicly funded health care provision continues to be endorsed by every political party in every

province. Proposing to abolish, or even alter it, is a form of political suicide. Recent reviews recommend changes within the system, rather than dismantling it.<sup>21</sup>

Notwithstanding the enthusiasm of their patients, Canadian doctors have not been universally vocal in their support of medicare; some continue to believe that their incomes would be higher with private practice. Many physicians claim that larger slices of the health care pie go to hospitals or to purchasing drugs rather than to medical services. In 2005, a successful Supreme Court challenge, launched by orthopedic surgeon Jacques Chaoulli and his patient, threatened the status quo by asserting that patient rights were infringed by wait times.<sup>22</sup> The Canadian Medical Association (CMA) endorses medicare in principle; however, recent CMA presidents, Brian Day (2007–2008) and Robert Ouellet (2008–2009), both advocated more private practice. In 2006, Canadian Doctors for Medicare emerged in response to these trends and now boasts nearly 2000 members.

One issue that gets lost in these cross-currents is that the actual amounts of physician net earnings are unknown to the general public. Since the 1990s, information on gross earnings (or billings) and on numbers of physicians is accessible from several sources, including the Canadian Institute for Health Information and annual provincial reports, such as British Columbia's “Blue Book.”<sup>23</sup> But these reports do not provide the expenses of practice, often between 40% and 60% of gross income; nor do they detail allowable deductions. As a result, they inflate indications of individual doctors' earnings and may also minimize benefits.



## CANADIAN MEDICAL INCOME

For this article on the history of physician income, the three periods under study were (1) before medicare, up to 1962; (2) during the advent of medicare, roughly 1962 to 1987; and (3) following the nationwide implementation of medicare, from 1987 forward.

### Before Medicare

No official reports track Canadian medical income before 1900, but examples from surviving account books offer information about individual practitioners.<sup>24</sup> By contrast, reliable statistics on wages of ordinary citizens are available. For example, from 1850 until 1880, the average wage of a laborer was roughly \$300 a year with a range of \$167 to about \$400 (Canadian dollars of the time).<sup>25</sup> Compared with ordinary workers, 19th-century doctors appear to have been well off (Figure A, available as a supplement to the online version of this article at <http://www.ajph.org>). Nevertheless, their assets were smaller than those of lawyers, and true wealth came from sources other than clinical practice. Studies of medical income in 19th-century United States suggest a similarly wide range and diversity in earnings.<sup>26</sup>

Between 1900 and 1930, most Canadian doctors enjoyed a “comfortable but not affluent income” that rose from Can\$2000 to Can\$6600.<sup>27</sup> According to the Canada Census between 1931 and 1961, physicians admitted to generous incomes rising from Can\$3095 to Can\$6575 and ranging between two and three times national averages.<sup>28</sup> During this

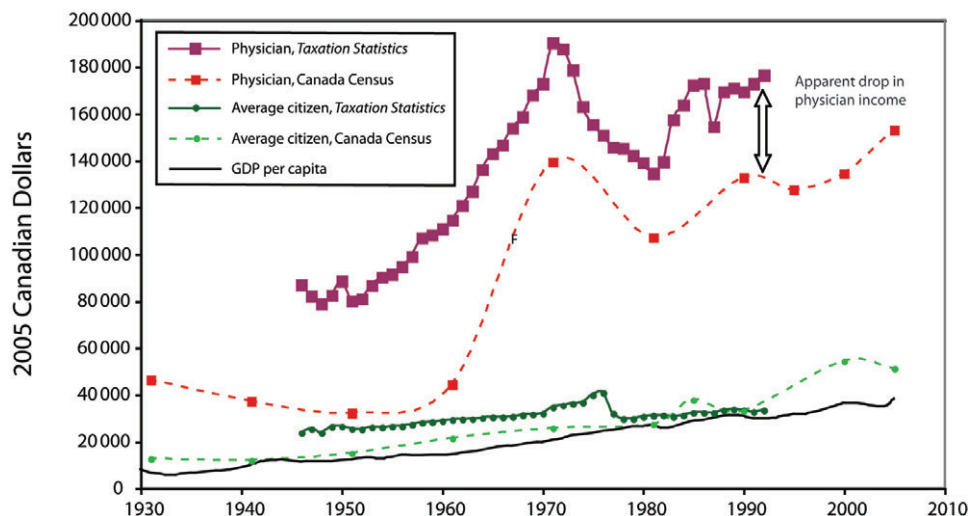
period, top earners were lawyers in 1931 and 1941; doctors in 1951; and chemical engineers in 1961. The Census relies on self-reporting. Compared with government taxation sources, it seems that doctors (and others) underestimated their earnings by 15% to 60%. Consequently, the ratio of medical income to that of average earners is probably a more reliable indicator than the actual amounts. Before medicare, according to the Census, medical income was above average, but it was declining from three and a half to two times that of all Canadians by 1961 (Figure 1).

### The Advent of Medical Care, 1962–1987

The best source on net medical income through this period is the annual *Taxation Statistics* of the federal Department of Revenue, the so-called “green

books.”<sup>29</sup> The amounts were taken from income tax returns. They were always greater than those reported in the Census for the professions and for average earners. From 1946, physician income was specified in *Taxation Statistics* under “professions,” with law, dentistry, engineering, and architecture. Figure 1 shows that, according to taxation data, medical earnings rose steadily through the advent of medicare.

More information on doctors’ earnings was made available during the Hall Commission survey. The federal Department of Health and Welfare reported physician income in a special “Health Care Series” with yellow covers.<sup>30</sup> These reports collected data back to 1957 and then tracked rising public expenditure on physician services that marked the shift from private to public payment forward to 1972. Attention was



Note. Conversion to 2005 dollars through historical Consumer Price Index, 1914–2006, Statistics Canada, CANSIM Table 326–0002, <http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&searchTypeByValue=1&id=3260002> (accessed August 28, 2009). Gross domestic product per capita, reference 56.

Source. Canada Census, 1931–2006, *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).

**FIGURE 1—Net income of Canadian physicians and average citizens from two sources (Canada Census and *Taxation Statistics*), with gross domestic product (GDP) per capita, 1930–2005.**

given to gender, location, and specialty, and comparisons were made with other professionals and ordinary workers. These “green” and “yellow” books show that medicare enhanced physician earnings at the outset—for example, Saskatchewan doctors saw an abrupt rise in income in the year following their 1962 strike, when the new medicare system ensured that all their bills were paid in full.

Three contradictory reasons were said to have prompted publication of the “yellow books.” First, the reports would allay medical fears and ensure that the profession was not being short-changed. Second, the books demonstrated the greater income from group practice, a method promoted by Hall. Third, physicians suspected that the government chose to publish the books in order to manipulate public opinion by featuring their wealth.

The media loved the “yellow books” and “green books,” but doctors resented them. D. A. Geekie, communications director of the CMA, opined that they were “malicious,” seeking to “compare sheeps to goats if not alligators”; the “only reason for publishing such data,” he wrote, “is to exaggerate the gap between the average Canadian and the high earning physicians.”<sup>31</sup> They were “inaccurate,” “inappropriate,” and morally “wrong.”<sup>32</sup>

To express these concerns in 1972, the *Canadian Medical Association Journal* constructed a medical metaphor. “Every fall,” it complained, “there is a short epidemic of newspaper articles . . . about physicians’ earnings. . . . The causative organism . . . [is] the publication of two separate but related government reports”: the “green books” and “yellow books.” “We receive a number of missiles asking why we don’t put a stop to

such reporting or provide an explanation to put the profession in a more favourable light.”<sup>33</sup>

The following year, medical frustration and suspicion prompted Geekie to construct an imaginary interview with the hypothetical “Dr Joe Average Canuck” and his wife, Ethel, who earns “no income but spends well . . . almost lavishly.” “[N]o male chauvinism intended for the 12% of the profession that is female,” wrote Geekie, but Joe “is a pretty nice guy. He works hard, is conscientious, and serves good Scotch.” Yet, Joe laments, “I am not nearly as well off as most people believe.” The fictitious interviewer “suggested there had to be a limit to what Canada could pay physicians.” Then the phone rang, and Doc Canuck rushed off to an emergency, although he was not on call.<sup>34</sup>

Sympathy for the doctors’ plight can be found in the graph of percentage change in net earnings through this same period (Figure B, available as a supplement to the online version of this article at <http://www.ajph.org>). With periodic controls set on their fees and no protection from inflation of expenses, a yo-yo effect of chaotic swings for the percentage of change of physician earnings contrasts starkly with the slow steady rise for average Canadians exemplified by employees and laborers. The supposedly reassuring numbers were alarming. Physician resentment over the “yellow books” ended with the books’ demise in 1973. This quiet execution coincided with the first year since 1957 that the percentage of change of medical income actually fell below that of average Canadians. For once, the government may also have found the report embarrassing.

Notwithstanding the marked drop in the percentage of change of earnings for 1972, medical income had peaked at an all-time high in the preceding year (Figure 1). Henceforth, analysts would refer to this rise as the “windfall” of early medicare, which ended after the 1971–1972 peak year.<sup>35</sup> In his annual rant of 1975, Geekie described a dramatic reversal in “pecking order of the various professional groups,” referring to yet another decline in the percentage of change of medical earnings, although actual income amounts continued to rise.<sup>36</sup> This “period of adjustment” set the stage for a future climate of mistrust.<sup>37</sup>

The 1970s was a decade of tension. Physicians continued to be the top earners, but their net incomes rose at a rate that was less than in the recent past, less than inflation, and less than those of other professions.<sup>38</sup> The result was a steady decline in medical income relative to average earners over a decade until about 1981, although earnings never dipped as low as they had been before medicare (Figure 1). To control costs, some policy analysts recommended closing immigration to foreign graduates and ending the fee-for-service system in favor of salaries.<sup>39</sup> Many anxious reports and editorials appeared; doctors threatened to move to the United States. Medicare was said to have taken a toll on physician morale, professional satisfaction, and financial status.<sup>40</sup> Some surveys aired in American media to emphasize the “dissatisfaction,” “bitterness,” and thoughts of leaving among Canadian doctors victimized by government interference.<sup>41</sup>

By 1980, an economist recommended what Hall had opposed: that fee schedules be reviewed

regularly by a third party.<sup>42</sup> This plan was never implemented. Fees are still negotiated by professional associations and governments without third-party mediators.

Notwithstanding the temporarily reduced rate of change in their earnings, physicians constituted the top-earning profession in Canada every year from 1958 forward and into the present. Their average net income increased at a rate that consistently outstripped that of all citizens: 1200% versus 676% over 4 decades. The ratio of physician income to that of all Canadians was higher than before medicare, ranging between three and five-and-a-half times with an overall upward trend. Sometimes the percentage of increase was less than that of other professions, but actual earnings remained greater. The gap between physicians and the next-highest income group peaked in the early 1970s “windfall” moment, readjusted in the mid-1970s, and then steadily widened again in favor of physicians. The relative drop during the decade of 1971 to 1981 exemplifies the profession–government tension in that time of anti-inflation measures and fixed fees—tensions that pervaded the media and the popular, uncontrolled surveys cited previously.

The “green book” figures were slightly higher than were those in the “yellow books” because *Taxation Statistics* included income sources other than practice, such as securities and real estate; in some years, salaried doctors were excluded. Doctors argued that the “green books” gave a falsely high impression of their earnings and blurred distinctions between general practitioners versus specialists, rural versus urban, male versus female, and



salaried versus private. After 1992, *Taxation Statistics* information on medical earnings dried up, owing to revisions in income tax law that relieved taxpayers of the obligation to specify their occupations.

### Late 1980s to 2005

For the most recent decades, the best source on net medical income remains the Canada Census.<sup>43</sup> Once again, the data are self-reported and probably underestimated. Turning from the more reliable *Taxation Statistics* to sole reliance on the Census source generates an apparent, abrupt drop in medical income between 1992 and 1995 (Figure 1). According to the Census, however, the trend in income continued upward with no drop, seemingly at the same rate as before 1992. Therefore, the “drop” between 1992 and 1995 may be an artifact of the Census source and the underreporting that characterizes it for all citizens.

From 1992 to 1995, the *Medical Post* reinstituted its satisfaction surveys, and the CMA conducted a similar study in 1997.<sup>44</sup> But these polls provided no details on income because such questions were not asked.

### COMPARISON WITH US PHYSICIANS

Finding reliable historical information about medical earnings in the United States is even more difficult than it is for Canada. Like their northern colleagues, US physicians have not been forthcoming about their earnings, except when it comes to protesting inflated estimates. As early as 1897, an American doctor suggested that rich doctors were charlatans.<sup>45</sup> In 1911, a remark that medics earned

“princely sums” drew a sharp rebuke.<sup>46</sup> In 1989, a physician wondered about the uncaring message of ostentation sent by the luxury cars belonging to his colleagues.<sup>47</sup> Most articles on physician earnings in the American peer-reviewed literature address concerns about income of particular medical groups identified by specialty, location, or other characteristics, such as radiologists, neurologists, surgeons, women, and academics.

Without a single-payer system, Americans must rely on volunteer surveys conducted by the profession, scholars, government, or the media. But surveys are vulnerable to the criticisms of definition, response rate, honesty, and variable motivation: those with perceived complaints respond more reliably. And, just as in Canada, disparities emerge involving gender, race, location, and specialty, and between reported versus actual income.

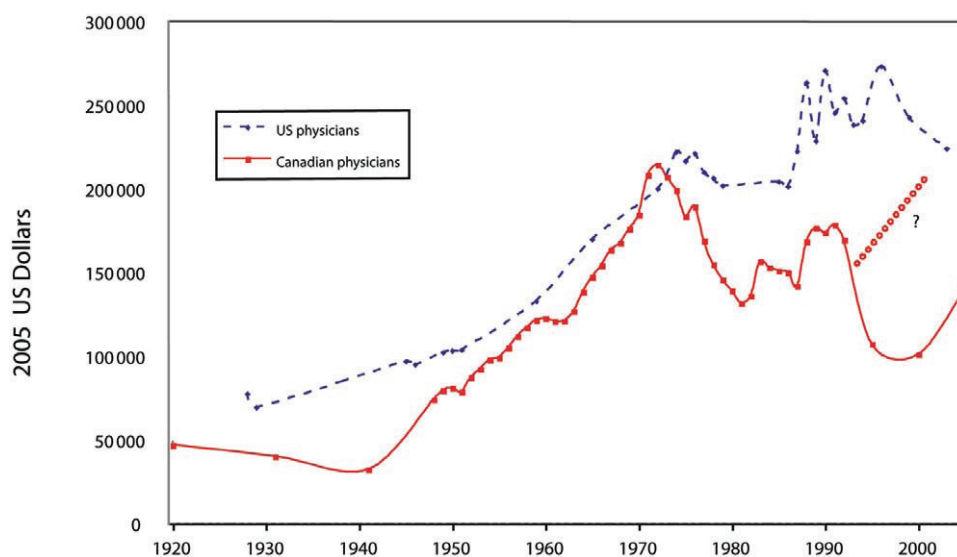
American sources for this research included a survey on physician income undertaken by the Committee of Costs on Medical Care just before the stock market crash of 1929,<sup>48</sup> a government study from 1945 to 1966,<sup>49</sup> and sporadic surveys conducted by academics,<sup>50</sup> by the journal *Medical Economics* from 1948 to 2003,<sup>51</sup> and by the American Medical Association in 1928,<sup>52</sup> 1949 to 1950,<sup>53</sup> and from 1988 to 2003<sup>54</sup> (Figure C, available as a supplement to the online version of the article at <http://www.ajph.org>). Median incomes, if given, were lower than average incomes, but not all surveys provided both figures.

The data points shown in the supplemental figure were consolidated. If two different incomes were reported when these surveys occasionally coincided, an average was taken. Converting Canadian medical incomes (as shown in Figure 1) to historical

equivalent US dollars and converting both American and Canadian figures to 2005 US dollars allows comparison of medical earnings in the two countries across 8 decades (Figure 2).<sup>55</sup>

Figure 2 shows that US physicians have almost always earned more than Canadian physicians. The gap closed at the advent of medicare during the 1960s and early 1970s, when Canadian doctor income soared to equal and even exceed that of American doctors. Then the gap widened again; however, the mid-1990s disparity may be apparent, owing to the Canada Census source for the years after 1992. The latest figures suggest a renewed trend to narrow the gap with a relative decline in US physician earnings while the Canadian equivalent continues to rise.

But these differences in income may be common to all Canadian and US earners, not only physicians. The historical

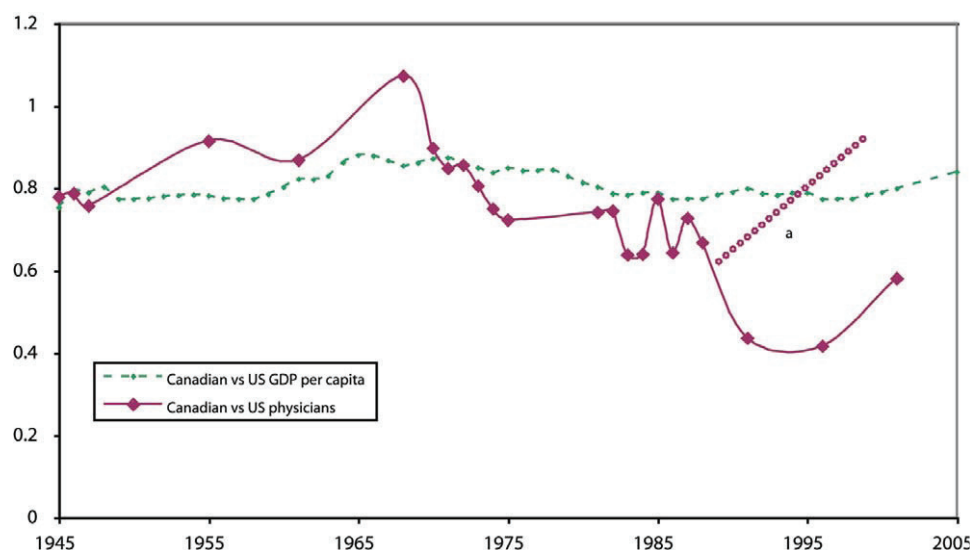


Source. For Canadian physician income, see Canada Census, 1931–2006 and *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).

<sup>24,28</sup> For US physician income, see references 48–54.

<sup>a</sup>Extrapolation of Canadian physician income based on *Taxation Statistics*.

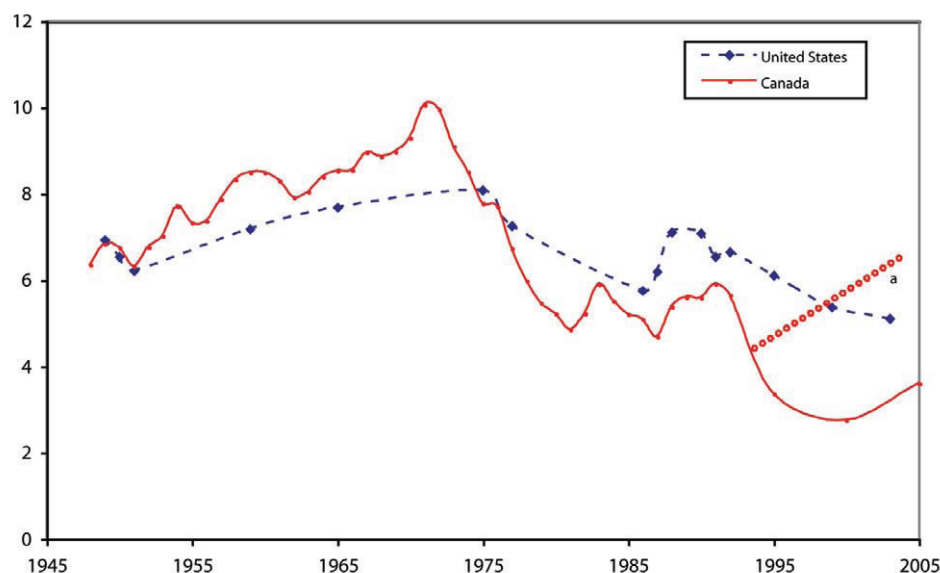
**FIGURE 2—Physician income in Canada and the United States, 1920–2005.**



Source. For Canadian physician income, see Canada Census, 1931–2006 and *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).<sup>24,28</sup> For US physician income, see references 48–54. For gross domestic product per capita in both countries, see reference 56.

<sup>a</sup>Extrapolation of Canadian physician income based on *Taxation Statistics*.

**FIGURE 3—Ratio of Canadian gross domestic product (GDP) per capita to US GDP per capita and ratio of Canadian physician income to US physician income, 1945–2005.**



Source. For Canadian physician income, see Canada Census, 1931–2006 and *Taxation Statistics* (Ottawa, Ontario: Revenue Canada, 1948–1995).<sup>24,28</sup> For US physician income, see references 48–54. For gross domestic product per capita in both countries, see reference 56.

<sup>a</sup>Extrapolation of Canadian physician income based on *Taxation Statistics*.

**FIGURE 4—Ratio of Canadian physician income to Canadian gross domestic product (GDP) per capita and ratio of US physician income to US GDP per capita, 1945–2005.**

gross domestic product (GDP) per capita in each country reflects average earnings of all citizens. Canadian GDP per capita is close to the income of the average worker (Figure 1). It has never equaled that of the United States, ranging from a high of 91.4% in 1904 to a low of 60.3% in 1934 with other peaks in the late 1960s and early 1970s.<sup>56</sup>

Through time, the ratio of Canadian to US physician earnings, as shown in Figure 2, has ranged from 0.4 to 1.1. Figure 3 compares this ratio of physician income in the two countries to the ratio of the GDP per capita between the two countries for the same period. It appears that, in the early years of medicare—roughly 1962 to 1970—Canadian doctors fared at least as well or better than their country as a whole relative to the United States. Then, as medicare became established, Canadian physicians fared less well. Once again, however, the wider gap after the mid-1990s could be attributable to the Census source that suggests a falsely lower medical income.

However, it is perhaps more meaningful to compare physician incomes to the GDP per capita within each country—i.e., Canadian physicians to Canadian citizens, and US physicians to US citizens—something the Canadian government had been trying to do with “yellow books” of the 1960s and early 1970s (Figure 4).

Figure 4 shows that the ratio of physician earnings to the GDP per capita in their own countries has been high, ranging from roughly 3 to 10 times. Surprisingly, the greatest ratio was Canadian, not American, from roughly 1962 to 1972, when physician earnings reached 10 times the GDP per capita of that

nation during the “windfall” years of early medicare. Indeed, Canadian physicians also seem to have experienced the lowest ratios in the 1980s and mid-1990s. Since then, the Canadian ratio has been increasing, although it remains smaller than its American equivalent. But, again, Canadian values from the mid-1990s may be falsely low owing to the use of the Census source in the absence of disaggregated tax data.

Overall, Figure 4 shows that the US ratio has usually been higher than the Canadian ratio, and its range narrower, from just above five to just over eight times the GDP per capita in that country; the trend may be declining since the mid-1990s. In 2005, US doctors earned about five-and-a-half times the US GDP per capita; Canadian doctors earned about four times their country’s GDP per capita. These estimates are backed by a recent international study of physician supply.<sup>57</sup>

## SUMMARY

To summarize these results, Canadian doctors were always well paid. Before 1900, they were comfortable, but they drew on many income sources and carried large debts. The advent of medicare resulted in a temporary boom that raised expectations and provoked a funding crisis. Following the 1971–1972 peak in medical earnings, controls—on fees, wages, and prices—set the thermostat for reactions between the profession and government. Annual percentage changes in medical income were sometimes negative or less than inflation for several years. This situation fostered insecurity and a lingering physician mistrust of government. However, the years

after 1981 saw a steady rise in medical income. Data for physician income after 1992 may be falsely low owing to the Census source. Changes promised to the Canada Census in 2010 imply that its accuracy could decline further in the future, and information on health and income data will be even more difficult to obtain.<sup>58</sup> Nevertheless, the trends revealed in this research are reliable. Over nearly 60 years, into the 21st century, physician income grew at a rate of increase that outpaced that of other Canadians. Since 1958 through the advent of medicare, until at least 1992 and probably into the present, physicians, as a professional category, were the top earners in the country.

Compared with the best figures available for US physicians, Canadian doctors have almost always earned less. However a comparison of medical earnings to the GDP per capita in each country shows that Canadian physicians earned proportionately most in the early years of medicare, peaking around 1972 when amounts equaled and briefly exceeded US medical income. Their earnings then returned to three or four times that of the GDP per capita, a level that is nonetheless greater than it had been before medicare, and that is still rising. An analogy can be found here with the apparent boom in US medical income associated with the advent of US Medicare in 1966.<sup>59</sup>

The observation that Canadian physicians are paid less than their American counterparts invites us to ask, what do Canadians “get” in exchange for paying their physicians less than their American counterparts? A 1990 study showed that, although per capita expenditures on health in the United States were higher

than those in Canada, the actual number of services was fewer.<sup>60</sup> In other words, Canadian citizens were getting more and spending less. Perhaps the corollary of this observation is that Canadian doctors suffer because they work more for less. Other comparisons suggest that the high costs of American care are not owing to the admittedly higher physician fees and income, but rather to the much greater costs of administration generated by the private insurance industry.<sup>61</sup>

In Canada, proportionately more resources are devoted to public health and to providing free access to all citizens through a system that costs less than its American counterpart and is associated with longer lifespan and lower infant mortality. In other words, better health indicators and greater accessibility are correlated with the lower physician income.

Is it possible that high physician income could be correlated with lower health outcomes? The health indicators of Cuba, for one extreme example, are among the best in the world for a developing nation; yet, physicians in that country—the vast majority of whom are in general practice—are known to exist on derisory salaries amounting to less than US\$600 a year.<sup>62</sup> Anthropological researchers characterize the health of the country as a “gift,” provided by the collective, including its doctors.<sup>63</sup>

Using the gift analogy then, Canada’s doctors, who often pay lip service to “advocacy,” “accountability,” and “teamwork,” can be seen to make an investment in public health stemming from their lower earnings relative to American doctors. But we have no idea what the contribution has been costing them in recent

years—if anything—because we cannot obtain the figures.

No one is proposing to cut physician incomes to the insignificant amounts of Cuba. Yet how much money do doctors really need? A few scholars have used a variety of economic theories to analyze physician income. By whatever model they chose to define the task, the amounts paid in Canada and the United States were said to be too great.<sup>64</sup> In other words, whether or not it correlates with lower health indicators, high medical income could be a moral problem.

## OBSERVATIONS AND RECOMMENDATIONS

From this research, we observe that even when the readjustments resulting from various policy and payment alterations are taken into account, Canadian medicare did not lead to a loss in physician income. Rather, physician incomes grew more quickly than those of other Canadians and are considerably greater. In short, the medical-income argument against moving toward a Canadian-style system is feeble. The only way to revive it would be to find different and more reliable data.

Therefore, a recommendation arising from this work is to make more data on physician income available. The information for this research was not easily gathered; better figures may reside in sources currently inaccessible to the average practitioner or historian. Distinctions between specialties, race, gender, and geographic location would emerge.

This information problem raises several questions relevant to both countries. Why should medical income be secret? Are physicians embarrassed by their



wealth? Someone has to be the top earner. What is wrong with that person being a doctor instead of a hockey player? Even more puzzling—if not ironic—is the effect of Canadian legislation, such as the Ontario Public Sector Salary Disclosure Act (1996), which ensures that the actual names and actual incomes of citizens paid more than Can\$100 000 from the public purse are published every year in the so-called “sunshine lists” at government Web sites and in leading newspapers.<sup>65</sup> This move to greater accountability makes an annual spectacle of the wages of teachers, professors, police officers, hospital administrators, and government employees—anyone paid by tax dollars. Journalists and voyeuristic citizens use the lists to scrutinize individual and collective use of resources.<sup>66</sup> But doctors’ names do not appear in these famous lists unless they enjoy public-sector salaries, such as stipends for academic or hospital administration. Yet, they are paid by the taxpayer whether their earnings derive from salaries or from fee billings; transparency and accountability dictate that taxpayers have a right to know how all their money is spent.

Therefore, physicians should join citizens in encouraging the revival of those annual “green” and “yellow” reports, or their equivalents. Doctors might be pleasantly surprised to discover that patients believe that they are entitled to high incomes because of their many years of expensive study, heavy responsibilities, and long hours of work. In turn, citizens might have reason to take pride in remunerating hardworking physicians at a level that is decent without being obscene.

The universal, single-payer system has been good not only

for Canadians but also for their doctors. At least, it has done no harm. ■

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