

**What Americans Living in Canada  
Think of the Canadian and American Health Care Systems**

Steven Lewis, MA (1) (2)  
Danielle A. Southern, M.Sc. (2)  
Colleen J. Maxwell, Ph.D. (2)  
James A. Dunn, Ph.D. (4)  
Tom W. Noseworthy, MD, M.Sc. (2) (3)  
William A. Ghali, MD, MPH (2) (3)

(1) Access Consulting Ltd., Saskatoon, Canada  
(2) Centre for Health and Policy Studies & Dept. of Community Health Sciences, University of Calgary  
(3) Department of Medicine, University of Calgary  
(4) Centre for Research on Inner City Health, St. Michael's Hospital, Toronto and Department of Geography, University of Toronto

**Corresponding author:**

Steven Lewis, President, Access Consulting Ltd.  
211 - 4<sup>th</sup> Ave. S., Saskatoon SK CANADA S7K 1N1  
[Steven.Lewis@shaw.ca](mailto:Steven.Lewis@shaw.ca)

Danielle A Southern - [dasouthe@uacalgary.ca](mailto:dasouthe@uacalgary.ca)  
Colleen J Maxwell - [maxwell@uacalgary.ca](mailto:maxwell@uacalgary.ca)  
James A Dunn - [jim.dunn@utoronto.ca](mailto:jim.dunn@utoronto.ca)  
Tom W Noseworthy - [tnosewor@uacalgary.ca](mailto:tnosewor@uacalgary.ca)  
William A Ghali - [wghali@uacalgary.ca](mailto:wghali@uacalgary.ca)

**Word count:** 3,174

## Contributors

Steven Lewis conceived the study. Lewis, William Ghali, Colleen Maxwell, James Dunn and Tom Noseworthy developed and refined the method. Danielle Southern posted the survey, gathered and analyzed the data, and prepared the quantitative data tables. Lewis analyzed the qualitative data. Lewis drafted the manuscript. All reviewed and contributed revisions to drafts and approved the final version for submission. Fatima Chatur staffed the toll-free access line and handled all inquiries.

Steven Lewis is the corresponding author and guarantor.

## **ABSTRACT**

**BACKGROUND:** There are no reported head-to-head comparative assessments of health care in any two countries by people who have experienced both. We sought to report the experiences and views of Americans living in Canada who have used both health care systems as adults.

**METHODS:** We conducted a survey study of a sample of Americans living in Canada. We used 5 communication strategies to obtain the sample, and asked respondents to provide experience-based ratings of various dimensions of health system quality.

**RESULTS:** 310 people who met the inclusion criteria completed the survey. They are a highly educated (58% with master's degrees or higher) and prosperous group (51% of households have income > \$100,000). 74% rated the overall quality of US healthcare as excellent or good compared to 50% in Canada. Most preferred the American system for emergency room, specialist, hospital, and diagnostic services. Respondents rated the Canadian system better for access to drug therapy, and expressed similar views of the two systems for care from a family physician. The most positive identified features of the US system were timeliness and quality; and for Canada's system, equity and

cost efficiency. The most negatively viewed features of the US system were its cost/inefficiency and inequity; in Canada, wait times and shortages of personnel were viewed negatively. Despite these experience-based preferences, when asked which system they preferred overall, 45% chose the US system and 40% chose Canada's.

**CONCLUSIONS:** Americans living in Canada generally rated the US health care system as being better than the Canadian system. However, they recognized the inefficiency and inequity of the US system and nearly half preferred the Canadian system despite perceived problems.

The comparative merits of various nations' health care systems are often and sometimes heatedly debated. Empirical comparisons are typically compilations of survey respondents' self-reported experiences or perceptions in their own countries<sup>1-6</sup>. This method assumes that study participants are equivalent to groups randomized to experience various nations' health care systems, and observed differences are attributable entirely to the systems themselves. The method overlooks differences in culture, preferences and expectations that may affect self-reported experiences of health care, and overall system assessments.

Experienced-based comparison is a stronger method. There are no reported head-to-head comparisons of health care in any two countries by people who have experienced both. This study reports the experiences and views of Americans living in Canada who have used both health care systems as adults.

The objectives of the study were to obtain the views of Americans living in Canada on their experiences of care in both countries; their absolute and relative ratings of the quality of various dimensions of care in both countries; and their overall assessments of the two countries' health care systems. The secondary objective was to establish the

feasibility and validity of a method to add a new dimension and richness to the field of comparative health systems analysis.

## **METHODS**

### **Target Participants**

We targeted Americans who had been responsible for their own health care as adults for at least two years prior to coming to Canada, and who had been living in Canada for at least two, but no more than five years, to ensure reasonable recall of experiences in both systems. We asked potential respondents to self-screen for eligibility based on these characteristics.

### **Methods for Recruiting Participants**

Americans living in Canada are a “hard to reach” population. Communication with provincial and federal agencies confirmed that there is no accessible database that identifies émigrés by country of origin and current address. Building on approaches used in other contexts<sup>7-9</sup>, we developed a novel method incorporating five techniques to solicit responses. First, through the offices of the University of Calgary, Faculty of Medicine, Office of Communications, we held a live media conference supplemented by a nation-wide media

release ([www.chaps.ucalgary.ca/release.htm](http://www.chaps.ucalgary.ca/release.htm)). Second, three weeks later, we distributed nationally an op-ed piece that outlined the purpose, uniqueness, and importance of the study, and how to participate. Third, we placed paid advertisements for the study in six newspapers: the Globe and Mail and National Post (both national newspapers based in Toronto); the Calgary Herald and Calgary Sun; and the Vancouver Sun and Vancouver Province. The three cities are home to 31% (79,000) of the 258,000 émigrés to Canada from the US<sup>10</sup> and about 40% of recent arrivals<sup>11</sup>. Fourth, we sent the study information to American consulates, Democrats in Canada, and Republicans in Canada, and asked them to forward it to their membership or contact lists. Fifth, the survey web site encouraged visitors to send the information to other people whom they thought would meet the eligibility criteria. This is often known as the 'snowball' method.

We developed and pre-tested an internet-based survey instrument ([www.chaps.ucalgary.ca/survey.htm](http://www.chaps.ucalgary.ca/survey.htm)) to gather information on respondents' demographics, reasons for moving to Canada, health status, use and personal costs of health care, assessments of the timeliness and quality of care in several categories in both countries, and overall system preferences. We assumed that a very high percentage of the target audience would be connected to the internet, and also

that respondents might be more willing to answer potentially sensitive questions anonymously in electronic format rather than in personal interviews. We posted the survey on the web from April 6, 2005 until July 31, 2005, and installed a toll-free telephone number to handle inquiries and provide technical assistance.

Our study received ethical approval from the Health Research Ethics board of the University of Calgary.

### **Data Analysis**

We estimated *a priori* that 200 respondents would be sufficient to generate relatively narrow confidence intervals around estimates of proportions (ranging from +/- 4% to +/-7%, for proportions of 10% and 50% respectively), and that a larger N would permit certain between-group comparisons. We used simple descriptive statistics to analyze the data, reporting proportions and 95% confidence intervals in most instances. We also used Chi-square tests to compare perceptions between groups categorized by length of time since arriving in Canada, health status, and household income.

Respondents also provided qualitative information in open-text form. We grouped these data thematically, and below



reproduce representative quotes that clarify and enrich the quantitative data.

## **RESULTS**

### **Study Population**

The sample exceeded our expectations: 452 people attempted the survey, of whom 393 (86.9%) completed all or parts of it. We excluded responses from those who did not complete the central study questions comparing their experiences and preferences between the two systems. The final analysis group had an N of 310.

As expected, the respondents are much more highly educated and considerably better off financially than the general Canadian population, as shown in Table 1. However, they are more representative of émigrés to Canada (in 2002, 46% of immigrants from all countries had at least a university degree). Half are resident in Alberta (which comprises 11% of the Canadian population), 41% in British Columbia or Ontario (together 50% of the population), and 8% from the rest of Canada. One-fifth work in health care.

### **Health Status and Health Care Utilization**

Respondents are healthy: 83% self-rated their health status as excellent or very good in the two years prior to moving to Canada, compared to the 73% of Canadians in the top income quintile. 80% rated the health status of their partner or spouse, and 85% that of other household members, as excellent or very good. Since moving to Canada, 31% reported that at least one member of their household has experienced a chronic disease, 21% have had surgery in a hospital requiring an overnight stay, and 25% have had day surgery procedures. The typical household made 5 visits to a family doctor, 2 to a specialist, 1 to an emergency room, and filled 4 drug prescriptions annually. Thirty percent received health care of any type in the US in the previous year, and 11% travelled to the US expressly for that purpose.

### **Insurance Coverage and Out-of-Pocket Costs**

Not surprisingly given their income and education, 98% of respondents were insured prior to coming to Canada, most through employer-paid, for-profit insurance plans. 91% had health insurance supplementary to the main plan. 72% were very or somewhat satisfied with their US health insurance overall, while 19% were somewhat or very dissatisfied.

Interestingly given their socioeconomic status, 32% reported that health care coverage had exerted quite a lot or a great deal of influence over where to look for a job in the US, and 29% over whether to stay in or leave a job. In addition, 24% reported paying out-of-pocket health care costs in the US that created significant financial hardships, compared to 5% while in Canada.

### **Expectations of Canadian Health Care Prior to Arrival**

Two-thirds of respondents had formed an opinion of Canadian health care prior to arrival. Of these, 35% anticipated that the system would be worse than what they were used to in the US, 29% thought it would be better, and 37% thought it would be the same. A quarter indicated that their opinion had some influence on their decision to move to Canada, and 95% of these said it was a positive motivator.

### **Comparative Assessment of Experiences in the Two Systems**

Figure 1 reports respondents' assessments of the timeliness and quality of Canadian and American health care services based on their own experiences. By considerable margins, respondents rated the US system as better than the

Canadian system in all categories except the cost of drugs, and administrative complexity. The gaps were larger for timeliness than for quality of care items. Notably, 41% rated the US as providing greater freedom to choose providers compared to 27% who rated Canada higher.

### **Comparative Assessment of the Merits of the Two Systems**

Figure 1 also reports ratings of a number of structural aspects of the two systems. These by and large reflect the ratings of the care itself, although the systemic views are somewhat more generous towards Canada. Respondents were particularly critical of the timeliness and availability of specialized services in Canada. Canada rated considerably better only on the dimension of out-of-pocket costs and somewhat better on cost relative to quality. Overall, 50% rated the Canadian system as good or excellent compared to 74% for the US system.

Similarly, we asked respondents to indicate where they would prefer treatment if they or a household member became seriously ill. Figure 2 shows majority preference for US care in 4 of 6 categories, for Canada in one (prescription drugs), and equal proportions in one (family doctor).

We asked respondents to list the 3 most positive and negative aspects of both health systems. Table 2 lists the most commonly mentioned responses. Quality, and comprehensiveness and accessibility of care appear in roughly equal numbers as perceived positives and negatives in the Canadian system. Equity/universality of coverage is considered a major positive in Canada and a major weakness in the US. Cost/efficiency is considered a major Canadian positive and major US negative, while waiting is perceived as the principal Canadian negative and its absence a major US positive.

#### **Differences in Opinion Attributable to Length of Time in Canada**

Our study included roughly equal numbers of Americans who moved to Canada in 2000 or later, and before 2000. Ratings and opinions generally did not vary according to how long people had lived in Canada. However, 39% of the earlier arrivals anticipated that health care would be better in Canada compared to 26% of more recent arrivals ( $P=.02$ ). Only 15% of the later arrivals rated the quality of care provided by Canadian family doctors as better than in the US while 41% rated it worse, compared to 29% and 24% respectively among the earlier group ( $p<.01$ ).

## **Qualitative Comments on Overall System Comparisons**

Respondents rated the Canadian system as a whole higher than its component parts. They often tempered their praise for the US system with caveats such as "if you're rich, you can get state-of-the-art care" or "all positive features are contingent on having good private health insurance". And they identified equity/universality as a major strength in Canada even though they were not personally disadvantaged in the less equitable American system.

These reservations are reflected in the response to the question: "all things considered, which system do you prefer?" Here the margin was narrow: 45% chose the US system and, 40% chose Canada's. Those who preferred Canada's observed:

After I moved [to Canada] I realized the extent that anxiety about cost of health care and cost of health insurance adversely affects a person's health and ability to heal.

Although the quality of care is better in the US for the large majority (including myself), I prefer the Canadian system because everyone has access to basic, competent care.

Canada's system is much more humane, and at least as good from a quality perspective. In the USA there is a very unfortunate and persistent tendency to equate availability of technology with quality.

Canada has universal coverage, doesn't ration based on ability to pay, doesn't leave 44 million uninsured. The US system is a complex nightmare that rations based on ability to pay and leaves millions uninsured, underinsured, or uninsurable.

Those preferring the American system explained:

Ease of access to quality doctors, medical care and hospital. Speed at which a specialist is seen, and use of high tech equipment.

Excellent health care is available when it's needed in the US and has not been available here in Canada.

For the insured, the US health care system is heads and shoulders above the Canadian system. However, there is virtually no health care for the uninsured in the US.

I have had the experience of requiring major surgery in the U.S. and a daughter needing it in Canada. The American system was far superior in that instance. Furthermore, in subsequent appointments (for CAT scans, etc.) the wait was virtually nothing in the US.

Many—even some who declared in favour of one system or the other—expressed divided opinions.

Canada - I like the fact that anyone can see a doctor. I do not like that it is near impossible to get to see the doctor. I also do not like that you need a referral for a specialist. I really do not like that my children cannot be seen by a paediatrician.

Both systems are flawed and have equal pros and cons. Access to everyday care and preventative care is better in the US. However, not having to pay out of pocket for specialists and serious illnesses is a big plus in Canada.

Because I am a fairly healthy person, I see not much difference in quality of care, ONCE you receive the care. It balances out to money and



politics on both sides of the border. If we could get a happy medium of both systems...that would be a great system.

I have had surgery in both countries. The outcomes were about equal. The only obvious difference is in the equipment and the facilities. They are newer and more plush in the U.S., but we paid for it....

## **DISCUSSION**

The recent Supreme Court of Canada decision that held Quebec's (and possibly other provinces') prohibition of private insurance for hospital and physician services to be a violation of the Charter of Rights and Freedoms<sup>13</sup> has renewed debate about the nature and direction of the Canadian system. Public confidence in the system has declined from its peak in the 1980s. People are concerned about access and wait times. Large numbers of Canadians (about 1 in 6) report difficulty getting timely care from a family physician<sup>14</sup>.

American health care has its own tensions. It is by far the world's most expensive system, yet it fails to insure nearly 50 million people. Catastrophic health care costs are a leading cause of personal bankruptcy<sup>15</sup>. There are huge

variations in costs<sup>16</sup> and major patient safety concerns<sup>17</sup>.

Drug costs are so high that many people travel to Canada to fill prescriptions, with the active encouragement of some American legislators<sup>18-19</sup>. Americans are as a whole less healthy than Canadians, with the largest disparities among those who lack health insurance<sup>20</sup>.

It is commonly held that the US has both the best and the worst health care in the industrialized world – the best for those with good health insurance and ample personal resources, and the worst for leaving many people vulnerable to either catastrophic costs, or severely compromised access to care. Our findings confirm “the view from the top.”

Clearly American health care serves well-educated, prosperous Americans well, and Canadian health care serves them less well, or at least less quickly. The sharpest perceived differences lie in the areas of waiting for care, and access to sophisticated diagnostic technologies.

The view that there is more freedom to choose providers in the US is counterintuitive. Canadians are formally free to obtain services from any provider, while for many Americans the choice is limited by their insurer. The findings may reflect a perceived absence of real choice in Canada due to shortages of physicians.

We wondered whether respondents' relatively high socioeconomic status informed their perceptions to a greater extent than their American experiences. A 2002 Environics poll<sup>21</sup> found that over 60% of both Canadians and Americans considered their health systems to be in crisis.

Surprisingly, low-income Americans were no more likely than high-income Americans to hold this view; perhaps just as surprisingly, low-income Canadians were more likely to perceive a crisis than high-income Canadians. A major bi-national survey found that Canadians' rating of the quality of care in their system matched how uninsured Americans rated theirs<sup>22</sup>.

Overall, Canadians' views of their system are not much different from the views of our American émigré respondents. A 2003 Canada-wide Pollara Inc. survey asked about the timeliness, range and comprehensiveness, and quality of care. The results were similar to those of our survey except that 30% of our respondents rated timeliness as excellent or good, while 43% of the Pollara respondents said they were very or somewhat satisfied in this regard<sup>23</sup>.

The challenge for Canada is whether it can maintain the egalitarian ethos of publicly financed health care for all with the timeliness and overall quality of care available to

the insured in the US. Only 30% of respondents rated timeliness in Canada as either excellent or good on that account, compared to a 75% positive rating for quality. Canadian governments have accelerated their commitments to reduce wait times, having announced benchmarks for 5 key clusters of services in December 2005<sup>24</sup>.

There is an ongoing ideological debate in Canada (and in some quarters in the US) about whether a mainly publicly financed system can respond to these challenges. The United Kingdom system may be instructive in that it is both more public (83% of health care is publicly financed compared to 70% in Canada) and cheaper (about 7.5% of GDP compared to 10.4% in Canada and 16% in the US). The National Health Service has embarked on a modernization campaign to streamline service access and improve the quality of care. In December 2005 the NHS reported that over 99% of people in England are offered an appointment with a general practitioner within 2 working days of making a call to a primary care clinic. In October 2001, 259,000 people had been on inpatient waiting lists for more than 6 months; by October 2005 the number was 25,000<sup>25</sup>.

## **Study Limitations**

Study participants were self-selected; we cannot know whether their views are representative of non-participants. The demographic, as noted, is somewhat skewed towards the highly educated and high-earning end of the scale. Alberta, and the city of Calgary in particular, is over-represented in the study population.

## **CONCLUSION**

A novel method to survey a hard-to-reach, important population has yielded new insights into the comparative performance of two health care systems. Americans who have used both the Canadian and American health systems generally perceive the timeliness, availability, and quality of care to be better south of the border. However, they recognize that the US system is both costly and inaccessible to many, and taking all factors into consideration, global ratings of the two systems were almost equivalent. For many, the universality and equity of the Canadian system more than offsets concerns about timeliness and availability of care. For others, it does not.

The views of relatively recent American émigrés about the Canadian system are not dissimilar to Canadians' own. In this sense the study complements previous research that

challenges two prevailing ideas: that Canadians idolize their universal coverage medicare program to the point of being wilfully blind to its flaws, and Americans accustomed to the best of American health care would be categorically harsh critics of the Canadian system and unsympathetic to its egalitarian ethos. These findings may be of interest to policy-makers not only in Canada and the US, but also internationally, as all countries struggle to improve quality, contain costs, and allocate resources among competing interests.

## **ACKNOWLEDGEMENTS**

The authors thank Karen Thomas, Gail Corbett and Rhonda Watson of the Communications and Fund Development Office, Faculty of Medicine, University of Calgary for organizing our media events and releases, and their support and advice on publicizing the study. We are grateful to the Max Bell Foundation, which funded the study. We also thank Ms. Becky Shaw and Ms. Ashley Halsey, Americans residing in Canada who participated in the media events that informed the public of our study. Dr. Ghali is supported by a Government of Canada Research Chair in Health Services Research. Drs. Ghali and Maxwell are supported by Health Scholar Awards from the Alberta Heritage Foundation for Medical Research. Drs. Maxwell and Dunn are supported by New Investigator Awards from the Canadian Institute of Health Research.

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**Table 1. Characteristics of Respondent Population**

<b>Study Population</b>	<b>N=310</b>	<b>Canadian Population</b>	<b>American Population</b>
Male	43%	51%	51%
Female	57%	49%	49%
No university degree	14%	85% (a)	72% (b)
Bachelor's degree	28%	11%	18%
Master's degree	29%	4%	7%
Doctoral degree	29%	<1%	1%
Household income level	15%	44% (c)	55% (d)
<\$50,000	15%	24%	18%
\$50,000 - \$74,999	20%	15%	11%
\$75,000 - \$99,999	23%	11%	10%
\$100,000 - \$149,999	13%	5%	3%
\$150,000 - \$199,999	15%		3%
\$200,000+			

(a) Statistics Canada. School Attendance (4), Highest Level of Schooling (12), Age Groups (13B) and Sex (3) for Population 15 Years and Over, for Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 2001 Census - 20% Sample Data. Note data are for 15+ population compared to 25+ in US; hence differences are overstated.

<http://www12.statcan.ca/english/census01/products/standard/themes/>

(b) Statistics Canada. Family Income Groups (22) in Constant (2000) Dollars and Census Family Structure (12) for Census Families in Private Households, for Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 1995 and 2000 - 20% Sample Data. Note that figures are 4 years older in Canada, but also that Canadian dollar traded between 70 and 75 cents during that period.

<http://www12.statcan.ca/english/census01/products/standard/themes/>

(c) US Census Bureau. Current Population Survey, March 2005. Data are for population aged 25 and over in 2004.

<http://www.census.gov/population/socdemo/education/cps2004/tab10-01.pdf>

(d) US Census Table HINC-06. Income Distribution to \$250,000 or More for Households: 2004. U.S. Census Bureau, Current Population Survey, 2005 Annual Social and Economic Supplement.

[http://pubdb3.census.gov/macro/032005/hhinc/new06\\_000.htm](http://pubdb3.census.gov/macro/032005/hhinc/new06_000.htm)

**Table 2. Most frequently identified positive and negative features of both systems**

<b>Positive - Canada</b>	<b>Mentions</b>	<b>Negative - Canada</b>	<b>Mentions</b>
Cost/efficiency	196	Wait times	260
Equity/universality	176	Shortage of personnel	125
Quality of care	132	Quality of care	115
<b>Positive - US</b>		<b>Negative - US</b>	
Quality of care	192	Cost/inefficiency	223
Timeliness	180	Inequity/unfairness	150
Access to services	152	Bureaucracy/paperwork	75

## FIGURE LEGEND

**Figure 1.** Comparisons of ratings of US and Canadian health care systems for Access to care (**PANEL A**), Comprehensiveness of services (**PANEL B**), Timeliness of services (**PANEL C**), Quality of Care (**PANEL D**), Out-of-pockets costs to me and/or household (**PANEL E**), Range of services (**PANEL F**), Availability of sophisticated services (**PANEL G**), Cost relative to quality of care (**PANEL H**) and Overall rating (**PANEL I**).

**Figure 2.** Which system would respondents prefer to go to for treatment if seriously ill by category.

**Figure 1**

A- Access to Care

B - Comprehensiveness of services

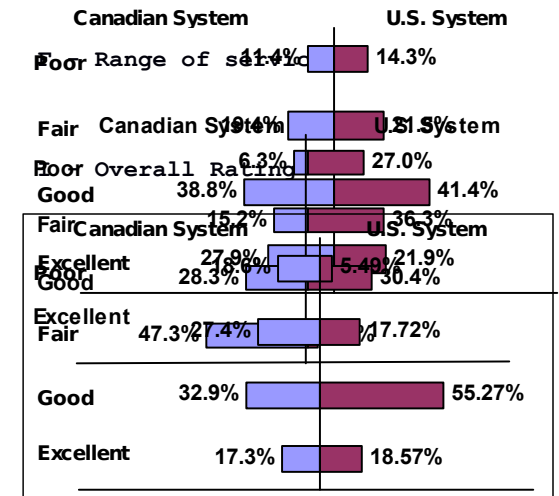
C - Timeliness of services

D - Quality of Care

E - Out-of-pockets costs to me/household

G - Availability of sophisticated services

H - Cost relative to quality of care





**Figure 2**