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"The Best Medicine the 1970s Can Provide"

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Editor's note: This article is the second in a four-part series.

In 1998, *The Toronto Star* reported that St. Joseph's Health Centre in London, Ontario, was renting access to its MRI machine to veterinarians for after-hours use on pets even as Canadian human patients waited for waited for diagnoses.

It prompted one 2002 candidate for Ontario premier, Ernie Eves, to ask, "Does it make any sense that your cat can get an MRI at 2:30 in the morning and you can pay $20 to do that but your mother can't? Is your cat more important than your mother?"

Most people would answer, "Of course not." But when you have a single payer system in which those picking up the bill are intent on controlling prices and costs such as Canada's health system, it doesn't matter what most people say. It depends upon what the health bureaucrats who run the system decide.

Americans with employer-based health insurance got a taste of that kind of decision-making when Health Maintenance Organizations began interjecting themselves into care decisions left before to consultations between doctors and their patients. Unlike their Canadian counterparts, though, patients and their health care providers raised loud and vocal complaints about it.

Unfortunately, rather than going at the roots of the problem, the political response has been to consider even more government involvement. At the same time, though, that they are mandating better quality of care by private insurance carriers, they are also pushing for Canadian-style price controls on things such as prescription drugs. Some have even gone so far as to propose extending Medicare to everyone, creating a Canadian-style top down system for managing health care. If the answer, though, to America's health care problem is government, why hasn't it been the solution to people's health care needs -- neither here nor in Canada?

Free Market Myth

The U.S. health care system is often characterized as a private, market driven system. And that is blamed for 41 million Americans being uncovered by any health insurance. It is a myth, though, to call the American system of health care a free market.

Governments control about 45 percent of health care spending directly through Medicare, Medicaid and government employee and veteran coverage. Additionally, the private health insurance market, which covers 74 percent of non-governmental workers, is distorted by tax policy. Tax deductions encourage businesses to pay -- and their employees to seek -- a part of their compensation as "health insurance."

This has produced much of the negative side effects of U.S. health care. While making it cheaper for individuals employed by third parties to get health coverage, it has raised costs to the self-employed -- who must pay in after tax dollars for the their health coverage -- and to small businesses with lower wage workers. That is one reason so many are uninsured.

Furthermore, the third-party payment system has encouraged those with insurance to overuse health care. In great part, that's because the coverage amounts to pre-paid medicine, covering not so much unexpected large bills but routine procedures. It's as if auto insurance covered oil changes rather than accident coverage. While this has had the salutary effect of encouraging checkups, it has had the ill effect of desensitizing patients to costs and ways to save money.

As Lawrence Mirel, the District of Colombia's commissioner of insurance and securities noted in a *Washington Post* article in 2001, "[Medical insurance] contains a built-in contradiction. The insurance system works best when the fewest people use it (i.e., make claims); the health insurance system works best when the most people use it (i.e., get checkups and tests). The goals are incompatible."

The bottom line: U.S. health care is expensive to payers because it is cheap to users. And those payers -- businesses and government -- manage their bills from their own narrow budget imperatives, not individual patient needs. Insurance companies thus either try to raise prices, which works to reduce the number of insured, or cut costs, which affects the quality of health care.

When HMOs chose the later course in the 1990s, patients and doctors howled and government responded with regulations mandating some coverage, tending only to increase costs more. The Patient's Bill of Rights that died when the House and Senate couldn't reconcile their differences was an example of that misguided approach. Even as the House bill declared that "increasing the complex Government regulation of the health care delivery system has proven ineffective in restraining costs and is itself counterproductive in fulfilling its purposes and detrimental to the care of patients," it would have piled on another 237 pages of new regulations, putting the government almost totally in charge of these private health care arrangements.

More of the Same?

Some have suggested that The Patient's Bill of Rights didn't go far enough.

"The answer (to the nation's health care problems) is a single-payer system that

covers everyone and more efficiently uses the resources we allocate to health care," Marcia Angell, former editor of The *New England Journal of Medicine* and a lecturer at Harvard's medical school, wrote in a 2001 *New York Times* column. "This is tantamount to extending Medicare to all Americans. Medicare is not perfect, but it provides a uniform set of benefits to nearly everyone who qualifies and it does so more efficiently than the private-employment based system."

Not in the eyes of many doctors and hospitals. A study by PricewaterhouseCoopers found that hospital administrators spend 30 minutes dealing with Medicare forms for every hour a hospital physician devotes to caring for a patient. Smaller physician practices spend up to half their time dealing with Medicare's 7,000 different billing codes.

The reason for all the paperwork -- to control Medicare's skyrocketing costs. When Medicare's hospital coverage was created it was forecast to cost only $9 billion by 1990. It cost $66 billion instead. By 2001, it had reached $143 billion. As for physician payments, they amounted to another $100 billion.

But as Medicare squeezes doctors by reducing their fees for services while demanding more paperwork for what they do, many physicians are reducing the number of Medicare patients they handle, leading to a reduction in the quality of care many seniors receive.

It is noteworthy that Medicare, unlike most private insurance plans that recognize the advantages drugs provide not only in better care but in lowering other health costs, lacks a prescription drug benefit, a fact that makes it less efficient in delivering the health services seniors needs. While Congress is wrangling over how to add such a benefit, some have proposed controlling spending on the benefit by essentially importing Canada's price control regime.

More government, whether in the form of new regulation or price controls, simply hasn't proven to be the answer, as the situation in Canada attests.

While American doctors may be leaving Medicare, Canadian doctors, nurses, and patients are leaving their country to come to the United States.

Canada's primary care physicians don't face a lot of hassle from the government in dealing with their patients. But they also aren't given many of the tools American doctors have to heal their patients or save lives. Price controls through global budgets, wherein hospitals are given a lump sum of money each year, make patients liabilities to be avoided. "[I]n Canada, the patient is a source of expense. So it's to the hospitals benefit to reduce costs [by] doing the least amount of operations as possible," Dr. Alfons Pomp, a Canadian laparoscopic surgeon told one writer.

Coupled with government purchasing controls, the arrangement virtually guarantees the unavailability of high-tech diagnostic equipment, modern medical procedures and new and better pharmaceuticals, all because they are considered too expensive.

One group of hospital bureaucrats in Queens Park went so far as to set a quota in December 2001 for the number of babies Queensway-Carleton Hospital in Ottawa could deliver the next year -- cutting it at first by 600, then by 200 -- figuring each new child cost about $1,000 to deliver.

As Dr. Jean Roch LaFrance, a 31-year veteran of Canadian medicine wrote in 2001, "Hospitals are overcrowded, waiting times are unacceptably long, services have to bought in the United States for cancer patients, doctors are overworked and demoralized, nurses are not given a fair shake, and the aging population is looming large."

Little wonder, then, that one in three Canadian doctors is considering leaving the country, according to one poll. At least 2 doctors are leaving Canada for every doctor that comes from the United States. A doctor shortage looms, as Canada is falling 500 physicians a year short of the 2,500 new physicians it needs to add each year to meet national health needs.

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Still, apologists for the Canadian system say it's better than the United States. "In Canada, queuing is far more acceptable than the notion of rationing American style which leaves consumers with the decision of whether treatment is needed and worth the price of the user fee or other deterrent," wrote Jane Fulton, in her 1993 book *Canada's Health Care System: Bordering on the Possible.*

Perhaps. But only because in many cases those Canadians who can't afford to wait can cross the border to take advantage of the wonders of America's health care system. Ontario sent nearly 1,800 cancer patients to the United States over 13 months in 1999 and 2000 at a cost of $20,000 each. Thousands of others make the trip on their own to take advantage of modern prescriptions and diagnostic tools.

In light of those facts, it is difficult to understand why American politicians would be so ready to adopt Canada's system, much less try to undermine one of the key and most advanced components of its own system, pharmaceuticals, through such devices as drug reimportation.

As Dr. Robert Lifeso told writer David Gratzer for his book *Code Blue,* "Canada has some of the best medicine the 1970s can provide."