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The Ugly Truth about Canadian Health Care

Socialized medicine has meant rationed care and lack of innovation. Small wonder Canadians are looking to the market.

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Mountain-bike enthusiast Suzanne Aucoin had to fight more than her Stage IV colon cancer. Her doctor suggested Erbitux—a proven cancer drug that targets cancer cells exclusively, unlike conventional chemotherapies that more crudely kill all fast-growing cells in the body—and Aucoin went to a clinic to begin treatment. But if Erbitux offered hope, Aucoin's insurance didn't: she received one inscrutable form letter after another, rejecting her claim for reimbursement. Yet another example of the callous hand of managed care, depriving someone of needed medical help, right? Guess again. Erbitux is standard treatment, covered by insurance companies—in the United States. Aucoin lives in Ontario, Canada.

When Aucoin appealed to an official ombudsman, the Ontario government claimed that her treatment was unproven and that she had gone to an unaccredited clinic. But the FDA in the U.S. had approved Erbitux, and her clinic was a cancer center affiliated with a prominent Catholic hospital in Buffalo. This January, the ombudsman ruled in Aucoin's favor, awarding her the cost of treatment. She represents a dramatic new trend in Canadian health-care advocacy: finding the treatment you need in another country, and then fighting Canadian bureaucrats (and often suing) to get them to pick up the tab.

But if Canadians are looking to the United States for the care they need, Americans, ironically, are increasingly looking north for a viable health-care model. There's no question that American health care, a mixture of private insurance and public programs, is a mess. Over the last five years, health-insurance premiums have more than doubled, leaving firms like General Motors

on the brink of bankruptcy. Expensive health care has also hit workers in the pocketbook: it's one of the reasons that median family income fell between 2000 and 2005 (despite a rise in overall labor costs). Health spending has surged past 16 percent of GDP. The number of uninsured Americans has risen, and even the insured seem dissatisfied. So it's not surprising that some Americans think that solving the nation's health-care woes may require adopting a Canadian-style single-payer system, in which the government finances and provides the care. Canadians, the seductive single-payer tune goes, not only spend less on health care; their health outcomes are better, too—life expectancy is longer, infant mortality lower.

Thus, Paul Krugman in the *New York Times*: “Does this mean that the American way is wrong, and that we should switch to a Canadian-style single-payer system? Well, yes.” Politicians like Hillary Clinton are on board; Michael Moore's new documentary *Sicko* celebrates the virtues of Canada's socialized health care; the National Coalition on Health Care, which includes big businesses like AT&T, recently endorsed a scheme to centralize major health decisions to a government committee; and big unions are questioning the tenets of employer-sponsored health insurance. Some are tempted. Not me.

I was once a believer in socialized medicine. I don't want to overstate my case: growing up in Canada, I didn't spend much time contemplating the nuances of health economics. I wanted to get into medical school—my mind brimmed with statistics on MCAT scores and admissions rates, not health spending. But as a Canadian, I had soaked up three things from my environment: a love of ice hockey; an ability to convert Celsius into Fahrenheit in my head; and the belief that government-run health care was truly compassionate. What I knew about American health care was unappealing: high expenses and lots of uninsured people. When HillaryCare shook Washington, I remember thinking that the Clintonistas were right.

My health-care prejudices crumbled not in the classroom but on the way to one. On a subzero Winnipeg morning in 1997, I cut across the hospital emergency

room to shave a few minutes off my frigid commute. Swinging open the door, I stepped into a nightmare: the ER overflowed with elderly people on stretchers, waiting for admission. Some, it turned out, had waited *five days*. The air stank with sweat and urine. Right then, I began to reconsider everything that I thought I knew about Canadian health care. I soon discovered that the problems went well beyond overcrowded ERs. Patients had to wait for practically any diagnostic test or procedure, such as the man with persistent pain from a hernia operation whom we referred to a pain clinic—with a three-year wait list; or the woman needing a sleep study to diagnose what seemed like sleep apnea, who faced a two-year delay; or the woman with breast cancer who needed to wait four months for radiation therapy, when the standard of care was four weeks.

I decided to write about what I saw. By day, I attended classes and visited patients; at night, I worked on a book. Unfortunately, statistics on Canadian health care's weaknesses were hard to come by, and even finding people willing to criticize the system was difficult, such was the emotional support that it then enjoyed. One family friend, diagnosed with cancer, was told to wait for potentially lifesaving chemotherapy. I called to see if I could write about his plight. Worried about repercussions, he asked me to change his name. A bit later, he asked if I could change his sex in the story, and maybe his town. Finally, he asked if I could change the illness, too.

My book's thesis was simple: to contain rising costs, government-run health-care systems invariably restrict the health-care supply. Thus, at a time when Canada's population was aging and needed more care, not less, cost-crunching bureaucrats had reduced the size of medical school classes, shuttered hospitals, and capped physician fees, resulting in hundreds of thousands of patients waiting for needed treatment—patients who suffered and, in some cases, died from the delays. The only solution, I concluded, was to move away from government command-and-control structures and toward a more market-oriented system. To capture Canadian health care's growing crisis, I called my book *Code Blue*, the term used when a patient's heart stops and hospital staff must leap into action to save him. Though I had a hard time finding a Canadian publisher, the book

eventually came out in 1999 from a small imprint; it struck a nerve, going through five printings.

Nor were the problems I identified unique to Canada—they characterized all government-run health-care systems. Consider the recent British controversy over a cancer patient who tried to get an appointment with a specialist, only to have it canceled—48 times. More than 1 million Britons must wait for some type of care, with 200,000 in line for longer than six months. A while back, I toured a public hospital in Washington, D.C., with Tim Evans, a senior fellow at the Centre for the New Europe. The hospital was dark and dingy, but Evans observed that it was cleaner than anything in his native England. In France, the supply of doctors is so limited that during an August 2003 heat wave—when many doctors were on vacation and hospitals were stretched beyond capacity—15,000 elderly citizens died. Across Europe, state-of-the-art drugs aren't available. And so on.

But single-payer systems—confronting dirty hospitals, long waiting lists, and substandard treatment—are starting to crack. Today my book wouldn't seem so provocative to Canadians, whose views on public health care are much less rosy than they were even a few years ago. Canadian newspapers are now filled with stories of people frustrated by long delays for care:

“Vow broken on cancer wait times: most hospitals across Canada fail to meet Ottawa's four-week guideline for radiation”

“Patients wait as P.E.T. scans used in animal experiments”

“Back patients waiting years for treatment: study”

“The doctor is . . . out”

As if a taboo had lifted, government statistics on the health-care system's problems are suddenly available. In fact, government researchers have provided the best data on the doctor shortage, noting, for example, that more than 1.5 million Ontarians (or 12 percent of that province's population) can't find family physicians. Health officials in one Nova Scotia community actually resorted to a

lottery to determine who'd get a doctor's appointment.

Dr. Jacques Chaoulli is at the center of this changing health-care scene. Standing at about five and a half feet and soft-spoken, he doesn't seem imposing. But this accidental revolutionary has turned Canadian health care on its head. In the 1990s, recognizing the growing crisis of socialized care, Chaoulli organized a private Quebec practice—patients called him, he made house calls, and then he directly billed his patients. The local health board cried foul and began fining him. The legal status of private practice in Canada remained murky, but billing patients, rather than the government, was certainly illegal, and so was private insurance.

Chaoulli gave up his private practice but not the fight for private medicine. Trying to draw attention to Canada's need for an alternative to government care, he began a hunger strike but quit after a month, famished but not famous. He wrote a couple of books on the topic, which sold dismally. He then came up with the idea of challenging the government in court. Because the lawyers whom he consulted dismissed the idea, he decided to make the legal case himself and enrolled in law school. He flunked out after a term. Undeterred, he found a sponsor for his legal fight (his father-in-law, who lives in Japan) and a patient to represent. Chaoulli went to court and lost. He appealed and lost again. He appealed all the way to the Supreme Court. And there—amazingly—he won.

Chaoulli was representing George Zeliotis, an elderly Montrealer forced to wait almost a year for a hip replacement. Zeliotis was in agony and taking high doses of opiates. Chaoulli maintained that the patient should have the right to pay for private health insurance and get treatment sooner. He based his argument on the Canadian equivalent of the Bill of Rights, as well as on the equivalent Quebec charter. The court hedged on the national question, but a majority agreed that Quebec's charter did implicitly recognize such a right.

It's hard to overstate the shock of the ruling. It caught the government completely off guard—officials had considered Chaoulli's case so weak that they hadn't

bothered to prepare briefing notes for the prime minister in the event of his victory. The ruling wasn't just shocking, moreover; it was potentially monumental, opening the way to more private medicine in Quebec. Though the prohibition against private insurance holds in the rest of the country for now, at least two people outside Quebec, armed with Chaoulli's case as precedent, are taking their demand for private insurance to court.

Rick Baker helps people, and sometimes even saves lives. He describes a man who had a seizure and received a diagnosis of epilepsy. Dissatisfied with the opinion—he had no family history of epilepsy, but he did have constant headaches and nausea, which aren't usually seen in the disorder—the man requested an MRI. The government told him that the wait would be four and a half months. So he went to Baker, who arranged to have the MRI done within 24 hours—and who, after the test discovered a brain tumor, arranged surgery within a few weeks.

Baker isn't a neurosurgeon or even a doctor. He's a medical broker, one member of a private sector that is rushing in to address the inadequacies of Canada's government care. Canadians pay him to set up surgical procedures, diagnostic tests, and specialist consultations, privately and quickly. "I don't have a medical background. I just have some common sense," he explains. "I don't need to be a doctor for what I do. I'm just expediting care."

He tells me stories of other people whom his British Columbia-based company, Timely Medical Alternatives, has helped—people like the elderly woman who needed vascular surgery for a major artery in her abdomen and was promised prompt care by one of the most senior bureaucrats in the government, who never called back. "Her doctor told her she's going to die," Baker remembers. So Timely got her surgery in a couple of days, in Washington State. Then there was the eight-year-old badly in need of a procedure to help correct her deafness. After watching her surgery get bumped three times, her parents called Timely. She's now back at school, her hearing partly restored. "The father said, 'Mr. Baker, my wife and I are in agreement that your star shines the brightest in our

heaven,' ” Baker recalls. “I told that story to a government official. He shrugged. He couldn't fucking care less.”

Not everyone has kind words for Baker. A woman from a union-sponsored health coalition, writing in a local paper, denounced him for “profiting from people's misery.” When I bring up the comment, he snaps: “I'm profiting from *relieving* misery.” Some of the services that Baker brokers almost certainly contravene Canadian law, but governments are loath to stop him. “What I am doing could be construed as civil disobedience,” he says. “There comes a time when people need to lead the government.”

Baker isn't alone: other private-sector health options are blossoming across Canada, and the government is increasingly turning a blind eye to them, too, despite their often uncertain legal status. Private clinics are opening at a rate of about one a week. Companies like MedCan now offer “corporate medicals” that include an array of diagnostic tests and a referral to Johns Hopkins, if necessary. Insurance firms sell critical-illness insurance, giving policyholders a lump-sum payment in the event of a major diagnosis; since such policyholders could, in theory, spend the money on anything they wanted, medical or not, the system doesn't count as health insurance and is therefore legal. Testifying to the changing nature of Canadian health care, Baker observes that securing prompt care used to mean a trip south. These days, he says, he's able to get 80 percent of his clients care in Canada, via the private sector.

Another sign of transformation: Canadian doctors, long silent on the health-care system's problems, are starting to speak up. Last August, they voted Brian Day president of their national association. A former socialist who counts Fidel Castro as a personal acquaintance, Day has nevertheless become perhaps the most vocal critic of Canadian public health care, having opened his own private surgery center as a remedy for long waiting lists and then challenged the government to shut him down. “This is a country in which dogs can get a hip replacement in under a week,” he fumed to the *New York Times*, “and in which humans can wait two to three years.”

And now even Canadian governments are looking to the private sector to shrink the waiting lists. Day's clinic, for instance, handles workers'-compensation cases for employees of both public and private corporations. In British Columbia, private clinics perform roughly 80 percent of government-funded diagnostic testing. In Ontario, where fealty to socialized medicine has always been strong, the government recently hired a private firm to staff a rural hospital's emergency room.

This privatizing trend is reaching Europe, too. Britain's government-run health care dates back to the 1940s. Yet the Labour Party—which originally created the National Health Service and used to bristle at the suggestion of private medicine, dismissing it as “Americanization”—now openly favors privatization. Sir William Wells, a senior British health official, recently said: “The big trouble with a state monopoly is that it builds in massive inefficiencies and inward-looking culture.” Last year, the private sector provided about 5 percent of Britain's nonemergency procedures; Labour aims to triple that percentage by 2008. The Labour government also works to voucherize certain surgeries, offering patients a choice of four providers, at least one private. And in a recent move, the government will contract out some primary care services, perhaps to American firms such as UnitedHealth Group and Kaiser Permanente.

Sweden's government, after the completion of the latest round of privatizations, will be contracting out some 80 percent of Stockholm's primary care and 40 percent of its total health services, including one of the city's largest hospitals. Since the fall of Communism, Slovakia has looked to liberalize its state-run system, introducing co-payments and privatizations. And modest market reforms have begun in Germany: increasing co-pays, enhancing insurance competition, and turning state enterprises over to the private sector (within a decade, only a minority of German hospitals will remain under state control). It's important to note that change in these countries is slow and gradual—market reforms remain controversial. But if the United States was once the exception for viewing a vibrant private sector in health care as essential, it is so no longer.

Yet even as Stockholm and Saskatoon are percolating with the ideas of Adam Smith, a growing number of prominent Americans are arguing that socialized health care still provides better results for less money. “Americans tend to believe that we have the best health care system in the world,” writes Krugman in the *New York Times*. “But it isn’t true. We spend far more per person on health care . . . yet rank near the bottom among industrial countries in indicators from life expectancy to infant mortality.”

One often hears variations on Krugman’s argument—that America lags behind other countries in crude health outcomes. But such outcomes reflect a mosaic of factors, such as diet, lifestyle, drug use, and cultural values. It pains me as a doctor to say this, but health care is just one factor in health. Americans live 75.3 years on average, fewer than Canadians (77.3) or the French (76.6) or the citizens of any Western European nation save Portugal. Health care influences life expectancy, of course. But a life can end because of a murder, a fall, or a car accident. Such factors aren’t academic—homicide rates in the United States are much higher than in other countries (eight times higher than in France, for instance). In *The Business of Health*, Robert Ohsfeldt and John Schneider factor out intentional and unintentional injuries from life-expectancy statistics and find that Americans who don’t die in car crashes or homicides *outlive* people in any other Western country.

And if we measure a health-care system by how well it serves its sick citizens, American medicine excels. Five-year cancer survival rates bear this out. For leukemia, the American survival rate is almost 50 percent; the European rate is just 35 percent. Esophageal carcinoma: 12 percent in the United States, 6 percent in Europe. The survival rate for prostate cancer is 81.2 percent here, yet 61.7 percent in France and down to 44.3 percent in England—a striking variation.

Like many critics of American health care, though, Krugman argues that the costs are just too high: “In 2002 . . . the United States spent \$5,267 on health care for each man, woman, and child.” Health-care spending in Canada and Britain, he notes, is a small fraction of that. Again, the picture isn’t quite as clear

as he suggests; because the U.S. is so much wealthier than other countries, it isn't unreasonable for it to spend more on health care. Take America's high spending on research and development. M. D. Anderson in Texas, a prominent cancer center, spends more on research than Canada does.

That said, American health care is expensive. And Americans aren't always getting a good deal. In the coming years, with health expenses spiraling up, it will be easy for some—like the zealous legislators in California—to give in to the temptation of socialized medicine. In Washington, there are plenty of old pieces of legislation that like-minded politicians could take off the shelf, dust off, and promote: expanding Medicare to Americans 55 and older, say, or covering all children in Medicaid.

But such initiatives would push the United States further down the path to a government-run system and make things much, much worse. True, government bureaucrats would be able to cut costs—but only by shrinking access to health care, as in Canada, and engendering a Canadian-style nightmare of overflowing emergency rooms and yearlong waits for treatment. America is right to seek a model for delivering good health care at good prices, but we should be looking not to Canada, but close to home—in the other four-fifths or so of our economy. From telecommunications to retail, deregulation and market competition have driven prices down and quality and productivity up. Health care is long overdue for the same prescription.