

# What America Needs to Learn from Canadian Medicare

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*“The first lesson of economics is scarcity: There is never enough of anything to satisfy all of those that want it. The first lesson of politics is to disregard the first lesson of economics.”*

Thomas Sowell

As a Canadian physician practicing in the U.S., I am confident that the systemic problems in American medicine pale in comparison with those of Canada.

During the late 1990s and until my family and I moved to the Twin Cities in Minnesota in 2001, I served as medical director of Diagnostic Imaging at Thunder Bay Regional Hospital (TBRH). At that time, our hospital’s waiting list for computerized tomography (CT) averaged 7 months. Patients waited 13 months for magnetic resonance imaging (MRI).

My duties included the nightmarish task of trying to rationally triage waiting lists, deciding which patients had immediate needs, and which would be left to suffer for months before receiving care. Some of TBRH’s imaging equipment was rundown and unsafe. The government forbade us as doctors to generate profits that could have been invested to provide safe, modern, and timely care. This put our patients at risk.

TBRH faced constant serious shortages of qualified medical and support personnel. The Canadian Association of Radiologists recommended one radiologist per 13,000 population.<sup>1</sup> Yet in the Thunder Bay region, there were only three full-time radiologists. We served an area of 250,000, giving us a ratio of one radiologist to 83,000 people.

The Fraser Institute reports that the average wait time to see a specialist in Canada is now 17 weeks.<sup>2</sup> Sixteen percent of Canadians have no access to primary care, yet referrals must be obtained from a family doctor prior to seeing a specialist.<sup>3</sup> In my hometown of Sault Ste. Marie, Ontario, unless “connected” to someone in the medical system, newcomers to town must wait 5 years to see a family doctor.

It is astonishing to discover that some Americans see Canada’s system of government-delivered universal health care as a utopian solution to systemic medical services delivery problems in the U.S. Voters just elected one of these Americans as President. President Obama’s long-term vision for the U.S. is a national single-payer system, although he covered this intention by expressing desire for “universal” health care.

From my life growing up in Canada, studying and practicing there, and working within the system, I have learned several key lessons. I hope that Americans will learn them, too.

## Lesson One: Central Planning Does Not Work

About 20 years ago, Canada grappled with medical cost escalation. Provincial medical insurance plans cover services and are paid by the government. Individuals had no personal financial responsibility (beyond exorbitant taxes). Costs ran rampant because people consumed as many medical services as they wished, and why not? Someone else paid for it.

To reduce expenditures, the government reduced the number of doctors. This intentionally created a limitation on availability of services.<sup>4</sup> Government planners looked at doctors as cost-generators,

not because of their fees, but because they engaged in costly acts, such as admitting patients to hospitals and ordering tests. The government reduced medical school admissions, but its plan worked too well: Canada now suffers from dire physician shortages. Canada has 25 percent fewer physicians per capita than does the U.S., a statistic made worse when one realizes that the U.S. is short a large number of physicians in various specialties.<sup>5</sup>

Humanity has witnessed improved treatments for heart disease and cancer that allow more people to live longer. The use of imaging technology has exploded. The need for doctors, and especially radiologists, has increased, not dropped. Along with the mandated decline in medical school admissions, the government of Canada turned a deaf ear to disgusted physicians like me who have moved to the U.S. About 11 percent of Canada’s physicians work in the U.S.<sup>6</sup>

When government pays for medical services, it inevitably must control them. Canada’s medicare system was, at first, merely government insurance to cover costs. Since no third party, even government, has infinite resources, it must establish obstacles in order to control delivery of medical services. Canada covertly rations care by limiting the supply side—the number of doctors, available CT and MRI scanners, and other resources.

In the U.S., insurers may deny claims or refuse to enroll sick people. When third parties control dollars, patients lose freedom and autonomy. Private-pay insurers function like mini-socialist systems in which power and decision-making are removed from the doctor and patient and placed in the hands of a central authority.

A few years ago, when I was visiting my ill brother in the hospital in Canada, I saw a coffee shop in the hospital lobby. It did a thriving business. People bought coffee with their own money. Ironically, though they could spend their own money for coffee and doughnuts, the government prohibited them from spending their own money for medical care in the same hospital.

Because Canada’s government prohibits profit, Canadian hospitals must cover operational costs from a government-derived global budget—a cap on total expenditures. The hospital coffee shop, like other free-enterprise businesses, covers costs from profits derived from providing service. The hospital’s prime motivation, in contrast, is not to provide services but to save money and stay within its budget. Therefore, the hospital closed its MRI clinic on weekdays after 5 p.m., and on weekends and holidays. The coffee shop stayed open.

My brother lay in the hospital during Christmas, suffering a life-threatening illness. He desperately needed an MRI to definitively diagnose his condition. He could have had all the coffee he wanted, but not an emergency MRI.

At TBRH, owing to our desperate manpower shortage, we required a rolloscope to facilitate reading large numbers of radiographs. These devices were common in U.S. radiology departments. Since the purchase of a rolloscope exceeded available funds in the hospital’s budget, we had to plead with bureaucrats in the Ministry of Health, 700 miles away, for funds to purchase this essential equipment. After three years, TBRH finally got its rolloscope. It then sat idle for another year because the hospital had no money in the budget to hire an employee to load the films.

After beginning my work in the U.S., I saw my caseload steadily rise. I requested a rolloscope, knowing it would allow us to read more X-rays better and faster, generating larger profits and enhancing service. My request was granted within a month. The potential for profit in America signaled the purchase of a rolloscope as a rational

allocation of resources, just as a hospital would be signaled to extend its MRI hours to meet demand in a market system.

Advocates of “universal health care” imply that a few bureaucrats are better able to decide where money should be spent than are millions of individuals interacting in the marketplace with a free exchange of dollars.

The rolloscope issue provides a microcosm of how the Canadian system functions. As Ministry of Health bureaucrats reviewed my funding request from afar, they would have simultaneously fielded a multitude of requests from other clinics, doctors, hospitals, and public health program administrators across a geographical area larger than France. It is not possible for bureaucrats to correctly discern the exact distribution of funds for all of these competing expenditures. By contrast, every time dollars exchange hands in a free market, information is propagated about where it is useful to direct capital to garner profit by meeting people’s needs and desires.

Canada’s central payment system also leads to central control. No individual or group of individuals can assimilate all of the information necessary to coordinate a complex enterprise like medical care through central control. Friedrich von Hayek, Austrian-school economist and critic of collectivist market planning, called the concept that this could be done “the fatal conceit.” President Obama suffers from this conceit when he asserts that the federal government can “fix health care.”

Obama plans to create a federal government agency to make sure that the uninsured can enroll in health insurance. Employers will be assessed penalties if they refuse to provide health insurance. Some Massachusetts employers, after the state implemented such a system, found that it is easier to pay the penalty and let their employees deal with the government. It is really an ingenious means of increasing government’s market share of health insurance.

Canada has clearly shown that as government takes over more medical financing, no matter the mechanism of payment, it will begin to control costs by limiting services. In the U.S., this will result in a more intense form of centralized control than I witnessed in Canada. At least in Canada, medicare is largely administered on a provincial level, allowing for some delivery experimentation. Canada’s population is a little more than one-tenth that of the U.S. Imagine the difficulties with having patients’ medical decisions made in Washington, D.C., for more than 300 million people. Stodgy, clunky bureaucracies cannot possibly meet patients’ needs in the way the marketplace does in almost every other economic sector.

## **Lesson Two: Price Controls Do Not Work**

Canadian physicians’ fees are paid based on a government-designated schedule, a form of price control.

When I worked in northern Ontario, I was the only radiologist doing peripheral angioplasties for almost 500 miles around. When I left Thunder Bay, nobody was willing to do the procedure because the doctor earned less than a plumber was paid to fix pipes.

With insufficient compensation for their time, effort, or investment of capital, doctors had a disincentive to provide services. Artificially low compensation created a shortage of angioplasty services. In a free society, government cannot dictate prices; instead, they are determined by mutual agreement between buyers and sellers. If a shortage occurs in supply, but demand continues, prices rise, but only temporarily. An increase in price signals others to offer the service. As more competitors provide the service, prices drop. Wage and price controls negate the price signal. A medical system handicapped by price controls will always suffer shortages.

Prices for medical services in the U.S. are not quite as rigidly set as they are in Canada, but there is some similarity. Fees are not tied to supply and demand, but to arbitrary Medicare fee schedules. As a consequence, the U.S. faces a shortage of family physicians, who are paid less than specialists. If the U.S. government’s role in medicine is allowed to expand, government planners will dictatorially reduce prices, and U.S. residents will be forced to tolerate Canadian-style shortages.

## **Lesson Three: Whoever Controls the Dollars Is Boss**

In free markets, power is decentralized and every consumer with even one dollar to spend has some power. When buying a new computer, a person endorses the vendor that produced it. Tens of millions of people participate in the computer market, and as they interact with it and make purchase decisions, designers and manufacturers produce a dizzying array of powerful new products at low cost with highly individualized features.

Contrast this with Canadian medicine, in which a relatively small number of bureaucrats decide how to disperse the medical dollars. To paraphrase economist Milton Friedman, in free societies generally people get what they want. In government-controlled societies, people get what a bureaucrat says they may have.

In Thunder Bay, we had a dilapidated 12-year-old angiography suite. It was as outdated and clunky as a 12-year-old computer. It frequently broke down in the middle of procedures. On one occasion, I had great difficulty threading the catheter from the femoral artery into the internal carotid artery. The iatrogenic risk of stroke was enhanced by tortuous atherosclerotic vessels. When I finally got the catheter in place and was ready to take the diagnostic pictures, the machine failed. My anxiety level soared because I knew that the longer the procedure was prolonged, the greater the danger to the patient. Fortunately, the technologist got the angiography unit to work, and I obtained the necessary images.

Concerned for patient safety after this troublesome procedure, I sought legal counsel. The lawyer told me that since I knew the equipment was unsafe, I was obligated to inform patients prior to procedures. The hospital had previously denied the funds necessary to replace this essential piece of equipment. After I began telling each patient about the usual risks of angiography, plus the additional risk from the unsafe equipment, change happened quickly. When I informed the hospital administrator of the lawyer’s advice to issue the warning, the necessary million dollars suddenly appeared.

Only a legal threat enabled me to influence those holding the levers of power. In the freer market in the U.S., no hospital could stay competitive using such dangerous equipment. Even though the average patient knows very little about angiography and the required facilities, reputation in the marketplace is crucial. Consumer opinion directly affects decisions about investments in the purchase and maintenance of equipment.

Canadian doctors and patients have little autonomy. I saw many shortages that could have been relieved through individual entrepreneurship, but the government disallowed it: The government could do this because it is the paymaster. Evolution of Canadian medicare has shown that increasing government influence creates more obstacles to care. This will happen in the U.S. if the Obama Administration’s plans succeed.

The original Americans placed immense value on the inalienable right to “Life, Liberty, and the Pursuit of Happiness.” Their concept of liberty is at odds with government-run medical care. Based on the Declaration of Independence and the U.S. Constitution, Americans are free and sovereign individuals. As more medical dollars fall under control of government rather than individuals, a loss of personal freedom is inevitable.

Since 2003, the U.S. federal tax system has encouraged the use of Health Savings Accounts. HSAs are a brilliant innovation that serves to decentralize power by placing it in the hands of individuals rather than third-party payers. HSAs allow patients to function as customers, and as such, their actions put downward pressure on the demand for medical care. In contrast, the low copayments in managed-care plans provide the opposite incentive.

Patients are best served when they directly pay for common health expenses and use insurance to protect their assets in case of a catastrophic loss. If millions of Americans switched to these catastrophic health insurance plans, the price of insurance and medical services would fall, at the same time that the number of people with insurance would increase.



Beneficial reforms put individuals in control rather than government. Unfortunately, President Obama's reform plan favors government intrusion, not patient initiative.

#### Lesson Four: Medical Care Is Not a "Right"

The United States is unique among nations in that it was originally based upon the value of individual liberty: freedom from coercion. No individual or government had a presumptive claim to the property or labor of others.

Liberty requires rights. Rights are a just claim to freedom of action. The original rights as recorded were "negative" in that they implied the absence of interference. The only individual obligation was to refrain from interfering with others. In contrast, positive rights impose an obligation for someone to do something for others. The Bill of Rights is a list of negative rights.

A "right to health care" implies that someone has to provide it. But what of the liberty rights of physicians, nurses, and other medical workers? Or the property rights of taxpayers and entrepreneurs? Some rights must be abrogated to meet the demands of a positive right. President Obama and other politicians who call a professional service a "right" do not understand the founding principles of the United States.

#### Lesson Five: People Can Be Persuaded to Accept Poor Care

Why do Canadians tolerate the current state of affairs?

Canadian culture is distinctly different from that of the U.S. Canadians are a more placid people, less inclined to object to government power. My maternal ancestors evidenced this: They were United Empire Loyalists and moved to Ontario to remain British subjects during the American Revolution.

Canadians are more inclined to know and keep their place, rather than to become like the "rugged individualists" of America. Canadians are more likely to accept what they are allowed to have, rather than demand the freedom to pursue what they desire.

Unlike Jefferson's bold assertion of God-given rights in the Declaration of Independence, the staid wording of Canada's Constitution calls for "peace, order and good governance."

According to the Canadian cultural ethos, profits are tainted, especially in medicine. The Canadian culture demonizes the more capitalist nature of American medicine.

Many Canadians prefer their system to America's. The fact is that at any given time, most people are healthy. They have no reason to compare the quality of, and access to necessary medical services. The 725,000 Canadians who languish and suffer while on waiting lists are a minority of Canada's 33 million citizens.<sup>7</sup> Canadians also continue to tell me that their care is "free," while forgetting the exorbitant taxes they pay.

Canadians fear the "Americanization" of medicine. They generally believe that Americans leave uninsured people to die from lack of medical attention.

Like most Canadians, for much of my life I believed that American and Canadian health care were "opposites," with one being a government system and the other being a "capitalist" system. The reality is that the defects of both are largely caused by government intrusion.

The decay of Canadian medicine took many years. Canada instituted its medicare-for-all system in a simpler time when far fewer diagnostic and treatment options were available. Canada's global budget does not allow it to keep up with new developments. In the U.S., the expansion of government medicine, with its emphasis on containing spending, will likely cause similar abrupt dislocations in resource availability.

Despite their professed individualism, however, Americans quietly accept statist programs like Social Security that have dangerously large unfunded liabilities. They also accept public education and its lackluster results. No U.S. politician would dare suggest discarding these vast social programs, regardless of their inability to deliver on their promises. Medicare reform, like these, is a "third rail" of politics.

Canadians were sold a bill of goods. There is no reason to believe that Americans will not also be seduced and willingly come to embrace more government medicine.

#### Lesson Six: There Are Major Similarities Between Canadian and American Medicine

When I moved to the U.S., I was stunned by the abundance of resources available to doctors. Doctors can schedule tests immediately, with a phone consultation with a radiologist and a typed report in minutes. In contrast, when my Canadian father needed an MRI scan last year for an expanding mass on his knee, it took 4 months just to get the report.

In Canada, imaging clinics may be 500 miles apart. There are more MRI scanners in Edina, Minnesota, than there were in the entirety of western Canada during my residency. This American abundance exists because the U.S. retains at least the vestiges of a market system in medicine.

Eventually, I realized the similarities of the two systems. Both systems rely on third-party payment with its escalation of demand. Canadian federal and provincial governments together pay 70 percent of medical costs—some services like Lasik eye surgery, dentistry, and prescription drugs for most non-seniors are not covered under the government plan.<sup>8</sup> In the U.S., government (at federal, state, and local levels combined) pays 46 percent of medical costs.<sup>9</sup>

In the U.S., Medicare exerts price controls that affect almost all payments for medical services. Governments apply heavy regulatory controls on the provision of medical care and the insurance industry. U.S. doctors have almost all experienced state and federal nonphysician bureaucrats telling them how to practice medicine.

"On health care reform, the American people are too often offered two extremes—government-run health care with higher taxes, or letting the insurance companies operate without rules," Obama's campaign website erroneously states.

A more meaningful dichotomy would be externalized control versus individual freedom. Obama tempts the public with his enticing promise of "universal health care." But Benjamin Franklin said it best: "They who would give up an essential liberty for temporary security deserve neither liberty or security."

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