Northern Exposure: Why Canada's Health Care System is No R*x* for America

Sally C. Pipes

Sally C. Pipes is president and CEO of the Pacific Research Institute, a San Francisco-based think tank. She spoke at an American Experiment luncheon in March.

I am going to focus on the findings of my upcoming book, ***Miracle Cure: How To Solve America's Health Care Crisis and Why Canada Isn't the Answer*** in which I debunk the myths and explain the realities of a fully socialized health care system—to be specific, the one that exists in my former home country, Canada. As P.J. O'Rourke says, "If you think health care is expensive now, wait until it is free."

I am probably not the only one here who can speak from personal experience. I would not be surprised if some of you have met or know Canadians who escape the cold winters and migrate to the sun of California or Florida (because you may go to those places yourself) to receive health care in the United States. You may also know doctors who were trained in Canada but emigrated to the United States to practice medicine.

There is a reason (other than the nice weather) that so many Canadians come to America to receive health treatment. It is because their system is not performing.

If you have not already seen it, I urge you to see the Canadian documentary, ***Barbarian Invasions*** that just received an Oscar. It exposes the Canadian health care system in a very poor light and Americans need to see it.

My message is an important one because the debate on health care is now center stage.

It is one of the major domestic policy issues on the table in the U.S. and will continue through the 2004 election; and the Canadian-style single-payer system is often held up by

politicians, activists, and members of the media, as a model for Americans to emulate.

Of late, we have seen Democratic presidential candidate John Kerry and others, including some legislators in California such as state senator Sheila Kuehl, announce that universal coverage and its ultimate successor, single-payer, are the only viable solutions to the problems facing the U.S. health-care industry.

And some of you may know that on the eve of being recalled as governor, Gray Davis signed SB-2, a "Pay or Play" health care bill for California. This is a disastrous piece of legislation mandating that employers with fifty or more employees pay 80 percent of health care premiums or pay into a state health care purchasing pool. This is the type of legislation that other states must avoid. The estimated cost to employers and consumers is $7 billion.

It provides another incentive for employers to leave California and is a disincentive for new businesses to move to the state or to establish or expand an existing business. It also flies in the face of the federal ERISA law. The court has cleared the way for an initiative to be on the November ballot that we hope will pass so that this evil legislation will be repealed.

My health care message today is a most important one, one that not many Americans have heard but need to hear. The Canadian single-payer system offers only a false promise for what ails governments, patients, and doctors.

Today, after thirty years of government intervention, the Canadian system suffers from long waiting times for critical procedures, lack of access to current technology, increasing costs to taxpayers and patients, and a brain drain of doctors, who head south for better working conditions and more money.

While policy talk and statistics are, unfortunately, unavoidable, I will focus on how the health system treats those it's set up to serve, patients.

Single-payer System

I would like to briefly explain the structure of the Canadian system—a system that I think is useful for Americans to conceptualize as a collection of HMOs run by provinces. Canadian governments maintain complete control of health insurance for the hospital and physician sectors of the health care system, through interventions referred to as "Medicare," a joint program of federal and provincial governments, referred to as a "single-payer system."

Unlike in Britain—where the government actually runs many health facilities—the majority of hospitals and doctor's offices in Canada are nominally independent of the government. But the piper's payer calls the tune, and in Canada the government is the only payer the law allows. Governments control hospital capital budgets and decide what technology they can purchase and what services they can offer. In fact, Canada is the only Western country in which private insurance for publicly insured procedures is actually outlawed.[1] Britain, when they established the National Health Service in 1947, allowed private health care to

run parallel to the government program. This is something that politicians in the United Kingdom today wish had never happened. People in the U.K. for the last fifteen years have been moving to private insurance at increasing rates because of the waiting times and rationed care under government medical care. Canada did not make that mistake.

Through Medicare, the federal government sets and administers the national principles and standards for provincial health care.

In the U.S. context, Canada's Medicare is similar to U.S. Medicaid, the system through which state governments provide health insurance for poor Americans.

Incentives matter and one only need examine the incentives of the Canadian system to predict the results: inefficient use of resources and severe rationing of expensive procedures. Patients consider health care to be free.

They pay for it for sure. Canadian doctor and author David Gratzer estimates that the system costs a Canadian earning $35,000 a year $7,350. But they don't pay for it when they use it. The result is an overuse—and inefficient use—of primary care services.

Physicians are paid fees for service at government-set rates. This increased expenditures so many provincial governments capped the total amount they could bill in a year. Doctors who hit this cap simply take extended holidays, something that doesn't do much for their patients.

A system in which consumers pay nothing at point of consumption and producers are left free to decide what to sell is bound to be one plagued by increasing expenditures.

The only way for government to control spending is through global budgets. Remember Hillary care and the global budgets?

Rationing Care

Hence, doctors' annual incomes are capped and, even more important, so too are the budgets of hospitals. This results in a severe underinvestment in high-tech equipment that, in turn, results in rationing of care.

There's no denying that Canada suffers from a lack of high-tech equipment, not just compared to the United States but to all advanced countries.

In 1999, Canada, for example, had only 2.5 magnetic resonance imaging (MRI) units per million people. And that same year when my mother was suffering from dizzy spells in Vancouver, she was told that because of her age she could never have an MRI and she waited six months for a CT scan. Meanwhile in San Francisco, my cat got an MRI on the very day she needed it.

This compares to an average of five MRIs per million for thirty Organization for Economic Co-operation and Development countries. Canada ranks twentieth out of thirty OECD countries in MRIs per capita and twenty-second in the number of CT scanners per capita.[2]

Even the equipment hospitals have is increasingly obsolete.

The Canadian Association of Radiologists (CAR) reports that one in two

diagnostic imaging units—ultrasound, x-ray, and CT scan machines—requires immediate replacement.

The association's CEO, Normand Laberge, estimates that half of the 150,000 Canadians diagnosed each day with these machines suffer from imaging inadequacies. "Our radiology equipment is in bad shape," says Laberge, who pegs the replacement cost at $2 billion.

"Without immediate action, radiologists will no longer be able to guarantee the reliability and quality of examinations."

This is an appropriate place to emphasize an important point about costs and government spending, two distinct concepts.

"The large and growing gap between the United States and Canada," wrote Canada's leading health economist R.G. Evans and others in 1989 in ***The New England Journal of Medicine,*** "drives home the point that, for good or ill, the form of funding adopted by Canada does permit a society to control its overall outlays on health care." [3]

Notice the authors said outlays, not costs. This is important.

By limiting spending or outlays, governments have just shifted costs from taxpayers, who pay in monetary form, to patients, who bear the non-monetary costs in increased pain and suffering, and the monetary costs of lost wages or traveling to the United States for prompt treatment.

Case Histories, Stark Choices

The troubles with the Canadian system can't be adequately understood, even though important, by dry statistics, comparisons of MRIs per million. It has to be understood in human terms, what this lack of investment, the socialistic incentives, mean for people who need treatment.

In a system that claims to deliver comprehensive, accessible, and universal care, many Canadians find they must wait months and sometimes years for critical care. Canadians confront few barriers, no out-of pocket expenses, no insurance verification hurdles, and no bills—when they make an appointment with a ***primary*** care doctor.

But should that doctor diagnose a serious disease, Canadians, both young and old, are fast exposed to their system's limits.

Recently, I had an op-ed on ***National Review Online*** entitled, "Canada's Drug Mythology." The email response was incredible with the bulk being supportive of my view. Let me quote from one of the respondents: "You hit the nail on the head. As a Canadian, I could not begin to portray to you how broken our health care system is in this country." He included a brief, illustrative story.

Recently moving back to Sault Ste. Marie, Ontario, where his wife had grown up, he decided at thirty-two, it was time to get a physical exam. When he called his wife's doctor's office, he was told the waiting list for being

accepted as a new patient was five years. Five years just to get an appointment with a primary care doctor for a physical! To make matters worse, he was told if he knew anyone in the medical profession, he should use that contact to "jump the queue," something he is still trying to do.

He went on to say that what disappointed him was that Canadian politicians talk about equal access for all Canadians while those employed in health care and politicians use scare tactics to portray private health care as evil. Being told to work the system by a doctor's office, he was amazed that Canadians are told that there is no two-tier system when it is actually the day-to-day routine. His solution: "I am going to simply grab my VISA, drive across to Michigan and pay for an exam." So much for universal "free" health, he concluded.

If we get this type of health care, what will be our escape valve?

Eighteen-year old Joshua Fleuelling ran into the limits in January 1999, when his ambulance was turned back from a Toronto emergency room because it was so crowded they could not accept any additional patients. He was suffering from asthma, and by the time he reached the doors of the next closest emergency room, he was brain dead from lack of oxygen.[4]

Fifty-three-year old Jan A. Norwood confronted the limits in the fall of 2000, when her doctor determined she needed her left hip replaced.

She didn't cost the government any money for sixteen months, because she languished on a waiting list of more than 150 people in need of similar surgery. But the wait cost her dearly, emotionally, physically, and financially. "My life and that of my family, is severely impacted by my pain," Norwood wrote to a newspaper columnist. "I sleep less, am tired all the time and my income (as a consultant) is significantly reduced. My client base is eroding. My costs are increasing and my drugs are expensive. The pain is unrelenting," continued Norwood, "it saps my energy and ruins my life."[5]

The tradeoff between government outlays and human costs are well illustrated by the case of Ottawa nurse Trish Besner. In 2001, the thirty-one-year old mother started experiencing fainting spells and was told in October 2000 that she needed an MRI to diagnose her condition. "The doctors keep mentioning MS to me," Besner told ***The Ottawa Citizen***. "There is only one MRI for 555,000 residents, and more than 7,000 were already lined up for care."

So while the government saved on the $3.5 million price tag of an MRI machine, and the $2 million a year it takes to keep it running, Besner and her family bore many costs. All her doctor was able to do was offer a raft of drugs, one pill for her anxiety, another for her sleeping problems, and yet another for her seizures. They didn't work, which left her unable to care for her toddler. Her mother took an unpaid leave from her job to take care of her family. "She's lost weight. She's thin and drawn," reported her mother. "But we have no information as to what is wrong with Trish."

Tom Holland, director of diagnostic imaging for the Ottawa Hospital and therefore the man who grants access to the MRI Besner needs, can only offer his sympathies. "Unfortunately, we hear these stories all the time," says Holland. "There's a tremendous amount of anxiety for the patients and a tremendous amount of anxiety for those who are working here as well. Everybody associated with this operation deals with this on a daily basis."[6]

Norwood and Besner's cases are routine. Patients in such straits face stark choices. Many, like Canadian Sen. Edward M. Lawson, run for the border and pay for prompt care in the United States. Lawson experienced chest pains in August 2001 and his doctor told him he'd have to wait a month for an angioplasty, the recommended treatment.

No thanks, he said, as he headed to Seattle to purchase prompt care.[7] When lines get too bad, the provinces may actually fund the ticket and treatment in the United States. Ontario, for example, sent just under 1,800 cancer patients south for care.

The Vancouver-based Fraser Institute has long been tracking waiting times in Canada through its annual surveys of doctors. Between 1993 and 2002–03, the median waiting time from referral by a general practitioner to treatment increased from nine weeks in 1993 to 17.7 weeks in 2002–03.

This is a doubling in ten years. Waiting times increased across all specialties. For cancer patients, the waiting time for medical oncology more than doubled from 2.5 weeks to 6.1 weeks, and the waiting time for radiation oncology increased from five weeks to 8.1 weeks.[8] The government of Alberta now has a website where citizens can log on to find out the waiting time for a particular specialty.

Doctors Without Borders

There is also the issue of many Canadian doctors that live close to the border emigrating to the United States. In recent years, the supply of family doctors in Canada has increased at a rate lower than population growth.

And, there are signs that the brain drain of specialists to the U.S. is becoming a serious problem.

There was a net migration of forty-nine neurosurgeons from Canada between 1996 and 2002, according to the Canadian Institute for Health Information, a significant loss considering that there are only 241 neurosurgeons in the whole country of 31 million.

Drs. Siva Sriharan and Srinivas Chakravarthi are pondering following others who have left.

They are neurosurgeons in the car-producing town of Windsor, Ontario, which is right across the river from Detroit. Now they can get all the hamburgers, ribs, and potato skins that they can eat for the rest of their lives from Casey's Bar and Grill. For the next year, they can also get their hair cut free at a Touch of Class and lease a Pontiac Grand Am without charge from a dealer. They have been offered free house repairs and landscaping. All the two doctors have to do is remain in Windsor.

Residents started offering gifts when the rumor surfaced at Hotel-Dieu Hospital a few weeks ago that the two neurosurgeons—of the four serving the city—were thinking about moving their practice to the United States

Why are they considering moving to the United States? Because the two surgeons are sharply critical of Canada's health care system, which is driven by government-financed insurance for all but increasingly rations service because of various technological and personnel shortages.

Both said they are also fed up with the two-tier system in which those with connections move to the head of the line for surgery. Are they tempted by the generous offers? They say while they are touched and embarrassed, they do not see how they can continue to practice in Canada. This is a growing problem in Canada and there is no end in sight.

And It's Not Even Cheap

Those who advocate a single-payer system for the United States need to acknowledge an important fact and answer a critical question. First, for all its rationing, the Canadian system is not inexpensive. In fact, it's the third most expensive health system in the world, after the U.S. and Switzerland. The question they must answer is would Americans tolerate the waiting times and limits on care that a single-payer system would impose?

These, in fact, are the questions that Canadians are asking themselves. Canadians are of two minds when it comes to their health system. They admire and cherish it as a collective accomplishment, a system that does not charge a ticket price at the point of admission to a hospital or doctor's office.

Yet, they are frustrated by the rationing and queuing that this accomplishment produces. This contradiction produces a stream of high-profile studies, and commissions to study ways to improve the system without ever changing it. They all come to a similar conclusion, that the system needs more money. The government commissioned a Royal Commission to investigate the problems with the Canadian health care system. After spending $15 million, the Romanow Report was released saying that the problems could all be solved with more money. The taxpayers are already taxed to death and the politicians know that they cannot increase the tax burden for the citizens. After spending all that money, the interesting point was that the commission said in the beginning, that they would not be considering any proposals to privatize any aspect of the Canadian system. The whole study was a further waste of taxpayer dollars and without any improvement in the problems with the Canadian health care system.

My focus on the problems with the Canadian system—and my adamant opposition to its replication in the United States—should not be taken as an endorsement of the status quo in U.S. health care.

Options for the United States

Although America's multi-payer system has many strengths, universal coverage isn't among them. In the United States, health insurance—which, if like other types of insurance, would cover catastrophic losses and therefore be used sparingly—has evolved into pre-paid medicine offered as a form of employee compensation. In this sense, the first dollar coverage offered by HMOs resembles the same incentive structure faced by Canadians. The low out-of-pocket expenditure at the point of consumption encourages demand that must be contained with restrictions.

The incentives of pre-paid medicine also increase the price of insurance, which, as we know, leads to fewer people purchasing it, either for their employees or for themselves individually. This feeds the major problem facing U.S. health care—the approximate 44 million Americans, most of them working, who lack health insurance.

The challenge we face is addressing this problem without destroying the dynamic nature of U.S. health care by moving down the path to more centralized government control.

President Bush gave us hope, during his 2004 State of the Union Address, that we will not follow Canada's lead.

> The American system of medicine is a model of skill and innovation," he argued, "with a pace of discovery that is adding good years to our lives. Yet for many people, medical care costs too much – and many have no coverage at all. These problems will not be solved with a nationalized health care system that dictates coverage and rations care.
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> Instead, we must work toward a system in which all Americans have a good insurance policy … choose their own doctors … and seniors and low-income Americans receive the help they need. Instead of bureaucrats, and trial lawyers, and HMOs, we must put doctors, and nurses, and patients back in charge of American medicine.

What the United States needs, and what Canada needs for that matter, is more health care freedom, freedom that provides the proper incentives to patients, doctors, and hospitals.

Specifically, both countries need versions of Health Savings Accounts, approved in the new U.S. Medicare bill passed in December, private insurance arrangements that combine a personal spending account with catastrophic health insurance. In Canada, this would allow for competition with the government system, and give patients control of their health care choices.

In the United States, it would do much to cut out the HMO and insurance company middlemen in most health care transactions.

Health insurance should not be tied to employment. This came about as a government concession to employers after WWII, when wage and price controls were in effect. This made sense at that time, given the tax incentive and the fact that people tended to work for one company their entire lives. In today's dynamic job market and changing family structures, it no longer

makes sense. This system ties people to their employer and limits their choices of health care.

The key to excellence in any endeavor or field is competition—competition among models and providers.

In the United States new ways of providing, and paying for care, are being tested all the time. Employer-based insurance—which won't be going away anytime soon—defined contribution plans—which limit the employer expenditure and provide employees with incentives to purchase care wisely—are emerging, as are Health Reimbursement Accounts (HRAs).

PPOs (Preferred Provider Organization), HMOs, HRAs (Health Risk Assessment), HSAs (Health Savings Account), fee-for-service plans should all be allowed to coexist in a competitive market. Consumers should be able to decide what arrangement best suits their needs.

By opening up the market to competition, reducing government mandates, and changing the tax treatment, we would also see a major reduction in the uninsured population in this country. After all, federal government employees have choice under the FEHBP (Federal Employee Health Benefits Plan). We should all have that choice.

A Call to Arms

I shall close with a short story. Last August, I attended the initiation—the so-called White Coat ceremony—for Columbia University's entering medical class of 2006. My best friend's son (also Canadian) was among those being admitted. The keynote address was delivered by Dr. Ben Carson, a noted pediatric neurosurgeon at Johns Hopkins University.

Dr. Carson has developed several of the latest techniques that are used in brain surgery today. Thirteen years ago, he performed the first separation of conjoined twins in Zambia in what turned out to be a twenty-eight-hour operation.

The interesting part of the story is that Dr. Carson spent his early life in Detroit and Boston living with his mother and brother in abject poverty. In the third grade, the class named him "dummy" because of his low achievement levels. However, by the fifth grade, young Ben Carson was the top student in his school and he never looked back.

He fulfilled a lifelong dream of becoming a doctor. As a neurosurgeon at Johns Hopkins, he has treated kings, queens, princes, and executives from all over the world. People still regard America as the place to come when they need the best and the latest in medical technology and treatment.

He said that regardless of the amount of money, cars, castles, or homes these people had, nothing was more important to them than restoring their health. We must fight to retain our position of having the best medical treatment in the world.

Dr. Carson concluded his emotional remarks with a call to arms for Columbia's medical class of 2006. He pointed out that his generation had been apathetic in fighting the changes that

have been slowly destroying health care in America.

He said, "You are the generation of doctors that must stand up and fight" for restoring the doctor/patient relationship, for halting and reversing the government takeover of medical care, for slowing down the consolidation of everyone into HMOs, and for the reform of medical malpractice law.

"If you are not prepared to engage in this battle," he said, "you may as well consider a career in a field other than medicine. You are the future and you are the individuals who can save health care in America—the country that has had the best medical care system in the world." Let's not lose this battle to a single-payer health care system such as exists in Canada. Today, Canada has the best health care that the 1970s can provide.

[Endnotes follow the questions and answers.]

Following her speech, Sally Pipes took questions from her American Experiment audience.

Bill Wenmark: I wonder if you can comment on what is going on here at the Minnesota Legislature with our Republicans, who are going to mandate that the commissioner of health get involved in what they call best practices, or regulating how the doctor will practice in particular disease areas, and, at the same time, if they agree to those guidelines that will be established by the commissioner that they will get relief from malpractice. We don't know who is going to provide that, but we think the state will provide that. I wonder if we aren't heading down the road of Canada by giving over that control of the practice of medicine to the commissioner.

Sally Pipes: I would definitely say yes. There are several states that are considering best practices, and it really is putting the government, as another form of a middleman, in control and taking the decision-making away from doctors. And that, you know, that is just moving down a slippery slope and is not opening up the market to more competition. So, I think it's bad for Minnesotans and I think it's bad for those other states that are looking at this kind of legislation right now, too. It's not a good sign.

Twila Brase: I'm from Citizens Council on Health Care and I want to reaffirm what Bill is saying. Because it's actually not just coming from the Republicans, it's coming from the DFL, as well. Our organization has a citizens' petition to help prevent that from happening. And I think that you're right. Do you see that at all in Canada, that they tell doctors how to practice and then reward them for practicing? Or is that just something now that's coming to the different states like it is coming to here in Minnesota?

Sally Pipes: I would say it's just coming here in the U.S. In Canada, the real issue is that the primary care doctor is the person that determines who's going to see who and at what time. That's why there are so few specialists and the specialists have these

global budgets that people have to go on the waiting list. It's just another form of control. But this best practices is another form of government control of health care. In Canada, as I mentioned, the Romanow Commission report was set up because there was such an outcry. When people in the media become concerned about waiting lists, when people in their family cannot get good care, that's when you saw the start of a huge backlash against the Canadian health care system. And you're seeing it growing more and more. And, yet, the government is not prepared to open up the Canadian system. Just like in public education, they say we need to add more dollars. Well, we've seen, in Washington, D.C., where we pay $10,000 per child and the scores are still going down. You know, it's not about more money. It's about opening up and letting people have more access to what they need.

Ken Richard: I'm a small business owner and I sit on the Small Business Policy Committee for the state Chamber of Commerce. I have testified at the Legislature on small business health care issues for a number of years. I wanted to remind everybody in the room that 56 percent of all employees in this state are employed by small businesses. So, small business is the biggest business in the state of Minnesota.

Sally Pipes: And actually all over America.

Richard: We have 88 percent of our health care with three major carriers here, and thirty-nine different mandates that help prevent us from having competition. We need the competition.

Sally Pipes: Absolutely. I completely agree. Because out of the 44 million uninsured in this country, 35 million are adults and 8.5 million are children. And the Urban Institute, which is not known to be in my camp, they said that one-half of the 8.5 million children are eligible for SCHIP—the State Children's Health Insurance Program—but they refuse to sign up. And of the 35 million uninsured adults, one in four is under twenty-four years of age; half are under thirty-five. They say that health care insurance is a bad deal because it's too expensive and they're healthy, so they decide not to buy it. And of the uninsured, one in three lives in households with an income greater than $50,000, and one in seven with an income over $75,000. So, those are important things to remember when we think about, you know, what is the makeup of the 44 million uninsured? Because if you follow the media, you think that the 44 million uninsured are people who are born today but when they get on Medicare at 65, that's when they get health care, and it's just not the case. Small business is very excited by HSAs, and the bulk of the purchasing of HSA accounts has not been in young people, it's been in the age group forty to fifty. I think that's very telling.

Janet Nilson: This is on the other side of the coin. I agree with a lot of what you're saying, but what happens to the individual who has insurance with Company A and develops a

chronic or long-term disease and cannot move, transfer coverage, etc. How would you recommend that a situation like that be handled?

Sally Pipes: That's why I think that health savings accounts are such a great idea. You have your health savings account and you put money in, which is tax-deductible, the premium, and it's also portable. You start building up money in your account. And then if you have a catastrophic problem, then your long-term catastrophic provider covers that insurance. And I think that is the answer to the problem in this country. It will really give people long-term coverage, and HSAs are a great way. Medical savings accounts were a good idea, but they were not portable and what you had left over was taxable. So this is a much improved part of the Medicare bill, of which I wasn't in support of except for the HSA aspect of it. Because we've already seen it go from a $400 billion mandate—actually over eight years, not ten, because it starts in 2006—to the administration saying now it's about a $534 billion program. And have we ever seen a government program when they do the estimate correctly? Look at what the Medicare program was supposed to cost and what it has cost. So, it's going to be a huge burden on young people, because we're not replacing ourselves in terms of renewing the population. When today's young people are in the workforce, they're going to be paying huge bills for people like me, and this Medicare bill is the greatest entitlement since the Great Society and Lyndon Johnson.

Dr. Richard Frey: Sally, I commend you on your remarks. And I think particularly where you were pointing out that there is some light at the end of the tunnel with the defined contribution plans. I think, however, the real problem that our system has is Medicare. As Medicare goes, so goes the nation. I believe, as you do, that we have to bring the consumer back into the equation. We've got 43 million in Medicare now, we're going to add 70 million probably in a couple of decades. And we have essentially been taking those patients out of the equation. There's no consumerism. I firmly believe that unless we get some fundamental structural changes in Medicare—bringing the consumer in with financial consequences for decisions—that we are doomed and we're going to have a national health service.

Sally Pipes: Absolutely, and I agree. There's been a lot of criticism about docs who are no longer seeing Medicare patients. When you look at the numbers, a lot of docs are losing about $30 per patient on Medicare patients. So, they're saying, "I'm not going to do this anymore."

With a third-party payer system, you're seeing some docs, whether they're with Aetna, Blue Cross, Blue Shield, Principal, starting to lose a dollar or two per patient. This really has a major impact. And so you get politicians like Ted Kennedy, who's been pushing the Canadian health care system since 1971—although he hasn't been quite as ebullient about it recently because he has seen a lot of the stories about waiting for care. When Paul

Tsongas was running for the Democratic presidential nomination, he actually did say that if he had been living in Canada, he wouldn't have been alive to be running because he wouldn't have had access to the type of cancer treatment that he had access to.

Jim Van Houten: I used to run a group of insurance companies that had about 15 percent of the small-group business in Minnesota. I took them out in the early 1990s, when national health care and the regulations in Minnesota made it unprofitable in the small-group business. But back then, one of the arguments being made was that one of the costs that would be eliminated by a more broad government program was the cost of litigation, basically medical malpractice, that people would be willing to pass laws that restrict that if it was a government program. They would not be willing to restrict that if the companies involved were for profit. You have experience with other nationalized systems. Do you have any comment on that?

Sally Pipes: One of the good things about the Canadian system is that it's far less litigious than the American system. With California and all the terrible things that go on in California, we were almost ready to slip into the Pacific Ocean, but we're not quite there yet. California actually has one of the better malpractice insurance laws. That's not the case in all states. I know several docs in Nevada who have stopped practicing medicine because they said they're having to pay so much in malpractice insurance. In Canada, the malpractice limit is very low; I think it was $2 million recently. And Canadians are far less litigious than Americans, so I think one of the big issues is the need for tort reform in this country. We really need reform of malpractice, because it's stifling a lot of good people. If you're a young person, you're very smart, you might think of going into medicine or into law or into business. A lot of young people are saying they're going to go into law because there's a lot of money in malpractice, and they're not going to go into medicine because it's just getting more and more controlled and, therefore, they aren't going to have the freedom to practice the kind of medicine they would be trained for.

Michelle Rifenberg: I have a question about reimportation, which is a big issue here in Minnesota. It seems to me the real impetus behind reimportation legislation is not so much to have Americans buy their drugs from Canada, but to put some pressure on pharmaceutical companies. There seems to be a distortion in the market with how the pharmaceutical companies do business and, as Americans, we are subsidizing the international socialized medicine. So, what can we do to, if we do reimportation, what do we do to bring back a real legitimate market for us for consumers in America on prescription drugs?

Sally Pipes: There are several issues in importation. One is safety, one is price controls and their impact on research and development and innovation, and the third issue is intellectual

property rights and patent protection.

If you look at the Canadian pharmaceutical industry, it's $8 billion. If Illinois and the state of California decide to reimport drugs from Canada—***re***imported drugs are drugs manufactured in the United States, imported to Canada, and then sent back into the U.S. ***Imported*** drugs are manufactured in India or China, sent to Canada, and are imported into the United States. That's where we've seen a lot of problems with safety. But California, with a $5 billion state pharmaceutical program, and Illinois at about $2.5 billion, that would take up all the Canadian drug market. Now, if you were an Internet pharmacist and you were selling drugs, you'd probably want to sell into the U.S. at slightly higher marginal costs, so you could make a profit, but lower than the Canadian price. So, the head of the Canadian International Pharmacy Association, the group that runs the Internet pharmacies, has said there's no way that we're going to allow all of our drugs to be exported to the United States to solve budget crises in various states. The real issue is about price controls. We've got price controls in the VA market, we've got price controls in the Medicare market, and it costs about $800 million to bring a new drug to market. There are many drugs that fail. The R & D costs are expensive. The industry itself spends about $30 billion a year on R & D. What this really is about price controls, because Americans want to have their drugs at a cheaper price. The only way they can be cheaper is if we have a price control program like Canada has, under the Patented Medicines Prices Review Board. They determine the consumer price of drugs in Canada. Then the Therapeutic Practices Directorate, which is their version of the FDA, determines whether the drug is actually going to be available in Canada and it takes, on average, thirty-nine days longer than the FDA to approve a drug in Canada, after it's already been FDA-approved. So, one thing we need to do is reform the FDA to shorten the process that it takes to bring drugs to market. That will reduce the price.

Somebody has to pay for the R & D. If we get rid of price controls in Canada and Europe, the price of the drugs in those countries will rise. And if we reform the FDA, we're going to see a slightly reduced price in our drugs. We will continue to be innovators in providing the best drugs in the world. We've got to get rid of price controls and I think we will see a bit of leveling in the playing field. The great drugs are developed here—we have 37 percent of the world market— and we have to keep it that way.

Notes

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4 Tom Blackwell, "Put moratorium on hospital bed closings, coroner's jury demands: Hospital overcrowding 'critical' in Ontario, inquest found." ***The Ottawa Citizen,*** November 18, 2000, A16.

5 Dave Brown, "Suffering patients demand answers," ***The Ottawa Citizen,*** October 24, 2000, C1.

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8 Michael Walker and Greg Wilson, "Waiting Your Turn: Hospital Waiting Lists in Canada," 11th edition, ***Critical Issues Bulletin,*** Fraser Institute, 2001. ■