

B. F. SKINNER'S REAL-LIFE UTOPIA • A TEST FOR DEPRESSION • WHITENING TEETH

IN HEALTH

JANUARY/FEBRUARY 1991

Liberty,
Justice, and
Insurance
for All

**CANADA COVERS EVERYONE.
WHY CAN'T WE?**

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Basketball in a Skinner Box

IMAGINE LIVING in the Mexican desert among a small community of people who put the good of the group above all else. Now imagine a game of basketball with the same bunch.

Contributing editor Steve Fishman joined such a game while researching his story on Los Horcones (page 50), a utopian settlement that lives by the behavioral rules of the late psychologist B.F. Skinner. The players were teenagers, all good athletes out to enjoy themselves. "But they seemed genuinely unable to keep score," Fishman says. "And they tried to keep score only so that the game would end and others who were waiting could play."

Later he found himself in a long game of "*caballo*," the Mexican equivalent of "horse," in which two players try to match each other's most challenging shots. Each time a player fails to match, he or she earns a letter of the word; the game ends when someone spells it out entirely. But Fishman's 14-year-old opponent had no interest in keeping track, so this *caballero* just kept on riding.

"I'd have some worries about him here at Sixth Avenue and West Fourth Street," says Fishman, who's used to the more competitive courts of New York City. "He's too polite." Not that he wouldn't play well enough, but Fishman suspects he'd quickly lose his ideals and pick up the rules of the street. "First, he'd be confused. Then after a few weeks he'd adapt by becoming another dysfunctional kid who sees basketball as an expression of hostility."

At Los Horcones, concern for the group, as opposed to Number One, is its own reward—people actually seemed to like helping each other. On the basketball court, that means having a good game, but not necessarily winning.

In Mexico, Fishman says, "I was constantly asking myself, 'Could I live here out in the middle of the desert, working only for the good of the community? Could I make a good breakfast for twenty-six people, work six hours in the fields six days a week, work on the toilets—without worrying about my own *individual* pile of rewards?'"

It's hard to read Fishman's story without asking yourself the same questions—and wondering at the ideals and idealism of these utopians.

Does that mean their remarkable philosophy—of basketball and of life—works only on their home court? Not necessarily, says Fishman. Even if you're not going to set up an unselfish alternative society, he thinks Skinner's techniques of behavior modification are probably useful in lots of situations. "I came home filled with the idea that I was going to be nicer to my loved ones—and, as a result, I'd get lots of niceness back."

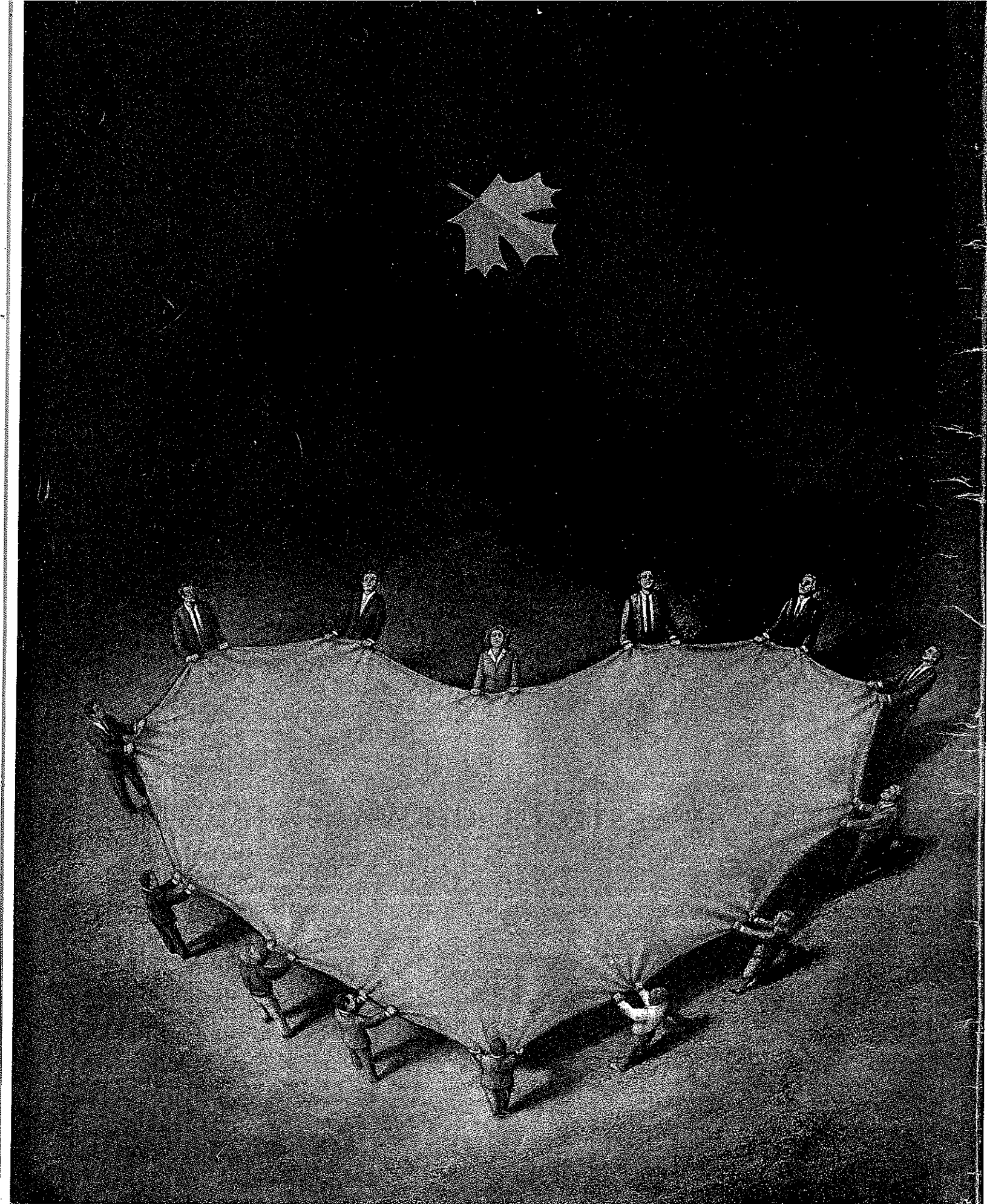
On the basketball courts of New York, however, Fishman still keeps score.

Michael Gold

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IN CANADA, A LITTLE PLASTIC CARD GETS YOU FREE CARE ANYWHERE. WHAT'S THE CATCH?

H E A L T H

ASSURANCE

By ANTHONY SCHMITZ

THE LAST SNOW HAD MELTED JUST DAYS BEFORE, though the mountains towering over Vancouver were still blanketed. In the city flowers bloomed—crocuses, daffodils. A fresh breeze swept in from the Pacific, through the open windows of the heart ward at Vancouver General.

Six days after open heart surgery, Tom Berrie lay naked on his bed. A nurse bent over him, tugging at the glinting metal staples that held the sixty-three-year-old retiree together.

"I'll be done here in a minute," he said in a Scotsman's brogue that was surprisingly hale, considering the circumstances.

Berrie had every reason to be pleased. He'd gotten the operation he needed. He'd lived to tell about it. And thanks to Canada's health care system, he hadn't paid a cent. Still, there was one substantial hitch. Berrie had waited to get his surgery for the better part of a year. During those long months he wondered if this were a bargain that would kill him.

When the nurse finished, he rose and wrapped himself in a hospital gown. With his full head of hair and trim dark mustache, Berrie looked fit—so long as he stood still. When he moved it was with the caution of a man who feared he might fly apart.

A Scot by birth, Berrie left Glasgow for Canada with his wife and two children in the 1950s. "I came here because it was far away from Britain," he said. "Too far to turn back. Once I got here I had to make a go of it." In Burnaby, a Vancouver suburb, Berrie returned to law enforcement, the occupation he'd left behind in Scotland. He'd been retired for just ten months in January of 1989 when he suffered a heart attack while reading the morning

Illustrations by

RAFAL OLBINSKI ~ TOMEK OLBINSKI

paper. His daughter rushed him to a local hospital.

Anywhere in the United States, an intake clerk would have grilled Berrie about how he planned to pay his bills. In British Columbia, Berrie simply handed over his bright plastic "Care Card," which guarantees him free treatment anywhere in Canada. A \$55 monthly premium, paid through Berrie's pension plan, covers him and his wife. "The emergency ward was packed," Berrie recalled, "but I was on a table, snap, with a cardiologist looking after me."

This, however, was the last aspect of his care that moved with any speed. After two weeks, Berrie was released with a May referral to a specialist for an angiogram, a procedure to reveal blockages in the vessels that supply the heart muscles with blood. The specialist referred him to Vancouver heart surgeon Lawrence Burr, and from Burr, Berrie learned that he needed a six-vessel bypass. On June 2, 1989, the surgeon entered Berrie on Vancouver General's waiting list. He joined no fewer than 720 other patients waiting in a nerve-racking queue for beds in British Columbia's three heart surgery wards.

Berrie waited through summer, fall, then most of winter. He lived in slow motion, fearful of another heart attack. Simple jobs like washing the car took three times as long. He relied on his sons-in-law for help around the house. During his many idle hours he fumed at the government. "They're more interested in giving away things people can see," he reckoned. "A new bridge, a new ferry. A guy waiting for a heart operation, he's all but invisible."

Finally in late February of 1990 he got a call from Burr. Another surgeon was leaving on a week's vacation, so Burr had appropriated his two surgery slots. He could operate on March 5. Berrie was simultaneously grateful and bitter.

"I'd get angry, but then I couldn't afford to get angry," he said. "I wasn't supposed to have any stress. I was supposed to take everything nice and calm." At this Berrie assumed a tone of mock tranquility. "'Oh,' I said, 'I'll get my operation eventually. They may do it with me in a wooden box, but I'll get it.'"

"Ah, but it was a worry. I worried when I went to bed at night, 'Am I going to be here in the morning?' Then I got here and, poof, the weight came off my shoulders."

As Berrie's eyes fluttered shut, I asked him one last question. "Do you think you'd have gotten better care in the States?"

He sighed. "I would not like to live under your system. If I tried to get insurance down there now, they'd tell me I had a heart problem. They'd cover everything but me heart. If I needed care for my heart again I'd finish my days on the street."

"Canada," he said slowly, "covers everything."

"I WOULD NOT LIKE TO LIVE UNDER YOUR SYSTEM.

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HEART. IF I NEEDED CARE FOR MY HEART AGAIN

I'D FINISH MY DAYS ON THE STREET."

ON OUR SIDE OF THE BORDER, as Tom Berrie observed, we cover neither everything nor everybody. The number of U.S. citizens with no health insurance at all—37 million—exceeds Canada's total population. Ask Americans whether they believe our health care system needs wholesale reform (as several polls have), and nine out of ten say yes. Most say they'd rather have care like Canada's.

This is not an opinion shared by the American health industry. Every few months, organizations such as the American Medical Association or the Health Insurance Association of America deliver a gloomy report on Canada's health scheme, portraying it as a rotten edifice on its way to ruin, a system only fools would emulate.

To make this argument requires that one skip lightly over a few niggling points. Canadians, for instance, spend \$7 on medicine for every \$10 we spend. They live longer than we do. Fewer of their babies die. Everyone has full health coverage. No one is denied insurance because of an expensive illness. No one pays a deductible for a doctor's care. People pick their own doctors. Their family doctors see them quickly, either in the office or, when necessary, at home.

Canada has accomplished all this with a system of sweeping controls. Private insurance that competes with the provinces' medical plans is illegal. Health ministry officials keep a lid on doctors' fees. Almost all hospitals are publicly owned. The government carefully limits the number of hospital beds and the purchase of expensive new equipment. In the process, it drastically trims costly paper-shuffling in doctors' offices and wipes out insurance company overhead and profit.

Our health industry charges that Canada runs a bargain-basement operation that Americans would never tolerate. The AMA claims that Canada jeopardizes the public health by scrimping on items such as magnetic resonance imaging, radiation therapy, and open heart surgery. The Health Insurance Association argues that Canadian bureaucrats' fear of spending stifles creative programs such as those that send surgery patients home that day. Doctors complain that Canadian fees are so low that brilliant surgeons and innovators flee to the United States, where their talents are rewarded.

But the objection most consistently raised against Canadian health care is that patients wait in line for major operations. The AMA, for instance, recently paid for ads depicting a winsome girl beneath the headline, "In Some Countries She Could Wait Months for Her Surgery."

It's the queues for heart operations that attract the greatest attention—and most sharply illuminate the distinctions between care in Canada and the United States. The Canadian newsweekly *MacLean's* defined the issues with the case of a particu-

larly hapless Toronto patient named Charles Coleman. The 63-year-old diamond setter's operation was postponed 11 times to make room for more seriously ill heart patients. Eight days after Coleman finally got his bypass, he died. Before his case could fade into obscurity, the issue flared again in British Columbia. Provincial health officials, beset by criticism of the long queue in which Tom Berrie and 720 others languished, announced a plan to send patients to the United States for their heart surgery.

Surely, if waiting for treatment routinely harms Canadian heart patients, the proof could be found in Vancouver. Or so I thought.

AFTER I LEFT TOM BERRIE I called on his surgeon, Lawrence Burr, to find out why Berrie had waited so long. We met in Burr's office, a modest room on a side street. Bamboo stood outside the window. Geese pecked at the courtyard grass. Perched on the corner of Burr's desk was a plastic model of a human heart.

An American surgeon, considering Burr's lot, might call this a hardship post. When Burr does a routine four-vessel bypass, the British Columbia government pays him \$1,700. He'd earn \$6,575 for the same piece of work at a teaching hospital in Minneapolis. There, he'd get as much operating time as he wanted, because the heart unit runs at about half capacity. In Vancouver, he's allowed to operate 12 times a month, eight times fewer than he'd prefer. Because Burr has far more patients than surgery slots, most wait months.

"I promised Tom Berrie he wouldn't wait more than a year," Burr said quickly, with the supremely confident manner of a person who holds a beating heart in his hands several times a week. "I had other patients who were worse, who had more chest pain. But they'd only been waiting two months. I decided come hell or high water I was going to keep this promise."

Berrie was one of 75 patients on a waiting list that Burr keeps in a small black book. The surgeon decided that Berrie was an urgent case, one of many in the broad range between emergency and elective surgery. Burr can take an emergency case into the operating room almost immediately by trading another surgeon for operating time. Urgent cases wait until Burr fits them into one of his three weekly operating slots.

"Every week I have to decide," Burr said. "Is the guy who's been waiting ten months worse than the guy who's been waiting five months? But even if he isn't, the guy waiting ten months has got to have some pride of place. After all, he's been waiting twice as long."

The long lists don't have to exist, Burr explained. If British Columbia's 15 heart surgeons took on a full, combined work load of 60 to 75 operations a week, the waiting list could be whittled down in less than a year. As it is, in a good week they operate 50 times. They're limited by the number of hospitals

TAKING COVER IN OHIO, NEW YORK, AND OREGON

WHEN LOUIS SULLIVAN, the top health official in the United States, unveiled his strategy for the 1990s recently, he suggested smoking less, eating right, and using seat belts. But as for extending health insurance to the 37 million Americans who have none, he had nothing to say.

The message from Washington to the states was clear: If you want all your citizens to receive decent health care, do it yourselves. And many have been trying. Hawaii, for instance, has beefed up its state-run health plan while maintaining the requirement that employers offer health plans, so all its citizens are covered. But several states are attempting the more aggressive reforms they believe their citizens want and need.

OHIO: EYEING CANADA Sometimes the burden of reform falls on unlikely shoulders. "I'm a locomotive engineer," says Ohio legislator Bobby Hagan. "What the hell do I know about health?" Yet shortly after he took office in 1987, Hagan dove into the debate on health insurance. He represents the Youngstown area, where steel mill shutdowns have left thousands with neither paycheck nor insurance.

"I felt compelled to do something to help protect those people," says Hagan. He introduced a bill proposing that everyone in Ohio be covered under a Canadian-style health scheme financed by taxes. Hagan's bill bars private insurers from competing with the state's basic coverage plan. The measure was quickly condemned by the state's medical association and by insurance industry representatives, but embraced by labor, church, and senior groups representing 3 million of Ohio's 11 million residents. Hagan's bill—considered a long shot by local observers—is slowly making its way through the legislature.

NEW YORK: PAYING THE BILLS ITSELF As a state where 2.5 million people lack health insurance, New York has seen its share of proposals. A provocative new one calls for all employers to cover their workers or pay a fine. The state itself will insure the unemployed and low-income part-time workers, with a sliding fee scale for the more affluent.

But this plan has an especially bold provision. Right now, doctors and hospitals send bill after bill to patients, to their insurance companies, and to the federal government—a bureaucratic nightmare that wastes millions. New York proposes instead that doctors and hospitals send all their bills straight to the state. The state sends out checks, then collects in bulk from insurance

companies and from Medicare and Medicaid. Doctors benefit from a simpler, cheaper payment system, while the state gains an advantage: As New York medicine's sole paying customer, it can demand lower rates and more efficient service. With the state's budget currently squeezed tight, however, the proposal is on hold.

OREGON: RATIONING CARE Hoping to get all its residents covered, Oregon recently passed legislation that will soon qualify 116,000 uninsured people for Medicaid, benefits they can't get now because they aren't poor enough. The state will then rank all medical procedures, weighing their costs against their known health benefits. Expensive, ineffective treatments will be lopped off the list. By this kind of rationing the state intends to save enough money to cover all the new people enrolled.

But a moral fog bank has now rolled in. The first attempt to create such a list ended in disaster, with care for thumb-sucking-related jaw problems ranked higher than some AIDS treatments. Oregon's number-crunchers are back at their computers, aiming at a new deadline in early 1991. Even if they concoct an acceptable list, Oregon will have to ask Congress to let it rob Peter to pay Paul—trim the roster of treatments now available to Medicaid patients so it can offer the same reduced care to a larger group. The state should instead be raising taxes, critics say, and looking for ways to cut waste so everyone can be given decent care.

"It's harder to do something than to build up an ideal that no one could ever actually pay for," says John Golenski, a bioethicist who helped design Oregon's plan. Among the states this is an increasingly common refrain: If we can't afford everything medicine has to offer, then how and where do we draw the line?

—A.S.



equipped for open heart surgery—three for a population of 3 million, or about a third the number you'd find in the United States—and by the amount of operating room time these hospitals parcel out.

The Ministry of Health limits the number of heart surgery wards, claiming operations are done cheaper and better at hospitals that handle at least 300 heart patients a year. It then gives these hospitals enough money to perform about 2,100 heart operations annually, a number set by ministry officials working with a panel of cardiologists and heart surgeons. The Canadian rate of heart surgery is less than half ours.

"In the States," Burr said, "too many cases are done. People have a bit of angina, they come into the hospital, get an angiogram done, and bang, they're referred to surgery without a good trial of medications. The bed is empty, the hospital wants to make money. I don't think that's an indication for surgery, but that's not a view that's always shared by my colleagues in the States. You're overeager to use the technology that's available. In Canada, on the other hand, we've been excessively conservative."

By carefully pinching the supply of heart surgery slots, British Columbia has created a sensible but high-strung system. Disruptions at any of the surgery units—the recent nurses' strike, for instance, or the chronic shortage of operating room technicians, or the brief walkout of workers who sterilize instruments—all lead to maddening backups.

Meanwhile the demand for heart surgery keeps growing. "Our population has increased," said Burr, "but even so the growth in demand is out of proportion to population growth alone. We've got better diagnosis, better treatment. We can operate on people now that we wouldn't have touched ten years ago. We've got a better product."

I asked Burr whether waiting for an operation harmed patients such as Berrie.

He tapped on the armrest of his chair. His fingers were surprisingly pale, the nails well-trimmed. "People decline while they wait," Burr said. "They're less active. They gain fat, they lose muscle. They can have a heart attack that makes surgery more risky. Some people have become depressed. They withdraw to their family."

"The only positive thing about waiting is that people have time to think about what's happening in their life. They can ask, 'Who am I? Where am I going?' All the questions we never have time to ask. Often they say, 'Okay, I've smoked too much or eaten too much. I can change these things.' They can start changing their life around."

But there's one other possibility. "They can die," Burr said. By his count, 15 British Columbia patients did just that last year while waiting for their heart surgery.

"HE SAYS FIFTEEN DIED on the waiting list?" said Robin Hutchinson with an odd touch of glee.

As senior medical consultant to the health ministry's heart program, Hutchinson helps decide how many people ought to get heart surgery each year in British Columbia. His office is in the capital city of Victoria, separated from Vancouver by about 30 miles of water. Not that the distance brings Hutchinson much peace. He dashed into our meeting late, just off a helicopter from a meeting on the mainland. His desk was piled high with papers, his phone rang incessantly, his hair was a mess.

"That's right," I said. "Fifteen."

"Well, now," said Hutchinson. "We know the mortality rate on the operating table is between two and three percent. So if they operated on the whole waiting list last year we'd expect them to kill off twenty-two! You don't hear about the guys who never get off the table. They only talk about the guys who die on the waiting list and some of *them* would die no matter what."

"Look, it's hard for me to sit here and say there is a huge amount of medical necessity to take care of every case on our waiting list. That's a little harsh because many people feel they need surgery. But

some medical necessity is iatrogenic—which is to say the docs themselves create it. So many surgeons portray coronary bypass as a lifesaving operation. But then you look at the outcome studies and they show it isn't."

Research to date generally reveals that except for patients with certain types of heart trouble, such as obstructions of the left main coronary artery or three-vessel disease, those with bypasses don't live longer than people who take heart medicine and watch their diet. In fact, the patients most likely to benefit from a bypass are also those most likely to die from one.

"So what do the surgeons say to this?" Hutchinson asked. "They say, 'Yeah, well, but a bypass relieves chest pain when medicine won't.' To which I say, 'Of course. But you bastards, you haven't been going to the press saying Mr. So-and-So has anginal pain and we think he'd feel better if he had an operation. You're saying this guy has a time bomb in his chest that only you can defuse, and the government is preventing you from laying your God-guided hands inside this guy's chest and making him better.'"

Nonetheless, 720 people waited for surgery they thought would help them. Taking up the American Medical Association's line, I proposed to Hutchinson that his government was rationing medicine, promising everyone health care, then withholding it to save money.

"We ration according to the severity of the disease," Hutchinson replied. "For us, those who need care most get it first, regardless of economic status."

"WHAT'S THE LONGEST YOU'D WAIT IN LINE
AT A BANK BEFORE GETTING REALLY ANNOYED?"

FIVE MINUTES? TEN MINUTES?

WHAT IF YOU NEEDED A HEART OPERATION?

HOW LONG WOULD YOU WAIT THEN?"

That's a fundamental philosophical difference between Canada and the States. Both sides ration. You've got thirty-seven million people who don't have diddley-squat for an insurance plan. They're rationed, too.

"Second, it's not a conscious decision by the bean counters here that there should be this many heart operations done and the rest can just line up and the ones that survive get it and the others, good, we don't have to pay for it. It's not a case of someone deciding we're not going to do these things because it costs too much. But we have a hard time grappling with this waiting list. We don't know who's waiting or for how long. We don't know how severe their case is. We do know that all the real emergencies are getting done, but we're left struggling with this nebulous class of elective operations."

The rewards of promptly operating on everyone are anything but certain. Research shows that far fewer than half the people who get bypasses later pronounce themselves free of chest pain. Follow-up studies of bypass patients show they're only 25 to 40 percent more likely to be relieved of pain than people who stay on heart medicine.

But the provincial ministry decided it couldn't afford to stand on statistics. As the waiting list grew, the British Columbia Medical Association hammered the government with radio ads that asked, "What's the longest you'd wait in line at a bank before getting really annoyed? Five minutes? Ten minutes? What if you needed a heart operation to save your life? How long would you wait then?" The association aimed to pressure the provincial government into spending more tax money on hospitals, medical hardware, and not coincidentally doctors' fees. Local newspaper editors, of course, heard news knocking every time a waiting patient fell dead.

"Because of the public outcry over these poor souls walking around with their hearts about to pinch off and drop like flies all over the province," said Hutchinson wearily, "we did a deal with the University of Washington in Seattle." The deal, he explained, called for the hospital there to take 50 bypass cases at \$18,000 per head, a bargain compared to the \$40,000 to \$75,000 a bypass typically costs in the States. Still, for the government it represented a loss on several fronts. The same operation costs \$15,300 in Vancouver. In addition, all the money was going out of the province. In theory the Seattle operations promised to take the heat off the Ministry of Health until a fourth heart surgery unit opened in the Vancouver suburb of New Westminster. If the first batch of Seattle bypasses went smoothly, Hutchinson said, then the government planned to buy three or four more 50-head blocks. But four weeks after announcing the plan, health administrators had to admit they were stumped.

"As of now," Hutchinson said, "we've had nine people sign up. The opposition party, the press, everybody's making a big stink about our waiting lists. And we've got nine people signed up! The surgeons ask their patients and they say, 'I'd rather wait.' We thought we could get maybe two hundred and fifty done down in Seattle and get our own list down to four hundred and some. Which sounds a little grisly but isn't really so bad. Ideally we'd have a four- to six-week waiting list to make the system flow smoothly. But if nobody wants to go to Seattle, we're stuck."

Did the people offered the Seattle operations actually need bypass surgery?

"If I can be convinced that this is a medical necessity I'll go to bat," Hutchinson said. "But there are a thousand other things all clamoring for attention and resources. I have to be very confident in believing these heart operations are a real need. Right now we just don't know what happens to these people. Besides just living or dying, what are they doing five years later? Are they back at work? What's their quality of life? We're trying to get some kind of handle on what the public is buying with its money."

In the States, the social cost of a dubious operation, paid for by an insurance company, is at best obscure. In British Columbia the tradeoff is obvious. Medicine is a staggering line item in the provincial budget—a third of all expenditures, for a total of \$3.65 billion last year. Money spent on medicine can't be spent on roads, schools, or job programs. That the money might be wasted on operations that profit only surgeons is more than a nagging thought.

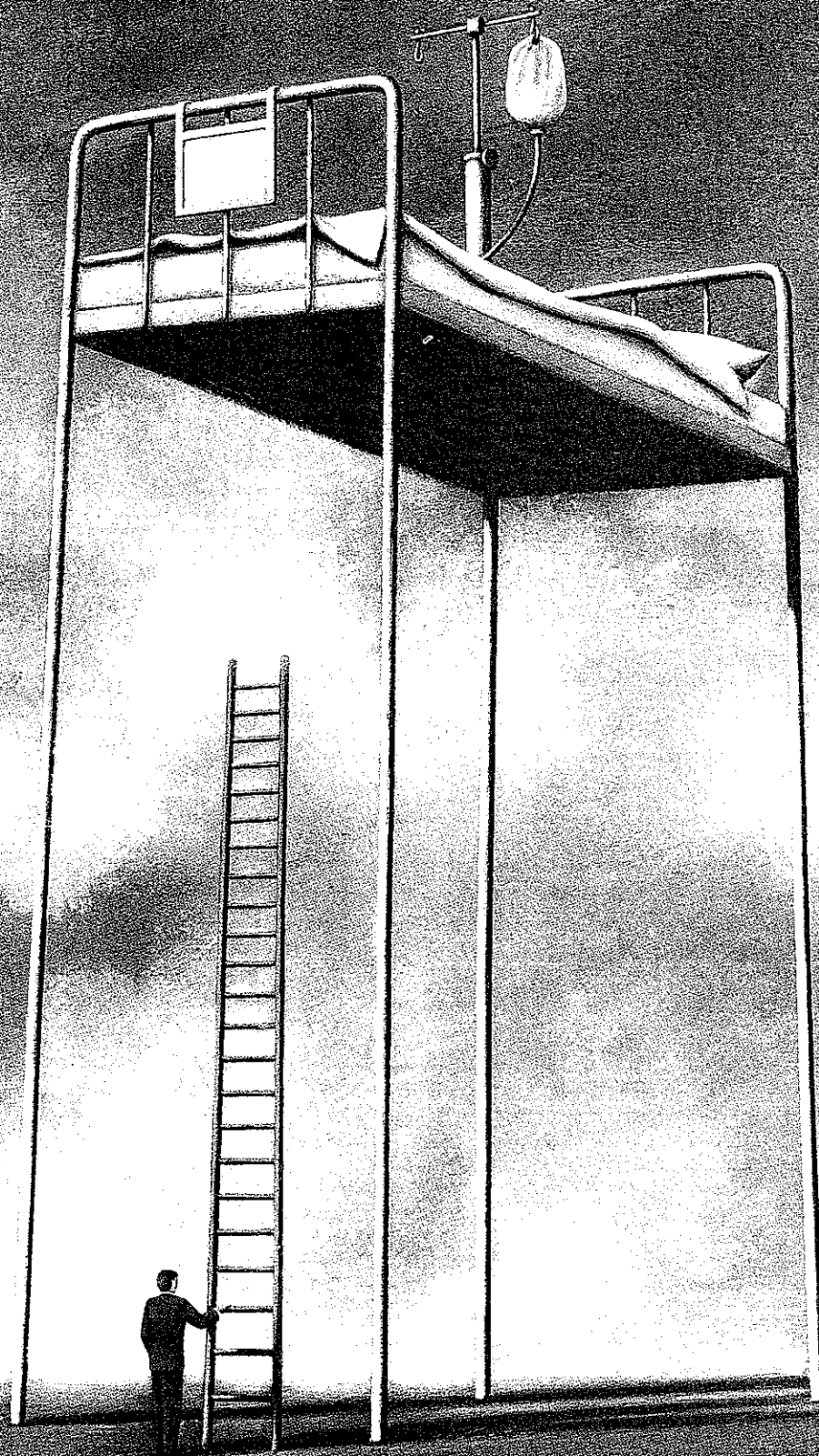
TOM BERRIE'S ANGUISHED WAIT for his surgery lingered in my mind as I drove from place to place in Vancouver. Yet as I talked to Canadians about their health care, the stories I heard were typically mundane. A reporter, a professor, a salesman, a clerk in a store—all had the same prosaic experience. If they or their children got sick they picked up the phone and called the doctor of their choice. Usually they got in within a day. They didn't have any complaints. Deductibles, copayments, preexisting conditions—the routine curses of American health care—seemed to horrify them more than their own waiting lists. "If our worst-case scenario happened to someone in the States," one labor leader told me, "they'd still think they got lucky." When pollsters asked Canadians if they'd prefer the American system over their own, only 3 percent answered yes.

"Here," said Morris Barer, an expert in health policy at the University of British Columbia, "you don't have to *think* about how much a doctor's visit is going to cost or whether you can afford to go at

WHEN POLLSTERS ASKED U.S. CITIZENS

IF THEY'D PREFER CANADIAN HEALTH CARE OVER
THEIR OWN, 72 PERCENT SAID YES.

AS FOR THE NUMBER OF CANADIANS WHO'D
CHOOSE THE U.S. SYSTEM: 3 PERCENT.



WOULD A CANADIAN UMBRELLA LEAK IN THE UNITED STATES?

"SOCIALIZED HEALTH AND MEDICAL SERVICES," said the politician, "are incompatible with the rights and responsibilities inherent in a free and democratic society." The year was 1959, and the speaker was J. Donovan Ross, Alberta's Minister of Health. Remarkably, Canada's citizens disagreed. By 1966 the government had declared itself the nation's only health insurer, and by 1971 every Canadian had full, free coverage.

Now Americans are jealous. Anyone bold enough to endorse Canada as a suitable model, however, can expect an argument. Here are eight objections and the rejoinders.

WOULDN'T NATIONAL HEALTH INSURANCE AMOUNT TO "SOCIALIZED MEDICINE," FULL OF BUREAUCRATS TELLING OUR DOCTORS HOW TO TREAT US?

THE THOUGHT of handing Washington power over everyone's health is indeed a little spooky. Who can forget the government's attempt to "simplify" our income tax forms by adding a mass of befuddling new instructions?

But look at U.S. health care now. Our doctors already obey legions of intrusive bureaucrats: Insurance officials regularly demand that your doctor call for permission to go ahead with treatment. Medicare officials dictate precisely how long patients can stay in the hospital. The number of U.S. health care administrators has climbed 3.5 times faster than the number of doctors. In Canada, there are no meddling insurers, while the government's main power is in raising money and paying bills, with minimal monitoring for outlandish practices. "No one second-guesses me," says the president of British Columbia's medical association. "I've got clinical freedom."

DON'T WE ALREADY HAVE THE WORLD'S BEST HEALTH CARE?

IT'S CERTAINLY the most expensive. In 1987, we spent \$2,050 per citizen on health care. Canada spent an average of \$1,480, most European nations even less.

Unfortunately, spending the most hasn't made us the healthiest. Canada, culturally most like the United States, has an infant mortality rate 25 percent lower. Their rate of heart disease death is 20 percent lower. Their average life span—77.1 years—is almost two years longer.

WHY NOT JUST FINE-TUNE OUR EXISTING SYSTEM SO IT REACHES ALL THE PEOPLE WHO AREN'T NOW COVERED?

MANY PROPOSALS for full U.S. health coverage would require all businesses (except the smallest) to insure the health of their workers, with the government looking out for everyone else.

Such fine-tuning can improve our system but won't really fix its biggest problem: the billions of dollars we waste every year on

paper-shuffling. (Even the picky Consumers Union recently came to that same conclusion and endorsed a Canadian-style plan.) In Canada, according to the latest study, citizens each spent \$18 a year for "administrative costs," while each of us spent \$95—for a total of \$20 billion more than we would have with Canadian-style insurance. That's not all. Our doctors, hospitals, and nursing homes spend much more—\$62.1 billion by a 1983 estimate—filling out insurance forms, billing patients, and collecting.

THERE'S NO WAY THE GOVERNMENT CAN PAY FOR EVERY AMERICAN'S CARE WITHOUT RAISING TAXES THROUGH THE ROOF.

THE FEDERAL GOVERNMENT *would* have to come up with billions of dollars more than the \$115 billion it now spends on its health programs for the poor and aged. Some could come from income taxes, some from luxury taxes on cigarettes or cosmetic surgery. In Canada, several provinces charge a small monthly premium.

But before you reflexively holler "No new taxes," consider what you're already paying. That grand total of \$2,050 we spend per citizen doesn't come out of thin air. It comes in dribs and drabs out of your own earnings—in existing state and federal taxes, insurance premiums, payroll deductions, deferred wages, deductibles, copayments, and ordinary cash transactions with doctors and hospitals. Canadians pay theirs once in taxes but get more care—for \$600 less out of each citizen's earnings. Last year our country spent \$640 billion on health care. With a Canadian-style system, at Canadian rates, we could cover everyone for \$365 billion.

WOULDN'T NATIONAL HEALTH INSURANCE MEAN THAT AMERICANS WHO ARE NOW FULLY INSURED MIGHT HAVE TO SETTLE FOR LESS?

IN CANADA, provincial insurance covers all health costs except dental care, eyeglasses, prescription drugs, ambulance service, and private hospital rooms—so many Canadians do end up buying some private insurance. A policy to cover all of these things runs about \$30 to \$40 a month.

In fact, however, most people in the United States don't really have full coverage. Overall, American insurance now covers just 74 percent of the costs of doctors' services, 39 percent of dentists' services, and 25 percent of prescription drug charges. We pay the rest out of pocket.

WOULDN'T FREE CARE ENCOURAGE PEOPLE TO RUN TO THE DOCTOR FOR EVERY ACHE AND PAIN?

PEOPLE WHO GET free treatment *do* go to the doctor and hospital about a third more often than those who have to pay a share of their medical bills.

Still, Canadians—who pay nothing at the doctor's—have a lower per-person health bill than we do. That's because, among other things, they've given their government power to bargain with doctors and hospitals over fees. An office visit that's \$52 in Seattle is \$18 in Vancouver.

DOESN'T LETTING DOCTORS SEND PATIENTS' BILLS STRAIGHT TO THE GOVERNMENT LEAD TO MORE NEEDLESS TREATMENTS AND TESTS?

WHEN PATIENTS get free care and doctors can charge no more than a set amount per treatment, the tide does tend to run toward more and more treatments. Studies in Canada have shown jumps in the number of doctors' billings—and in their incomes—after the government froze their fees.

But the same thing's now going on in this country—except here federal regulators *and* private insurers have been trying, with even less success, to keep a lid on physicians' incomes. Last decade American doctors increased their cut of the national income by 40 percent while Canadian doctors captured only another 10 percent.

ISN'T THE PRIVATE HEALTH INSURANCE INDUSTRY JUST TOO BIG AND POWERFUL TO KILL?

DISMANTLING the health segment of our insurance industry would be "politically thorny," in the quiet words of one advocate for a national plan. Some 1,200 firms now sell more than \$192 billion in health insurance. They'd put up a hard fight. Not only has the industry grown eightfold since Canada shut down its own health insurers, but our government leaves politicians more open to lobbyists than does Canada's parliamentary system.

Still, there's no legal barrier to making health insurance an American public service. The states have broad powers to legislate business affairs and to promote citizens' health. Likewise, the federal government can use its control of tax revenues—as it does with highway funds—to set standards for the states.

all." Barer, for example, with a wife and two children, pays a \$51 monthly premium. Around 20 percent of his income tax is set aside for health care. Above that, the only bills he'll ever see are for prescription drugs, ambulance service, or a private hospital room. He's never had trouble finding a likable family doctor with an office nearby. In Canada, as in the United States, there are about 490 people per physician. In both countries, in fact, the number of practicing doctors keeps going up.

Barer's one experience with the trumpeted shortcoming of Canadian care began when he realized his daughter had a problem with her feet. He took her to the doctor and was told there'd be a six-month wait to see an orthopedic surgeon. Instead of waiting, said the doctor, she could see an occupational therapist next week. The therapist recommended shoe inserts; but when Barer's daughter finally did get in to see a surgeon, he declared there was nothing wrong with her. And that was it: Case closed.

Had she needed surgery, Barer's daughter would have gone on a waiting list, just as Tom Berrie had. In some Vancouver area hospitals, queues for elective surgery are 13,000 patients long. Similar situations abound across Canada. People in Saskatoon can expect to wait almost five months for a hip replacement. In Winnipeg, patients who need emergency surgery routinely wait an extra day.

That's the landscape in Canada, though it's changing continuously and not necessarily for the worse. The lists regularly shrink or even vanish when new medical centers open, or when citizens and doctors pressure the government into spending more on health care. And no citizen who needs surgery—or any other form of treatment—ever goes without it, except by choice. Emergencies, of course, get top priority. It's rationing by medical need, as Hutchinson said, but Barer and most other Canadians accept it the way we'd accept waiting for someone in a wheelchair to board an airplane. Even Tom Berrie preferred his own long delay to a roll of the dice with American health care.

I couldn't help but wonder, though: Was Berrie's surgeon wrong when he claimed that heart patients decline while waiting for surgery? Wouldn't patients in the United States fare better?

"Right now, no one knows whether being on the waiting list is any more harmful to you than being operated on earlier," Barer said. "Studies that would show that haven't been done. Meanwhile, no one in the States has demonstrated that your heart surgery rate is optimal or anything close to it."

Just the opposite seems to be true. A study recently completed by Geoffrey Anderson, a university colleague of Barer's, revealed that American Medicare patients get bypass operations at double the rate of Canadians. Yet a 1988 Rand Corpora-

tion study showed 44 percent of all U.S. bypasses were performed for dubious or inappropriate reasons. (For instance, some patients with one clogged heart vessel got bypass surgery though no evidence indicated it would do any good.) At one hospital the rate of unwarranted surgery was more than six in ten. If a waiting list withholds operations from patients who'd be better off without, then some American hospitals could use one.

"You've got to remember that you've got a waiting list as well," Anderson said when I asked for his view. "Your waiting list is based on finances, just like ours, but it's not as obvious. If you're poor and you don't have insurance, you don't go to a surgeon. In the States you ration by ability to pay."

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A SHORT WHILE LATER I headed back to the United States, a trip that for Canadians evokes a sense of dread. What if they get sick or have an accident? Their health plan pays U.S. doctors the going rate in Canada—\$277 for an emergency appendectomy, for instance, less than half the typical surgeon's bill across the border. Prudent Canadians buy special traveler's insurance before they leave.

Still, they fear the worst that American medicine can do. They believe that Americans routinely die from lack of insurance right in the hospital foyer. They're appalled by the unfairness of American care as well as by its bloated costs—\$2,000 a year for each citizen, compared to Canada's \$1,400. People with no particular reason to know, such as a retired cigarette salesman I encountered, can cite with reasonable accuracy the cost of both paper slippers and major heart surgery in a U.S. hospital.

At the Vancouver airport, a customs agent took it upon himself to give me one last lecture. He asked the usual questions: occupation, nature of visit. His ears pricked up when I said I was reporting on Canada's health care system.

"And what's your conclusion?" he asked me suspiciously.

"Some people wait for surgery." I shrugged. It didn't seem like the place for a symposium.

"I just want to make sure you understand," he said in that commanding tone of a man with a badge. "When my kids need to see a doctor, I call in the morning, they get in that afternoon. When I hurt my shoulder I got sent to the top joint man in the province." He was getting worked up, waving my passport to make his point. "It doesn't matter how much money you have. This is a great system."

A line backed up behind me. I nodded earnestly.

"Okay," he said. Then, noticing that he still held my passport, he stamped it with a flourish and sent me on my way. ■

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