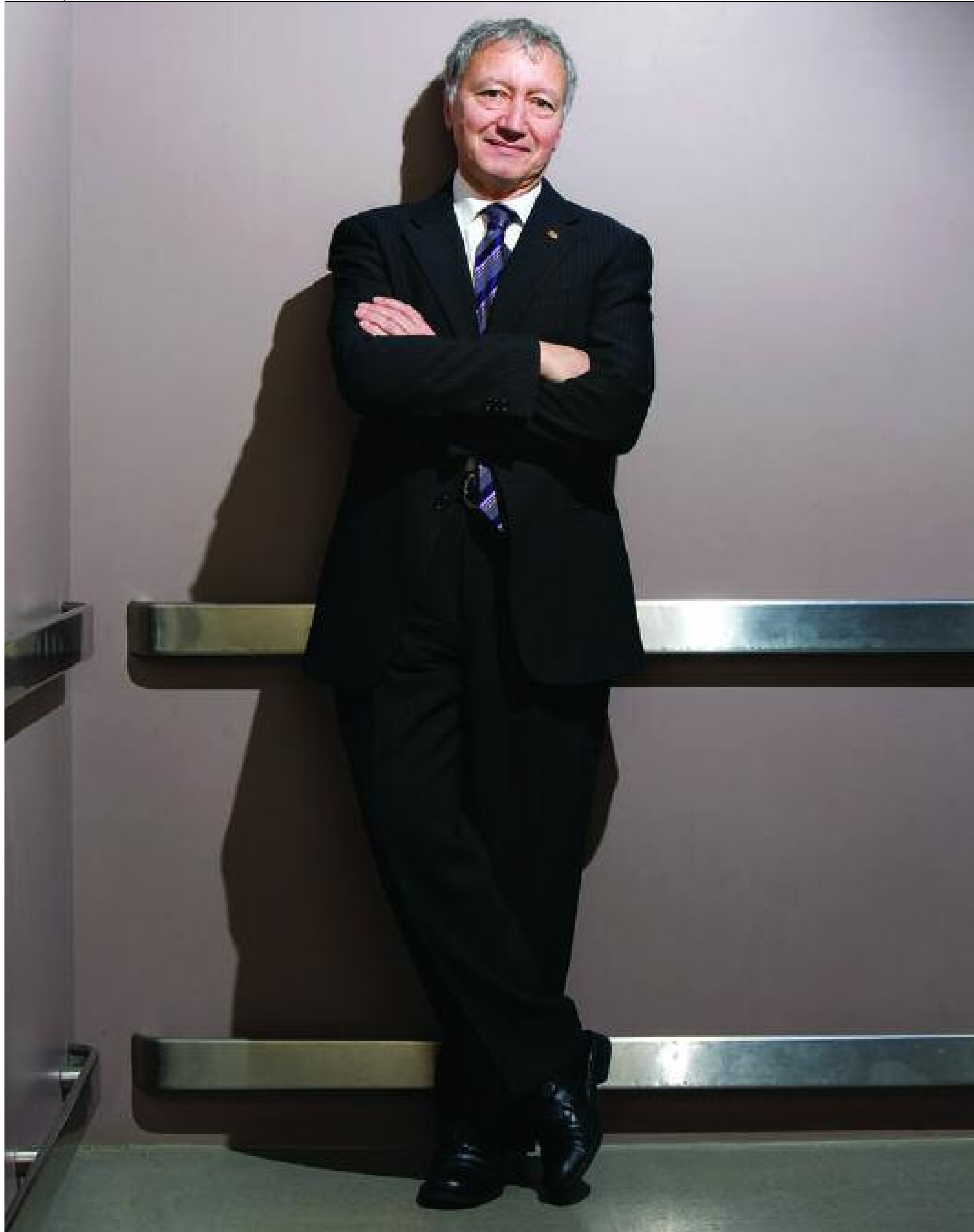

Photography: Peter Holst

Dr. Profit or Dr. Prophet ?

An outspoken proponent of private health care for Canadians, Dr. Brian Day brings controversy to his position as president of the Canadian Medical Association | by Marcia Kaye

You have to wonder what the heck is going on with our health-care system when there's no timely treatment available for a man with a golf-ball-sized tumour in his head. Two years ago, Lindsay McCreith, a 66-year-old man from Newmarket, Ont., had a seizure. After a seven hour wait in a hospital emergency room and a bunch of tests including a CT scan (but no MRI), McCreith received the verdict: a benign brain tumour and a stroke. He was sent home with a prescription for anti-seizure pills. Not satisfied, McCreith's family doctor wanted an MRI, only to find the shortest wait time in the entire Greater Toronto Area was four months. Desperate, McCreith drove across the border to Buffalo and paid for an MRI, which showed the size and location of the tumour. Back in Canada and armed with his MRI results, McCreith tried to see a neurosurgeon. The earliest appointment: three months away. So back he went to Buffalo and had surgery immediately. The tumour was removed, and tests showed it wasn't benign at all; it was a malignant Grade 2 cancer.

What could have been an eight-month wait in Canada from seizure to surgery was shrunk to four weeks, albeit at a cost of $27,000. McCreith was told he couldn't recoup the money from the province since he hadn't sought prior approval, a process that can take several months.

Now healthy again and suing the province for the money, McCreith believes Canadians should be clamouring for the right to buy private insurance for their own health as they can for their dog or car. "If I ever told people they couldn't get their car fixed for eight months," says McCreith, a retired body shop owner, "they'd go crazy!"

Stories like this make Dr. Brian Day crazy. While many Canadians treat the health-care system as a sacred cow, Day says that's a bunch of bull. He calls the system "ridiculous," "ludicrous" and "silly." Day, 61, is a physician and, by all accounts, a very good one. An orthopedic surgeon born in Liverpool, Eng., and practising in Vancouver, he has been a doctor for almost 40 years. He's a world expert in arthroscopic knee surgery. He's also worked in Europe and the United States and has even discussed health-care systems in Cuba with Fidel Castro and his physician son. And Day says that our system ranks right down with those of former Soviet Bloc countries in terms of quality – even lower in value for money. "Where is all our money going?" he demands.

If Day were a lone voice in the wilderness, perhaps all medicare-loving Canadians could justify ignoring him. But Day is the president of the Canadian Medical Association (CMA), which claims almost all of Canada's 68,000 doctors as members. Day is their elected spokesperson, which suggests that we might want to listen to what he has to say. And he's saying things like this: "The status quo is not working. We're paying more to keep people on wait lists than to get them off. That's how stupid the system has become."

Day believes that our system needs not just a tune-up but a complete overhaul, including a greater role for the private sector. "It's not that I support private health care," he says. "What I do support is the right of an individual if they so choose to spend their money on their own health." Day is trying to facilitate that: he owns one of the largest private medical clinics in Canada, a luxurious marble-floored, leather-couched, 14-bed facility with six operating rooms and a staff of 120 part-time doctors and 45 nurses. It's pay-as-you-go. An ankle replacement, for instance, costs $15,000 (British Columbia has not licensed the clinic for complete hip or knee

replacements), and wait times are virtually nonexistent – but only for a select few. The 5,000 patients the Cambie Surgery Centre treats each year include those who, unlike most of us, have a legal right to buy private care: the RCMP, Canadian Armed Forces, people from other provinces and countries including high-paid professional athletes, patients covered by Workers' Compensation – and criminals in federal prisons.

Day certainly doesn't want us to copy the U.S. system, which he deems even worse than our own. Nor does he recommend emulating the British model with its parallel private and National Health public systems, which failed him personally. His mother was treated in the National Health system for a heart attack when, in fact, she was dying from an undiagnosed bleeding ulcer at age 51; his father, a pharmacist, was murdered a few years later by two drug addicts who wanted the keys to his pharmacy. Day, who emigrated in 1973, says, "Canada is the greatest country in the world. We should have the greatest health-care system in the world."

But is Day's call for greater privatization the best solution? Many don't think so. "Brian Day is a businessman, and we should be wary of someone who wants to organize health care along market lines," says Michael McBane, national co-ordinator of the Canadian Health Coalition, a not-for-profit organization dedicated to protecting and expanding the public system. McBane is the first to admit the system isn't perfect, but he says Day's prescription could worsen the problems. "If you followed Day's logic, the whole public system would go to hell in a handbasket."

It's a hotly contested debate with much hyperbole and fear-mongering on both sides, but maybe it's a debate we should be having. Here we present some of the most contentious issues, with arguments from both camps and, it's hoped, some much-needed balance.

IT'S A HOTLY CONTESTED DEBATE WITH MUCH HYPERBOLE AND FEAR-MONGERING ON BOTH SIDES, BUT MAYBE IT'S A DEBATE WE SHOULD BE HAVING

WAIT TIMES

Everyone agrees that Lindsay McCreith's wait times were outrageous, but there's little agreement on a solution. Day believes the first step is eliminating wait lists. Accurate wait-list statistics are tough to come by, but he estimates that between one and two million Canadians are waiting to see a specialist, have a diagnostic procedure or undergo elective surgery. "These are just made-up figures because we don't know," he says. "But say the average procedure costs $10,000. We should invest in getting rid of the wait lists at a cost of $10 to $20 billion – which is not that much." It's cheaper, he reasons, than keeping people on wait lists since, he says, that as patients wait, they get sicker, develop complications and end up costing more. A 2008 CMA study reported that wait lists cost the Canadian economy $14.8 billion in 2007 in decreased income, production and consumer spending.

But wait lists have been coming down, argues Steven Lewis, a health policy and research consultant in Saskatoon and adjunct professor of health policy at the University of Calgary. Virtually every province has a wait-time reduction initiative, thanks to a federal government $4.5 billion Wait Times Reduction Fund begun in 2004. The latest Ontario budget, in March, pledged $180 million to reduce wait times in ERs, plus another $64 million for additional general surgeries. Wait times are now posted online in most provinces. Ontario's site – **www.waittimes.net** – shows that by spring 2008, wait times for most procedures, including surgery for cataracts, breast cancer, prostate cancer and heart bypass, had dropped far below provincial targets. But the average wait for a hip replacement was still seven months, and for an MRI, four months – just what Lindsay McCreith would have had to wait if he hadn't gone to Buffalo.

"There should be no wait lists that long for an MRI," says analyst Lewis. "But I'm sure there are other people who got their MRI ahead of this gentleman, and they might not have needed one. We have to look carefully at excess utilization. The solution to medical problems is not always more – it's sometimes less."

There's a general perception, which Day supports, that waiting for treatment results in sicker people with poorer outcomes. But a 2003 OECD report on wait times in 12 countries said, "one surprising result is that there is little evidence of health deterioration from a review of studies of patients waiting for a few months for different elective procedures across a range of countries."

Still, it's shocking McCreith had to wait at all for an MRI considering he'd had a seizure, says Danielle Martin, chair of the advocacy group Canadian Doctors for Medicare and a family physician in Toronto and northern Ontario. "If I had a patient who was actively seizing, I could get an MRI tomorrow," she says. She adds that even if we pay huge amounts to eliminate wait lists, they'll zoom up again unless we make permanent changes to reduce inefficiencies. A much better investment, she says, would be expanding electronic records. Used throughout Europe, these would vastly improve patients' access to care, reduce medical errors and provide better holistic care, says Martin.

DOCTOR SHORTAGES

Canada needs more working doctors. According to the 2007 National Physicians Survey, 4.5 million Canadians, or nearly one in seven, is without a family doctor. OECD countries average three physicians per 1,000 population; Canada has only 2.2. Day says we would need 26,000 more physicians just to

reach the OECD average.

Several factors have caused a shortage. In the early 1990s, governments cut medical school spots by about 10 per cent. Moreover, doctors are aging; 4,000 will retire in the next two years. And many doctors are cutting back their hours for a better work-life balance.

Day wants to see more available spots in medical schools and perhaps a private Ivy League-type medical school in Canada. He adds, “We need to repatriate some of the 4,000 doctors that have left in the last 15 years to go down to the United States.” And Richard Baker, founder of Timely Medical Alternatives Inc. in Vancouver, a company that finds private medical services for people unwilling to wait (and the company that McCreith used to get his treatment in Buffalo), says that while some wait times for surgeries have gone down, wait times for consultations with doctors and specialists have gone up.

Physician Martin agrees that we do have major problems with access to primary care, but as for Day’s concern about the so-called brain drain, she says, “The statistics don’t bear out what he says.” The Canadian Institute for Health Information reports that since 2004, more doctors actually enter Canada every year than leave it. Still, both she and Day would like to see a more efficient route for foreign-trained doctors to become licensed here – a process that now takes up to six years. As for a private medical school, Martin says today we’re seeing major public medical schools opening campuses in smaller communities, such as on Vancouver Island, in B.C.’s Fraser Valley and in Ontario’s underserviced areas of Sudbury and Thunder Bay.

“We also need to utilize the resources we have more effectively,” Martin says. Instead of individual doctors working in solo practices, implement team-based health care involving several doctors who can cover for one another and handle far more patients. She also recommends better use of nurse practitioners. Last August, a clinic led by four nurse practitioners opened in Sudbury, Ont., the first in Canada.

DAY WOULD LIKE TO SEE A MORE EFFICIENT ROUTE FOR FOREIGN-TRAINED DOCTORS TO BECOME LICENSED HERE – A PROCESS THAT NOW TAKES UP TO SIX YEARS

Policy analyst Lewis says we must change the way we pay doctors, as the current fee-per-visit method rewards volume and penalizes physicians who take time with patients with chronic conditions. He also believes we’re wasting our specialists by keeping them busy with simple procedures. He says that in India, non-ophthalmologists perform straightforward cataract surgery after only six weeks of training. “Having people with nine years’ medical training do a 12-minute procedure strikes me as overkill,” he says.

USER FEES

Stop denying it, says Day – we already have user fees in this country. “You break a leg; there’s a fee for your crutches,” he says. “I write you a prescription; there’s a user fee.” So would there be user fees in his vision of the perfect health-care system? Maybe. Or there might be for certain things. “Quite honestly, I would be happy to pay a user fee when I went to see my doctor. I can afford it and it makes me feel better.”

He adds that Tommy Douglas, the founder of medicare and the person voted the Greatest Canadian of all time in a nationwide TV poll, supported user fees. “He did not believe health care should be free. He felt you had to pay something.”

Day is right. Douglas suggested fees for health cards. In a 1961 address to the Saskatchewan legislature, Douglas said, “I think there is a psychological value in people paying something for their cards. It is something that they have bought; it entitles them to certain services. We should have the constant realization that if those services are abused, then, of course, the cost of the medical care is bound to go up.” In most parts of Canada, people do pay a modest fee to get or renew their health cards.

As for user fees for services, such as a $10 fee to see a doctor or a $20 fee for a procedure, the World Health Organization has issued numerous reports showing that user fees reduce unnecessary services – but unfortunately they also reduce necessary services. Saskatchewan implemented user fees in 1968 and abolished them seven years later because they deterred older and lower-income people from going to doctors. “User fees are a terrible idea,” says policy analyst Lewis. “The literature is very clear that even a very modest fee would deter poor people.” McBane of the Canadian Health Coalition adds, “User fees are a tax on the sick.”

Wouldn’t the collection and payment of user fees create a whole new level of bureaucracy? Day says they wouldn’t – if you keep the government out of it. He also suggests poor people be exempt from user fees. But critics caution that health care should never be charity; it’s a universal entitlement. Physician Martin says, “There’s a much more equitable and progressive system that we have now, and it’s called income tax. If Day wants wealthy people to pay more for their health care, then perhaps we should look at how we tax the wealthy.”

WHAT’S COVERED

As the World Health Organization says, “If services are to be provided for all, not all services can be provided.” We need a reality check, Day says. “We can’t order MRIs on every runner who gets a sore knee. If you get sore feet after playing two hours of tennis, do you think the orthotics in your tennis shoes should be covered by the medicare system? And the price you pay for that is a two-month wait when you get cancer? You choose.”

Day says it's completely illogical that medicare doesn't cover most dentistry or vision problems. For instance, it covers a brain infection from a virus but not a brain infection from an abscessed tooth; cataract surgery but not refractive laser eye surgery. "Who in their wisdom decided that a lens that is crooked is private but a lens that is opaque is public?" He adds that as a society we have to decide whether we want to pay for problems that people bring on themselves. For instance, should we be paying for a professional hockey player's jaw surgery after he gets into a fight on the ice? Day suggests people who engage in high-risk activities should pay an extra insurance fee. "If I can spend $70 on a lift ticket at Whistler, can I afford to spend $75 to cover myself in case I get injured skiing?" When asked how we should cover health problems caused by smoking or obesity, he says, "It gets really complex. But it's not a doctor's decision; it's a societal decision."

There's general agreement there's often no logic as to what's covered and what isn't. But Martin of Canadian Doctors for Medicare says, "As a physician, I'm not interested in making value judgments about my patients. Smoking and obesity, for instance, are profoundly linked to socio-economic conditions." Even Timely Medical's Richard Baker, who supports private health insurance, says, "I might have a problem with what he's saying here. If I choose to live in an area with smog and I get asthma, should I have to pay for treatment?"

Analyst Lewis says, "The problem with our system isn't that it covers too much; it's that it covers too little." McBane agrees: "We should expand the system to cover eyes and pharmaceuticals and home care. We haven't finished building medicare. We've only completed stage one."

PUBLIC/PRIVATE FUNDING

While we talk about our "public health-care system," Day says it's really only 70 per cent public. The other 30 per cent is private, including dentistry, health professionals such as optometrists and drugs. Since many Canadians have private health insurance through their employer, this creates a two-tier system, Day argues. "You'd be amazed at the number of people who say they're opposed to the private system yet they have private health insurance. Well, I say to them you have an ethical responsibility to write your employer and say you don't want it. It's hypocritical to say you don't support it when you have it."

WHILE WE TALK ABOUT OUR "PUBLIC HEALTH-CARE SYSTEM," DAY SAYS IT'S REALLY ONLY 70 PER CENT PUBLIC. THE OTHER 30 PER CENT IS PRIVATE

Day would like to see private insurance available for anyone to buy. He also wants hospitals, which are now largely non-profit organizations, subject to market forces such as competition. A 2008 report by Claude Castonguay, who established medicare in Quebec, also calls for a greater private sector role. Currently, hospitals receive global funding – a set amount at the beginning of their fiscal year. Instead, Day recommends hospitals be paid according to how many patients they attract. This way, he says, hospitals would have to start viewing patients as valued consumers and generators of income, rather than a drain on funding. Statistics on surgical outcomes and infection rates for every hospital's procedure should be made easily available to patients, who, as consumers, can research and choose where they want to be treated. If a patient in Yellowknife, for instance, wants a hip replacement and the best hospital is in Calgary or Toronto, Day suggests the hospital pay to fly the patient there. "It's called patient-focused funding, and it puts the patient at the centre of the health-care solar system," Day says. "Right now, the patient is like Pluto, hardly even a planet."

Day's suggestion makes perfect sense, says Timely Medical's Baker. "It should have been done years ago." Health policy analyst Lewis completely agrees with Day that information about outcomes and infection rates should be readily available, though he adds research shows patients rarely use it, preferring doctors make those choices on their behalf. Lewis also agrees there should be competition – but for excellence, not to end with winners or losers.

On Day's idea of hospitals paying for patients' flights, McBane says, "This is ludicrous. Patients don't want to travel thousands of miles for a routine procedure." As for patients being treated as consumers, he says, "Do you really think a sick person, a frail elderly person or someone who's unconscious can act as an informed consumer?"

A 2004 U.S. study from Cambridge Hospital/Harvard Medical School, published in the *Canadian Medical Association Journal*, found for-profit hospitals and clinics had higher costs and higher death rates than not-for-profit hospitals. Why? "Investor-owned hospitals are profit maximizers, not cost minimizers," say the authors. The largest hospital firms in the U.S. have paid billions to settle lawsuits for overbilling Medicare, kickbacks to physicians for referrals and inappropriately detaining patients to fill beds. A review of 149 U.S. studies over 20 years also found that non-profit centres performed better and at significantly less cost than for-profit centres, according to the Canadian Health Services Research Foundation.

WHAT'S NEXT?

So where do we go from here? Brian Day's term as president of the Canadian Medical Association ends in August, but don't think for a minute that the debate will end then. Day's successor will be Dr. Robert Ouellet, a 62-year-old Quebec radiologist. Ouellet is part-owner of five private clinics in Laval and Terrebonne, including Canada's first private CT scan facility and a pair of MRI clinics. ●