On policy and cherries

Better medicine: reforming Canadian health care
David Gratzer, editor
Toronto: ECW Press; 2002
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Most medical students would put their feet up after publishing a single article, let alone an entire book. Not David Gratzer.

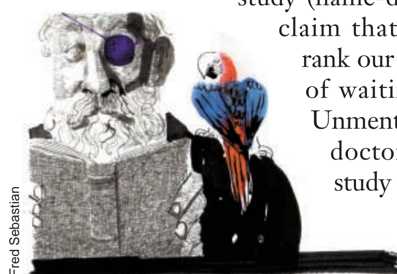
Gratzer, now a psychiatry resident at the University of Toronto, has followed *Code Blue: Reviving Canada's Health Care System* (written while Gratzer was a medical student at the University of Manitoba, winner of the $25 000 Donner Prize and now in its fifth printing) with *Better Medicine: Reforming Canadian Health Care*.

In many ways, *Better Medicine* makes for a better read. Compared with *Code Blue*, it is less repetitive and more methodically referenced. The layout is tidy, and a wider range of topics is discussed. And, instead of relying solely on his own analysis, Gratzer has assembled a distinguished group of essayists, ranging from economist William Watson to newspaper columnist Margaret Wente.

Gratzer is correct to say that his contributors are "deft with a pen," but his claim that they span the political spectrum would be insulting if it weren't so absurd. The biographical notes for well over half the contributors mention ties to right-leaning organizations. This homogeneity swiftly carries *Better Medicine* toward its inevitable, final chapter on the benefits of medical savings accounts. *Code Blue* readers will recognize this terrain.

But back to the beginning. After a breezy introduction (thankfully, Gratzer keeps this book mostly jargon-free), historian Michael Bliss describes the evolution of health care in Canada from Confederation to the 21st century. This chapter, informative and erudite (as we would expect from Bliss), dispels some myths but propagates others. For example, no data are presented to buttress the claim that the Pearson health insurance scheme, implemented in 1968, became "hellishly expensive." In fact, OECD data show that Canadian health care expenses rose from 5.4% of GDP in 1960 to 6.2% in 1967, and from 6.5% in 1968 to 7.1% in 1980. The argument that health insurance was responsible for the latter increase but not the former is not persuasive.

Wente's chapter of anecdotal stories, most of them familiar to *Globe and Mail* readers, is perhaps the most powerful of the book. The tale of Christian Yau, a motorcycle accident victim who languished for 12 hours in the emergency department of a Vancouver hospital before being airlifted to Seattle for emergency surgery, is infinitely more affecting than a flotilla of bar graphs and tabular data.


Fred Sebastian

Other chapters are less compelling. Demographer David Baxter claims that the age of a "typical" Canadian will rise from 36 in 1998 to 68 in 2030. Readers will be misled by the use of the lay expression "typical" for the statistical term "mode" and equate "typical" with "average," as Gratzer himself does in his introduction. The chapter "by" William Orovan, former president of the OMA, is a transcribed interview. Gratzer should have heeded Sir Francis Bacon's advice that "reading maketh a full man, conference a ready man, and writing an exact man" and asked Orovan to write the chapter himself.

Even more frustrating, however, is the selective use of data. More than one chapter refers to the RAND Health Insurance Experiment, a massive trial of several health insurance models in the US. A single result from the study — that families assigned free care used more services but had equal health outcomes compared with those in the user-fee group — is used to argue that a Canadian-style health care system is inherently inefficient. *Better Medicine* fails to mention, though, that the RAND study excluded both elderly and chronically ill people. Within their robust population, when the RAND investigators focused on the 25% of patients with risk factors such as hypertension or elevated serum cholesterol, they found that those offered free care were 10% less likely to die. This is not an isolated misrepresentation. Three times, *Better Medicine* invokes a Harvard study (name-dropping each time) to claim that Canadian physicians rank our system poorly in terms of waiting times and quality. Unmentioned is that Canadian doctors in the five-country study were also least likely to say that their health care system needs an overhaul. Canadian physicians were also least likely to say that patients are having difficulty affording out-of-pocket expenses.

The varied contributions from Gratzer's team set up the editor's one big idea, presented in the final chapter, that medical savings accounts (MSAs) will solve our health care woes. Although a panoply of options exists within the MSA model, the basic premise is simple: patients — or consumers, if you will — would pay for small expenses out of an account designated for health care purchases. A financial incentive would encourage thrift, and catastrophic expenses would be covered by insurance. The crucial

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advantage of MSAs, as Gratzer puts it, is that they "would reinvigorate the doctor–patient relationship with financial ties."

Gratzer should be commended for attempting to freshen the sometimes stale health care debate in Canada, and MSAs do deserve close scrutiny. Again, however, Gratzer cherry-picks the data. Yes, Singapore (where everyone has an MSA) spends less than 4% of GDP on health, compared with more than 9% for Canada. But Singapore has always spent less than Canada; in fact, health care expenditures rose faster after the introduction of MSAs than before. This seeming paradox has a simple explanation: hospitals competed not by lowering prices but through marketing and by offering the latest fancy doodads. Yes, health care spending fell by 27% in two Chinese cities after the introduction of MSAs, but this may have been the result of concurrent reforms that limited the use of imported drugs and expensive diagnostic tests.

In the end, Gratzer leaves the most important health policy questions unanswered. For example, how do we structure our health care system to deal effectively with chronic and preventable illnesses like obesity and diabetes? How do we shift resources from often futile end-of-life treatment to early diagnosis and prevention?

Should you read *Better Medicine*? It depends on your outlook. If you share Gratzer's ideology, you will delight in his analysis and enjoy his contributors' clear prose. If you find yourself on the other side of the political spectrum, you will benefit from giving *Better Medicine* a critical once-over. But the ideologically unattached must continue to wait for the great, unwritten health policy book that explains it all.

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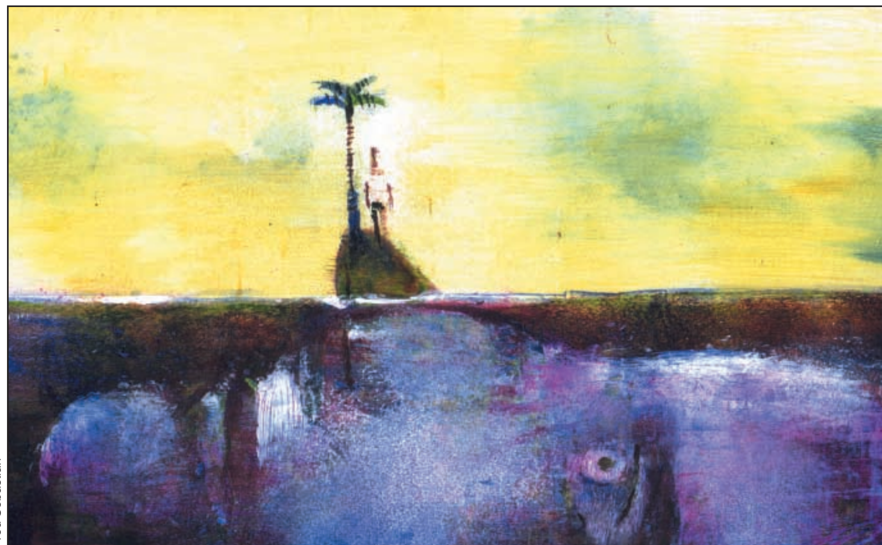
Room for a view

Alone

The first time I attempted to raise the dead was during my pediatric residency, when I was summoned to deal with an otherwise normal newborn infant who simply refused to breathe. The nurses offered the laryngoscope and endotracheal tube while I bagged the baby, trying to persuade her to start living in this world. After the elapsed time that this furious ritual required, I looked at my watch and declared the end.

I then tried to understand what had happened, and why. I had to convey to the distraught young mother that I had done all that was necessary, but it simply hadn't worked. But fate was certainly looking at this episode differently. The resident colleague who relieved me shortly after the incident noticed that the sheet covering the deceased baby was moving rhythmically. He called me on the phone to declare laconically, "You remember Baby Smith? The one that just died? She's okay now." I ran up the three flights of stairs to the newborn nursery. The baby was pink, breathing and alert, and all that was left for me to tell the amazed and delighted mother that there had been a slight mistake.



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In all of my other resuscitation attempts I was on my own. The second one occurred during an otherwise boring on-call evening at the chronic disease facility of our hospital, where we normally did very little except authorize a change in medication dosage. I received an emergency call to the playroom, where the adolescents were having a party. A young girl with rheumatic heart disease had been allowed to attend as long as she rested in her chair. But the music was too much, and the impulses of youth took over. She had joined the dancing crowd and, before long, suddenly dropped to the floor. I reached her side, diagnosed cardiac arrest and screamed (yes, screamed) for the resuscitation cart. Her sick friends were a sea of faces above me as I tried to initiate the resuscitation ritual alone. By the time the cart arrived it was too late. There was nothing left to do.