

# Care in Canada - Perspective of Former Canadian Physician

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My name is Dr. Lee Kurisko. I graduated from the University of Ottawa Medical School in Ottawa, Canada in 1988. Along with my post graduate residency years, I have worked in Canada both as a primary care physician and as a specialist in diagnostic radiology for a total of thirteen years. I have been working in Minnesota with Consulting Radiologists Ltd. for the last sixteen years.

In my last job in Canada, I was Medical Director for Diagnostic Imaging at Thunder Bay Regional Hospital. Although I used to be a supporter of Canada's system of government health care, facing the reality of trying to deliver quality care in this system completely changed my views. I am here today to share my concerns that Mr. Walz believes Minnesota should move towards a Canadian style health care system with government as the single payer.

It is basic economics that since a single payer system of health care has zero attached costs at the point of service, the system is overrun with demand for care. Since no government on earth can finance infinite demand for anything, the inevitable occurs and the government must ration care. In Canada, rationing is done in a covert manner by limiting medical resources.

For example, our wait time for an elective CT was seven months. For an MRI, it was thirteen months. I knew specialists with two year waiting lists. MRI wait times in the province of Newfoundland have been as long as 2.5 years.

When a new doctor moves to town, many communities run lotteries to see who gets to have access to the physician.

According to Statistics Canada, 14.9% Canadians have no access to primary care. In Thunder Bay, at the time I left, 40% of the population had no access to primary care. That means that their chronic conditions like diabetes, high blood pressure and lung disease were not cared for at all until the patients were in crises and had to go the Emergency Department.

According to Canada's Fraser institute, average wait times for medically necessary treatment in Canada now averages 21.2 weeks, the longest they have ever recorded.

In the province of New Brunswick the wait is 41.7 weeks. My own brother paid the ultimate price of dying because of a diagnosis of cancer that was delayed by about a year compared to how things would have unfolded here in Minnesota.

As health care costs ran out of control in Canada, it was official government policy to limit the number of physicians trained. This resulted in dire shortages.

In Thunder Bay, with a catchment population of 250,000 people the Ministry of Health said we needed 13 radiologists to be adequately serviced. For a while, we only had three. Needless to say we were worked to death trying to provide care. The American College of Radiology at that time recommended one radiologist per 13,000 people. We only had three for 250,000 people. Do the math. It wasn't pretty. We could not deliver the timely quality service that people deserve.

Canada's system of health care was started simply as a payment system but as costs grew out of control, government has insidiously imposed itself between the doctor and patient by restricting resources including things like the number of MRI and CT scanners, operating room hours and the number of physicians trained. In fact, the government attempts to control all of the moving parts of the system just as the Soviet central planners tried to do so with food production and the Soviet people starved just as Canadians starve for the health care that they need.

The situations that I have been describing are not for Botswana but Canada, one of the wealthiest industrialized nations in the world. I have been challenged in the past that the US would not have such a impoverished system with a "Medicare for all" type of plan and that it would be more richly funded. Canada spends a lot of money on health care and is tied with Germany for the 4th highest per capita expenditure on health care at 11.4% of GDP and yet care is still not delivered effectively.

Even with a higher level of funding, a single party payment system still faces the insurmountable problems of a need to ration to control costs and the inevitability of central planning leading to a loss of decision-making power for individuals, families and physicians.

Furthermore, costs will always be higher than expected without the price restraining effect of the patient functioning as a consumer. In 1966, it was anticipated that Medicare would cost 12 billion dollars in 1990. The actual costs were 107 billion.

Because we had such limited access to CT and MRI, it was part of my job to triage requests for scans. With about 12 slots per day and about 20 requests per day, our waiting list for MRI was rapidly growing to infinity. I would look at the clinical history on the requests and try to eyeball what an appropriate wait time was for the severity of the problem.

At times, I would triage people to the end of the line only to read their scans several months later and see that they had an out of control tumor or infection and I had personally made them wait. I could not sleep at night participating in such an immoral system that claimed a monopoly on providing care leaving patients and doctors limited choices.

It is true that there are serious problems with health care here in the US that are not to be neglected but more government involvement is not the solution. With Mr. Johnson as governor, rather than looking towards bigger government, we can have leadership towards innovative solutions in which patients have more control over their health care with less intrusion from government.

Thank you.

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