You can go home again

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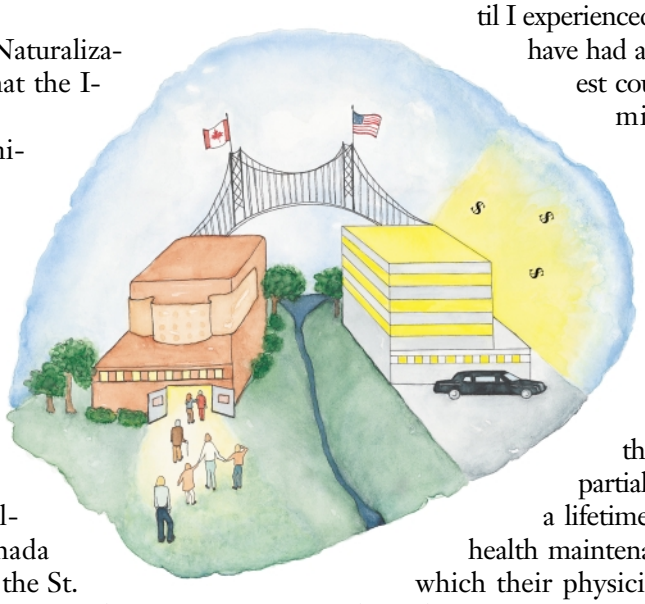
Time is that wherein there is opportunity, and opportunity is that wherein there is no great time. Healing is a matter of time, but it is sometimes also a matter of opportunity.

— Hippocrates

I knew I was back in Canada when the immigration officer asked if I was sure I didn't want to keep my US immigration card, the I-94. "Don't you want to keep it, just in case you want to go back?" he asked in disbelief as I returned from a year at Johns Hopkins.

"No," I said, shaking my head. "I won't be needing it again." But I could understand his wonderment.

The US Immigration and Naturalization Service (INS) requires that the I-94 be given to a Canadian immigration officer every time the border is crossed. And since our immigration officials have always refused to take it, this time I was determined to surrender it.



I don't know what was on the immigration officer's mind, but his attitude spoke volumes about the cultural difference between Canada and the US that is wider than the St. Lawrence and deeper than the Grand Canyon. He couldn't believe that a doctor was actually coming back to Canada. Who in his right mind would leave the land of milk and honey?

Because I am licensed to practise in Maryland and have a US work permit, many people, including non-physicians, have asked why I chose to come home. The answer, I believe, is buried in the fog of health care reform. In essence, it involves the future of health care and the future of medicine — on both sides of the border.

For many years governments in Canada and the US have been trying to get their fiscal houses in order. During this painful exercise physicians have witnessed the impact of health care cuts and have grown weary of the rhetoric of reform. Doing more with less has become a way of life, and this has left many physicians dispirited. Still, opinion polls indicate that Canadians want physicians to play a role in improving the country's health care system.

Last August Allan Rock, the new federal health minister, chose the CMA's 130th annual meeting in Victoria as the venue for his first public speech and asked the association to identify areas where the health care system is underfunded. In Canada, at least, our opinion is being sought.

I never appreciated the Canadian system fully until I experienced the American one. Unless you have had a taste of life in the world's richest country, where you live beside 40 million people who have no health insurance, you won't realize exactly what we have accomplished: our system provides coverage for everyone, including those who could never afford to purchase it.

Compare that with the US, where besides the millions of uninsured Americans there are millions more with only partial coverage or coverage that has a lifetime cap. Millions more belong to health maintenance organizations (HMOs) in which their physicians are not allowed to advise them about treatment options not covered by the HMO.

During my year in the US I learned that health care is a US$1 trillion a year business and that the care itself is a commodity like any other. Unfortunately, this commodity doesn't follow the usual rules. With a booming economy and more people working, more Americans should be covered by health insurance. Instead, the number of uninsured Americans is expected to grow to 45 million people over the next 5 years.

As the insurance problem grows, the managed care that health insurance provides is changing the way doctors

practise and the way patients get care in a far more dramatic way than anything that has happened in Canada.

Here we value health care for all, with emphasis on the *all*. We have always understood that cost-containment is an important fiscal reality, but as a nation we evolved to value a financial-free barrier to health care. However, managed care and the zealots of the primacy of cost-containment won't stop at the 49th parallel: a tsunami of reform initiatives is headed this way.

When they arrive, we will truly find out how different Canadians are from Americans. In the US a buck is a buck, even if it's a 73-cent buck. The challenge for us will be to maintain our cultural perspective in the ensuing brouhaha when national values come face to face with concerns about costs.

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In Canada health care is considered a fundamental right, and despite the problem of affordability the system remains anchored on the principle of community sharing and universal coverage. Here, the provinces and territories seek to contain costs by controlling the provision of services — which, by the way, is a common definition of managed care. The challenge for managed care organizations in the US is to expand coverage while controlling costs at the same time.[1]

In 1997 the US Congress tentatively approved a "bill of rights" for patients, and if adopted it would build consumer protection into health insurance plans. The far more encompassing Canada Health Act already outlines the principles of universal coverage for Canadians.

On both sides of the border there is no way to escape health care reform, and every physician needs to "retool" to meet this challenge. Building international linkages between physicians is important for this reason, for we have much to learn from our American colleagues. These linkages are already being built. One example is a conference on physician health and well-being, cosponsored by the American Medical Association and the CMA, that will be held in Victoria next April.

The structural changes that have taken place within medical practice in the US because of managed care are every bit as stressful for them as the regionalization and other developments that are reshaping Canadian medicine.

The changes taking place in health care are creating different issues on each side of the border. In Canada, for instance, career flexibility is becoming a priority. In the US, meanwhile, the move to managed care, with its emphasis on primary care providers, means that specialists in some areas are finding it increasingly difficult to find work.

In both Canada and the US, restrictions on access to care have been raising questions about the goals of medicine. Both types of restrictions — one is political, the other corporate — speak to the need for professional solidarity as the principle of equity is called into question.

If "healing is a matter of time," as Hippocrates said, the time may be right for Canada's doctors to play a key role in healing the country's medicare system. We have an opportunity to move beyond anecdote to document evidence of problems affecting the accessibility and portability of health services.

What road has the profession travelled over the past year? Where we are going? Most important, what lies ahead for medicine? The latter question could be asked on both sides of the border, but in Canada, at least, physicians are seeking answers. And maybe, just maybe, the federal government is listening.

And so, when the Immigration officer asked if I wanted to keep my I-94 just in case I wanted to return to the US, I said, "No."

I said this not out of a perverse sense of duty but because of a realization that Canada offers a prime opportunity to address structural problems in health care based on evidence derived from research. Even with a patient's "bill of rights," this is something US-style health care will never achieve.

The preceding opinions are the author's and do not necessarily reflect CMA policy.

Reference

1. Smith BM. Trends in health care coverage and financing and their implications for policy. *N Engl J Med* 1997;337:1001.

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