editorial may give comfort to the politicians and academics in Canada, but we believe it does not reflect the reality of patient care in Canada or the United States.

In our experience, the American system generally provides more expedient and better quality health care to the majority of its citizens than most Canadians receive. We worked in an area in the mid west where the market was not dominated by the large employers health maintenance organizations, and we were not in the immediate referral area to a large academic center. About one third of the patients in the practice had coverage from the federal medicare system which insures all patients over the age of 65 as well as those who have qualified for social security disability. Medicare patients do have a copay, up to the limits of a yearly deductible and are not covered for medications. Most of the rest of the patients were covered by insurance they either bought themselves, or obtained through employers, or were covered by the state program for the poor, called Medicaid. About five percent were private pay, meaning they had no insurance, but the city had a clinic funded by the United Way where these patients could get care. The hospitals provided emergency care and necessary inpatient care and the patients negotiated with them afterward regarding the bill if their insurance would not pay it all.

Patients with acute ischemic neurological events did not spend days on an emergency room stretcher waiting for a bed, or wait days in hospital for appropriate imaging (if available at all) like they often do in Canada. Evaluation and urgent treatment with agents such as tPA for stroke is denied to most Canadians because of overcrowded emergency rooms and distant geography, but is the standard of care for cardiac and appropriate neurology cases in most US emergency rooms. Patients with progressive nerve root deficits from lumbar or cervical discs could be quickly imaged and expediently treated, while in Canada we see them wait weeks or months for appropriate imaging and then again for the appropriate surgery. Patients and physicians in Canada have had so little experience with this type of expedient care that they don't expect it, and have come to accept, or not even recognize, the neurologic deficits that result from these delays in treatment.

Dr. Sarnat has conveniently ignored the American federal regulations that deal with some of the abuses he implies. The Stark laws impose harsh penalties on self referral and largely protect the patients from physician financial self interest. The Emergency Medical Treatment and Active Labour Act (EMTALA) ensures that adequate emergency care is provided to everyone regardless of ability to pay. Not-for-profit hospitals are allowed a tax free status in return for indigent care and each state has Medicaid to provide for its most disadvantaged citizens. Dr. Sarnat is correct in noting that health insurance is tied in with employment, so that people are not as free to take part time jobs as they are in Canada for fear of losing coverage, but many state governments are implementing group insurance for the self employed and their families. However, such plans vary a great deal from state to state. The US system is far from ideal, but in the twelve years we practiced there we never saw patients denied essential care and almost always it was provided more expediently than happens in much of Canada.

Before accepting Dr. Sarnat's statement that the Canadian system of universality is fixable, perhaps we should question the idea that equal health care for everyone is a right. What about food and shelter? These are not provided for everyone at an equal level by government monopolies. Human behavior seeks the best for one's self and family. Most western countries, including Australia, New Zealand, Britain and Western Europe, that had monopolistic healthcare have moved to a mixed system. Only Cuba remains in this ideologically legislated state. No country can afford to provide all possible care to all citizens all of the time. Technology has surpassed governments' ability to pay. How we distribute the best care for the most people is our challenge. Dr. Sarnat's satisfaction with Canada's single tier and very bureaucratic system may mislead your readers. Extolling the virtues of a system because it is "essentially fair" is supporting more fairytale than reality in a system that delivers something as personal as health care. By publishing Dr. Sarnat's letter as an editorial rather than an opinion piece, the CJNS comes dangerously close to endorsing one individual's very personal views. This is not the way to encourage critical reading or true debate.

Our experience of both the US and Canadian health care systems is very different from that of Dr. Sarnat. We hope that our views will encourage a more thoughtful debate on the challenges in the neurosciences in providing high quality and comprehensive care for patients with neurological conditions in Canada.

Sherrill J. Purves
G. Barrie Purves
Vancouver, British Columbia

To the Editor

An American-Canadian Neurologist Returns to Canada. *Harvey B. Sarnat. Can. J. Neurol. Sci. 2004; 31: 436-437.*

In a recent editorial, Harvey Sarnat shared with us his painful and lingering distemper towards health care in the United States.[1] We are accustomed to extend to cheerless men the effects of our understanding. Given the current political climate, and the readership of the Canadian Journal of Neurological Sciences, it is difficult to imagine a more likely recipient. We must remind ourselves, however, that it is not usually in the language of a polemic that we can discern the true character of a flawed system.

I have spent close to five years immersed in the medical culture of the United States. While professionalism in U.S. medicine may appear to have been overtaken by brash mercantilism, or at least undermined by lack of social/ governmental constraint, it has been my experience that most physicians' primary interest rests in the pure and humble challenge of helping their fellow man. Some have degraded their professional dignity, by condescending, for the pursuit of material gain, to join the ranks of the commercial class. But they are in the minority. And a large segment remains intensely devoted to the pursuit of knowledge.

Poverty and access to primary care for the poor are, of course, the great public health challenges in the United States today. And the inflexible, and, if we may use the expression, intolerant free market zeal of the government in power suggests that a solution is not around the corner. But the less restrained laissez faire approach does allow for some advantages.

Because health care spending has not been as limited by government policy as it has been elsewhere, there is more money in the medical economy of the United States. And as a direct result

medical research, both industry and government sponsored, and pure and applied, is better funded. According to a recently published analysis of the output and quality of general scientific activity around the world, Canada compares favourably to the U.S., as do other countries; but the United States dominates in the realm of clinical and pre-clinical health research.[2]

From a personal perspective, the resources available for patient care, teaching and scientific investigation in the largely "charity" hospital in which I practice, part of a publicly-funded institution in one of the poorest of the United States, are profuse by Canadian standards. I take issue with Sarnat's contention that Americans view "the academic pursuits of teaching and research as … non-profit-generating, hence inefficient, time-wasting activities, and that all research should be focused upon finding marketable (ie: profitable) new drugs and devices."

Canadians ambitiously commend the fairness and general efficiency of their health care system which, in these respects, arguably, has led the New World; but they do forget to observe that, despite its imperfections, U.S. medicine continues to contribute relatively more to the foundation of knowledge. Progress comes through research and development, not just the provision of compassionate care. While both are necessary for the health of our profession, which system is truly leaving a more lasting benefaction, for the greater good of all mankind?

I do agree with much of what Sarnat says. Canada has chosen a health care structure, justified by the common good, which works well for its citizens. As long as I notice limited opportunities for practice and research, however, I fear that there will be some sourness in my taste for it. The structure or lack thereof, here in the U.S., is certainly not sweet. Its flaws do detract; but the result is not wholly unpleasant, and much of the world gains from the high price that its citizens pay for it.

Ian B. Ross
Jackson, MS, USA

1. Sarnat HJ. An American-Canadian neurologist returns to Canada. Can J Neurol Sci 2004;31(4):436-437.
2. King DA. The scientific impact of nations. Nature 2004; 450:311-316.

Response to Letter to the Editor

An American-Canadian Neurologist Returns to Canada. *Harvey B. Sarnat. Can. J. Neurol. Sci. 2004; 31: 436-437.*

I thank the Drs. Purves and Ross for their thoughtful letters. One comment by Drs. Purves cuts to the heart of the issue: "…perhaps we should question the idea that equal health care for everyone is a right…" This is the very point I underscored in my essay, that almost the entire civilised world does regard basic health care as a human right. The United States is unique in its corporate view that basic health care is a business. Basic health care as a right does not signify that every chronic alcoholic is entitled to a liver transplant upon demand, nor is it an entitlement for vanity cosmetic surgery. It does mean that no epileptic should go untreated for poverty. They continue, "What about food and shelter?", stated almost as a rhetorical question with an implicit foregone conclusion, *of course not*. My foregone conclusion is, *of course yes!* Because this is what responsive, caring governments do for its citizens in a social democracy. Charity by religious or other institutions is laudable but only as a supplement.

After having spent many years during my training and subsequent academic practice in 7 states of the U.S., I take issue also with the Purves' assertion that "the American system generally provides more expedient and better quality health care to the majority of its citizens than most Canadians receive." For the poor, health care is sporadic, capricious and often unavailable.

Many institutions that serve the poor survive by philanthropy more than by public funding, continuously vulnerable to economic conditions. The Shriners' hospitals are rare exception. The closure of hospital emergency departments threatens access to emergency care for the rich as well as the poor. The Purves' statement about acutely ill patients spending days on ER stretchers in Canada is a grotesque exaggeration.

It is often stated that Americans have a personal choice with their multipayer privitised system. There really is no choice to be made in health care insurance: all patients want the best they can get, which translates to which plan they can afford. Sadly, for many working individuals, the only choice is "none of the above".

Even insured patients in HMO plans have limited "choices" of physicians.

Dr. Ross asserts that the United States continues to be the leader in medical research in the world. U.S. Government funding for medical research, particularly for the N.I.H., has been steadily eroded. In comparing American neurological journals of one or two decades ago with current issues, in most cases the ratio of the source of scientific articles (excluding endless drug trials sponsored by pharmaceutical companies) has changed; most articles are now from countries other than the U.S. Indeed Canada is prominent amongst these and research is thriving well within our socialistic medical system.

Dr. Ross states, "… health care spending has not been as limited by government policy…there is more money in the medical economy of the United States." At this time, indeed all domestic programmes in the U.S. have had sacrifices imposed because of different priorities and decreased revenue from tax cuts. Regrettably even Medicare, an efficient and successful government program for half a century, also is now under threat by the obsession for privatisation.

The Purves state, "No country can afford to provide all possible care to all citizen all of the time." Canada is proving this statement false. It is a question of national priorities, and confronting the question of why health costs are increasing disproportionately, rather than simply asking how we will afford this escalation.

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