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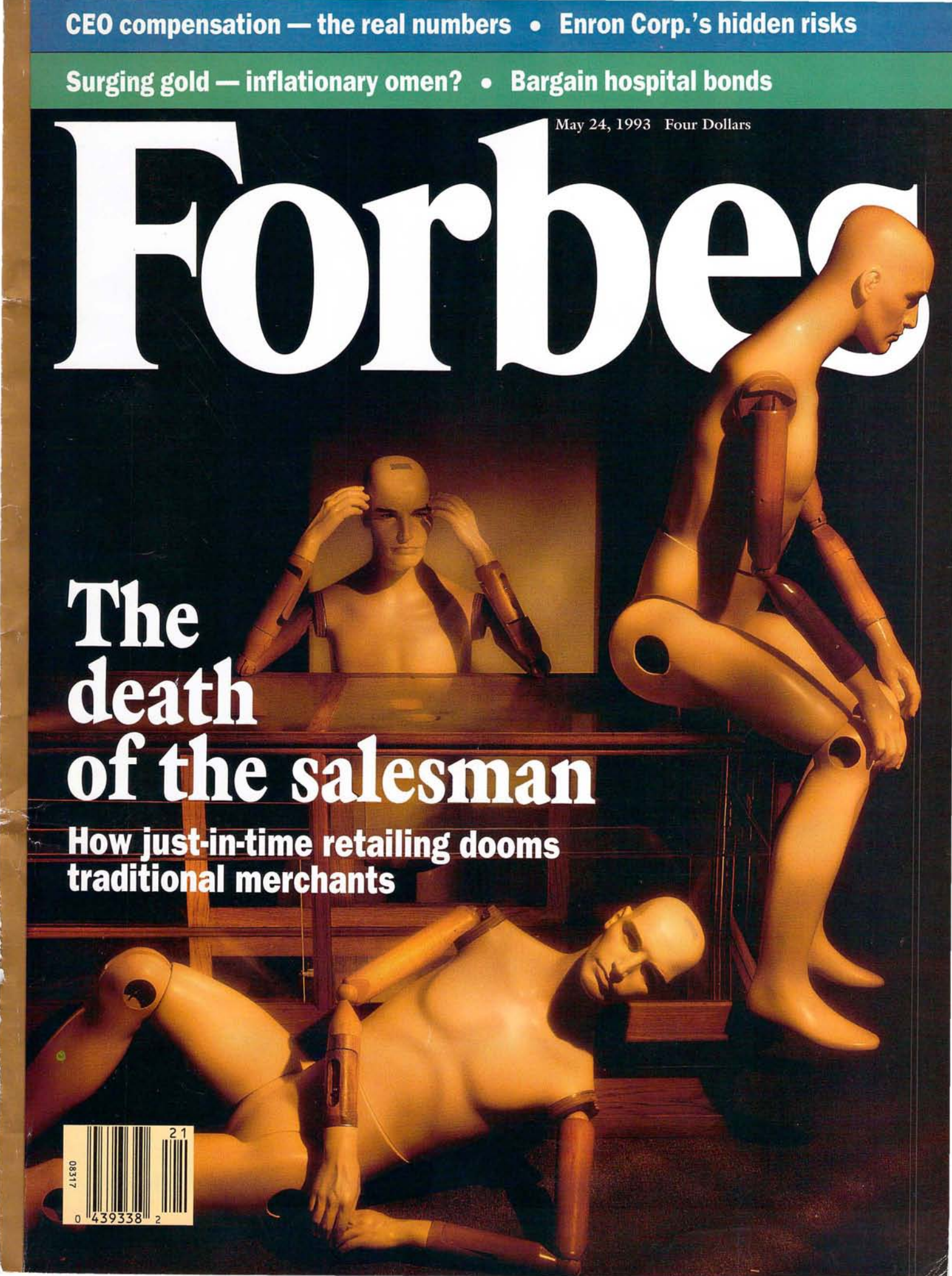

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If the U.S. health care system is remade to look more like Canada's, that will be very bad news for a lot of Canadians.

"Our system is just overwhelmed"

By Marcia Berss

AFTER LISTENING to advisers urging her to adopt a Canadian-style health system for the U.S., Hillary Clinton might learn something from a talk with Ronald Stokoe, of Prince George, British Columbia. Stokoe, 70, is a retired timber inspector who has been sent at Canadian taxpayers' expense to a Seattle hospital for the radiation therapy he needs to treat prostate cancer.

"Canada let me down," says Stokoe. His treatment costs are entirely paid for by the British Columbia health authority, but Stokoe resents the fact that he must undergo the uncomfortable treatments far from his wife and family.

Such stories are heard increasingly these days all along the border, from Seattle to Buffalo. For decades, better-off Canadians frustrated with standing in the long lines their state-run health care system produces have dug into their own pockets and paid for care in the U.S. Now Canada's provincial health authorities are making U.S. care available to ordinary Canadians.

"We see this as a safety valve," says Dr. Robert MacMillan, head of health insurance for the Ontario Ministry of Health. "All of Canada faces a lag in accessibility, particularly in highly sophisticated care."

Since 1991 the British Columbia government's agency overseeing cancer services has contracted with U.S. hospitals for radiation oncology treatment. Already about 750 people, some 10% of all British Columbians requiring cancer therapy, have been sent to the U.S.

Out east, in January, Ontario's provincial health authority contracted with hospitals in Buffalo, Detroit and Duluth to provide magnetic resonance imaging services for Ontario citizens. This month Ontario will also sign contracts with U.S. hospitals for acquired brain injury care, and it is considering contracts covering child and adolescent psychiatric, eating disorder, and drug and alcohol addiction treatment. Canadians now account for 75% of the patients in the chemical dependency unit at the Falls Memorial Hospital, International Falls, Minn.

"It seems ridiculous that we have to send people to the U.S.," says Irene Bergman, a senior addictions counselor in Ontario. "But our system is just overwhelmed." Her patients requiring in-hospital chemical dependency treatment wait three months in Ontario. In Minnesota they wait only three days.

Here's an international comparison not trumpeted by those who advocate a Canadian-style health care system for the U.S.: According to a recent study in the *New England Journal of Medicine*, nearly one-third of Canada's doctors sent patients outside their country for treatment in the last five years. Compare that with 19% of West German physicians and 7% of U.S. doctors.

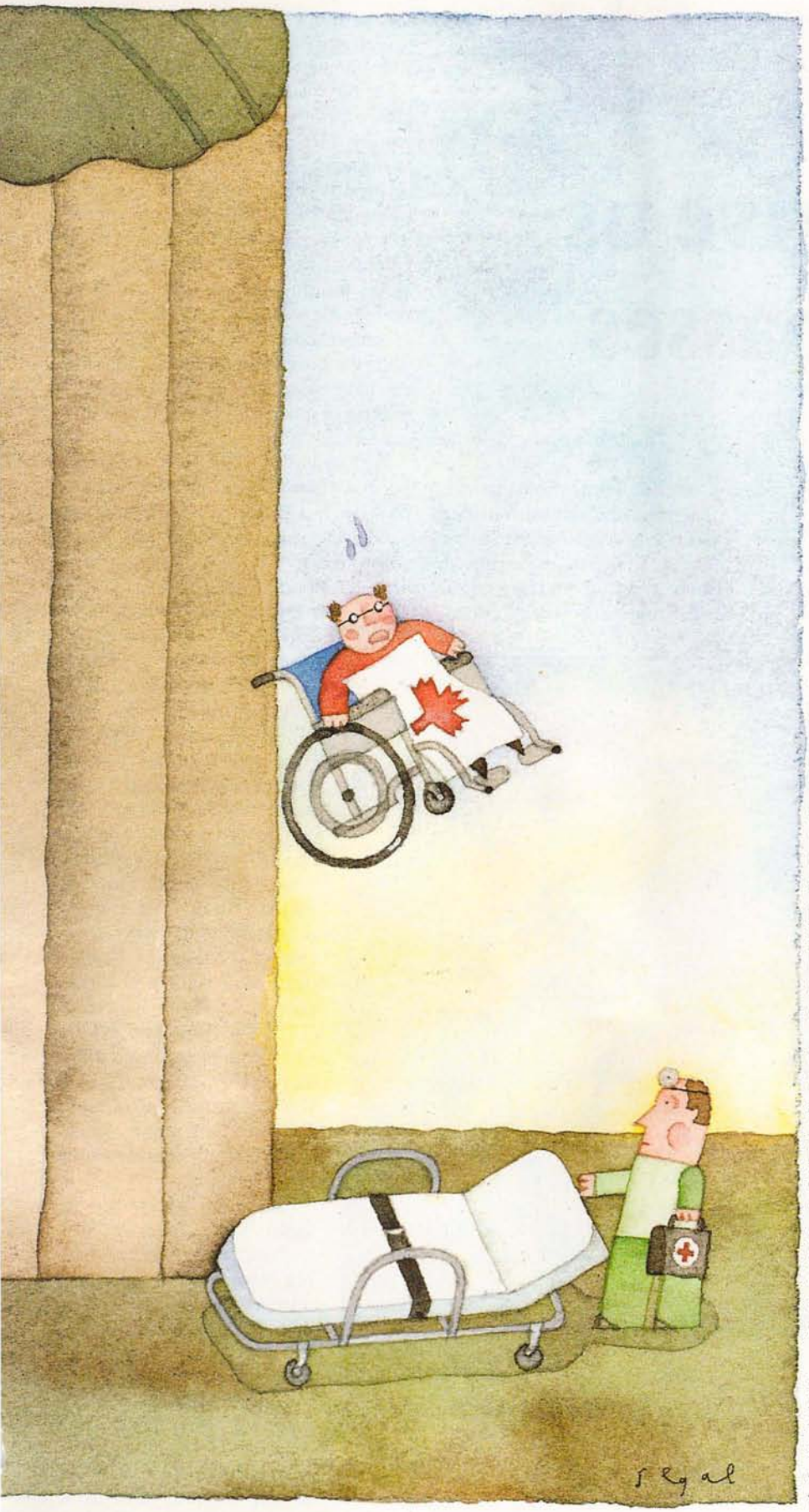
As any Frenchman, German or Brit—but hardly any American—knows, the problem with state-run health systems is that bureaucrats and their computers aren't very good at allocating resources to where they're needed, when. As in any planned economy, shortages quickly develop and the planners must then hustle to fill the gaps. Sighs Dr. David Klaassen, executive director of British Columbia's Cancer Agency: "We didn't do a good job predicting [demand for] radiation treatment for British Columbia or Canada in general."

As a result, British Columbia has 9 linear accelerators for radiation oncology to treat a population that is two-thirds of Washington State's, while Washington State has 20 machines. Despite the shortage, Klaassen says it will probably be two or three years before British Columbia gets new accelerators.

Are there too many machines in Washington? Yes, but which is better, a surplus or a shortage? The surplus means fast access to treatment for Washingtonians, and the saving of hundreds of Canadians' lives.

Economically, Canada's taxpayers get a great deal when Canadians are sent south of the border for treatment. Canada is able to buy U.S. health care goods and services at a cost far below what it would cost Canada to provide the products itself.

Secondary benefits make the cross-border treatments even more attractive. For example, for about one year British Columbia's Workers Compensation Board sent workers to Bellingham, Wash. for magnetic resonance imaging (MRI), at the going rate of around $1,000 per test. Buying U.S. service was attractive because the line for an MRI in British Columbia was up to two months long, during which time patients could collect workers' compensation. Sending patients to Bellingham speeded treat-



ment, saved on the cost of buying new MRI machines and saved on compensation claims. (A Vancouver hospital recently added a second shift in its MRI unit, and workers' compensation claimants are now being treated in the province.)

With so many advantages, why doesn't Canada send more patients to the U.S.? Because doing so would eliminate the Canadian government's primary means of controlling health care costs—namely, the state's authority to tell Canadians who can get what care, when.

Runaway cost was the reason that in 1991 Ontario tightened the screws on a partial easing of cross-border medical care trade. In 1989 Ontarians had to wait seven months for heart surgery. But then the province's cardiologists found a loophole in the health insurance law that required the province to pay 75% of the cost of treating an Ontarian overseas.

Ontarians began flocking south. Pretty soon, Canadians seeking other treatments, notably for drug and alcohol addiction, joined the flood, wooed by American chemical dependency centers.

The market was working. The lines in Canada began to shrink. But at a cost: Ontario's out-of-country payments more than doubled, to $244 million in 1991 (nearly 2% of the province's health budget) from $81 million in 1988 (less than 1% of the budget). So in 1991 Ontario capped out-of-country payments at $175 per day, virtually shutting off U.S. care.

Many knowledgeable Canadians believe their health authorities may again move to curtail cross-border medical trade. In anticipation, David Miller, a Winnipeg insurance broker, has teamed up with a U.S. health insurer, American Medical Security of Green Bay, Wis., to offer a policy that covers American medical treatment for Canadians who have to wait longer than 45 days for surgery or diagnostic procedures at home. Cost: about $450 a year.

Miller says his first customer for the new policy was a Canadian doctor. But if the Clinton Administration adopts Canada's health care system as a model for the U.S., where will Canadians—and Americans—go to get well? ■

Health "reform" may do even more damage to long-term interest rates than to hospitals. Strategy: Buy intermediate-term hospital bonds.

Defensive medicine

BY BEN WEBERMAN

Ben Weberman is a columnist for FORBES magazine.

THE TAX-EXEMPT MARKET is in a tizzy over the possibility of price controls on medical care. The result is that hospital bonds yield 0.2 to 0.5 percentage points more interest than general obligation munis of the same credit quality and maturity.

Buying opportunity? Yes—at least if you stick to well-run hospitals. But avoid the longest maturities. That way you'll avoid getting killed by a runup in inflation and interest rates—a real possibility if the Clinton Administration manages to push through a radical reform of the country's health care system.

Here's an example of an attractive bond: City of Rochester, Minn. (Mayo Foundation) noncallable 5.8s of 2007, which carry a rating of AA-plus. Priced at 103, the bond delivers a yield to maturity of 5.5%. For someone in a top tax bracket—figure on 40%, by the time Congress gets through with the new "millionaire's" surcharge—that yield is equivalent to 9.2% on a taxable bond.

There's another reason that hospital bonds are priced cheaply against other tax-exempts. A handful of bad apples—poorly managed, financially unstable institutions—are giving the whole sector a bad reputation. But if you shop carefully, you can dodge the bad ones. Stick to hospitals that have A or better credit ratings, are in your home state and have good reputations in your community.

It's not that I think the health sector "reform" being concocted at the White House will do no damage. Quite the contrary. If the reform gets through Congress, its main effect will be to expand the number of Americans whose health insurance is paid for out of tax revenues, at an additional cost of perhaps $100 billion a year. The resulting taxes will get built into the prices of everything—driving up inflation and long-term interest rates, and driving down a lot of bond prices.

If you are very worried about taxflation, stay short. Robert Froehlich, director of municipal research and investment strategy at Van Kampen Merritt, recommends North Central Texas Health Facility Children's Medical Center 7⅞s of 2018, prerefunded to call in 1997. They're priced at 116 to yield 4.25% and are rated AAA. LaPorte County Indiana Hospital Authority has an 8¾% bond due 2012 prerefunded to 1997 and trading at 117 to yield 4.4%. These are equivalent to 7%-plus yields for "millionaire"-bracket investors. You simply can't get that on high-quality taxable paper maturing in three years.

A typical ten-year A-tagged hospital bond pays 5.5%, as compared with 5.2% for a general obligation muni of that rating and maturity. If the bond is from your home state, it's probably exempt from local income tax. Compare: If you otherwise would have bought a ten-year Treasury yielding 6.1%, you would again be exempt from state tax, but you'd have less than 4% after federal tax under our "millionaire's" scenario.

How might legislative changes hurt the hospitals? There could be a push toward more "managed care"—meaning that the insurance underwriters would take a more active role in deciding what is reasonable and cost-effective treatment. Vigorous application of this concept could make some hospital beds redundant.

At the same time, however, the government will be picking up the tab for some patients who aren't now covered by insurance. At present, hospitals have to recoup losses on uninsured patients as best they can by overcharging the privately insured.

On balance, then, the reforms shouldn't jeopardize well-run private hospitals. Providers will be rewarded for good cost management, not for big losses calling for subsidies.

Troy Gerleman, senior municpal bond analyst at Kemper Securities, cites these issuers as the sort that should be attractive to bond buyers: City of Rochester, Minn. (Mayo Foundation); City of Minneapolis, Minn. (LifeSpan, Inc.—Abbott-Northwestern Hospital); and the Illinois Health Facilities Authority (for the Northwestern Memorial Hospital in Chicago).

The Abbott-Northwestern 7.1s of 2003, rated A1/A-plus, trade at 111 to yield 5.4% to first call in 1999. Managed care doesn't threaten this hospital: It already gets 39% of its revenues from managed care billings.

The Illinois Health Facilities Authority's noncallable 6½s of 2001 on behalf of Northwestern Memorial trade at 109 to yield 5.2% to maturity. The bond's rating is AA. This teaching hospital gets 34% of revenues from managed care.

Kenneth Willmann, portfolio manager of the excellent USAA Tax-Exempt Intermediate-Term Bond Fund, is fairly cautious. The 12% of his $1.4 billion portfolio invested in hospitals is largely confined to bonds rated AA or high A. Among the issuers: William Beaumont Hospital of Royal Oak, Mich. and the Medical University of South Carolina. ■