Healthy alternatives

by Stephen E. Lammers in the November 18, 1998 issue

By Pat and Hugh Armstrong, with Claudia Fegan, M.D., Universal Healthcare: What the United States Can Learn from the Canadian Experience. *(New Press, 176 pp.)*

It is not likely that American society will have a discussion about our health care nonsystem anytime in the near future. We will complain about the expense of our medical treatment, be suspicious of HMOs because of the profit motive which drives many of them, continue to try to regulate those same HMOs by forbidding them to make certain kinds of treatment decisions, and perhaps, just perhaps, bemoan the fate of those who have no health insurance. As good Americans, we will look only to ourselves in all this complaining and regulating.

For those interested in alternatives, this book is a good place to begin to think about other options. Pat and Hugh Armstrong, both currently working in Canada, and Claudia Fegan, a physician in Chicago, outline the road our neighbors to the north have taken. In easily accessible prose, the authors show the financial and moral costs of continuing on our present course in health care. In financial and moral terms, the conclusion is clear: our health care nonsystem is bankrupting us.

The authors organize the book around what they take to be the important principles that govern medical care in Canada: universality, comprehensiveness, portability, accessibility and public administration. Once these principles are outlined, the authors use stories and easily understood charts to point out the differences between health care in Canada and in the U.S. Let me use a story of my own to illustrate.

Some years ago a colleague of mine, having heard of my interest in health care, stopped by my office. He was a Canadian and had just made his first visit to a local physician, where he was given a bill. To my amazement, he wanted to know what he should do with it. He had never seen a bill for medical services. That was not part of the Canadian experience of health care. In order to understand that experience, a brief explanation of the five principles is in order.

First, universality. As they organized their medical care system, Canadians decided that everyone should be covered for medical care. There should be no exceptions. Everyone should have a stake in the system. In this sense, the system promotes equality and citizen participation.

Along with universality came accessibility. Health care must be provided in ways that do not preclude access. Since fees are one major obstacle to access, they are forbidden. Access would also be limited if physicians and hospitals were not compensated fairly. Thus part of ensuring access is requiring that physicians and hospitals are compensated for the services rendered. Note one significant difference from the U.S. here: there is no mention of health insurance being provided through employers. That would limit accessibility for those not employed.

Third, portability. The consequence of this principle is that Canadians do not have to worry about changing jobs or locales. Although each province oversees health care, Canadians may move from province to province and job to job without fear that they will lose coverage. Their medical care travels with them. All they need is their health insurance card.

Fourth, comprehensiveness. Canadians struggle with this, as do all health care systems. They have concluded that all that is "medically necessary" should be covered. If a procedure is not medically necessary, the patient has the option of paying for it. The consequence is that most hospital and physician charges are covered by the system. To be fair, dental coverage is not provided by the system, and drug coverage varies by province. One arena for health insurance in Canada is employer-based insurance covering drug costs. The results of this are predictable. The healthy and wealthy who are employed pay less for their drugs than do the poor and sick.

Finally, public administration. Given the animus among so many in this country against government, it is strange to point to this as a virtue of the system in the eyes of Canadians. The public authority is responsible for paying for the health care system, not for managing the health care system. The focus of the system is on physicians and hospitals; other kinds of care receive less of the public purse. Some provinces have programs that attempt to fill in the gaps in the system.

The most surprising statistic in the book concerns the amount of public monies spent on health care in Canada and in the U.S. The percentage is not that different; the

difference is that in Canada 100 percent of the population is covered by these public monies while in the U.S. only 30 percent of us are covered by programs such as Medicare, Medicaid and military health care.

Do the Canadians fare as well in terms of health outcomes? In fact, they fare better on the recognized indices of mortality and morbidity. The U.S. ranks so far down the list of industrialized nations on some of these measures, such as infant mortality, that we should be embarrassed.

Doctors are free to practice medicine without being second-guessed by insurance companies or other health care organizations. This alone might make the system attractive to American physicians. Of course, Canadian physicians are not paid as well as American doctors are.

Canadians do have less medical technology than Americans do and they use it less. One of the consequences of this is that there is often a wait for the use of a technology such as MRI. The simplicity of the system amazes Americans. There is no need for the myriad of forms which are a hallmark of American medicine today. That kind of paperwork and detail, all of which costs enormous sums, is not part of the Canadian system.

Is the Canadian system perfect? No. Critics of the system point to waiting lines for noncritical procedures. These same usually do not comment on the lack of accessibility for millions of Americans; better that some of us receive first-class care without a wait than that all of us receive good care with a wait for some procedures. The justification for this implicit judgment is not given. Nor is there evidence that the waiting time for noncritical procedures affects health outcomes for Canadians.

The point of all of this is that our health care nonsystem is the result of a series of choices that we have made, and that there are alternatives, if we have the political will to implement them.

What might we do about this? If the "we" includes churches, we might make parishioners aware of the situation. That would mean making some unwelcome facts available to congregations. Among other things, churches ought to be proclaiming, in season and out, that the fact that the uninsured do not receive health care in this country is a scandal. Theologians from many different Christian communities have come to this conclusion many times; official church documents have proclaimed it. I have yet to hear this message from any pulpit.

My suspicion is that I will have to wait a while before such a message is preached. In the meantime, those of us who might forget that there are alternatives to our system would do well to read books such as this one. The Armstrongs remind us that it is possible to have a different kind of politics, one inspired by a vision of justice for all persons in our society.