SUSAN ROSENTHAL

SICK AND SICKER

The US and Canada: Different Forms of Medical Rationing

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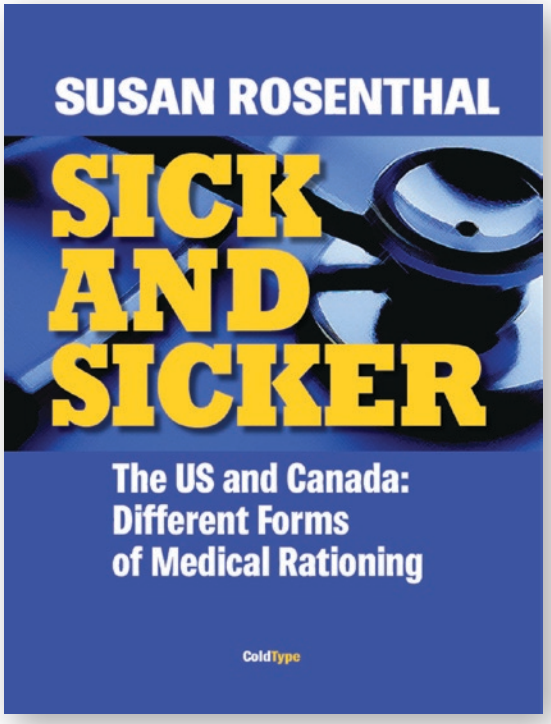

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A young woman without medical insurance goes to a hospital emergency department for treatment of severe pain. She's turned away because her pain does not qualify as an emergency. She takes a seat in the waiting room and collapses shortly after. At that point her condition qualifies as an emergency, and she is treated.

This outrage did not occur in the United States, but in Canada.[1] Under capitalism, all nations limit access to medical care, and Canada is no exception.

Why Ration Medical Care?

Most people believe that healthcare is a human right, and everyone should get the medical care they need.

However, when profits matter more than human rights, medical care is rationed. People get only what they can pay for, or what employers, insurance companies and governments decide to give them.

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The only way to provide healthcare as a human right is to provide universal access.

Universal access should not be confused with improved access. Universal access means no rationing, so that the CEO, the factory worker and the homeless addict would all receive the best care that society can provide.

Politicians who talk about universal access to medical care don't mean equal access, they mean that everyone should have some access or more access.

One cannot eliminate class inequality in medicine without also eliminating it in society, so capitalism keeps universal access off the agenda. We are not allowed to question whether medical care (or any essential service) should be rationed by class. We are allowed to dispute only the form and extent of this rationing.

Opposition to universal medical care is not only political, it is also financial. While productivity and profits are linked to the health of the workforce, employ-

ers don't want to pay taxes to provide expanded medical services. And some capitalists reap huge profits from privatized medicine.

The ruling class shows no interest in what is medically preferable – universal access with an emphasis on illness prevention and social health. Its priority is to cut costs, maintain profit-making opportunities and keep the working class subordinate.

Those goals are best achieved by a class-based, treatment-oriented medical system, where the rich have access to the best services, the middle class and skilled workers have limited access through pooled insurance programs, and the poor are provided with a bare-bones basket of government-funded services. This is the standard formula for all medical systems under capitalism, with different nations displaying variations on this basic model.

While the debate to reform American medicine emphasizes the differences between the Canadian and American systems, both nations are deeply divided by class, and their medical systems reflect and perpetuate those class divisions.

In the US, medical rationing is based on ability to pay. The resulting inequality is up-front and obvious. Canada rations medical care by under-funding the public health care system, bringing inequality through the back door.

US Rationing

All Americans can access medical services – if they can pay for them. Most can't.

Sixty percent of the US workforce make less than $15 an hour. In 2005, the average annual insurance premium for a family of four ($10,880) cost more than the annual income of a full-time minimum-wage worker ($10,712), before deductibles, co-payments and the cost of non-insured treatments. [2]

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Currently, 47 million Americans have no medical insurance. Those who have insurance can't count on getting the care they need because insurance companies refuse to cover many conditions and set limits on how much they will pay. Whenever possible, they deny payment, forcing people to go without or pay out of pocket, making medical bills a prime source of bankruptcy.

In America's free-market system, access to medical care is based on the ability to pay, and the working class is free to go without.

Canadian Rationing

Canada has established medical care as a legal right. In reality, the medical system is too poorly funded to provide comprehensive services to all, so some people are excluded altogether, and access is limited for everyone else.

To reduce the cost of medical programs, each province sets conditions on who qualifies for coverage. To obtain Ontario health insurance (OHIP), one must:

- be a Canadian citizen or a documented immigrant
- be a permanent resident of Ontario
- be physically present in the province for 153 days in any 12-month period

Visitors, transients, undocumented immigrants, and refugees without status are not covered.

As a final obstacle, a three-month waiting period is imposed before coverage begins. The Ontario government web site "strongly encourages new and returning residents to purchase private health insurance in case you become ill during the OHIP waiting period."

In Canada, as in the US, the capital-

ist class exerts constant pressure to reduce government-funded social services. Bureaucrats are employed to measure "cost-efficiency" and achieve "cost-containment" by reducing the number of services provided, forcing health workers to do more for less and outsourcing to the private sector.

To keep costs down, medical school enrollment has been restricted to the point that Canada needs 26,000 more doctors just to meet the OECD average number of physicians-per-population.

Under-funding forces patients to wait for assessment and treatment, and half of Canadians report waiting longer than they consider reasonable.[3] The seriousness of this problem is hotly debated on both sides of the border.

Advocates of privatized health care emphasize how long Canadians wait in order to discredit all government-funded systems, even though millions of Americans with no insurance essentially wait forever. In contrast, defenders of medicare minimize the problem of wait times, making it harder to fight for more funding for the system.

When people have to wait for essential services, those with money and connections find a way to get to the front of the line or to bypass it altogether. The longer the line, the more inequality grows, and the more pressure there is to develop private-sector alternatives.

Comparing the US and Canada

In Canada, 13 provinces and territories administer medical care, resulting in 13 different payers with limited transferability between them. There is also a market of competing private companies that provide workplace, group and individual insurance to cover medical services not funded by the provincial plans.

In Canada, government pays 70 percent of medical costs, while individuals and private insurance companies pay the rest. In the United States, this proportion is reversed

In the United States, government is the largest single provider of medical funding. About 100 million Americans (one in three) receive medical care through government-funded programs like Medicaid, Medicare, the military and government employee health benefits.

The basic difference between the Canadian and US medical systems is the proportion of government funding to private funding. In Canada, government pays 70 percent of medical costs, while individuals and private insurance companies pay the rest. In the United States, this proportion is reversed.

Government-funded medical systems offer two important advantages: the cost of medical care is socially shared, so that individuals aren't crippled by medical expenses; and medical benefits are removed from the employers' control, so that workers can change jobs without fear of losing access to care.

These advantages diminish when governments under-fund the medical system, forcing people to pay for their own care or rely on workplace medical benefits.

Because most Americans want a government-funded universal medical system, they could benefit from learning how Canadian medicare was won, and how it is now being lost.

The Fight for Canadian Medicare

Until the 1960's both the American and Canadian medical systems were dominated by the private sector. Charitable organizations provided minimal care for the poor. Regular medical care was reserved for those who could pay and for those whose employers would pay for them.

Like their American counterparts, Canadian physicians and insurance companies vigorously opposed any reforms that

smacked of "state medicine" or "socialism." Neither business nor government supported access to medical care as a human right.

During the 1960s, popular pressure grew for universal health care. To contain demand, the federal government launched a Royal Commission to "study" the problem. In 1962, the Canadian Labour Congress (CLC) made its preference clear:

"We favor a system of public health care that will be universal in application and comprehensive in coverage. We favor a system that will present no economic barrier between the service and those who need it. We are opposed to any provision which will require some people to submit themselves to a means test in order to obtain service. We look to a system of health care that will be regarded as a public service and not as an insurance mechanism."[4]

Despite the grass-roots demand for socialized medicine, where the State is both payer and provider, the Medical Care Insurance Act of 1966 established socialized insurance, a publicly-financed, private enterprise system "free of government control or domination."4 It took five more years to implement the Act in all provinces.

In the province of Quebec, union demands peaked in the 1972 general strike. In response, Quebec incorporated medical services into a broad social benefits system, paid for and provided by the provincial government. The Quebec working class is rarely credited for winning the most comprehensive socialized medical system in North America.

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Rolling Back the Gains

The initial funding agreement for medicare was 50-50, with federal and provincial governments sharing the cost. In 1977, the federal government created a more complex system for transferring payments to the provinces and dropped its share of medical funding to 20 percent.

As federal funds diminished, the provinces were forced to pay more. The result was round after round of cuts to hospital budgets and other medical services. Because the provinces varied widely in their ability to pay for medical programs, the principle of equal access was eroded.

Medical care was still free, but there was less of it available. Private insurers rushed into the breach created by underfunding. The more services were cut from the medicare basket, the more individuals had to purchase insurance, pay out of pocket or go without.

In 1984, the federal government passed the Canada Health Act to reassure nervous Canadians that medicare was safe. Universal access to medical services was guaranteed on paper, but no funds were provided to implement the principle. Behind the scenes, politicians were preparing the ground for privatized health care.

In 1994, the Ontario government stated, "To have the effective launching pad it needs, the health industries sector must expand its share of its own home market. Steps must be taken to ensure that, as in other countries, the domestic market supports the development of globally competitive companies."[5]

One of these steps was to scrap regulations that ensured a minimum level of daily care for patients in nursing homes.

In 1997, the federal government declared, "Promoting Canadian companies as global health-keepers is the main objective driving the strategies and plans of the government for the medical devices, pharmaceutical and health-services sector."[6]

Behind the mask of health-care "reform" and "restructuring," the Canadian medical system is being handed, piece-by-piece, to private industry in a manner similar to the dismantling of Britain's National Health Service.[7]

Publicly-provided medical care is under-funded to the point of crisis, then condemned for its inadequacies. The private sector is proclaimed the only possible savior, and opponents are ridiculed as old-fashioned and sentimental. When the market fails to deliver, the public is told to adapt to "the new reality."

Canadian medicare is currently so under-funded that, in 2004, Canada's Supreme Court declared, "The Canada Health Act [does] not promise that any Canadian will receive funding for all medically required treatment."

The CUPE Hospital Strike

Unionized hospital workers have been the strongest defenders of medicare. As health-care budgets shrank, Canadian hospitals became a battleground with hospital workers fighting cuts to staff and programs and out-sourcing of services to for-profit, non-union corporations.

In 1981, the Canadian Union of Public Employees (CUPE) struck the Ontario Hospital Association. At one hospital, workers locked out management and continued working under their own elected committee. For seven days, 13,000 strikers defied provincial back-to-work legislation, the jailing of top union officials and the firing of key strike leaders.

When management refused to budge, the next logical step would have been to mobilize the other sections of CUPE for an all-out public-sector strike. Unwilling to take that step, union officials caved.

The defeat was substantial. Most small, local hospitals were closed. The remaining hospitals were merged into giant conglomerates managed by business consultants.

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Privatization has decimated Canadian medicare. Tens of thousands of hospital nursing jobs have disappeared at the same time that hospital stays have been cut, so that fewer nurses care for much sicker patients. Deadly, infectious diseases sweep through hospitals that no longer have enough cleaning staff.[8]

Most rehabilitation and chronic-care facilities have closed or gone private, transferring the burden of caring for the sick, injured and frail to their families.

Hospital out-patient clinics have closed, and discharged hospital patients are now directed to family doctors for follow-up. But there are not enough doctors to meet the demand.

By 2006, fewer than 10 percent of Ontario family doctors were accepting new patients. Currently, five million Canadians (one in six) have no family doctor. Patients can wait weeks to see a doctor, months to see a specialist and many more months for treatment.

Funding cuts have severely damaged Quebec's model medical system. In 2005, Canada's Supreme Court ruled that lack of timely access to treatment in Quebec was so serious that the province could no longer prohibit private funding for medically necessary services. Similar legal challenges are expected in the other provinces.

The Canadian experience proves that government-funded medical systems don't guarantee timely access to needed medical services. Ironically, while many Americans long for a Canadian-style medical system, that system is disintegrating under the pressure of market forces.

We Need a Fighting Labor Movement

Hundreds of American labor organizations have endorsed HR 676 – The United States National Health Insurance Act to establish a national insurance system. However, endorsements alone will not be enough to defeat a powerful medical insurance industry, overcome resistance to increased State funding and counter the right-wing campaign against "entitlements."

The people at the top of society believe that medical services should be rationed on the basis of class, and they raise the highest stink when anyone suggests that they share access with everyone else. They don't want any restrictions placed on their access to "Rolls Royce" medicine, and they will fight tooth and claw to keep their class privileges. If you have any doubt of that, read What Happened in Chile: An Analysis of the Health Sector Before, During, and After Allende's Administration

If allowed to vote on the matter, most Americans would choose a universal health care system.[9] Because we will never get to vote on it, we must build a mass movement that is large enough and determined enough to win it.

The extent of medical rationing that exists at any point in time in any nation is determined by the balance of class forces. Too little rationing generates a sense of mass entitlement (or equality) that can be difficult to contain. Too much rationing generates class anger that can also be difficult to contain.

It took a revolution in France to scare Germany into establishing Europe's first national medical plan in 1883. In Britain, the National Insurance Act of 1911 was rushed through Parliament during a strike wave. And Canadian medicare was consolidated in 1972, the year of the Quebec General Strike.

Every day, the world becomes a sicker place. And every day, the gap grows between what people need and what capitalism is willing to provide

The US is the only industrialized country without a national medical plan, because the American labor movement has been too weak to win it.

During the crisis of the 1930s, President Roosevelt conceded the New Deal, but excluded national medicare. To quell the protests of the 1960s, President Johnson conceded Medicare and Medicaid, but held the line on universal coverage.

American workers continue to be divided by race and dominated by union bureaucrats who collaborate with management.10 As a result, working and living conditions for most Americans continue to deteriorate, along with their health and their access to medical care.

We need to build a new labor movement that will fight for comprehensive, universal medicare. The trillions of dollars being spent to impose US control over the Middle East would more than cover the cost of a top-notch national medical system.

We need a fighting labor movement that pays more than lip-service to the principle of "an injury to one is an injury to all" and actively supports health workers who are fighting for higher staff-to-patient ratios, lower work loads and the right to blow the whistle on deficient and dangerous patient-care conditions.

Every day, the world becomes a sicker place. And every day, the gap grows between what people need and what capitalism is willing to provide.

Our challenge is to build a labor-based, mass movement that will reject medical rationing, fight for universal medical care and keep on fighting to end all class inequality.

References

1. Cited in Lepage-Monette, A. (2008). Programs that work: Ensuring health care for the uninsured. Medical Post, Toronto. March 4, p.6.
2. Colliver, V. (2005). Health plans dwindle in U.S.: Number of firms offering insurance drops as costs rise. San Francisco Chronicle, September 15, p.C-1.
3. The mortality risk for those who waited longer for hip surgery was 22 percent higher than for those treated within two days of admission to hospital. The Canadian Institute for Health Information. Health Indicators, 2007.
4. Cited in Fuller, C. (1998). Caring for profit: How corporations are taking over Canada's health care system. Ottawa: Canadian Centre for Policy Alternatives.
5. "Healthy and Wealthy, A Growth Prescription for Ontario's Health Industries." Report of the Health Industries Advisory Committee to the Ontario Ministry of Health, March 1994.
6. National Sector Team: Health Industries, "Canadian International Business Strategies – '97-'98," Report for Industry Canada, March 20, 1997.
7. Pollock, A.M. (2004) NHS plc: The privatization of our health care. New York, NY: Verso.
8. Valiquette, L. et. al. (2004). Clostridium difficile infection in hospitals: a brewing storm. CMAJ, July 6, Vol.171, No.1.
9. On November 3, 1998, Illinois residents voted on the "Bernardin Amendment for Universal Health Care" which states, "Health care is an essential safeguard of human life and dignity, and there is an obligation for the State of Illinois to ensure that every citizen is able to realize this fundamental right. On or before May 31, 2002, the General Assembly by law shall enact a plan for universal health care coverage that permits everyone in Illinois to obtain decent health care on a regular basis." Eighty-three percent of voters in Cook County and 71 percent in the downstate/suburban areas endorsed it. The vote was not binding.
10. Solidarity Divided: a Welcome Return to Class Politics

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