

HEALTH CARE: AMERICA WAITS FOR GODOT

David T. Jones

From Washington, David Jones notes that the US health care debate “both puzzles and irritates Canadians.” It puzzles them because Canadians generally regard universal health care as a right, not a privilege; and it irritates them because critics of a public option in the US invariably point to Canada as a place where the health care model is broken. But, as he notes, the most obvious flaw in the Canadian model is that taxpayers “pay up for health care throughout their working lives” and then find diagnostic treatment or surgical procedures only available to them with long waiting times. Meanwhile, back in the United States, it is far from clear what a consensus health care bill will look like, whether one will pass by year’s end or even at all. This is Washington, where interest groups and lobbyists often have the last word.

Depuis Washington, David Jones note que le débat sur le système de soins de santé américain semble à la fois « intriguer et irriter les Canadiens ». Ils sont intrigués parce que la plupart considèrent l’universalité des soins de santé comme un droit plutôt qu’un privilège, et ils sont irrités de voir les détracteurs américains d’un régime public dénoncer invariablement le modèle canadien. Un modèle dont la faille la plus évidente réside dans le fait que les contribuables financent durant toute leur vie active un système qui se révèle incapable de leur assurer des services de diagnostic et des interventions chirurgicales sans délais d’attente interminables. Mais on ne saurait prédire à quoi ressemblera une loi sur les soins de santé qui fasse consensus aux États-Unis, ni même si elle sera votée d’ici à la fin de l’année ou avant la nuit des temps, car à Washington, le dernier mot revient souvent aux lobbyistes et aux groupes d’intérêt.



As of early October, there was nobody in the world who knew what a US health care/insurance reform agreement might resemble — or whether there would be one by year’s end (or even at all). Smart money insists there will be a health care agreement — the effort is “too big to fail” and failure would permanently scar the Obama administration with intimations of future failure. This judgment reflects recent polling, with a majority of Americans in favour of significant health care reform and legislation passed by year’s end — but with a majority rejecting current proposed health care legislation. Thus regardless of whether the outcome is akin to a camel (the result of a committee to design a horse) or a pitiful “mountain-laboured-and-produced-a-mouse” result, eventually there will be something that can be labelled “health care reform” — even if passed by party line, simple majority vote, regardless of the subsequent political costs.

The US debate doubtless both puzzles and irritates Canadians. Puzzles because in Canadian eyes who can be against health care for every citizen? Irritates because critics of a comprehensive US health insurance program invariably

start their criticism with invidious critiques of north-of-the-border health care shortcomings. But Canadians should not take it personally; if the “French model” for health care were being embraced, critics would be even more pleased to belabour persnickety Parisians. The critics focus on Canada because “it is there” — and advocates of something akin to a single-payer system for the US tout its specific virtues of nonprofit, universality, portability, comprehensiveness, and accessibility. Consequently, these virtues are depicted as vices (or inadequate) by critics.

It is not that the Canadian “single payer” system is flawless. Every engaged Canadian recognizes its flaws but endures them. Canada’s health care fits the national self-image of stoic patience and a strong, caring social safety net. The most obvious of the Canadian health system’s shortcomings is that Canadians pay up front for health care through higher taxes throughout their working lives, but, often in their declining years or when expensive diagnostic or quality of life interventions are needed in the form of MRI imaging, cancer treatment, heart bypass surgery, hip and knee replacements, and/or cataract surgery, there is

extended delay. There is a “free lunch” — but the service can be very slow. And sometimes the delay is fatal. Always the delay is frustrating and provokes fear in the afflicted and their families. In the end, however, the average Canadian mutters the equivalent of Winston Churchill’s comment about democracy, that it is the worst of all systems, except for all of the others. And we Americans should ignore the Canadian example: we are not Canadians.

There are various *canards* associated with US health care. Perhaps the most persistent of these among Canadian commentators is that huge numbers of Americans are uninsured, with the coincident intimation that they die scratching on locked emergency room doors. This number surges up and down depending on the observer and who is being counted (should illegal immigrants be included?) but, for the sake of the discussion, let us say that 10 percent of Americans are uninsured, perhaps equivalent to the population of Canada. Dramatic, eh? Of course, approximately 10 percent of Canadians lack a primary care physician, so the right to free care (when nobody is available to provide it) may balance the problems of accessing the care if you lack sufficient insurance.

But while horror stories can be true (although those cited by President Barack Obama in his September 9 speech to Congress were not precisely as depicted), the reality incorporates nuances that are little appreciated, including:

- Some decline health insurance for religious reasons, believing that the power of prayer provides the necessary healing. Such beliefs may be best for the healthy, but they are nonetheless heartfelt among believers;
- Some are young and healthy and, consequently, decide logically that they do not need health insurance and would prefer to use the thousands of dollars that would be

spent on health care for HDTVs, pleasant vacations, gourmet dinners, or other personal consumption. There might even be those who choose to invest this money, delaying gratification for future security. At most, they might pay for “catastrophic insurance” — the totally unforeseen accident occurring while participating in extreme sport, etc. — and purchase more comprehensive insurance only when they acquire responsibilities such as a spouse/children. We might not care to take such chances; however, in a society that values personal freedom of choice very highly, it is not a trivial element of such freedom;

- A significant number of the uninsured choose to practice “medicine by emergency room.” Even if they can afford insurance, they go to hospital ERs for their specific complaints, often delaying their treatment over concerns that are more psychological than financial. It is questionable whether universal health insurance would change their pattern of engaging with health services.
- The truly destitute, even if they cannot pay for the medical services they receive in the ER and/or hospital, are treated. The costs for their services are absorbed by the overhead fees

absorbs disproportionate amounts of resources), the more questions arise regarding whether this money could be spent more usefully elsewhere. Do we extend the life of an octogenarian by six months or devote the funding to saving the snail darter? Do we make heroic efforts to save the gang member appearing in the ER with multiple (potentially fatal) bullet wounds or put greater funding into recycling hard plastics? Do we create a societal right to have a child by financing in vitro fertilization rather than extending early age child care for those already born? In short, money is fungible and efforts to save babies born at the edge of viability, individuals “brain dead” from massive traumas, and those whose contribution to society will never be equal to the funds devoted to them mean that other socially worthy projects will not be undertaken. Or they cannot be undertaken at an endurable level of taxation.

This reality weighs particularly heavily on the elderly. Many are desperate for the last second of life, but others are acutely aware that their children and grandchildren are sacrificing for these extra moments. In societal terms, probably the perfect citizen is the one who works vigorously throughout an adult life, paying taxes and consuming minimal services, but then dies at the point when just retired

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and charges at individual hospitals. In effect, we all pay for them.

“Death panels.” Nobody gets out of life alive. And, in that regard, all expenditures on health care face the green eye shade reality that we die, if not immediately, eventually, regardless of the money spent. And the more that is spent, especially in the end game of life (that famous “last year” that

(s)he would begin to absorb services, notably for declining health, in excess of current earnings. Thus there is the *sotto voce* intimation that the responsible citizen has a “duty to die” and should voluntarily step onto that legendary iceberg and be swept into the hereafter rather than “wasting” medical resources by accepting “heroic measures” at life’s end.

Normal hospital and medical procedure for those receiving services is to provide information regarding a “living will” as part of the standard operations of medical staff. However, one of the initial variants of the health bill would have provided payment for doctors to deliver such counselling — and prompted the reaction that vulnerable elderly would interpret discussion of end of life options

technology and the supporting medical research never seems to become less expensive.

Consequently, many were taken aback by the Congressional Budget Office’s estimate suggesting the administration’s proposal would add a trillion dollars to the deficit over 10 years, at a point when gargantuan expenditures relating to great recession rescue have left the USA adrift in

able deaths,” where we stand last among 19 industrialized countries. Some of these problems may be amenable to “behaviour modification” — if you don’t overeat; if you exercise, stop smoking, limit alcohol; if you don’t do drugs, if you discourage single-mother pregnancy and stop shooting each other, many preventable deaths would indeed be prevented.

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as a polite “go now” imperative. The proposal has since been dropped; however, it still feeds the real fears of the elderly who know that their life marathon is ending but who are not in a hurry to sprint to the finish.

Consequently, polls suggest that the elderly are most skeptical about prospective changes in insurance/health programs that appear to be working reasonably well for them. The presidential contention that vast savings will be found in Medicare reform don’t pass the sniff test for the elderly who have seen the ritualistic maxim that there would be vast savings from eliminating “waste, fraud, and abuse” proved risible. And one should always remember that the overwhelming majority of Americans are indeed insured and essentially satisfied with their medical services.

Astronomical costs. The United States pays a disproportionate amount of its GNP (reportedly 16 percent) and significantly more than the OECD average for health care. Reports indicate this cost is reflected in higher salaries for physicians, higher administrative costs, and higher prices for medical services and medications. Americans absorb greater amounts of expensive technological attention in the form of imaging and surgical procedures such as cataract surgery, hip and knee replacement, and Caesarean sections. Such cutting edge

stormy seas of red ink, with no indication of a safe harbour near at hand.

There is intense skepticism over the president’s commitment that no health bill will add to the deficit. History says otherwise. Likewise, the question of increased taxes on the average worker is a serious issue. To be sure, the complex compensation proposals for those who cannot afford payment may work, but for the normal consumer of medical services/insurance (and not just those currently uninsured by choice, who will be required to purchase insurance), it looks like a tax grab.

Some existential problems. The two most troubling elements of standard insurance are denial for “preexisting conditions” and de facto denial of continued insurance after significant illness by raising premiums to unaffordable levels. Insurance companies now say they will eliminate these restrictions if all citizens are required to purchase health insurance, which would provide them with a new pool of the young/healthy who will pay but not require expensive services. It is conceivable that a “public option” — government-funded insurance — could provide an expensive mechanism for insuring the “uninsurable” but continue to preserve “choice” for the healthy to go without insurance.

Likewise, troubling is the problem of US failures regarding “prevent-

A touch of politics. Canadians fought their national health care battle a generation ago; they cling across the political spectrum to a “single tier” of health care. For the USA, revised health insurance is a political “third rail,” which badly scorched the Clinton administration at its inception and threatens commensurate damage to the Obama presidency. Elected on a flood tide of “change” against a rip tide of recession, Obama’s administration seeks to resolve multiple issues simultaneously. The list sometimes appears endless: financial restructuring, health care, domestic security, global warming; Iran, Iraq, Israel, Afghanistan, Russia, China, North Korea, and even the location of the 2016 Olympics, where the president’s failure to sway the International Olympic Committee judges illustrated the limitations of rhetoric.

In the end, there is one vast pool of alternative funding — the US defence budget. We may be forced to conclude that we can have the world’s best armed forces (at a cost essentially equal to the total of the rest of the world’s national defence budgets) or health care equivalent to current standards extended to the entire population. But we cannot have both. Such a judgment could force a brutal rebalancing of our national priorities, both domestic and foreign.

And nobody is yet ready to address such tradeoffs.

David T. Jones, a former minister-counsellor at the US embassy in Ottawa during the Clinton years, follows Canada-US relations closely from Washington.