

WAITING FOR CARE:

Challenging the Agenda in Health Care Reform

Pat Armstrong

Health care is fundamentally about social justice, about our commitments to each other and about collective rights and responsibilities. The struggle over reform is a struggle over what form of justice will prevail, over whether solidarity, community, equity, compassion and efficiency defined in terms of public good will take precedence over individual rights to sell, purchase and consume based on market principles and profits. It is a struggle over power and equity.

While health care reform is about evidence, it is fundamentally about values, as Romanow pointed out in his report some years back. The debate is not simply about my good vs. your good. It is also about what we know about what works for whom in what ways. There is evidence we can use as the basis of our values debate. It is often hard to sort the evidence from the values, partly because they are integrally related. But we do have solid research, research developed from a variety of sources and perspectives, research that provides a firm basis for policy development and change. Unfortunately, as Paul Krugman and Robins Wells put it in their recent *New York Review of Books* article on U.S. health care, “the bad news is that Washington currently seems incapable of accepting what the evidence on health care says.” We could say the same about Ottawa, Toronto, Edmonton and Québec City as well.

The debate over health care reform is further complicated because our health care system is very complicated, because similar reforms are often put forward both by those promoting social justice and those promoting profits, because reforms frequently have contradictory consequences and because we are so individually and personally involved in health care. Just think of the recent *Globe and Mail* articles on access to specialized drugs; articles that attack the public system for denying what is presented as life-saving care; or think of the Supreme Court in the Chaoulli decision using the Morgenthauer case as a basis for supporting individual rights to private health insurance; or the confusing discussions about what is private and what is public in health care. Such complications make democratic decision-making more difficult to maintain.

The debate is also complicated by the representation of health care as a system in crisis. For well over a decade, we have been told the sky is falling in health care. Crisis after crisis has been front-page news, the subject of talk shows and elections, of even family and Supreme Court disputes.

First, it was panic over debt and deficits. “Costs are out of control,” we were told, “think about the debt we are leaving our children.” Drastic cuts followed at both the federal and provincial

levels. Hospitals were closed; nurses, cleaners, laundry, dietary and clerical workers, but not doctors, lost their jobs. Most of those who lost their jobs were women, in part because they account for 80% of the health care labour force. The deficit and debt receded as issues, but we have not left behind the fear that health care eats up a growing share of government budgets. Indeed, health care’s share of spending has led the news stories on recent provincial budgets.

Then we had the panic over an aging population and abuse of the system. ‘All us baby boomers are going to bankrupt the system,’ we are told. Given that most of the elderly are women and that women use the health system more than men, this too is an area where women bear the brunt of the attack.

After that we had a panic about nursing and doctor shortages. Headlines appeared regularly about crowded emergency rooms, patients in hallways, about people without family doctors. This too has not gone away as an issue.

Now, it is hard to pick up a newspaper today without seeing an article about wait times. The Supreme Court decision reinforced this panic, but it was news long before that. Indeed, the federal/provincial/territorial agreement on new funding makes reporting on wait times almost the only condition for funding.

Are there problems in the system? Of course there are problems with rising costs, aging populations, health care workers and wait times. These are real issues, among others, that we need to address collectively, while recognizing their impact on individuals. Do these constitute a crisis in the public system? For the most part the answer is ‘no’ in that these are problems that can be addressed without dismantling the system.

Is privatization the answer? Definitely not. Here the evidence is clear.

In short, these are not problems of panic proportions and they are best solved within a public system. The headlines themselves are creating a crisis because these representations of crisis are being used as a means of undermining faith in the public system and of justifying privatization. Let’s unpack two ‘crises’ which are used to argue for greater privatization: costs and waiting time.

First, costs and sustainability.

Is public health care the major cause of debts and deficits? According to Mimoto and Cross, two mainstream Canadian economists, “Expenditures on social programs did not contribute significantly to the growth of government spending relative to GDP.” Undoubtedly, governments were spending more on care. How-

ever, the growth rate alone cannot explain the focus on cost and the language of crisis. A recent article in *Health Affairs* noted “In most countries the rate of increase in real health care spending was highest during the 1960s and generally has been declining since then, and the percentage of GDP spent on health care has been relatively stable since the early 1980s.” Canada’s rate of growth in health spending during this period averaged 3.6%. In 2002, Canada stood eighth among 26 OECD countries in terms of public expenditure as a percentage of GDP, allocating 6.7% of GDP to health care. Moreover, as health economist Robert Evans makes clear, the provincial health budgets are not significantly different from the past in terms of health care spending and it would be false to claim that pressures from health spending are squeezing out other programmes. Tax cuts are a more important factor because they reduce the size of the government pie.

In short, expenditures alone do not seem to justify the label crisis. Nor do they justify a shift to for-profit delivery and private payment, given that the highest spending countries are the U.S. and Switzerland, the countries with the most private involvement. Nevertheless, we cannot ignore that fact that health care costs have been rising. But we need to ask which costs have been rising if we are to assess the privatization alternative.

Traditionally, labour costs have accounted for the lion’s share of health spending. And it would not seem unreasonable to focus on these expenditures. However, it would be a mistake to see un-

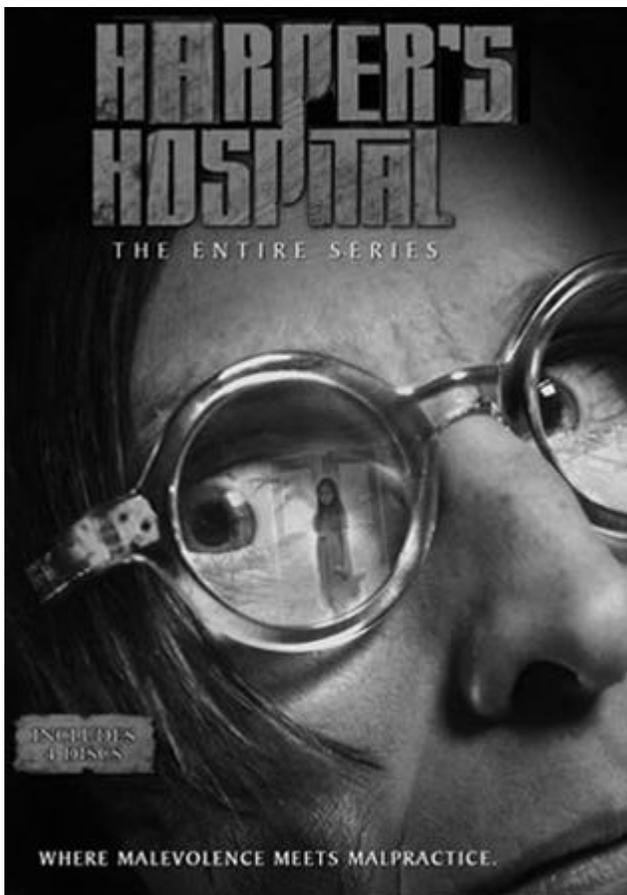
reasonable demands from labour as a primary cause of cost increases. According to the Canadian Institute for Health Information, “Census data show that, on average, employment incomes for full-time workers in health occupations rose at about the rate of inflation between 1995 and 2000. That compares to almost a 6% after-inflation increase for all earners.” In other words, health care workers got less than their share. Moreover, there are huge disparities in incomes among health care workers and in their wage gains in recent years. Ancillary workers are the lowest paid of all those employed in this sector, yet these mainly female workers have been a primary target of cost cutting in the form of contracting out the services to the private sector. Eliminating jobs or reducing wages for the lowest paid saves much less money than would be saved by doing the same for managers or physicians, although this has not prevented ancillary workers from being targets for privatization. Research in the UK shows that, while there may be initial cost reductions through this form of privatization, the “savings are made principally at the expense of the terms and conditions of the work force” and that quality of service declines.

If it is not the workers, what does account for the increase? Well, much of the recent growth in health expenditures is attributable to drugs. In 2004, \$8.5 billion was spent by the public sector on prescription drugs while spending on retail drugs rose from 9% of total health spending in 1984 to 16% in 2004. New technologies, especially information technologies, also accounted for a significant share of these new costs – although it is much more difficult to count their contribution to expenditure growth. Expenditures on drugs and information technologies are growing rapidly even though there is often little evidence to show that many of these drugs and technologies significantly improve patient care or increase efficiency. According to an editorial in the *Journal of the American Medical Association*, “roughly 75% of all large IT projects in health care fail” and the problems “are not simply bits of bad programming or poor implementation.”

In other words, the rapidly rising costs in health care come from the private for-profit sector even though they have not necessarily proven to be either efficient or effective in health care terms. But they have been profitable. If we want to control costs, we should be targeting drugs and technologies rather than the services and the mainly female providers. And we should be extending public control over costs through means such as drug regulation and bulk purchasing rather than moving to contracting out services and public/private partnerships.

The Supreme Court, among others, is increasingly telling us that every one is doing it. All the countries similar to ours are turning to the private sector. Even if this were the case, I would still challenge the notion that we should follow their lead. I never allowed my children to use that argument and I do not see why I should accept it here. Let’s look at the evidence in terms of equity, access, effectiveness, efficiency and quality. It all tells us to not go the private way.

What is not sustainable is rapidly growing profits in health care and increases in for-profit delivery that allow public money to go to profit rather than care. →



Secondly, let's consider wait times.

Wait times are our newest crisis. Not long ago, I was phoned by a major Toronto newspaper asking for a horror story on wait times. I offered a story about someone who did not wait and was told that was not news.

Wait times have become a major preoccupation of governments in recent years. The Supreme Court decision on Chaoulli, that rejected the prohibition against private insurance in areas covered by public care, was justified in terms of unreasonable wait times, making governments pay attention to this issue. According to lawyer Andrew Petter, the Court's 4/3 decision reflects a "liberal legalism that protects negative liberty and imposes a formal vision of equality that harms the disadvantaged" or, as Hutchinson puts it, the decision is based on the false assumption that citizens are "most free when their negative liberty is protected from state interference." The individual right to buy was reinforced and the decision has opened a floodgate of demands for more private purchasing and for-profit delivery.

It was the Fraser Institute that first made wait lists a crisis issue, producing a series of studies they claimed revealed dramatic growth in wait times for surgery and tests in Canada. They were based on some doctor's belief that wait times were increasing rather than on actual measure of wait times.

What do the actual measures show? Well, first it depends on what we are measuring. Waiting for what – an appointment for an

annual checkup, for elective surgery, or for emergency care? Waiting in each case may have very different consequences. Second, wait times are hard to measure because it is hard to tell when to start the clock and what is an appropriate time to wait.

The Canadian Institute for Health Information, unlike several provinces, counts from booking form received to surgery. According to that measure, CIHI reports that median wait times for non-emergency surgery remained virtually the same between 2001 and 2005 and the number of surgeries increased enormously. Meanwhile, Canadians do not wait long for emergency care. And we should also remember that we are doing many surgeries frequently now that were mainly experimental a couple of decades ago, so we have made significant progress within the public system. In short, the data do not suggest a crisis, although there are certainly areas where we need work.

Equally important, the research indicates that a public system is the best way to reduce wait times. There is no reason to assume that private payment and investor-owned service delivery will reduce wait list. There are a lot of assumptions about for-profit delivery being better, but lots of evidence that quality is lower and access more limited. As Michael Rachlis shows in his paper on "Public Solutions to Health Care Wait Times," specialized clinics and managed wait times in the public sector can provide superior service "while reducing overall administrative costs and providing broader societal benefits" such as equity.

Adding private insurance, as the Court suggests, and adding investor-owned delivery services, as Senator Kirby and other suggest, can only increase rather than improve overall wait times because the system will be more fragmented, and less coordinated.

In their *New York Review of Books* article, Krugman and Wells conclude that the U.S. way means high government costs while "the actual delivery both of insurance and of care is undertaken by a crazy quilt of private insurers, for-profit hospitals, and other players who add cost without adding value."

Making the wait list the crisis of the hour also distorts our priorities. The five priority areas get all the attention and resources, leaving out the majority who have other health issues. And it can mean bad quality care. A March issue of the *Guardian* reports that National Health Service hospitals are "having to repair damage done during botched operations on people who have been sent to private centres for hip and knee replacements to cut waiting lists." In two centres where the figures were examined, the failure rates were significantly higher than in NHS hospitals, three times the rate in one and ten times the rate in another. The article also claimed that training for surgeons also suffered, leaving a questionable future for quality care.

In sum, wait times do not constitute a crisis and privatization is not an appropriate solution to the problems there are in waiting.

We need to shift the debate from one of crisis to one of strengths. We know the strengths in a public system. The onus should be on those who want to privatize delivery and payment to show how investor owned services and private payment will maintain or improve on these advantages.



There are at least ten established advantages in the public system. So those who want to privatize payment and delivery must address these in order to justify their claims.

1. The quality of care is higher, in part because the rich must use the same services as the poor and thus have an interest in making sure all services are good.
2. The administrative costs are lower. Much less money is spent sorting the deserving from the undeserving; less is spent on billing and on chasing those who have not paid.
3. Distribution of services can be centrally planned, making services more fairly distributed across the country and especially in rural and remote areas. While we clearly have not been entirely successful, in part because we have left many of the decisions up to private organizations and individual doctors, we have reached many who have not been reached before.
4. Wait lists can be centrally managed to allow an efficient and needs-based distribution of services.
5. Wasteful duplication of services can be reduced through central planning.
6. Access is based on need, not ability to pay.
7. Jobs are better in the public sector, especially for the overwhelmingly female labour force that does the ancillary work.
8. Employers save significant amounts of money through a public system, especially for the retired. Now costs are shared among us all and this is particularly important for those with catastrophic illness costs.
9. Innovation on a large scale has been possible in the

public system. We need only think of cataract surgery, insulin, lasers and antibiotics, all of which were developed in the public realm.

10. Now costs are controlled through government budgets. How will costs be controlled, and what happens when complications arise, in the private system when there are cost overruns, when people trained mainly with public money seek to work only in private care while reducing resources in the public system, when business fails, when people are refused care?

We are told nearly daily this system is in need of improvement. But the evidence demonstrates that the privatization solutions being advanced will not address these issues. Only a public system can hope to meet the criteria of access, equity, quality, and cost effectiveness based on democratic decision about care. Private solutions will leave too many of us waiting for care.

It is simply bad logic to say we already have some private care and some people can now push to the front of the line, therefore we should have more of both. It is like saying you already had some crime so why not allow more. Of course some aspects of care will remain private. But we need to demonstrate how the line should be drawn in relation to both the demonstrated advantages of the system and our notions of justice and how that line can be drawn in ways that are based on evidence, principles and public participation not on the basis of power and ability to pay.

We have a collective responsibility to ensure this is the case. These are value questions to be debated in a democratic society but ones we should address on the basis of the evidence. Let's do it now. **R**

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