# Response to the "Opinion" Of the Canadian Health Care System

On May 29, 1991 your newspaper published an article under the weekly column, "Reinvestments in the Community", submitted by the Amalgamated Publishers, Inc. While the article's title suggests it would provide facts to support its contention that the Canadian health system wouldn't work here it instead decries the Canadian health system with such weak assertions as, "Americans are not Canadians", that "Canada is fairly homogeneous with only small, scattered ethnic populations", and that "social variances (in the U.S.) also account for higher health care costs; teenage pregnancy, poverty and violence - as well as illness and injury related to alcoholism, drug abuse and cigarette smoking". This is deeply disturbing on several levels, not the least of which is the lack of adequate explanation given for our runaway spending for bureaucracy and expensive equipment as well as the strong hint of racism contained in the article.

The US spends more money than any other country in the world on health care. Pooling public and private money, in 1990 we spent $602 billion nationally; $6.5 billion in Oregon alone! That is equivalent to $200 per person per month. What does that money buy us? We have the highest infant death rate among 20 industrialized nations and the lowest life expectancy among 12. That $200 per person per month buys us the 18th highest rate of child deaths, the 11th highest rate of maternal deaths in the world and a 21st ranking in the rate of infant immunization against measles. Despite Oregon's $6.5 billion in health care spending in 1990 more than 400,000 Oregonians were without insurance, close to one in 5 of our state's population; 1/3 of those uninsured were children.

Closer examination of where the U.S. places its health care priorities demonstrates it has little to do with our rich diversity of ethnic minorities. IT HAS EVERYTHING TO DO WITH the fact that our health care continues to be dictated by a system that operates for profit, not to be confused with a health care system. Our escalating health care costs are tied to hospitals which average barely more than 50% room occupancy overall yet purchase fancier and more expensive equipment to compete for an ever-decreasing pool of affluent patients. The rising costs referred to in the API article are also tied to the 1500 private insurance companies in the U.S. spending 20% of our total health care dollar on pushing papers.

Closer to home, Portland has 13 Magnetic Resonance Images, (MRI's), more than the entire country of Canada. These state-of-the-art machines cost $2 million each and return an incredible profit to doctors and hospitals who pass on their costs to us in higher rates. Since Oregonians who possess insurance often won't see the costs of ordered testing, they may give little thought to the fact that those MRI tests can run as much as $400,-700, or that ultimately insurance rates or higher premiums for uninsured, employers continue to reduce their health benefits contributions and more working families are unable to purchase or maintain their health insurance coverage.

Insured patients even pay for capital improvements which can include high-profit surgery centers or "Hilton-like" maternity centers for affluent mothers-to-be, or even state-of-the-art employee fitness centers, since hospitals pay off their often unnecessary expansions by raising our rates.

It is worth noting that 87% of Oregon's hospitals are non-profit, yet they netted $92 million in "Excess revenues" in 1989.

In the private, corporate world those "excess revenues" are called profits which they, unlike our non-profit hospitals, would be required to pay taxes on.

To claim that our health system costs more because we have a greater number of minorities ignores the fact that the rate of non-insured, even the rate of maternal and child deaths, is for minorities, on average, more than twice that of the population as a whole. To suggest, as the API did, that we need to spend more money on health care than a country like Canada because we have greater number of ethnic people is racist.

The health needs of our minority populations are no more expensive than the population as a whole. Yet it is precisely because minorities have inadequate access to health care, that they are disproportionaly shut out of decent-paying employment, that they are more often underemployed and unemployed, that they lack financial resources to purchase healthcare insurance, and that they must navigate the racism, sexism and classism which permeates the fiber of America, including the health care industry, that their quality of health indicators are much higher.

If we focused the money we now spend on health care on satisfying the basic health needs of our entire population, and aimed at providing a basic level of service which stresses prevention, encourages patient participation and responsibility, and promotes cultural sensitivity and appreciation as well as equitable access, we could guarantee, like Canada has, equal access to the best health possible for our entire nation. Holding our physicians to a higher standard of accountability, and the checking and review that the API article briefly passed over is not the primary contributor to many of runaway costs of our health care industry.

The Canadian system is not federally run. It is provincially-based. Within broad criteria each providence defines what their health package will be and funding mechanisms. Our closest Canadian neighbor, British Columbia, spends about 35% less per person on health than Oregon. Yet all of its residents are provided with equal access to comprehensive, affordable, quality health care. No, they don't get everything they may want nor do doctors get to prescribe every expensive procedure that might make a difference. Yes, long term care and prescription drugs and mental health are included without a deductible. The system in British Columbia does not allow for a different, inferior level of care for Medicaid recipients; all are treated equally. Everyone may have to wait but Americans are also accustomed to waits, delays, cancellations and rescheduling.

We Americans are misled if we assume we have a health care 'system'. We have good service and access to those who can afford medicaid for some low-income, poor people; Medicare for people over 65, and self-treatment or emergency rooms for the uninsured. We have physicians who are increasingly opting out of provision of service to Medicaid and Medicare payments because the reimbursements are too low. We have physicians who treat Blue Cross and Blue Shield patients with respect not accorded to Medicaid or Medicare patients.

The Oregon Health Services Commission was created by the legislature to develop a listing of ranked health services both responsive to public values and incorporating experience-based information on treatment effectiveness. These were prioritized in declining value from the most to the least important - which would provide the greatest benefits in improving and maintaining the health of previously-uninsured Oregonians. While the effort has been a controversial one, this pioneering effort has drawn attention from around the world for its efforts to grapple with the complex issues of investing in and responding to the needs of both our society and the individual in guaranteeing a level of health and wellness to all citizens.

Many other states are now engaged in grappling with escalating costs, spiraling rates and inadequate health services for their citizenry. It is a problem which won't go away simply because we ignore it or attempt to shove it aside by claiming more pressing national interests. Oregon's bold effort, to tackle, in the open, what had previously been a closed discussion, must be applauded and an important, significant beginning if we are going to truly develop a health system that is available and accountable to all Americans. While it is not necessarily the final word, it certainly is a start.

It should be noted that the only source citedi n the API article is a member of the American Society of Internal Medicine. Over the years, the biggest opponents to proposals for national and state health plans are members of the American Medical Association. That body opposed Medicare, they opposed Medicaid, they even opposed expansion of pre-natal care as interfering with the doctor/patient relationship. Our country's health care statistics show we have nothing to lose and everything to gain from studying the efforts of other, more-enlightened countries, like Canada. No, their system is not perfect, without flaws or serious disputes. It is, however, a real system that is achieving quality of life indicators with much less money than the United States.

Finally, I am personally embarrassed that the only other industrialized country that fails to provide all of its communities with quality health care besides the U.S. is South Africa. That certainly isn't company that I'd choose to keep. Perhaps the greatest investment we could make in our community is to create a health system that gives everyone equal access and affordable, comprehensive services. Yes, it will cost us plenty. But we've been paying that a long time with nothing much to show for it...other than increasingly-poor health and death rates for our children, and their mothers.

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# Perspectives

By Professor McKinley Burt

## Taking The Next Step

This most recent series of articles has dealt with the preparation of African American youth for success in a culture increasingly driven by science and technology. This approach has necessarily evaluated the current processes of education, community support and parental involvement. And consistently I've addressed that "gap" I cited last week - "between 'our' knowledge of the world around us and realities of the workplace and infrastructure."

Accompanying my experience-based effort to bring about effective change has been a reevaluation of 'my own' contributions. As you well know, this is not an easy task and my first assessment-that the record looks pretty solid-could well be a cause for alarm. On the one hand I look at a 25 year collection of awards, plaques, acknowledgements and media accounts, but on the other hand, there is always that great secret between the doer and his maker; WHAT WAS THE REAL GOAL? And in any case, why question success?

I did not have to seek very far to find the source of my unease. In the very areas in which I believed my efforts and innovations would make the difference (as vain as that may sound), we find the greatest gulf between African American aspirations and achievements. Particularly, I have had to look at my successful (temporarily) innovations in education; the design, demonstration and implementation of award-winning techniques in developing curriculum and classroom procedures for teaching science, mathematics and technology at all grades. But what has happened? Millions of dollars are allocated for a galloping horde of unproven experiments to 'build the wheel all over again', amid a shrill cacaphony of rhetoric and poloemics: "Year 2000, import European genius". Most wouldn't know a radical from a natural log.

A second area that has demanded another look is where there was pioneering in the incorporation of Black History and the reclaiming of 'roots' into a pardigm for academic motivation and achievement. This is especially true of my eleven years of related teaching and course development at Portland State University. A prime example is a three quarter course I developed, "Black Economic Experience"; (three credit hours). So successfully did this section integrate the elements above, but also a frame of reference for the student to comprehend (and function in) the economic and cultural dynamics of the innercity, that the university took the unprecedented step of GRANTING CREDITS IN FOUR SEPARATE DEPARTMENTS: SOCIOLOGY, BUSINESS, URBAN STUDIES AND BLACK STUDIES!

Back to that business of the "workplace and the infrastructure" mentioned earlier. I was so certain when this course drew many scores of full time students (black and white)-as well as managers and other personnel from urban programs and other public sectors-that I had managed to tailor what would prove to continue as a viable and broadly accepted methodology for comprehending our urban trauma. To this day, I am meeting public sector officials and professors who took that course and the comments are pretty much standard: "That sure was a neat session-we really need something like that now, I'd send my entire staff-do you ever think about doing something in 'Continuing Education'? so what dropped out?

Then, too, there was the community interface developed in conjunction with the pioneering university courses. A prime example here is my technique of structuring 'real time' community development projects right into the classroom curriculum. For instance the students participated as I designed a short letter to accompany proposals to foundations requesting that they FURNISH FUNDS FOR THE PURCHASE OF REAL PROPERTY TO SITE CERTAIN NORTHEAST EDUCATION AND SOCIAL PROGRAMS. The particular technique worked like a charm, though the written policy directives of the foundation said this would never be done. So right there in the classroom students saw how a comprehension of the relationship between the goals of a foundation and the goals/track record of THE BLACK EDUCATION CENTER (in the particular case, and community programs in general) could be related in a fashion of immense economic benefit to a community (1974).

Two of the students used the technique to acquire a permanent domicile for the mental health program for which they worked. Both organizations still own the properties acquired (I believe). However, and this is one source of my "unease", neither these nor several other organizations followed through with the NEXT STEP I developed through a concurrent academic course sited right in the community:" Minority Business Operations". I knew from a long past experience as a real estate broker that acquiring property is one thing-but keeping, managing and developing it is quite another. In these dynamic situations the needed "next step", not taken, was to develop the parcels and move to acquire the then-cheap adjacent properties for additional 'program-sustaining' income.

So, what is it I have been saying here? Is it just how great it all could have been had I achieved the full promise of those "goals"? Am I caring about what 'other' people should have done? Not at all, I'm simply getting ready for the next phase of my 'retirement'. I've given serious thought to mama's advice of fifty years ago; "Quit complaining Junior. If you're not satisfied that it's being done right, do it yourself!" So now it is a case of how much I want to do-or interest others in doing-as I get very favorable responses from foundations, industries and the public sectors offering to support "those NEW, forward-looking programs you've designed Mr. Burt!" Please!

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## Reinvestments in the Community

# GIVING AND ACCEPTING ADVICE

**BY: ULLYSSES TUCKER, JR.**

Accepting advice or suggestions from people close to your life can be extremely difficult, especially when you already have your mind made up. How many times did your parents, or someone you respected, tell you that "if you play with fire, you will get burned?" How many times did you do it anyway?

My grandmother used to say, "Junior, I'm going to tell you about a lot of things that are right in this world, but you are still going to do wrong. Despite her wisdom and insight, I had to learn life's lessons the hard way. I could have saved myself some pain, conflicts, and adversity had I paid more attention to her. Though I failed to listen or take heed, I experienced a great deal of growth and stronger appreciation for my grandmother. Why are people so hard-headed? Sure, I knew that fire would burn if I played with it. Ouch! There's something to be said about feeling the pain of fire or seeing the terrible burn on your fingertips. Believe me, I learned something in the process even though I knew the outcome before it happened. Adversity builds character and as the old saying goes, no pain, no gain.

In my opinion, there is no right or wrong time to take advice from others. It's strictly a judgement call or it might boil down to the level of respect one has for the person presenting the advice. Then again, I had great respect for my grandmother, but I acted foolishly anyway. First of all, every human being has experienced a different reality and a unique perspective. No one is totally correct with their advice. It's valid according to their perception. Everyone has positive intentions when attempting to provide others with advice, for the sake of argument, but what is relevant to your life? People must choose wisely or listen carefully to those offering advice because not everyone has positive motives. In the case of doctors, lawyers, or economic advisors, we pay for constructive results or sound advice. I, though do confess not to know it all, have enough experience to trust my own judgement and make decisions that will enhance my life. Sure, I listen to what others have to say, but most of the time I file it away for future use. Listening is important because at some point, the advice someone is trying to give may eventually come in handy. Some of the advice will, more than likely, never be utilized, but it's always there in my subconscious, waiting to hopefully make my life better or stop it from taking a bad turn. People can sometimes give advice based on their perception of where they think you that are. My grandmother thinks that I should be married with children. I say that she is wrong and furthermore, I'm not ready. Is this bad advice?

In high school, I was advised by my academic counselor to join the armed forces or to study a trade because I wasn't college material. Yes, my GPA was less than 2.0 overall and yes, I scored less than 500 on my SAT test. Still, had I taken her advice, I would not have a Master's degree today. My 3.45 GPA (senior year) was more indicative of my potential as a college student, not my past academic history. Ironically, that same counselor presented me with an award (1985) honoring me as one of the "Most Outstanding Alumnus of the Decade" from my high school. I told the story to her, but she could not recall it and that was the turning point in my life. How many others did she discourage with her advice?

Common sense is important, too. Now, if someone advises you that if you jump off a 2,000-foot cliff, you're going to die...take heed! Some things, like playing with fire, are just facts of life. Some advice is concrete and real. Other advice is based on individual experiences. The only true advice that I can give about taking advice from others is simple, be man or woman enough to admit it when the "advisor" is right, regardless of whether it hurts your pride or not. It's a sign of growth and maturity.

API "Reinvestments in the Community" is a weekly column appearing in API publications throughout the USA.