

(a) funds and time for education on such matters as nutrition and occupational health, (b) hours and transportation that suit the needs of the community, and (c) a multidisciplinary staff that includes public health nurses who could bring the system to those with less access. In this way the system could become more effective, democratic, and accessible.

REFERENCE

1. Birch, S., and Abelson, J. Is reasonable access what we want? Implications of, and challenges to, current Canadian policy on equity in health care. *Int. J. Health Serv.* 23(4): 629-653, 1993.

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COMMENTS ON BIRCH AND ABELSON'S "IS REASONABLE ACCESS WHAT WE WANT?"

Arthur Schafer

The author analyzes and discusses several of the "equity" issues raised by Birch and Abelson, identifying nonfinancial barriers to health care access and defending the ideal of "equal access," subject to certain pragmatic limitations.

For almost any disease one can name—cancer, clogged coronary arteries, hypertension, clinical depression, diabetes, arthritis—incidence in the population goes up as income goes down. In the language of health economists, "there is a negative relationship between the need for medical care and income class." Or, to put the matter baldly, the poor are sicker than the rich. From this it would seem to follow that justice in the distribution of health care will require that the poor receive a greater share of health care resources than the rich.

Should we describe this as "discrimination" in favor of poorer groups? As "unequal" access to services among income groups? One could, I suppose, adopt this language, as Birch and Abelson (1) invite us to do; but, since talk of "discrimination" and "inequality" typically carries a pejorative overlay, it might be preferable to decline the invitation. When you, who suffer from a bacterial throat infection, are given a doctor's prescription for an antibiotic, while I, who suffer from a viral throat infection, am sent home sans prescription, but with instructions to rest, it would scarcely clarify what has happened by saying that we were treated "unequally." Even less would one want to say that the doctor had "discriminated" in your favor. Each of us has received treatment appropriate to our needs. Health care is justly distributed when it is distributed according to need.

Leaving aside questions of descriptive terminology, one would expect in a nation (such as Canada) that claims to provide for all its citizens "equal access" to medical services that those who are poorer (and hence sicker) will visit doctors more often than those who are richer (and hence less sick), will spend more days in hospital, have more things stuck into them and pulled out of them, receive more medications, and so forth. Surprisingly, there are data that suggest, for example,

that "the relative risk of having visited a physician in the last year is shown to be independent of income."

How is this to be explained? Why do those Canadians who need health care more, or need more health care, not receive the greater amounts of care that they need? When the Canadian health care system permitted user fees, studies showed that such charges at the point of service delivery did deter the poor from obtaining needed health services. But such financial barriers do not exist at present. Indeed, they have not existed for many years.

Birch and Abelson quite reasonably draw our attention to nonprice factors that influence the demand for and/or supply of care. They focus predominantly on "opportunity costs associated with going to health care facilities and waiting for care." In other words, the poor sometimes do not seek the health care they need because they cannot afford to take the time off from work, or cannot afford the transportation costs involved in traveling to the nearest health care facility.

Without wishing to detract in any way from the importance of these "opportunity costs," one could easily suggest additional factors that potentially exert an even greater barrier to access than "lost wages." The rich are usually much better informed than the poor about the availability of potentially beneficial health care services. Even when the poor possess the requisite knowledge, they typically lack a strong sense of control and autonomy in their lives. It would be surprising, indeed, if someone raised in an authoritarian family, socialized in an authoritarian school system, and conditioned to accept an authoritarian workplace would then, on falling ill, take control of her or his life and seek needed care and attention with the same vigor (and sense of entitlement) as someone whose sense of personal efficacy has been nurtured at home, school, and work. That is to say, social class may affect health care utilization not only because it imposes financial barriers but because it is associated with ignorance of service availability or with such cultural factors as "fatalism" or a sense of helplessness or low sense of entitlement or poor self-esteem.

What follows from all of this? According to Birch and Abelson, quite a bit follows. If Canadian health policy were truly committed to the goal of "reasonable access" to health care *for all*, and if reasonable access were interpreted as "equal use for equal need," then Canadians and their governments (national and provincial) would have to favor radical redistribution of income. A society in which wealth and income are very unequally distributed cannot claim to offer all its citizens an equal opportunity to use the health care system, even when there are no charges for service at the point of delivery. To this important point I would add that a society in which large numbers of people lack self-esteem and are socialized to feel powerless and alienated will fail to provide equality of access in the fullest sense.

There are, perhaps, some health policy economists and analysts who will find these conclusions unacceptable—even shocking. And we ought to be grateful to Birch and Abelson for spelling out some of the implications of our espoused ideal

of "equal access," even if this means that some analysts (a majority, even) may prefer to scrap the ideal rather than to work for its full and proper implementation.

It would be naive, however, not to recognize that the present political climate in Canada, as in the United States and Europe, is one of cutbacks, claw-backs and retrenchment. Virtually every social benefit, however hard won, is under threat. The public agenda is dominated by proposals to make us as "lean, mean and competitive" as the leanest and meanest of our competitors.

Under the rubric of "delisting," medicare coverage in many provinces is being withdrawn for such "nonessential" services as eye tests, annual physical check-ups, tubal ligations, cosmetic surgery, and a lengthening list of medications. Many of those who favor the ideal of equal access may feel that a campaign to prevent the reintroduction of user fees and to combat the trend toward "delisting" ought to be the overriding priority of the moment. So, to answer the question posed by Birch and Abelson: reasonable access is what some of us want, but the struggle to protect and preserve such equality of access as we have already achieved must be won before an attempt is made to achieve the vastly more ambitious goal of truly equal access.

REFERENCE

1. Birch, S., and Abelson, J. Is reasonable access what we want? Implications of, and challenges to, current Canadian policy on equity in health care. *Int. J. Health Serv.* 23(4): 629–653, 1993.

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