Universality: a call for compassion

Howard Ovens, MD

A cyclist is struck by a car and lands on the pavement, motionless. Paramedics arrive within minutes and determine that he has multiple fractures, a head injury and possible intra-abdominal trauma. Barely conscious, the victim whispers, "I have no insurance!"

This poses a dilemma. The nearest hospital, St. Avarice, has an excellent reputation but high co-payment charges. Riffraff General is farther away and often has long waits, but the care is free. To complicate matters, St. Avarice is known to "dump" uninsured patients. The paramedics head for Riffraff, where the patient later dies of treatable injuries while waiting for an operating room.

Dumping, defined as "denial of or limitation of emergency care, and referral elsewhere, usually for financial reasons," was, until recently, a widespread practice in the US.

Farfetched? Hardly. Dumping, defined as "denial of or limitation of emergency care, and referral elsewhere, usually for financial reasons," was, until recently, a widespread practice in the US. Economically motivated transfers led to significant unnecessary mortality,[1] and "dumped" patients were predominantly young, male, uninsured, minority members, therefore provoking the observation that dumping is a practice "which appears to reinforce racial and class inequities of access to medical care."[2] In 1986, an estimated 250 000 patients were dumped,[3] leading to passage of federal anti-dumping legislation in the form of COBRA (Consolidated Omnibus Reconciliation Act) and EMTALA (Emergency Medical Treatment and Active Labor Act).[4]

The US emergency medical experience shows us that the coexistence of private and public health care can be problematic. "Denial of care" entered the emergency lexicon in the 1990s when managed care organizations began requiring advance authorization (gatekeeping) for emergency care. Authorization decisions were often made by telephone, sometimes by nonclinical staff working from protocols. Patients faced difficult decisions when emergency staff warned them not to leave without care, while, simultaneously, gatekeepers told them their visit was unwarranted and would not be covered. The emergency department (ED) staff then faced a dilemma of their own because EMTALA mandates that they provide care, but the gatekeeper's decision means they will not be paid for doing so.[5] One published report from California found that 516 of 545 patients denied care by telephone gatekeepers left the ED, and that 9 of these later returned with life-threatening diagnoses such as pulmonary embolism, myocardial infarction, respiratory failure and sepsis.[6] In addition to denial of care, many patients avoid primary and preventive care or fail to attend follow-up visits because they lack adequate insurance.[7] US emergency physicians have all seen patients who delayed care for financial reasons, sometimes with tragic results.

Private and public hospitals provide stark contrast. Private hospital EDs are often well appointed and well staffed, generating profits from as few as 15 to 25 000 patients per annum. Many offer amenities like valet parking and no waiting, while their physicians earn substantial incomes seeing 1.5 to 2 patients per hour. Down the road, county hospital physicians treat 2–3 times the number of patients per hour and burn out quickly, while their hospitals processes upwards of 100 000 patients per year, who

Director, Schwartz–Reisman Emergency Centre, Mt. Sinai Hospital, Toronto, Ont.

This Commentary is an abridged version of Dr. Ovens' contribution to the Canadian Association of Emergency Physicians' submission to the Commission on the Future of Health Care in Canada (www.caep.ca/002.policies/002-04.romanow/romanow-05.htm#main).

may wait up to 24 hours for assessment. EDs provide care to all those without other access and, based on their experiences, US emergency physicians have led the call for comprehensive, universal health insurance.[7,8]

In Canadian health care, EDs are the "canary in the coal mine." We are in the news due to overcrowding, prolonged waits, hallway care, delayed offloading of ambulance patients, and other problems. When patients fall through cracks in the system, they land in the ED. Changes in health policy have profound impact. Across the country, cuts to acute care beds, long-term beds or community care options predictably compromise EDs. Social policy also affects EDs, as the poor and homeless turn to us for whatever comfort or relief we can provide. The Canadian public depends on the fact that, whatever the pressures and limitations, every citizen is treated equally in the ED. Patients may purchase privacy and special amenities on the wards but in the ED, patient care is always based on clinical need, not economic circumstance.

Although the US situation seems distant to us, "reforms" — like de-listing, co-payments, private alternative clinics, hospitals and imaging centres — are all beginning to hack away our universality. Each blow creates wider cracks, allowing more people to fall through into our overburdened EDs.

As humans, we all face the prospect of illness, injury, pain and suffering. The Canadian health care experiment was based largely on the fundamental idea that each of us, regardless of income, race or status, is treated the same if we are the cyclist bleeding on the pavement. This fundamental principle of equality, which has led to the most popular government program in Canadian history, is now under attack. A growing minority argue that we use our money to purchase better food, clothing and shelter, so why not health care? Some claim the private sector can provide health care more cheaply and effectively, although evidence is lacking. Others, economically secure, resent being taxed to support the care of strangers.

Although the US situation seems distant to us, "reforms" — like de-listing, co-payments, private alternative clinics, hospitals and imaging centres — are all beginning to hack away our universality. Each blow creates wider cracks, allowing more people to fall through into our overburdened EDs. Our country is more affluent now than when Medicare was conceived, and our fiscal situation is better than it has been in decades. Only our will to care for fellow human beings is failing. As emergency care providers we are the voice for our patients. We should fight to maintain the universality of the Canadian system, to enhance rather than diminish the comprehensive nature of the care we provide, and to close the cracks through which so many are falling.

If you were on the pavement bleeding, what system would you want?

References

1. Schiff RL, Ansell DA, Schlosser JE, Idris AH, Morrison A, Whitman S. Transfers to a public hospital: a prospective study of 467 patients. N Engl J Med 1986;314(9):552-7.

2. Himmelstein DU, Woolhandler S, Harnly M, Bader MB, Silber R, Backer HD, et al. Patient transfers: medical practice as social triage. Am J Public Health 1984;74(5):494-7.

3. Ansell D, Schiff RL. Patient dumping. Status, implications, and policy recommendations. JAMA 1987;257:1500-2.

4. Schiff RL, Ansell D. Federal anti-patient dumping provisions: the first decade. Ann Emerg Med 1996;28:77-9.

5. Derlet RW, Young GP. Managed care and emergency medicine: conflicts, federal law, and California legislation. Ann Emerg Med 1997;30: 292-300.

6. Abbuhl SB, Lowe RA, Stahmer SA et al. What happens to managed care patients who are denied care in the ED? Acad Emerg Med 1995;2:370-1.

7. Knopp RK, Biros MH, White SP, Waeckerle JF. The uninsured: emergency medicine's challenge to our political leaders. Ann Emerg Med 2000;35:295-7.

8. Goldfrank LR. Health care reform or return to social Darwinism? Ann Emerg Med 1995;25:692-4.

Correspondence to: HOvens@mtsinai.on.ca