COMPARISON OF HEALTH CARE IN THE UNITED STATES AND CANADA

By

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Abstract

Comparison of Health Care in the United States and Canada

Abstract: It has long been noted that the systems of health care in both the United States and Canada are markedly different, given the similarities of the two countries to which the health care system belongs. This thesis applies the philosophy of John Rawls's "Justice as Fairness" from his book "A Theory of Justice" to determine which system of health care is the most just, and thus promoting a more just society. This paper uses cancer as a narrowing point for investigation.

Using data from different studies, this paper first notes the similarities between the two health care systems before delving into the differences and noting the statistics from three different studies that cover cervical cancer, prostate cancer, and breast cancer. This paper concluded that if one is a least advantaged member of society, such as one who would be without insurance in the United States, then, given the data found from various sources, that person would have better care in Canada, despite its disadvantages. According to John Rawls's Theory of Justice, Canadian society is more just than that of the United States given its health care system.

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Comparison of Health Care in the United States and Canada

What is “health care”, and how does it support a just society, from a normative standpoint? What is a just society? This thesis will answer these questions, in the following manner. First, an introduction will be made about health care in general, and issues that can divide health care in both Canada and the United States. Then, the health care systems of both Canada and the United States will be examined in detail. Third, this paper will use studies made of cancer care and treatment in both the United States and in Canada, to give data on the normative effectiveness of both systems. Fourth, the paper will introduce philosopher John Rawls, whose idea of “Justice as Fairness” is used as a point of reference of what constitutes a “just society” for the purposes of this paper. Finally, an analysis is given, applying Rawls’ philosophy to the data found, to determine which health care system is the most just.The health care system in Canada, given our research of how cancer is treated, with regard to the “worst off” as according to John Rawls, is more just, and therefore helps to make a more just society, than that of the United States.

One aspect of health care that this thesis addresses is "rationing by waiting": that is to say, given Canada's "socialistic" health care system, patients are forced to wait in lines to receive care, given that everyone is placed on "equal ground".To think about the health care distributed in the United States by a normative standard, we can turn to several studies that conclusively show the quality of health care. This particular study, "The Quality of Health Care Delivered to Adults in the United States" gives us insight to the quality of health care and allows us to compare it to that of Canada.

This study was conducted in 2003, and included a random sample of 12 adults living in the United States. According to the study, women tend to seek health care more than men do, and minorities visited less than whites. Several types of care were used in this case. The first type was "preventative" overall care, including preventive, acute, and chronic, and screening, diagnosis, treatment, and follow-up. In each case, less than sixty percent of "recommended care" was received. To determine the recommended care, the doctors in the study came up with national guidelines for each phase of care. According to the New England Journal of Medicine: "We developed indicators to assess potential problems with the overuse and underuse of key processes. We primarily chose measures of processes as indicators, because they represent the activities that clinicians control most directly…"(New England Journal of Medicne) In other modes, more quality care was received. With medication, immunization, physical examination, and laboratory testing or radiography, more than 60 percent of recommended care was received. With Surgery, history, and counseling or education, the numbers were much lower: fifty-

seven percent for surgery, forty-three percent for history, and eighteen percent for counseling or education. (The New England Journal of Medicine) It seems that this study shows that the recommended care is not met for the majority of Americans, based on the sample that was selected. The participants in the study were of decent means, meaning that they had the money to pay for health care, but it was still not up to standard.

In order to understand the context by which we are determining which system of health care, in terms of justice as fairness, is most conducive to a just society, we must examine the two systems of health care in consideration in detail. This paper will begin with the main facets of the health care system in the United States. In the United States, the health care is primarily distributed privately. However, social programs and government-based health care do exist. For example, Medicare, is an American entitlement program that provides health care to those over 67. (Medicare.gov) Similarly, Medicaid, a similar entitlement program, provides health care to those below the poverty line. As such, Americans who do not fall into either of these two categories are not normally insured publicly. Usually, Americans are provided health insurance through their employer or one of the employers of a family member. Eighty-five percent of Americans are insured in one way or another. Government programs cover twenty-eight percent(Medicare.gov).

Insurance is the third party that works to negotiate with the health care provider for a fee. If an American is unable to receive health insurance from an employer or the employer of a family member, then he or she may choose the new public option that is part of the patient protection and affordable care act of 2009.

However, if one works for the government, then that person's health insurance is provided through the state (healthcare.gov)

One of the first questions that one may ask is the "effectiveness" of the relative privatization of health care in the United States. Of the developed countries, the United States is ranked among the lowest for infant mortality and life expectancy (cdc.gov). The life expectancy in the United States is forty-second in the world (cdc.gov). American health care for this reason is considered to be expensive without the quality to explain it.

Despite the fact that health care in the United States is primarily at the private rather than the public level, health care is strictly regulated. All doctors must be licensed, and states have their own departments of health, called a state board, which all doctors must be licensed under. Non-profit hospitals encompass 70 percent of hospitals in the United states; the rest are government owned or privately owned (for profit)

The Patient Protection and Affordable Care Act of 2009 changed the American health care system radically. Since the passage of the bill, lacking insurance is illegal (obamacarefacts.org) If one is ineligible for government programs, then one must secure private insurance or be subjected to a penalty. One of the issues that existed with the American health care system prior to the passage of the Affordable Care Act was that the coverage of insurance was up to the discretion of the insurance provider if a patient had been too sick previously, having a "pre-existing condition" then it would be too expensive to cover him or her and

they could be denied health insurance. Through the Patient Protection and Affordable Care Act, this is now illegal (obamacarefacts.org).

As of 2010, 16% of the United States had no health care (Gorey 1). Does this represent an inherent problem in the United States that, compared with Canada, shows that its health care is inherently worse because it helps fewer people? "Adequate health insurance, itself a type of social and economic capital, has been observed to be profoundly lacking among people who live in high-poverty US neighborhoods, especially among those who may need it most, such as people with illnesses that require costly care"(Gorey 1). Between 2007 and 2011, the economy of the United States fell harshly. People living in poverty increased greatly, and, likewise, the number of Americans without insurance also grew.

Therefore, as a result of this recession, many Americans were left uninsured and without access to health care. As is common knowledge, the United States doesn't possess a unified universal health care system as does other industrialized countries, such as Canada. "Health Care Reform", in the words of President Obama, has, of course, been on the mind of many Americans and politicians for decades, but it was the Great Recession that really showed Americans the necessity for change. (Breast Cancer among Women… Gorey 1). During this time, in 2010, President Obama's Affordable Care Act became law.This is hardly the case in Canada, of course, but The Affordable Care Act is, to some, an instance of "socialism" in the United States, but the United States has been working on making health care more affordable for decades. Health care in general in the United States is the most expensive in the world, and certainly the most expensive of developed countries.

(Gorey). “in no other country other than the US did citizens pay over the 4520 paid by Norwegians… [t]hat is, in the most expensive health care system outside the US, health care still costs only about two-thirds per citizen has much as it does for Americans.”(Gorey)

To have background on the health care system in the United States, one must look past into the past fifty years or so to see how this country has progressed from privatized to public. Of course, the United States does have social programs that provide health care to those that… and these programs have been in existence since 1965. Another attempt at “universalizing” health care was the 2008 Massachusetts Health Care law.

Now we will turn to a discussion of Medicare and Medicaid with regard to the American health care system, which can be considered the first social insurance programs that were ever implemented in the United States with regard to health care.

Medicare is considered a “social insurance program”, and is funded by Americans “paying into the system their whole lives”. Theoretically, if a small amount is taken from each paycheck, then by age 65, the age of entitlement for Medicare and Medicaid, then the elderly who are in most need of health care. For all social insurance programs in the United States, one must be a citizen or a lawful permanent resident. The benefits are not afforded to illegal aliens.

The age for Social Security benefits and Medicare is the same; those who are eligible for Social Security are also eligible for Medicare. Medicare is also extended to those younger than 65 with disabilities, end stage renal disease and amytrophic

lateral sclerosis. Medicare is supposed to be given to those 65 or older regardless of income. (Medicare.gov) Medicare at the time was seen to be a necessity because those 65 or older, given their higher proportion of health problems, needed to pay more for health insurance, which was a problem with health insurance before the Affordable Care Act.

Medicare in the United States is a large extensive program. Medicare has four parts, Medicare part A,B,C, and D. Medicare part A is hospital insurance, and is not supposed to include a premium. However, if one is actually in need of it and staying in the hospital, the inpatient deductible is as follows (according to the Medicare.gov website) : $1,260 deductible for each benefit period, Days 1-60: $0 coinsurance for each benefit period, Days 61-90: $315 coinsurance per day of each benefit period, Days 91 and beyond: $630 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime), and Beyond lifetime reserve days: all costs." As shown, even one part of Medicare is far from free. Part B is typical medical insurance, including procedures such as X-rays.

According to Medicare.gov, Medicare part B includes medically necessary services, preventive services, Medicare part B is slightly "cheaper": according to the Medicare.gov website, medicare costs about $104.90 a year in terms of premiums and $147 USD per year in terms of deductibles for "most people". However, Medicare is stagnated by income: the "majority", earning below $85,000, pay the $104.90 in premiums and $147 USD in deductibes. (Medicare.gov) An income up to $107,000 pays $146.90 in premiums, and an income up to $160,000 pays $209.80. an income up to $214,000 pays $272.70 in premiums, and an income above this

$335.70.

Part C is Medicare Advantage plans (which is offered by a private company), and Part D is prescription drug plans. Basically, Medicare part C is what elderly Americans buy when they want their Medicare given to them through private insurance. It is not a separate service that Medicare provides, such as in parts A, B, and D. Medicare claims (according to the government website) that it could be cheaper for some to enroll in Medicare part C because However, similar to part C, part D is only offered by pharmaceutical companies that have a contract with the original Medicare system. Part D is a relatively new system: it was only put into effect in 2006. Medicare part D is connected to prescription drug plans, and if one wants Medicare part D then one must also have a general Medicare package, which usually includes parts A and B. (Medicare.gov) Or, one has the option of signing up for Medicare part C, which usually includes Medicare part D.

Some insurances work with Medicare part D and some do not, depending. Medicare can be deducted from Social Security. Medicare is not as much "paid into one's whole life"(Medicare. Gov) The current tax rate for Medicare is only 1.45% for the employer, and 1.45% for the employee. For Social Security, it is 6.2% for the employer and 6.2% for the employee. The taxes for social security and Medicare may not seem high, but it is important to note that the taxes are proportionally lower of one's income if one's income is low. So, those with lower incomes may suffer more due to having to pay a higher proportion of taxes from Medicare, and these are the people who pay less in premiums later. However, it is also interesting to note that with Medicare, deductions can be made with social security. (Medicare.

Gov) Like Canadian programs that can be supplemented with private insurance, in addition to Medicare part C, according to the Social Security Office, one can buy a "Medicare supplement policy" called "Medigap".

Now that we have finished our discussion of Medicare, we can move on to Medicaid. Medicaid,by contrast, is supposedly for individuals below the poverty line, so premiums do not exist the way they do for Medicare. Those who have a low incomes can have some sort of insurance while visiting doctors or having hospital visits. The Affordable Care Act has increased spending for Medicaid (Medicaid. Gov) Now, the baseline for benefits has increased to 133% of the poverty line. However, states are not technically required to give people benefits who did not previously qualify for benefits under the Patient Protection and Affordable care Act (Medicaid. Gov).

The way Medicaid works is that each month individuals below a designated line receive a certain amount for health insurance, akin to an insurance plan. Additionally, although Medicaid is traditionally a program for those living below the poverty line, this is not the only requirement for those who may qualify for Medicaid. By the US government, people are put into categories which helps the US government decide if someone is eligible. Like Canada, each state has different qualifications and therefore different spending for Medicare. In 2010, the average cost for everyone (not separated by age) was approximately 5 thousand dollars per person. Medicaid includes dental care, and is obligatory for those under 21 years of age. Much of federal and state funding goes to Medicare. Up to 22% of Medicare

Like health insurance, Medicaid recipients do not receive the money directly in a

sort of bank account system. They can go to hospitals or doctors who accept Medicaid, and sometimes they have to pay a copay. In this way, it is very similar to insurance, except it is publicly funded.

This essay will now turn its discussion to a full background of the health care system in Canada. Health care has also changed substantially in Canada in the last decade. Besides the previously discussed Canada Health Act of 1984, the Medical Care Act (1966) and the Diagnostic Services Act (1957) together comprise the basis for Canada's "socialistic" universal health care system. The ratio of people to doctors in Canada is not high. However, Canada has a large number of "general practicioners" as opposed to specialists(Primary Health Care in Canada, 258). Family practice doctors, who fall under the category of general practicioners, make up slightly over half of doctors in Canada.This thesis focuses on health care with regard to the treatment of cancer within the United States and Canada, but a study focused on health care in general can give us insight into the quality of health care in both places before getting into specifics.

Canada uses a system of insurance, but unlike in the United States, insurance is primarily public rather than private. Actually, types of private insurance can be acquired along with private and may be necessary, but public insurance is guaranteed and used by most Canadians for their primary health care needs. Health insurance is distributed individually by each of Canada's thirteen provinces. "[Canada's] entire population is insured for medically necessary care by a single, public payer" (Gorey 1).The Canadian government is furthermore required to distribute health insurance. Every Canadian citizen is entitled to health insurance

and health insurance must cover all essentials including dental insurance. If a Canadian citizen moves from one province to another, he/ she has the right to coverage; however, upon moving he/she has to reapply for health insurance through his/ her new province. There may be an extended waiting period for receiving this coverage, but it cannot be more than three months under Canadian law. However, in certain cases in certain provinces, a premium must be paid to get certain services, such as vision insurance.

However, a Canadian cannot be denied these services because of inability to pay. The provinces furthermore are only obligated to provide "medically necessary" in the Canada Health Act, which came into law in Canada in 1984. However, the law is not realistically comprehensive as it claims- according to the Canadian government (canadahealthcare.org) each province may determine which procedures are "medically necessary" and which are not. Therefore, health coverage may vary from province to province if each province provides slightly different care. It seems that Canadian health care does not completely live up to its reputation of government- subsidized health care.

Another way that one can say that Canadian health care is not entirely government- sustained is the widespread existence and usage of private health insurance. Given that the Canada Health Act is vague with regard to "comprehensiveness", the types of health care covered by the Canada Health Act are not sufficient to cover Canadians' health care needs. Therefore, as in the United States, private insurance exists and is necessary for services such as dentistry, optometry and prescription medications(Canadahealthcare.org) However, if the

Canada Health Act subsidizes a certain medical procedure, it must remain that way- private clinics that offer services covered by the Canada Health Act are not legal. However, many exist anyway and private insurance can be used to cover the cost. Many Canadians opt to pay a larger fee to avoid waiting in lines for free services. Not all Canadians rely on private health insurance plans, however.

Just as the United States uses social security cards as a means of identification for social programs, Canadians are required to own a health card to access social programs. Once the card is received, then one can register with one's primary care physician of their choosing. The card is used in place of registration paperwork. There is 1 health care doctor for every 1,000 Canadians. The United States has about two and a half times that amount of doctors per every American.

One of the manners that one can use to compare Canadian health care to American health care is expenditures. Canadians can spend about 33 hundred US dollars on health care per year. Between one half and one third of public expenditures per province is spent on health care. Three-quarters of health care in Canada is privately funded. While Canada's system may seem to give health care to a wider audience of people, there is the issue of rationing by waiting: first, there exists the question of the wait time to even get a health card; second, the wait time to get into the doctor. For someone with a disease that requires urgent care, such as cancer, wait times cannot merely be an annoyance but a detriment to health care itself. Canada has a shortage of doctors , perhaps due to their lack of compensation because of the 'universal' health care system. Because of this shortage of doctors longer wait times may be necessary.

Now that we have discussed the health care systems of both Canada and the United States in detail, we can turn to a comparison of the two systems and evidence from scholarly journals to analyze the effectiveness of both systems.With the Canadian system of premiums, it seems that people actually aren't entitled to certain services. If one has to pay out of pocket (as in for premiums for certain Canadian provinces or paying for private programs) as opposed to paying taxes for the government subsidization of programs and the widespread and accessible use to such programs, then it seems that the "right" to health care is not universal. However, it is Canadian law that a citizen who cannot pay for a premium cannot be denied it. It seems that even in Canada, for citizens with the money to pay, health care is not a right but for the citizens without money to pay, it is. This almost seems like a similar policy, however, to Medicare and Medicaid. Medicaid is a US social program that guarantees health care to the very poorest, but not to everyone else. The idea here is that those with money have to pay for those without. In this way Canada can be seen as not totally socialist and their system may seem to be similar to that of the United States.

Just as the United States has taxes on the state and federal level for programs such as Medicare and Medicaid Canada's health care system is funded on both the federal and provincial level. In Canada, taxes are collected federally and then distributed to individual provinces. However, The expenditures of health care in the United States per capita are twice that of Canada.

Now that we have discussed the health care systems in detail of both the United States and Canada, to have a starting base, we can delve into specific examples of both systems to be able to see in practice how they work, and, more specifically, how they work with regard to cancer. An article in the journal named "Medical Care" called "A Comparison of Health Care in Canada and United States"- the case of Pap Smears, can show this. According to the article, American women, who live under a system of health care that is more "privatized" than that of Canada, are more likely to get Pap smears(Gohmann 1) which are vital for women's health in determining whether one has HPV, or human papilloma virus, which can lead to cervical cancer. (Gohmann 1) If American women are much more likely than their Canadian counterparts to obtain a pap smear, then American women may be safer from cancer by comparison.

It is true that some women in the United States are insured and some are not, meaning one could view the discrepancy between insured and uninsured women as a class divide, and therefore unable to be compared with Canada. However, uninsured women in the United States receive Pap smears at the same rate as Canadian women in general, and those with insurance of course receive pap smears at a higher rate.

The article "Primary Health Care in Canada: Systems in Motion" discusses how health care in Canada has changed as well as how cancer is now treated in Canada as of the early 2000s. " In 2007, the Ontario Ministry of Health and Long-term care created the Quality Management Collaborative… in 2009 QIIP became a private, not-for private organization… with a broadened mandate to support

sustained quality improvement across the primary care sector" (Primary Health Care in Canada). This collaborative improved treatment and screening for many diseases for Canadians, such as diabetes and pulmonary disease, including cancer.

An article published in 2004 named "Prostate Cancer Incidence and Mortality Rates and Trends in the United States and Canada", compares death rates and treatment rates with regard to prostate cancer (McDavid 2004). The prevalence of prostate cancer in the United States and Canada is equal; it is the second greatest cause of death in both countries and has been for the past thirty years. Men over the age of fifty are much more likely to get prostate cancer. This study did not classify the cancer patients based on income, but only on age, so this article could possibly classify which health care system is "better" at treating prostate cancer as a whole. In terms of the increase of prostate cancer rates in the United States and Canada, the rates have increased equally between the two countries. Prostate cancer is tested in the same manner in the two countries , using the Prostate specifc antigen test. According to the article, not much evidence exists that this test is effective, but the fact that it is used in both countries sets a starting point.

From 1969 to 1993 in Canada, the rate of prostate cancer rose, but from 1993-1996, the rate dropped by six percent. The United States had a similar figure; from 1973 to 1992 the rate of prostate cancer rose. From 1992 to 1995 the rate of prostate cancer declined by twelve percent, which was then followed by an increase. According to the article: "Both countries experienced a gradual rise in prostate cancer incidence rate, then a rapid increase beginning in 1989-1990. The rapid increase was more dramatic in the United States than in Canada… the rate was

higher in the United States than in Canada"(public health reports). If prostate cancer rates were indeed higher in the United States than in Canada, then one could perhaps assume that the methods used to cure prostate cancer in Canada were more effective at curing cancer than those in the United States.

Additionally, the study was separated by age groups: fifty to fifty-nine years, sixty to sixty-nine years, seventy to seventy-nine years, and eighty years. In each group, the prostate cancer rate was higher in the United States than in Canada, with the exception of the oldest age group. (public health reports 2004). "Canadian men had a higher incidence rate that United States white men only in 1993-1998 among those aged eighty years or older" (public health reports, 2004).

The older a male becomes, of course, the higher risk he has of getting prostate cancer:" [i]n both Canada and the United States, the prostate cancer incidence rate was higher in each advancing ten year age group…"(Prostate Cancer incidence Mortality Rates and Trends). The two countries, as we have seen, seem to have similar incidence rates for each category; however, in the category of men fifty to fifty-nine years old from 1988-1992, a large discrepancy exists. For this category, the rate in Canada is half that in the United States: "the rate in the United States was almost 1.9 times the rate in Canada"(Public Health Reports). If incidence rates in Canada are lower, then one can assume patients in Canada are somehow able to access preventive care at a higher rate.

The death rate for prostate cancer, however, is not as high as the incidence rate for prostate cancer. However, the mortality rates in Canada were lower than the mortality rates in the United States, but the difference was mostly not "statistically

significant" (Public Health Reports). This study showed overall that both the mortality and incidence rates in Canada and the United States, while similar, were not equal, with the rates in the United States being higher. The article was published ten years ago, and there have been certain expansions since in the United States with the passage of the Affordable Care Act and the expansion of Medicare and Medicaid, but the basic health care system in the US remains the same, so the article can nevertheless be used for comparison purposes.

According to the article, "Inequity in Access to Cancer Care: a Review of Canadian Literature", published in 2011, gives a comprehensive review of health care in Canada in the modern era, and how it is used to treat cancer. The article states, as discussed above, that although Canadian health care is universal, it is not the case that every group receives health care equally. In Canada, "cancer has been within the two leading causes of death in Canada since the early 1970s"(Inequity in Access to Health Care). A main issue with cancer, as shown by the issue of rationing by waiting, is that prognosis and treatment depend greatly on early detection. Are the "wait times" too long in the Canadian system to properly treat their citizens, and prevent untimely deaths? Are the costs and lack of insurance too high for Americans, which would prevent their own health care system? Which is worse, from a normative standpoint?

An issue in answering these questions that one must face if one were to attempt to answer them is that cancer does not just usually require one form of treatment and it is very expensive. Another point that should come to light is that Canada's universal health care system does not eliminate the issue of inequality in health

care. According to the study: “Specifically, studies suggest income-related inequity in access to screening, diagnosis, systemic therapy, and end-of-life care. In all circumstances, individuals with lower incomes are less likely to access services and more likely to experience longer wait times for services”(Inequity in Access to Health Care). It seems here that Canada not only rations its health care “by waiting” but also with income. Additionally, “lower income has also been found to be significantly associated with lower rates of survival for cancers of the head and neck, esophagus, colon, breast, lung, and cervix, even after controlling for age and year of diagnosis” (Inequity in Access to Health Care). If health care is rationed by more than one means in Canada, then it seems that the universal system may not reach the quantity of people that may be commonly thought when thinking of a universal health care system.

Given that, according to the Canadian government and the Canada health act of 1974, health care is considered a right in Canada and is funded by taxes. Given this, there must exist reasons for the inequity that Canadians face with regard to health care. According to the article, two main explanations are “differences in patient choice for care” and “differences in patient advocacy for care” (Inequity in Access to Health Care). Additionally, those with higher incomes usually have more access to knowledge of treatment, health care options, and decisions. “Screening services and end-of-life care are often associated with both patient and primary care provider initiative”(Inequity in Access to Health Care). There exists less equality with regard to treatment for cancer at the beginning and end of treatments, however, as stated above; this is often pivotal in treating cancer. Even if access to

health care has high equality in Canada, but detection does not, then survival rates will include inequality based on income.

Additionally, inequities based on age exist in both the United States in Canada. The early detection aspect of screening does not necessarily apply to the elderly; they are "More likely to adhere to Canadian screening guidelines" but less likely to be referred to a specialist physician. The case is the same in the United States.

However, although inequity may exist, the article "Breast Cancer among Women Living in Poverty: Better Care in Canada than in the United States" published in the "Social Work Research" article in 2015, shows that, although inequity may exist between those with higher incomes than those with lower incomes in Canada, between those with lesser incomes, Canadian women fare better. The study compared women who were living in poverty-stricken areas in both Ontario and Canada, and the study found that poorer women in Canada achieved a faster diagnosis, had better access to treatments, and the wait times were much less in Canada than they were in the United States (Social Work Research). Breast cancer is the most common type of cancer among women in North America. (Social Work Research). Therefore, a study such as this one can provide insight into which health care system betters the lives of their citizens as a whole, because more citizens have cancer. One in every eight or nine women will be diagnosed with it in their lifetime, so each country's dedication in minimizing breast cancer in their citizens should be a priority.

This study was also conducted just before the Patient Protection and Affordable Care Act was passed, so it could show us the necessity of the Affordable Care Act and

how much work may still need to be done Basically, the health insurance that the poorer women in the United States had simply did not cover enough, whereas the state health insurance covered enough for the Canadian women. According to the article: “Universal health care is a strong element of Canada’s safety net that, relative to the United States’. Seems to have provided better protection during a time of economic decline”(Gorey 1). Whether the rich people in both countries, the best off, would have faced such a discrepancy in health care remains to be seen, but as far as caring for the poorest in each country with regard to cancer, Canada’s system seems to take care of the most people.

Those who are poverty stricken in the United States, are, of course, more likely to be covered by social insurance programs such as Medicaid, but are not likely at all to be privately insured. Additionally, as stated above, Medicaid is not an all-inclusive coverage; for individuals with cancer, it may be even more lacking than for individuals who simply need a yearly check-up, given the extensive costs of cancer treatments.

This paper is concerned with comparing cancer treatment between the United States and Canada, as a means to compare the effectiveness and the tradeoff between “rationing by waiting” and “rationing by money”. Breast cancer, as one of the most common types, can be a key indicator of which health care system is the most efficient. “For a number of reasons it is particularly instructive to US- Canada comparisons. First, income has been observed to be strongly associated with breast cancer survival and care in the United States, but not in Canada”(Gorey 2009). Additionally, those with private health insurance (in the United States) or under

Medicare (also in the United States, were better off and better treated than cancer-stricken women with other forms of coverage.

Canada, unlike the United States, seems to have less of a class difference in regard to how cancer is treated. As stated above, the poor in Canada fare much better than the poor in the United States, but there is not much difference between the care that the rich receive, or the care that the rich, poor, and middle class receive (Gorey 2009). So, maybe the rich or middle class in the United States are able to receive better quality care than their Canadian counterparts given that they have insurance and those who have insurance fare better than those who do not. However, the poorest fare better in Canada. We will return to this conclusion after our discussion of the article.

The study got information from the poorest neighborhoods, the ten to twenty percent poorest(Gorey 2009). A study held before the one described in the article found that Canadian women were, as a whole, diagnosed earlier and did not have to experience as much waiting as commonly thought. However, since health insurance is now added to many Canadians' plans, this is seen as a somewhat plausible explanation for it. Both of the women in Canada and the United States were viewed as living below the poverty level. Four "predictors" (Gorey 2009) were included in the study: the country, the country of each patient along with the amount of health insurance(if any) that each patient had, the country, insurance, and the stage of breast cancer, and the country, insurance, stage of breast cancer, and what treatment would be done (Gorey 2009). Those using this study used these predictions due to the fact that whether or not one has heath insurance, the stage of

disease, and treatment are correlated and can alone predict the effectiveness of each country's health care.

As a result in this study, the hypothesis of those who took samples of Canadian and American women was generally correct. Survival, as a whole, was greater in Canada than in the United States, with few exceptions, namely those with health insurance. In terms of node-negative disease (cancer had not yet reached the lymph nodes and therefore was in the lower stages and the patient has a much higher rate of survival), the survival rate for eight-year survival in general was 77 percent in California and 79 percent in Ontario, which is quite similar. However, those with private insurance had a survival rate of 83 percent, which is higher than the survival rate in Ontario; however, the survival rate among the uninsured in California for this particular type of cancer was only 70 percent, showing that , as a whole, the public health care system in Canada is much stronger than that in the United States, and those with private insurance in the United States only fared better by a small margin.

In terms of a Node-positive form of breast cancer, the survival rate in California given the people studied was sixty percent, and the survival rate in Ontario overall was 74 percent. Those who were insured with private insurance or under Medicare had a survival rate of 63 percent, those who were uninsured or under Medicaid had a survival rate of 58 percent, and those who were uninsured completely had a survival rate of 55 percent. The survival rate for the Ontarians for this select group of people in the study was higher than that of the Canadians for any of the four categories, but the largest gap occurred between those who were uninsured in

Canada and the survival rate for Ontario in general. The gap of twenty percent seems to be quite a noticeable indicator for the lack of available care for the uninsured in the United States, especially compared to that of a similar country.

In terms of metastasized disease, which is cancer that has spread throughout the body and therefore has a low chance of survival, three-year survival overall was only 22 percent for the Canadian group compared to 33 percent for the Ontarian group. For those insured under private insurance or Medicaid, the survival rate increases to thirty percent. However, for those uninsured or under Medicaid, the figure drops to fourteen percent. ,In terms of how early the diagnoses were able to be obtained, in which case breast cancer is at its most treatable and becomes one of the most easily treated forms of cancer, and arguably the most critical aspect of treatment the figures are all at a similar point although they show the same patterns that have been previously seen.

In California, by contrast, the overall figure was 62 percent; for private insurance, 65 percent, and for uninsured or under public benefits, 58 percent. For Ontario in general, the figure is 65 percent. In terms of access to surgery, we see the same pattern, and each category of people who have access to surgery is over ninety percent. “However, about four percent fewer of the uninsured or Medicaid insured received surgical treatment of their breast cancers”(Gorey 2009).These figures show that, even if the disadvantages in terms of Canadian health care prove to be true, such as extended wait times, the Canadian health system is nevertheless more effective in terms of saving lives.

Interestingly, however, the study also recorded “wait times” for both groups. In terms of waiting sixty or more days for surgery, the rate was ten percent in California and seven percent in Ontario. In terms of those covered by private insurance or under Medicare, the figure drops to nine percent, but in terms of those who are uninsured or under Medicaid, the figure rises to 12 percent. (Gorey 2009). However, one main aspect of this study that must be noted is the sample size in California was much greater than the sample size in Ontario; for example, the sample size for the node-negative disease cure rate for California was 724 patients; in Ontario it was only 125.

The comparisons are in terms of percentages, and the study has useful conclusions, as will be discussed shortly, but comparisons of other studies are necessary to compare Canadian and American health care systems in greater detail.Therefore, this study shows that prior to the Affordable Care Act, the health care in terms of cancer care in Canada is better than that of the United States.

The most interesting parts of this study, that show that perhaps popular opinion about Canadian health care has incorrect assumptions are: 1) wait times in Canada are not necessarily notably more than wait times in the United States; on the contrary, they can be less, and especially when comparing the uninsured in the United States to those in Canada. 2) among the poorest in this given sample, so it can be assumed for the poorest in the United States, those even with insurance fared worse than those in Canada. This study does not compare the health care for those who are middle and upper-income, but it does show that, even for those who have insurance, the poor fare worse in the United States than in Canada, and 3) among

those who are uninsured and poor in the United States (and it can be safely assumed for the point of this discussion that those who are uninsured are more likely to be in the poor segment of society), the health care options open to them are sadly limited, especially given the resources of the country in which they live.

It seems that, for the worse off in the United States in particular, the health care system is not effective. The Affordable Care Act mandated that all Americans have some type of insurance; however, given that the public option, an original part of the bill, was never materialized the fine that Americans would have to pay for not having health insurance is less than health insurance would actually cost, so this hardly guarantees that all or even most Americans would be able to be under insurance. The Affordable Care Act also increased Medicare and Medicaid spending, but does not seem that this would close the gap between the discrepancy between the health care of the United States and that of Canada. Finally, even those who were insured but were low income, did, at best have a slightly higher survival rate than their Canadian counterparts, but mostly had a slightly lower or about the same. This shows that even if every American were insured, which the Affordable Care Act far from guarantees, the Canadian system may still be superior in providing its citizens with health care.

The discussion between the "haves" and the "have-nots" and each industrialized country's responsibility to bridge this gap and provide its citizens with the highest quality form of health care leads us to John Rawls, a philosopher whose theory centers on this very issue. Rawls's philosophy, entitled "justice as fairness", is discussed in the greatest detail in his book, "a theory of justice"(Stanford

encyclopedia of philosophy). According to the Stanford encylopedia of philosophy: "… justice as fairness envisions a society of free citizens holding basic equal rights cooperating within an egalitarian economic system"(Stanford encyclopedia of philosophy).

To Rawls, the first two principles of Justice as Fairness are as follows: "[First Principle]: Each person as the same indefeasible claim to a fully adequate scheme of equal basic liberties, which scheme is compatible with the same scheme of liberties for all. [Second Principle]: social and economic inequalities are to satisfy two conditions: a) They are to be attached to offices and positions open to all under conditions of fair equality of opportunity. b) They are to be to the greatest benefit of the least-advantaged members of society (the difference principle)"(The Stanford Encyclopedia of Philosophy)

This essay, comparing American and Canadian health care, focuses primarily on Rawls's second principle of justice. Of course, "fair equality of opportunity", can be applied to equal access to adequate health care; even if this idea can be said to not include health care at all, in order to receive fair opportunity, one must be in adequate health in order to pursue equal opportunity. Indeed, according to the Stanford encyclopedia of philosophy: "Rawls's first principle accords with widespread convictions about the importance of equal basic rights and liberties" (Stanford Encyclopedia of Philosophy). If we are calling health care a basic human right, or an "equal basic liberty" for the purposes of our discussion, then according to the First Principle of Rawls's theory of justice, the Canadian health care system is more "just". If anyone, regardless of income, can receive health care and proper

treatment that (especially) can be expensive, then Canada is abiding by Rawls's first principle of justice.

However, his second principle, which shows in more detail the difference between American and Canadian health care, is our primary focus in this paper. Given our discussion of Canadian health care compared to American health care, what seems to be the most marked difference between the two is how well the "worse-off" are. The "best-off", those who are in the middle-to-high income category, always have access to at least adequate health care in developed countries. Our discussion showed that the "worse-off" may be better off in Canada, which may show that Canada is a much more just society, to Rawls. The Stanford Encylopedia of Philosophy explains the difference principle further, basically stating that a just society has the least difference between the rich and the poor. "…difference principle…regulates the distribution of wealth and income. With these goods inequalities can produce a greater total product… the difference principle requires that social institutions be arranged so that any inequalities of wealth and income work to the advantage of those who will be worst off".(Stanford Encyclopedia of philosophy)

Canada, given its single-payer system with a lack of reliance on health insurance, seems to achieve this. It is not that the health care the Canada can provide is overall of a higher quality than that of the United States, but the discrepancy between the rich and the poor, while large in the United States, is comparatively nonexistent in Canada.

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