"Weighing the Evidence" Health Care Conference presented by Friends of Medicare Calgary, April 30 – May 1, 2005[1]

350 people attended this conference that focused on the evidence around the world that not-for-profit health care is better than for-profit[2] health care in terms of:

Quality:

- **Waiting lists** are not reduced when for-profit health care is introduced – for example, in Australia, some waiting lists have increased (Maher). The introduction of for-profit health care increases wait times in non-profit health care. Wait should be determined by need (Horne);

- We want a waiting list, otherwise capacity is sitting idle which is inefficient (Yalnizyan);

- **For-profit hospitals can fail to attract health care staff** – in Australia, at the Armidale Private or For-Profit Hospital, nurses who left the non-profit hospital to go work for the for-profit Armidale Hospital, returned to the non-profit hospital since staffing ratios were better (Maher);

- **P3 hospitals** are dysfunctional since there is **no collective team approach** that a hospital needs (with the division between for-profit management and non-profit management) and the contract is much longer (sometimes 66 years with **little or no "out" clauses!**) compared to any contracting-out contract, which is usually 2-3 years with a 60 day "out" clause (Shrybman);

- In a meta-analysis study on the type of health care delivery (for-profit vs. non-profit) and the impact on patient death rates between 1982 and 1995 in the U.S. with 38 million Medicare patients, there was a 2% **higher likelihood of dying** in a for-profit health care setting, a 10% higher likelihood of newborns dying and a 8% increase in death because of dialysis. This would mean 2200 extra deaths a year if Canada went

[1] For conference and speaker information and a transcript of each presentation, please click on the conference website, http://www.weighingtheevidence.ca and see Endnotes

[2] Dr. Devereaux explained that the term "private" is often misused. Most health care delivery in Canada is private. The difference is whether it is private for-profit or private non-profit. I will be using the term "for-profit" to mean what is sometimes referred to as "private" health care delivery – coming from the term "privatization".

to a for-profit health care system. This is the same number of people who die from suicide in Canada each year (Devereaux);

- Uninsured U.S. citizens are less likely to get preventative health care, less likely to receive health care and more likely to die than Canadians (Fegan);

- For-profit health care insurance is poor – for instance, the average length of time of a U.S. citizen in any one plan is less than two years in the U.S. (Fegan);

- For-profit health care systems beget **fraud** – NME (Tenet) was charged and paid $683 million in fines – Columbia, charged with upcoding, fined $745 million and the investigation is ongoing (Fegan);

- Doctors invest in the for-profit health care centres they work in. The result is a lower per capita rate of kidney transplant (compared to Canada) instead of dialysis. Dialysis pays more (Fegan);

- HMOs (for-profit health maintenance organizations) in the U.S. are integrated with tobacco companies – Etna HMO wellness newsletter pulls anti-smoking article (Fegan);

- The life expectancy of a man in New York City is less than a man in Bangladesh! (Fegan);

- In Ontario long **term care, there is the greatest portion of for-profit delivery and the lowest standards in Canada.** For-profit long term care companies are lobbying against regulations and minimum staffing levels (Cohen);

- On-going BC and Manitoba study finding for-profit long term care admission rates to hospitals are higher than those in non-profits (Cohen);

- Good quality care can cost less – see Sask. Fyke Report in 2001 (Rachlis).

Cost:

- **Non-profit health care costs are *not* spinning out of control** – for Canada - 9% GDP in 1990, 1990-92 10% GDP, 2004 10% GDP (Yalnizyan);

- However, governments have cut their revenue base through tax cuts, so health care makes up a larger percentage of government expenditure. Also, the amount of what governments pay for is shrinking (Yalnizyan);

- **Costs increase as level of privatization increases** – for example, in Australia costs were at 8.5% of GDP when system was more non-profit, now the system is more privatized and costs are 9.1% of GDP (Maher). The U.S. pays 19% more than Canada for health care. If Canada went to for-profit health care, we would pay 7.2 billion per year more (Devereaux);

- Private health care insurance premiums escalate 8-20% per year in Australia (Maher). Private health care insurance increases health care costs for individuals, employers and government. This is partly why drug prices have increased so rapidly (Horne);

- **Research in Australia in 2002 showed that $2.5 billion spent on private health insurance premiums could have bought three to five times more health care in the single-payer (non-profit) system** (Maher);

- New South Wales government in **Australia bought back a P3 hospital** in Port Macquarrie after it cost $144 million to build a P3 versus $52 million if the hospital was built in the public sector (Maher);

- For-profit health care is expensive as it includes large administration and advertising costs and is costly to collect [we already pay for collection through the income tax system] (from the floor)

- **Without investment in long-term care, inefficiencies in acute care** – for instance, in Australia, one patient was in an acute-care hospital for 24 years (Maher). In Manitoba one study found 5% of seniors use 78% of acute care services in hospitals (Cohen). Acute care costs four times more than long term care (Cohen). BC is spending more on health care since more long term care patients are going to the emergency department (Cohen);

- **P3 finance and service hospital schemes are complicated agreements that cost more** – for example, Ottawa's P3 Royal Ottawa 66-year lease will cost more than a non-profit hospital (Shrybman);

- Tax payer dollars go to **legal fees** and "middle men" in P3 deals – for example legal fees for the Royal Ottawa P3 hospital are $9 million and counting (Shrybman);

- Need to **train** more health care workers so doctors' wages aren't artificially high. Don't only focus on retention and recruitment when addressing the health care worker shortage in 5 years (Yalnizyan);

- Toronto Sunnybrook Hospital for-profit radiation clinic closed after the Ontario Auditor general found it cost $500/patient more than non-profit (Douglas);

- Good jobs would not exist in Canada if we didn't have Medicare. Medicare is worth $6/hour/employee says GM in Windsor (Rachlis).

Equity:

- The goal of health care on "the left" is to make all people well (regardless of ability to pay) which **reduces inequalities between the rich and the poor** (Maynard);

- The goal of health care on "the right" is that people should be "free" to choose which health care they want while user fees tax the poor, elderly and the ill (Maynard);

- The new "health care deductible" in Alberta is a user fee for the sick when income tax is paid. Health care premiums are user fees (Horne);

- In 1990, 25% of citizens in France are not attempting to get health care because of high costs/user fees (Dubreil);

- In 2005, in France, computer companies and shareholders are profiting from the health care system as the complex patient fee system is computerized. In France, the private for-profit sector deals with more profitable care while the public non-profit system deals with chronic care and care for the elderly, which is less profitable (Dubreil);

- **In New Zealand, the rich have access to for-profit acute care, while the poor have to fly to Australia for emergencies** (Maher);

- Non-profit health care often subsidizes for-profit care – for instance, in Alberta for-profit laser eye surgery was $2,000 now $500 since for-profit laser clinics do cataract surgery that is reimbursed by the province (Horne);

- Investment in non-profit long term care is an equity issue. Long term care patients are usually unattached women, low income people, over age 85 (Cohen). Now it costs an individual $66,000/year for a for-profit long term care home in BC (Cohen);

- In Canada right now, people are going without food or medication to get long term care or home care (from the floor);

- Half of bankruptcies in U.S. due to medical costs (Federal Health Minister Dosanjh).

Canadian domestic impact considering "free" trade agreements:

- Foreign investors can sue Canada if for-profit hospital deals (including P3s) break down. Only the federal government has standing to participate in a "free trade" court process (Shrybman).

Instead of looking to for-profit health care delivery, non-profit health reform should include:

Emphasis on prevention:

- For example – in France – 2/3 of illness is caused by pollution and other factors including asbestos poisoning (Maher);

- Lack of efficiency when illness prevention is not emphasized (Maher);

- Pay attention to the **social and economic determinants of health** (i.e. poverty). On average social and economic status affects 50% of our health (with 25% affected by access to health care, 15% genetic factors and 10% physical environment) (Yalnizyan). See Conference Board of Canada study (Horne). Poor people often have to call an ambulance to get to the hospital (even if the illness is not acute) since there is no other way to get there quickly and they can't afford a taxi, etc (comment from floor);

- Greater immunization (Yalnizyan);
- Prevention programs similar to Edmonton Capital Health diabetes control program (Yalnizyan);
- Restore funding to governmental environmental programs, social assistance, etc. (Yalnizyan).

Integrated health care teams and the appropriate care by the appropriate staff person:

- Improves efficiency and sustainability (Yalnizyan);
- Canada spends too much on acute care and drugs instead of on integrated primary care (Yalnizyan);
- Community health care centres are an example (Yalnizyan) (Horne) (Rachlis) – for instance, in Saskatoon, same day servicing (Rachlis);
- Learn what the "public" system is doing well. For example see the *Taming The Queue* conference [Canadian Medical Association, Canadian Nurses Association] (Yalnizyan);
- Change payment scheme for docs (Horne);
- Limit poaching from other regions in Canada and the world – for example, Filipino nurses being "poached" as live-in nannies for Canadian families (from the floor). Recognize foreign credentials (from the floor and Dosanjh);
- Patient centred care – see www.iom.org (Rachlis);
- Health care workers working to their scope of practice (Rachlis).

Federal and provincial government building infrastructure (Yalnizyan)

National drug bulk purchase plan (Yalnizyan)

- Look to Australia National Drug Plan – costs 9% lower than Canada (Horne);
- Positive step that Alberta Drug Utilization plan is using information from pharmacists, not drug companies (Horne);
- Stop misuse of drugs (i.e. Vioxx) (Rachlis);
- Stop under use of drugs (i.e. for pain control, chronic disease management) (Rachlis);
- Stop over-prescribing drugs – i.e. pharmacists should be on health team (Rachlis).

Centralized booking to reduce waiting times

- Alberta already doing in some areas (Horne);

More emphasis on non-profit continuing care (Horne)

- Long term care is a neglected sector – nowhere in Romanow report (Cohen). However, long term care *is* referenced in the Canada Health Act (Wendy Armstrong, Alberta Consumers Association, from the floor);
- Assisted living is not long term care. Long term care is where patients get 24 hour support (Cohen);
- Need non-profit long term care where staff and management work together (Cohen);
- Need whistle-blower protection for staff (Cohen);
- Mandatory family councils are a good idea such as in Ontario – need public participation. Federal government should fund health care advocates and watchdogs for provinces (Cohen);
- As in Denmark, health care at home may be substituted as long as the funding follows the patient (Cohen);
- Need to switch emphasis from acute illness and accidents to more chronic care such as diabetes (Rachlis).

Healthier workplaces for health care staff (Rachlis)

- 50% turnover in long term care in Canada (Rachlis).

Strong federal regulations – for instance, the Canada Health Act (Dosanjh)

- **Dosanjh** says, "The time is right" to act on compliance of the Canada Health Act and we need "public pay and public delivery of health care in Canada". The public should "not be charged out-of-pocket" *in* for-profit health care clinics. The public "can't jump the queue" by using for-profit health care clinics. Provinces cannot "undermine or gut" Medicare. He says Harper in June 2001 wanted to "experiment with market reforms and private delivery" of health care.
- **Shirley Douglas** says we need to get community groups such as the Rotary and Variety club much more involved in the preservation of non-profit health care.
- Overcome the 'democratic deficit' and get involved (Kenney).

Conclusion:

The problem in health care is a lack of political will to strengthen and continue non-profit care. Efficiency cannot be evaluated without comparing health outcomes. Political organizing and advocacy for non-profit health care must accelerate and continue. Using evidence-based research is advised.

May 6, 2005
Heather Farrow

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Endnotes

References refer to video and audio recordings of the speakers at the conference "Weighing the Evidence: International Experience with Health Care Reform" now available at www.weighingtheevidence.ca

Friends of Medicare has also made available on the website the speakers' power point notes from this excellent conference which was held in Calgary on April 30th & May 1st, 2005.

The conference sections are:

International Perspectives on Reform
Alan Maynard PhD (United Kingdom)
Jim Maher PhD (Australia)
Dr Patrick Dubreil MD (France)

South of the Border: Lessons from the U.S.
Dr P.J. Devereaux MD (Hamilton)
Dr. Claudia Fegan MD (Chicago)
Steven Shrybman LLB (Toronto)
Dr. Nuala Kenny MD (Halifax)

The Attack on Medicare in Canada
Marcy Cohen (Vancouver)
Armine Yalnizyan (Toronto)
Tammy Horne (Edmonton)

The Way Forward: Visions for Reform
Dr. Michael Rachlis MD (Toronto