# DÉJÀ VUE. . .

## MEDICARE IS THE WISE CONSUMER'S CHOICE

We recently ran across speaking notes for panel presentation in Calgary by a representative of Consumers' Association of Canada (Alberta) on **April 3rd, 1995**.

It's worth a look. . . and as pertinent today as a decade ago.

Speaking Notes for Panel Presentation
" The Americanization of Health Care"
sponsored by the Council of Canadians.
Calgary Convention Centre
April 3, 1995
Wendy Armstrong, President, CAC Alberta
(Note: Delivery may vary from actual text)

*Founded in 1947, Consumers' Association of Canada is an independent, non-profit, volunteer driven organization, representing and informing consumers. The association is committed to safety, justice, and fairness in the marketplace.*

*CAC Alberta's work is funded by memberships, private donations, ad hoc project grants and our Speakers' Bureau.*

Thank you Barb.

Before I leap into the topic at hand I think it's important that everyone understands just who and what the Consumers' Association of Canada represents.

The word "consumer" is bandied about a great deal these days. You'd think from all the use of this word in economic pronouncements and advertisements. . . or the latest offering from your local cable company. . . that consumers are simply a group of compulsive and sometimes petulant shoppers, with never ending pocket books, a love of new toys, and a total disregard for the community in which they live.

In reality, the word "consumer" is understood internationally to mean the end user of a good or service be it bought and delivered in a public or private market. *And* at the heart of the consumer movement, indeed what drives our association, **is a belief in the wise use of both personal and community resources**. That is the perspective I hope to bring to tonight's discussion.

There are three points I'd like to touch on briefly in my opening remarks. I hope there'll be a chance later to provide you with more supporting information.

One - market failure in healthcare

Two - the risks of not clearly separating public and private interests in a marketplace, and

Three - the facts and myths of private health insurance.

**First : Market Failure in Healthcare**

We are hearing a lot about a new "consumer driven" healthcare system in Alberta these days. We are also hearing a lot about "consumer choice" and THE MARKET. These words have sounded hopeful and promising. But what do they really mean ?

• To many observers it's starting to look as though "consumer driven" means that Alberta consumers *will be driven out* of a relatively efficient public market and *driven into* a higher cost private market.

• "Consumer choice" is starting look more and more like the right to choose between making a mortgage payment at the end of the month or paying for your family's health care treatments.

• And most end user groups who have the expertise and insight on just what may work to improve things have been marginalized as special interest groups - or been unable to get to the table because of lack of funds.

*There are very good and very sound economic as well as social reasons why many so many Canadians and our Association support the principles of the Canada Health Act.*

**There is widespread and well documented market failure in healthcare**. And you don't really have to be a health economist to recognize why the markets don't work for this particular commodity.

• people don't plan on being sick
• genetics and one's working and home environment affect one's health as much as individual lifestyle choices.
• there are not too many parents who want to be faced with shopping for the cheapest chemotherapy for their child
• asthma attacks do not wait until payday
• a seniors ability to see directly affects his/her independence and quality of life
• driving around a city or a region with an injured child to find out which hospital takes children, which one takes broken bones and which one takes VISA, can be costly and potentially dangerous

*Finally, the grim reality is that there is almost no limit to what the " market will bear" when it comes to saving a life or stopping the suffering of a loved one.*

***Competition occurs based on marketed perceptions of quality- not price.***

Prices in private healthcare markets are driven up through high cost advertising, unnecessary duplication of sometimes questionable expensive technology - and an over capacity of "bricks and mortar".

Demand must then be created to fill that excess capacity and meet investors expectations. Lack of experience means quality is difficult to judge.

In a 1992 comparison of prices for physician fees between the two countries Consumer Reports found New York surgeons charging $2700.00 while Manitoba physicians billed for $550.00. Here in Alberta private cataract clinics already charge twice the documented "facility fees" (or per case overhead costs) required by Wetaskiwin and Stony Plain Hospitals.

**Another example.** In 1985 the State of Arizona decided to further unleash free- market forces in health care by no longer controlling the number of hospitals allowed to do open heart surgery. At that time there were four hospitals in Phoenix performing this

surgery. At the end of the year there were eleven. One year following the State did a study to find out what had been the effect of this deregulation. They found that the mortality rate for the procedure had gone up 35 % and the cost of the procedure had gone up a full 50%. (Consumer Reports, 1992)

**Advertising is also a fact of life in private markets**. Most of it is based on incomplete information, fear-mongering and false hopes.

Do we really want to find ourselves "Sitting on *another* fence" with Sprint's Candace Bergen ? Trying to decide which of the over 168 long distance carriers now able to market in Alberta we should sign up with is already making our heads' ache.

How *do* we feel about desperate people being reduced to making often complicated individual health care decisions based on the which advertisement has the biggest star or the catchiest tune? Or having surgery because a family member bought you a gift certificate for surgery for Christmas and you wouldn't want to disappoint them.

During this past holiday season, many Albertans expressed dismay over ads for non-insured nearsightedness surgery in Alberta papers suggesting that family members buy their loved one "the gift of freedom" with a gift certificate. Yet this surgery is still part of one large clinical trial because of a lack of long-term documentation of it's effectiveness – and not yet allowed to be sold in commercial settings in the U.S.

Don't think about long-term value or safety or who pays for your additional treatment if complications occur. Just think of that sun filled vacation in Puerto Rico with all those extra Airmiles points on your card. . .

It is enlightening to read articles in US Medical Trade Journals on how to maximize profits and minimize financial risk through Preferred Provider Contracts or specialized clinics. The key to "success" is to offer a high volume, low overhead procedures to a vulnerable or heavily insured groups. Examples often given are cataracts for the elderly and cardiac bypass for middle aged corporate executive.

Finally, probably the biggest failure of all in private healthcare markets is the funding of public health measures such as immunization and proper waste disposal. I still have the press clippings describing the reaction of the major pharmaceutical companies about a year and a half ago when President Clinton proposed a massive publicly funded immunization program. They reacted with outrage and threats. Why? Because the volume involved in such an immunization process would drive down the price of the

serum and they would lose so much money that they wouldn't be able to continue their efforts to find new drugs to cure illnesses such as cancer. Honest, I have the clipping.

**Now my second point: the risks to both the public purse and patients' cheque-books by failing to separate the interests and activities of the public and private sectors in healthcare.**

Private/public partnerships in healthcare services and the ability to "work both sides of the fence" have led to unexpected and untoward risks and costs for both the public purse and consumers of healthcare services in US and now in Britain. For example, studies done in the US indicate that doctors who own diagnostic facilities will often order those tests up to 2-3 times more often than those who do not.

And just how many doctors are going to make their work in the lower paying public sector a priority? It's a temptation few can resist. Rapidly rising prices in the private sector then also work to put inflationary pressure on public system. That's how parallel private and public markets work. CAC Alberta's Access to Cataract Surgery survey in Alberta conducted in April 1994 found that only those patients whose ophthalmologists did surgery in private clinics as well as in public sector faced waits longer than 2- 6 weeks for the same procedure in the public sector.

Problems with the abuse of self-referral between private entities and Medicare and Medicaid have grown so significantly in the US over the past decade that stringent "Safe Harbor" and "Anti-Kickback statutes" have recently been brought in. Affiliations and ownership are now going to be rigidly controlled.

Cuts to Alberta Health expenditures will not be effective at reducing our provincial deficit if we find ourselves having to pay excessive costs through other government departments and the courts to legislate and regulate the mess we may find ourselves in with anti- trust activities in the private sector and abuse of the public purse.

Closer to home the ability of the private market to take advantage of the public purse to make higher profits is already evident. Alberta Health continues to pay physician fees for clinics that also charge inflationary prices directly to patients. According to statistics published yearly by Alberta Health on physician incomes, one enterprising Alberta ophthalmologist managed to chalk up 1.7 million in personal billings for physician fees to Alberta Health in 1993 alone. . . . **Move over Gretsky!**

One final comment on the failure to adequately separate the interests and activities of the private and public sector:

Perhaps the most disturbing trend in Alberta today is one which will take us into far deeper and murkier waters than even the Americans dare venture. That is the current development and promotion of a new breed of for-profit non-profits (such as the recently proposed Gimbel Foundation) who feel they need special deals and tax-breaks to be able to compete with a more efficient public sector. Such arrangements will take away desperately needed tax revenues required to maintain a viable public system, siphon off limited charitable dollars from traditional and very necessary charities - and remove public scrutiny, influence and accountability in the spending of health care dollars. Beware!!

**The third thing point I'd like to raise briefly is the issue of private insurance.**

Albertans expressing concern with either decreased access to health care services or shifts to significant out-of-pocket costs are being told that supplementary private health insurance will become a necessity and a responsibility. It's interesting to note that one of the outspoken proponents of this model in Alberta (Gerry Chipeur) also happens to be a partner in a newly legislated health insurance company.

CAC Alberta has been advised that even Blue Cross Extended Benefits Plan has a 30% rejection rate in some of their programs. One of the realities of private insurance is that perceived risks to the insurer because of pre-existing conditions or certain occupations are rejected. Just ask the Alberta Council on Aging which years ago tried to obtain a private group plan for dental care coverage for their members. They were practically laughed off the block.

In the US, it is being reported that related family members are now being denied insurance by some companies because someone in their family has been found to have

a gene which may express itself later in a certain disease.  Remember that scientists around the world are currently busy working on a project to identify all such genes. Also remember that Insurance companies in North America pool their pertinent medical information on individuals in an agency called the Medical Insurance Bureau. They are also not required to validate the accuracy of that information before acting upon it.

One sure thing about Insurance companies is that the more they pay out the more they must collect in premiums. And whether it's our public health insurance plan or a private plan, it all comes out of our family budget one way or another.

As consumers we have a vested interest in keeping the prices in both public and private insurance plans under control.  The difference is that in public insurance plans we don't do it by kicking people out of the plan or upping premiums in order to maintain adequate profit margins for investors.

The only truly affordable option for adequate health care coverage for most Albertans in the future may be through group insurance plans with employers. This will be an extra burden for business, particularly small business. Not only does this add to the costs of business – but it drives up consumer prices for their products.

CAC Alberta is concerned that this will rapidly become an " Alberta *Dis*advantage" for our companies attempting to compete in the new global marketplace. **General Motors in the US has long supported healthcare reform there.  In the recent debate over health reform it was revealed that GM spends more on healthcare for their workers than they do on steel.**

It seems somewhat ironic that the inability to access affordable health care may eventually serve as a disincentive to the individual entrepreneurship we take such pride in here in Alberta.

**In conclusion,  I'd like to make one increasingly apparent observation.**

While most Albertans went into these health care cuts expecting some pain, we believed the experts who told us there was fat in the system and the pain would be reasonable. That we could do more with less. That safety and access wouldn't be compromised. That new strides in treatment meant less need for institutions. So why are so many of these **<u>same</u>** people now promoting an expansion of a theoretically unnecessary private system?  *After all, how many people would pay twice as much for something that provided no substantially improved benefit?*

**The public system therefore must fail for a private system to succeed.**

Maybe the plan all along was ***not*** to reduce health care costs to the community. Perhaps it was to simply " pass the buck" and maintain or create even more profits for already highly profitable pharmaceutical companies, surgical supply companies, insurance companies - and some enterprising entrepreneurs. It's certainly starting to look as though someone has done a great marketing job.

**But Albertans are starting to ask "Where's the beef!"**

Will Alberta family budgets or the Alberta economy be better off paying for higher cost health care in a private market rather than lower cost health care in a public market? CAC doesn't think so. And we doubt that you do either.

For over 50 years our Association has represented the consumer interest in Canada. If private markets in health care worked, you can bet your bottom dollar we'd be the first to support them. But they don't.

Medicare is not only a value statement by Canadians about the kind of community we live in and want our children to grow up in - a community where safe and timely medical care is not denied because of a lack of money - a community where desperate people are not subject to fear-mongering and price-gouging. **Medicare is also the wise use of both personal and community resources.**

*It's time to send a clear message to all the politicians and the health care entrepreneurs. The buttons on the table at the door – "Don't Mess with Medicare" say it well.*

**MEDICARE <u>IS</u> THE CONSUMERS' CHOICE.**

**Thank you.**