



Response to Zoltan Nagy

President, Canadian Independent Medical Clinics Association (CIMCA)*



Re: The Canadian Health Coalition's June 2007 [Fact Check on Brian Day](#)

* Note: Brain Day, MD, is past-President of the CIMCA, 2005-2006

In August, Zoltan Nagy wrote¹:

“Michael McBane, National Coordinator of the Canadian Health Coalition, has disseminated unsupported claims² and misinformation about certain statements made by Dr. Brian Day³, the incoming president of the Canadian Medical Association. McBane twists the truth and trots out a number of tiresome and self-serving myths that attempt to keep the public in the dark on Canadian health care. “The following list sets the record straight on Dr. Day.”

1) Day's statement: “The Canadian health system has been ranked 30th in the World by the WHO.”

McBane's reaction: “The 2000 World Health Organisation study presented a misleading representation of health care systems including Canada's. The WHO abandoned this ranking system because of seriously flawed methodology.”

Nagy: McBane uses the WHO report selectively. While he dismisses the WHO's healthcare rating system as unreliable, he acknowledges the validity of Michael Moore's film “SiCKO.” Moore uses the identical WHO study to condemn the U.S. health system, rated by 37th in the World by the WHO.

McBane's response to Nagy: The ranking system is seriously flawed, as the WHO now acknowledges. Moore's excellent movie is, nonetheless, an accurate exposé of corporate greed and cruelty in the private health insurance industry.

¹ http://www.cimca.ca/newsletter/issue07_FactCheck.pdf

² <http://www.healthcoalition.ca/DayFactCheck.pdf>

³ http://www.smcma.org/Bulletin/BulletinIssues/May06issue/counter_viewpoints.html

- 2) **Day's statement:** "At \$4,400.00 per capita [Canada] is the most expensive of all countries that offer 'universal' coverage."

McBane's reaction: "Canada's per capita spending in 2004 was \$3165 U.S. It is above the OECD average but below Norway, Switzerland, and Luxembourg. The U.S. spent \$6100 per capita in 2004."

Nagy: Health care spending per capita was projected to be \$4,548 in 2006, the second highest (after Iceland) among other OECD countries that offer universal care. In spite of having one of the most expensive health care systems in the World, Canada has fewer physicians per capita than the OECD average (2.2/1000 vs. 3.0/1000), fewer acute care hospital beds than the OECD average (2.9/1000 vs. 3.9/1000), fewer MRI machines than the OECD average (5.5/1 million vs. 9.8/1 million), and fewer CT scanners than the OECD average (11.2/1 million vs. 20.6 million). In addition, there are approximately 1 million people on wait lists to see a specialist, to get an MRI or other medical imaging, or to have surgery. Canada has one of the most expensive health care systems in the World, and is ranked 30th by the World Health Organization.

McBane's response to Nagy: Health care spending in Canada is rising fastest in areas not covered by public health insurance (especially pharmaceuticals, but also home care, dental care, etc.). If someone is concerned about rising per capita spending, as Day and Nagy claim to be, why are they advocating more expensive, inefficient, and inequitable private health insurance? Why aren't they advocating more public health insurance, which has been proven by a number of independent studies to be less expensive, more efficient and more equitable? The real issue is whether or not more of the items cited by Nagy would lead to a healthier population. While we don't have all of the data, what we do know is that Canada ranks well in terms of life expectancy for men and women. Having lots of medical technology doesn't mean that the population will be healthy. For example, evidence shows that despite having many more neonatal ICU beds, infants in the U.S. do worse than in Canada, Australia and the U.K.

- 3) **Day's statement:** "In Canada, 65% of sick children wait a "medically unacceptable" period of time."

McBane's reaction: "There is no evidence for this claim."

Nagy: The source of the statistic is an audit by staff at B.C. Children's Hospital, described in the January 12, 2006 edition of the Vancouver Sun by Dr. Geoffrey Blair, the chief of surgery at B.C. Children's Hospital, and spokesman for a consortium of surgical chiefs from more than dozen paediatric hospitals in the country. The audit was also described in the Canadian Medical Association Journal (Dec. 6, 2005) by Dr. Blair.

McBane's response to Nagy: Dr. Blair, in the Canadian Medical Association Journal, does not claim that "65% of sick children wait a 'medically unacceptable' period of time." He writes: "35% of BC children undergoing elective surgery did so within recommended wait times." Obviously still unacceptable, but a big difference from the claim made by Day. Moreover, the study Blair cites does not appear to have been published (despite the fact that the letter is now almost 2 years old). Unfortunately, it is typical of Dr. Day that he would change 'children waiting for elective surgery' to 'all sick children', 'B.C'. to 'Canada', and use unpublished data with unverified methodology.

4) Day's statement: "The assertion that our single-payer system is administratively efficient is hogwash."

McBane's reaction: "Before Canada introduced a single-payer system, spending in Canada and the U.S. was escalating in parallel. After 30 years of single-payer administration, Canada now spends almost fifty percent less than what Americans spend (9.9% of GDP in Canada vs. 15.2% in the U.S.) while providing equal or better care. All Canadians are covered while the U.S. has 46 million citizens with no coverage."

Nagy: McBane is comparing apples to oranges. Comparing the Canadian system to a very different U.S. health care system (which does not offer universal care) adds no value to any meaningful debate. Moreover, Canada should not aspire to equal or compare itself to the 37th ranked country (the U.S.). Many countries with universal care and access have no wait lists and spend significantly less than Canada. They all have a vibrant private sector to keep the public system accountable and honest.

McBane's response to Nagy: The European countries which Nagy offers as a model for us actually fund a greater percentage of their health care systems from public funds than Canada does, not a lesser percentage as Nagy suggests. Insofar as their systems work better than ours, the lesson to be drawn is the opposite of that which Nagy draws: more public funding equals more efficiency, better health results and lower overall costs. As a percent of total health care funding coming from the public, Canada was ranked 19th (out of 24) among reporting countries in 2005. This OECD data also shows that as a percent of GDP, Canada ranked 9th. Moreover, it is important to keep in mind that it is the U.S. health care industry that is eyeing Canada as an unopened oyster. It is no coincidence that shortly after being elected President of the CMA, Brian Day spoke to an audience of American health insurance entrepreneurs, inviting them to invest in Canada. Following the Supreme Court decision in June 2005, Dr. Jacques Chaoulli also went to the U.S. and said: "I would like to make a team with American entrepreneurs and go to Canada and create a private, parallel health care system." (Globe & Mail, June 22, 2005). When Day and Nagy say: 'this is not about the U.S.', it is about the U.S.!

5) Day's statement: "In our country a dog can get a hip replacement in under a week, but a human may wait two years."

McBane's reaction: "Access to veterinary care for animals is based on ability to pay. Dogs are put down if their owners can't pay. Access to care should not be based on ability to pay."

Nagy: "Patients are suffering and dying on wait lists." (June 2005, Supreme Court of Canada). Recommended maximum by Canadian governments to get a new hip is six months. In reality, however, it can take two years or more. Today, only very few Canadians can afford to buy a new hip privately in the U.S., Europe, or India. With the introduction of private health insurance, a hip replacement done privately in Canada will be an option for the rest of us.

McBane's response to Nagy: Wait times in Canada for hips and knees are too long. However, this problem is being successfully addressed with innovative changes in the public system. For example, the Alberta Bone and Joint Institute reduced hip and knee replacement wait times for surgery from 47 to 4.7 weeks by using better management techniques, and ensuring the orthopaedic surgeons shared their patient wait lists and addressed them with a more efficient team-based approach.

6) Day's statement: "All other models of universal health care differed from the Canadian model in one fundamental way: They did not exclude competition from the private sector. Canada shared this distinction with just one other country – North Korea!"

McBane's reaction: "30% of what Canadians spend on health care is private expenditure. Canada is below the OECD average on public health care spending. The argument that private for-profit health care does not play a significant role in Canada is false."

Nagy: This is a misleading argument. The 30% private expenditure covers dentistry, out-patient drugs, chiropractic and physiotherapy services, cosmetic surgeries, etc. Over 99% of physician and hospital services (a.k.a. "medically necessary services") are controlled by the state monopoly and are publicly funded. Result: a million Canadians are on wait lists. Only North Korea has such a rigidly-controlled monopoly on physician and hospital services.

McBane's response to Nagy: First, each country has its own unique culture and history which affect its health care goals and the means used to achieve them. Unlike Brain Day, the vast majority of Canadians are proud of the ethical health care vision enshrined in the *Canada Health Act*: access to care based on need, not ability to pay. Second, Markets are simply not designed to deal effectively with the delivery of medical care, which is a social function that needs to be addressed in the public sector. Harvard Emeritus Professor of Medicine, and Emeritus Editor-in-Chief of the *New England Journal of Medicine*, Dr. Arnold S. Relman, agrees. He favours the elimination of all for-profit facilities and health care businesses: *"The facts are that no one has ever shown, in fair, accurate comparisons, that for-profit makes for greater efficiency or better quality, and certainly have never shown that it serves the public interest any better. Never."*

Finally, wait times need to be fixed in the public system for all citizens, not just wealthy Canadians who can afford to use private clinics. Allowing a parallel, for-profit system would siphon away doctors and nurses from public hospitals. The reality is that Day and Nagy's so-called solution to wait times would benefit a privileged few at the expense of the general public who will wait longer. The comparison with North Korea is too silly to deserve a response.

- 7) **Day's statement: "At the [Cambie Surgery] Centre we spend only 30 percent of our gross revenue on wages and salaries, compared with 70 percent in the public hospitals, yet we pay our nurses more."**

McBane's reaction: "Peer-reviewed evidence shows that for-profit investor-owned facilities skimp on staff and patients are at risk as a result. Where is the rest of Cambie's revenue going? Profits?"

Nagy: The nurse to patient ratio at private clinics far exceeds that in the public system. Private clinics could not survive if they provided inferior services. They achieve savings in reduced management and administration costs, in utilizing high-end technology, in developing more efficient systems, and they pass on the savings to their patients. It is hardly surprising that the utilization of private clinics in Canada has been increasing steadily.

McBane's response to Nagy: The American Hospital Association explains why private, for-profit surgical clinics, and limited-service hospitals like Cambie in Vancouver, are so profitable. They avoid emergency and complicated cases, focus on patients in good overall health, focus on well-reimbursed procedures like Workers Compensation referrals, and focus on patients with good insurance coverage. In other words, they cream off the easier cases leaving the difficult ones for the public system. (www.healthcoalition.ca/aha-surgical.pdf). Moreover, when their cases do turn complicated or go wrong, they can then dump them onto the public system, adding further stresses to our understaffed hospitals. You too can make pots of money as a physician if you select healthy and wealthy patients with a view to maximizing your profit. Private clinics also often encourage nurses to keep their employment status in the public health care system in order to avoid paying their benefits package, further feeding off taxpayers. Finally, until private, for-profit investor-owned clinics like Cambie open their books to the public, we'll never know where their revenues are going, or how much public subsidy they obtain.

- 8) **Day's statement: "In striking down the existing laws, the judges said, "The evidence shows that delays in the public health care system are widespread and patients die as a result of waiting lists for public health care.... the courts have a duty to rise above political debate."**

McBane's reaction: "The Supreme Court of Canada's Chaoulli decision recognized that failure to ensure timely access to care endangers Canadians' well-being. But the remedy must be to ensure access for all – not just for those who can "afford to pay" for private care. Three dissenting judges warned that the Charter should not be used to roll-back benefits enjoyed by all Canadians, especially the poor."

Nagy: The Supreme Court struck down Quebec’s healthcare legislation. Six of the seven judges ruled that the Quebec laws violated the rights to life, liberty, and security of person, and described the system there as a “de facto monopoly”. Seven of seven judges ruled that patients experienced “physical and psychological suffering”, and all ruled that the system imposed the risk of death and irreparable harm to patients waiting for care. The Court asserted that they must rise above political debate.

McBane’s response to Nagy: The majority opinion in the Chaoulli judgment was powerfully critiqued by three dissenting judges. One of the key fallacies of the majority decision is the mistaken assumption that excessive wait times are caused by a public monopoly on insurance. Other countries, that do not have a public monopoly on hospital and physician insurance, also have serious problems with wait times. One should not forget that the majority judges in the Chaoulli case threw out the evidence established at trial level in the Quebec court demonstrating that private health insurance undermines public health care systems. The final decision was indeed ‘evidence-free’ as not a shred of evidence anywhere in the world could show that private health insurance would solve wait time problems. Indeed, in a country like Canada, with a shortage of doctors and nurses, the establishment of a parallel, private, for-profit system is only possible by poaching doctors and nurses from public hospitals and clinics. This will increase wait times for patients who cannot afford, or who choose not to pay, for private insurance or private care.

9) Day’s statement: “Health care is approaching 50% of all spending in the provinces.”

McBane’s reaction: “Health care spending is rising as a percentage of provincial budgets because of tax cuts and cuts to other program spending. Health care spending as a percentage of the economy is stable and takes up the same share of national income as 25 years ago - approximately 4 percent of GDP for hospitals and physicians. Why would someone concerned about rising costs advocate transferring cost from governments back on to patients and private insurance?”

Nagy: Health care is approaching 50 percent of all spending in the provinces. This is a statistical fact, authenticated by auditors nationwide. One might be concerned about this because increasing health spending starves out other government programs (transportation, education, child care, research, etc.).

McBane’s response to Nagy: Two key points: first, the most dramatic escalation in costs to the health care system have occurred within the private, for-profit pharmaceutical sector. Second, Canada has saved a fortune by not following the heavily privatized American health care model, which costs vastly more than our system, produces worse results, and leaves a third of Americans with inadequate or no health care. Also keep in mind that if a government reduces its spending on non-health-related items and cuts taxes, as Canadian governments have done, the percentage of expenditures devoted to health care will increase automatically. The fact remains that spending on public health care as a percentage of GDP (hospitals and doctors) has been stable for 25 years and is forecast by the federal Finance Department to be stable for the next 40 years as long as the economy grows at a moderate pace (www.healthcoalition.ca/finance-note.pdf).

10) Day's statement: "The coming changes will create a massive new industry and enable the Canadian health industry and its workers to enter the international health market and participate in the \$2 trillion American health economy. On the basis of extrapolations from other countries, we may see \$40 billion a year added to the Canadian health system."

McBane's reaction: "There is a lot of money to be made by wrecking Medicare in Canada. But how is it in the public interest to drive up spending to U.S. levels? If current levels of health care spending are said to be 'unsustainable' why would one advocate spending an additional \$40 billion a year?"

Nagy: The assertion by Day was that the public system would benefit to the tune of \$40 billion. His examples were of foreign public hospitals that generate funds for the state system, as the Royal Marsden Cancer Hospital in London (25% of core revenue) and the communist run Frank Pais orthopaedic hospital in Havana, Cuba (\$US 20 million a year for the state hospital system).

McBane's response to Nagy: How will Canadian patients be better served by Day's plan which calls for the diversion of scarce and limited health care resources (nurses, surgeons, technicians, etc.) to treat healthy and wealthy Canadians and medical tourists from the U.S.? This just moves people with money to the front of the line. Poaching publicly educated and trained health care professionals out of the public system does not add capacity to deliver more health care. If Dr. Day and his like-minded peers are allowed to cannibalize the public system, the rest of us will be left with even longer waits.

Note on Dr. Brian Day's Conflict of Interest

The Canadian Medical Association has elected as its new president a corporate CEO whose claims about the merits of private, for-profit health care are not supported by the evidence. Brian Day's corporate duties and responsibilities make it impossible for him to represent the merits of Canada's public, not-for-profit health care system. His selective use of evidence promotes a business model in which he has a financial stake. This is known in ethics as a financial conflict of interest.

Before publicly releasing the [Fact Check on Brian Day](#) in June 2007, the Canadian Health Coalition consulted an expert reference group of physicians, medical ethicists, health economists and lawyers. Fair and reasonable people can agree on what the evidence says. Dr. Day's claims are not supported by the evidence.

More Resources on Brian Day, MD:
<http://www.healthcoalition.ca/doctorprofit.html>

