Health Care
An Unregulated Monopoly

David Zitner, MD
Family Medicine
Professor, Faculty of Medicine
Director of Medical Informatics-Dalhousie
Health Policy Fellow, Atlantic Institute for Market Studies

The Problem

- Canadians uniformly want a health system that provides a broad range of services to rich and poor alike.
- We have major problems
  - Canadian health system is socially irresponsible. It covers a small set of services for rich and poor equally, while others including the working poor do not have access to the full breath of care including expensive drugs.
  - Workers have few choices when the government health employer is irresponsible. No choice between public sector organizations or between public and private sector
  - Access problems for rich and poor alike but mainly for those who are poor, inarticulate and not well connected
  - Serious problem with health system error

Root Cause of the Problem

- Health care is an unregulated monopoly not subject to the same regulatory environment as other industries such as food, automobiles and transportation. The monopolist is the regulator
- Price controls lead to rationing and poor quality
  - cherry picking for overpriced items such as walk in care,
  - insufficient supply of more costly services like comprehensive continuing care

Health Workers Demoralized

- Terrible morale among unionized and non-unionized health workers. They can't do their job properly and some are forced to flee to other industries or non-clinical work.
- Demoralized nurses on some hospital units
- Family Medicine
  - Major decline in numbers of family doctors
- Government discourages most collaborative practice. Government won't pay and won't allow patients to pay for excellent collaborative services.

Solution

- Social economy
- Group insurance, through cooperatives for example for the many items that are not covered by public health care
- Accountability in public health care by separating government role as an insurer from their role as an evaluator and regulator
- Choice for health workers

Serious Problems No Regulatory Responsibility

- Access:
- Alan Paterson
  - Deferrable death
  - Accelerated by inappropriate waiting times
  - Previous warnings to Board Quality Committee and to Health services administrators
- Emergency Department
  - Deaths while waiting in ER. Miscarriage in waiting room
  - Prolonged Waits
- Virtual Destruction of Family Medicine Through Price Controls
  - $25 per visit and doctor as a private provider pays the full cost of infrastructure

Uneven Application of Ideas

- Access to services not insured by government is unequal
- Health worker unions negotiate insurance support from employers (private and public) to pay for private services not covered by medicare
- Social economy-cooperative provide less advantaged people or those not employed by large organizations the opportunity to pool risk to obtain access to services not insured by government on a pooled risk basis

Medicare Background

- **Before:** People shouldn't be denied care because they can't or won't pay for the health care services they need.
- **Now:** People must be denied care because their neighbor can't or won't pay for necessary health services (or because governments can't organize the system properly)

How Are Canadians Harmed Canada Health Act

- Accessibility
  - Emergency Waits, Specialist Consultations, Surgery Cancellations,
- Universality
  - Workers Compensation Board, Different Levels in Different Districts and Provinces. Governments pay for patients (and practices) in unfair, unequal ways.
- Comprehensiveness
  - Coverage in Canada is Narrow compared to other developed countries with Universal Insurance (cf. Romanow, Kirby, Definitely Not the Romanow Report). Ear wax removal in Nova Scotia

Supreme Court

- Unconscionable waits for care violate Canadian's rights because of preventable death, discomfort and disability brought about by inappropriate waits

Are Treatments Safe?

- In Canada, Baker et al. suggest hospitals are not safe
  - Baker et al. estimate that 3 in 200 patients admitted to Canadian Hospitals are killed because of preventable adverse events.
- Adverse events 7.5/100 admissions
- Preventable 37.5% 2.8/100 admissions
- Deaths 21% **1.5/100** admissions
- MUCH GREATER THAN NUMBER REPORTED IN SIMILAR USA STUDIES ALTHOUGH BAKER SUGGESTS THE REPORTING MAY NOT BE COMPARABLE

Baker GR, Norton PF, Flintoft V et al.: The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. CMAJ 2004; 170(11): 1678-86

Carnage?

- Baker and Norton
  - Canadian Health Care rife with error and resulting carnage
  - Canadian Patient Safety Institute spends $10 million of your money and has no information on whether the error rate is increasing or decreasing or staying the same.

From Baker and Norton ADVERSE EVENTS WITH Virtually certain evidence of preventability

- Acute on chronic renal failure caused by NSAIDs
- Acute renal failure with hyperkalemia and intractable constipation with large-bowel obstruction ending in death. Lack of effect of enemas recorded in nurses' notes and results of
- bowel radiograph not acted upon

Baker Norton EventsCertain Evidence of Preventability

- Admission because of severe anemia. The anemia had been documented in previous admission but not investigated fully, which resulted in delayed diagnosis of colorectal carcinoma
- Delirium caused by benzodiazepines given to patient with hepatic encephalopathy
- *Clostridium difficile* colitis following antibiotic therapy. Patient did not receive sufficient volume expansion, which led to acute renal failure and death

Certain Evidence of Preventability

- Cardiac valve replacement. Three days before discharge nurse noted wound was red, inflamed and painful, but no treatment or medical note. readmitted at 2 weeks with a wound infection,
- Nontherapeutic international normalized ratio (INR) on discharge. echogenic mass on prosthetic valve and possible infective endocarditis
- Chronic renal failure in patient taking sotalol and given increasing doses of digoxin, which led to increased QT interval, digoxin toxicity, heart block and worsening renal failure
- Blood transfusion administered too quickly, which resulted in congestive heart failure and death

Certain Evidence of Preventability

- 8 Delayed diagnosis of rectal cancer in patient with long-standing rectal symptoms
- 9 Delayed diagnosis of uterine cancer in patient with vaginal bleeding for over a year
- 10 Delayed treatment of digoxin toxicity in patient with acute renal failure, diarrhea and
- dementia
- 11 Delayed treatment of pseudomembranous colitis
- 12 Delirium secondary to aminophylline toxicity. No measurement of drug level in clinical
- context of renal failure
- 13 Digoxin toxicity in patient with chronic renal failure possibly contributed to death
- 14 Drug-induced acute urinary retention and postrenal failure
- 15 Delirium and vomiting caused by electrolyte imbalance after chemotherapy
- 16 Excessive blood loss during extensive surgery resulted in anemia, which was not treated

Certain Evidence of Preventability

- 8 Delayed diagnosis of rectal cancer in patient with long-standing rectal symptoms
- 9 Delayed diagnosis of uterine cancer in patient with vaginal bleeding for over a year
- 10 Delayed treatment of digoxin toxicity in patient with acute renal failure, diarrhea and
- dementia
- 11 Delayed treatment of pseudomembranous colitis

- 12 Delirium secondary to aminophylline toxicity. No measurement of drug level in clinical context of renal failure
- 13 Digoxin toxicity in patient with chronic renal failure possibly contributed to death
- 14 Drug-induced acute urinary retention and postrenal failure
- 15 Delirium and vomiting caused by electrolyte imbalance after chemotherapy
- 16 Excessive blood loss during extensive surgery resulted in anemia, which was not treated

Certain Evidence of Preventability

- 8 Delayed diagnosis of rectal cancer in patient with long-standing rectal symptoms
- 9 Delayed diagnosis of uterine cancer in patient with vaginal bleeding for over a year
- 10 Delayed treatment of digoxin toxicity in patient with acute renal failure, diarrhea and
- dementia
- 11 Delayed treatment of pseudomembranous colitis
- 12 Delirium secondary to aminophylline toxicity. No measurement of drug level in clinical
- context of renal failure
- 13 Digoxin toxicity in patient with chronic renal failure possibly contributed to death

- 14 Drug-induced acute urinary retention and postrenal failure
- 15 Delirium and vomiting caused by electrolyte imbalance after chemotherapy
- 16 Excessive blood loss during extensive surgery resulted in anemia, which was not treated

Certain Evidence of Preventability

- 8 Delayed diagnosis of rectal cancer in patient with long-standing rectal symptoms
- 9 Delayed diagnosis of uterine cancer in patient with vaginal bleeding for over a year
- 10 Delayed treatment of digoxin toxicity in patient with acute renal failure, diarrhea and
- dementia
- 11 Delayed treatment of pseudomembranous colitis
- 12 Delirium secondary to aminophylline toxicity. No measurement of drug level in clinical
- context of renal failure
- 13 Digoxin toxicity in patient with chronic renal failure possibly contributed to death
- 14 Drug-induced acute urinary retention and postrenal failure
- 15 Delirium and vomiting caused by electrolyte imbalance after chemotherapy
- 16 Excessive blood loss during extensive surgery resulted in anemia, which was not treated

Certain Evidence of Preventability

- 17 Failure to follow protocol in management of acute ST-segment elevation myocardial
- infarction (MI). Patient readmitted after third MI 1 month after index admission
- 18 Multiple readmissions owing to failure to perform endoscopy or find source of gastrointestinal
- bleed before discharge
- 19 Transfer to intensive care unit (ICU) delayed because of failure to recognize and address the
- critical nature of the patient's illness. Respiratory failure led to death
- 20 Cirrhosis of the liver caused by hepatitis C transmission from transfusion
- 21 Inadequate investigation and post-discharge follow-up in patient with severe acute
- pancreatitis and probable pseudocyst
- 22 Recurrent infection and need for secondary surgery because of incomplete removal of
- nonfunctioning artificial uretheral sphincter
- 23 Patient with malignant coronary artery disease referred for urgent cardiovascular surgery.
- Treatment delayed 3 months because of misplaced films at cardiovascular case conference
- 24 MI following delayed transfer of patient with unstable angina because referral hospital beds
- were unavailable
- 25 Misdiagnosis for over 1 year and resulting drug therapy without adequate monitoring led to
- delirium and multiple admissions because of falls
- 26 Missed diagnosis of anemia associated with recurrent gastrointestinal bleed. Appropriate
- blood work not done and patient inappropriately discharged
- 27 Normal blood pressure and no hypovolemia, while chest radiograph showed pulmonary
- edema. Patient given 2100 mL of normal saline intravenously over 48 hours; when saline
- stopped and furosemide given, confusion and dyspnea cleared
- 28 NSAIDs in context of chronic renal failure and coumadin with lack of proper monitoring
- resulted in digoxin toxicity and hypercoagulability
- 29 Ovaries removed during hysterectomy; consent indicated that patient understood they would
- be left

DM COMMITTMENT 1994 "WHEN LESS IS BETTER"

- ***Timely access must be guaranteed and information about waiting times made public.***
- ***Quality of care will be ensured by ongoing monitoring and publication of outcomes as changes are implemented.***

Canadian Health Care
Single Tier for Price, Multi-tier for Quality

- Canada's Health System Functions as a Single Tier for Price with Different Levels of Quality – Not What Canadians Expect
- New Glasgow – A tale of two practices
  - Shouldn't people be permitted to pay to get care equal to their neighbors?
  - Beyond Face to Face Visits
    - Avoiding the rationing and inefficiency imposed in our current health care system.

Public Administration: Health Care an Unregulated Monopoly

- **N.S. Health Authorities Act: Section 19**

  "The objects of a district health authority are to govern, plan, manage, monitor, evaluate and deliver health services"

- Public Administrators focus, as would any other monopoly on maintaining their monopoly and avoiding competition

- CMA reply to Supreme Court Decision
  - **Privatization if Necessary but Not Necessarily Privatization. No one wants to pay for ideological reasons only**

Public Participation

- **Self Respect:Tommy Douglas**
- On October 13, 1961, in a special session of the Saskatchewan legislature, then Saskatchewan premier, and the man known as the "Father of Canadian medicare," T. C. Douglas, said:

"I think there is a value in having every family and every individual make some individual contribution [to the cost of their coverage under medicare. I think it has psychological value. I think it keeps the public aware of the cost and gives the people a sense of personal responsibility."

Social Economy

- Direct government resources to those who need them.
- Broaden insurance coverage
  - Drugs and other necessities of modern health care
- Have a deductible for government insured services
- Encourage communities to become self sufficient to provide for themselves the services not covered by governments and direct subsidies to those who need them most