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COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
REPUBLICAN POLICY COMMITTEE

EDINBORO UNIVERSITY
BUTTERFIELD HALL, ROOM 101
EDINBORO, PENNSYLVANIA

THURSDAY, APRIL 30, 2009
1:00 to 3:00 p.m.

UNIVERSAL HEALTHCARE: GOVERNMENT CONTROL
OF HEALTHCARE SYSTEMS

BEFORE:

- HONORABLE STANLEY E. SAYLOR, CHAIRMAN
- HONORABLE SCOTT HUTCHINSON
- HONORABLE MICHELLE BROOKS
- HONORABLE JOHN EVANS
- HONORABLE BRADLEY ROAE

SONYA HOFFMAN
REPORTER - NOTARY PUBLIC

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1 MR. EVANS: Good afternoon, Ladies and Gentlemen.
2 I'm Representative John Evans. And I'm very pleased to
3 welcome Representative Stan Saylor, the Chairman of our
4 Policy Committee, to Edinboro University today for this very
5 important hearing.

6 To start things off, I'm very pleased to introduce
7 the President of Edinboro University. I know this is a very
8 busy time as graduation commencement exercises are set to
9 take place tomorrow here, so it's a very busy place. And we
10 want to thank Edinboro for their cooperation in helping us
11 secure the room here for this public forum.

12 It's my great pleasure to introduce Dr. Jeremy
13 Brown, the President of Edinboro University.

14 DR. BROWN: Thank you very much, Representative
15 Evans. And, frankly, personally, thank you so much for
16 everything you do as a member of our Council of Trustees,
17 and also everything you do to support the University. It's
18 very much appreciated.

19 I'd also -- it's terrific to welcome everybody to
20 the campus today. Those people who have, perhaps, not been
21 here in a while will see a few new buildings going up and a
22 multitude of buildings which are no more, but that's a sign
23 of progress. And that's what we're talking about today;
24 progress. What are the current issues? What are the ideas
25 out there? What do we do to ameliorate the situations which

1 we believe to be quite difficult and concerning to many
2 constituents here in the Commonwealth. And so it's terrific
3 that we have an opportunity to have a broad discussion about
4 particular issues; health care, of course, is a major one.

5 And so with allowing to have that take place on
6 our campus today, I look forward to a very lively and
7 meaningful discussion with also some ideas as to how to move
8 forward from this point.

9 So, again, welcome to everybody. I'm delighted to
10 have you on campus. And as I keep telling people, it's
11 always like this in Edinboro; it never snows in the winter
12 and it's nice and sunny. So welcome again, and thank you
13 for the opportunity to be here.

14 MR. SAYLOR: Thank you. Before we take testimony
15 this afternoon here, I do want to talk -- the reason for
16 this hearing is -- as Jeremy talked about, is to talk about
17 the health care systems. And what we've been taking notice
18 to in -- across this state and across the country, has been
19 as government has been expanding health care coverage for
20 individuals, we've been seeing more people in the business
21 world drop that coverage because there's no incentive
22 anymore for them to provide health care to the employees;
23 they're assuming that government's going to pick it up.

24 And the biggest concern I think a lot of us have
25 about that is will we have the same kind of health care,

1 quality health care, that we had if we have an insurance plan
2 versus that of a government plan. And so we're going to
3 hear some testimony on that today.

4 Also, as we must realize as we look to other
5 countries that have national health care -- or universal
6 health care, whatever term you prefer to use, we see a high
7 tax raise.

8 Now, I visited Ireland and talked to some of the
9 residents there and some of the people over there about
10 their health care system and found that they have a
11 21-percent sales tax on everything, including cars, which
12 would shock Americans, and a very high income tax rate.

13 So today we're going to have a video clip to start
14 off and to have some people talking about their experiences
15 with government health care. And then we'll have our first
16 witness.

17 Tell you what, while you're working on that, why
18 don't, Scott, you start the introduction.

19 MR. HUTCHINSON: Great. My name is Scott
20 Hutchinson. I represent the 64th Legislative District,
21 which includes all of Venango County and a portion of
22 Butler. And I want to thank Representative Evans and
23 Edinboro for opening your doors to us today.

24 MS. BROOKS: Michelle Brooks. I represent the 17th
25 Legislative District, portions of Mercer, Lawrence, and

1 Crawford Counties. And I am welcoming the discussion. I,
2 also, would like to thank Edinboro University for hosting us
3 today, and all of you for participating and attending today.

4 MR. ROAE: I'm Brad Roae. I represent District No.
5 6 in Crawford County. I am also on the House Insurance
6 Committee, so meetings like this are very useful to me. And
7 I would also like to thank Representative Evans for
8 organizing this and the University for hosting us.

9 MR. SAYLOR: Are we about ready to go with the
10 video? Lights.

11 (Video shown.)

12 MR. SAYLOR: With that, Nadeem Esmail, will be
13 presenting testimony. Mr. Esmail is a Health System
14 Performance Studies, Director of Canada.

15 MR. ESMAIL: Thank you for having me here. I'd
16 like to speak, specifically, about the view that the United
17 States should adopt the Canadian-style single-payer health
18 insurance program, because it really has long been present
19 in the American health care debate.

20 Proponents of the Canadian-style single-payer
21 insurance team claim that its adoption will resolve the
22 uninsured problem, provide all Americans universal access to
23 high-quality care in a time frame that provides comfort and
24 peace of mind, and do this all without increasing the total
25 cost of health care for Americans. Nothing can be farther

1 from the truth.

2 A careful look at reality finds, in fact, that
3 Canada's Medicare is not the panacea that many portray it to
4 be. Rather, Canada's health care system is more of an
5 example of how not to organize health care policy. In fact,
6 the situation has become so dire that many Canadians seek
7 and pay out of pocket for care in other countries. They
8 also purchase insurance for care in the United States now
9 increasingly. And, in addition, some Canadians have even
10 resorted to the courts in hope of better access to care.

11 Looking at the facts, first, I point out that
12 Canada's health care system is not cheap. While it's less
13 expensive than the U.S. health care system, in fact, Canada
14 maintains, on an age-adjusted basis, the developed world's
15 second most expensive universal access health insurance
16 program. Only Iceland -- only Iceland, sorry, spends more
17 than Canada as an age-adjusted share of GDP. We tie with
18 Switzerland at second, and the average OECD country spends
19 18 percent less than we do on health care.

20 The affordability of Canada's health care
21 insurance program is also in question. Government health
22 spending is, and has been for many years, growing faster
23 than our ability to pay for it, whether we measure that as
24 the growth of government revenues or in the economy as a
25 whole.

1 In addition, Canada has a substantial future in
2 unfunded liability or program obligations for Medicare,
3 which is the calculation comparing future revenue streams to
4 future expenditures. The unfunded liability for Medicare
5 added up to \$364 billion in 2004, which tells us that we are
6 either going to have to see large increases in taxation or a
7 reduction in services for Canadians. To put that \$364
8 billion in perspective, we spent \$89.5 billion on health
9 care in 2004.

10 In spite of these very high and unaffordable
11 expenditures, Canadians endure service that ranges from
12 mediocre to terrible. Physicians are in very short supply.
13 In 2007, in fact, slightly less than 1.7 million Canadians,
14 about 6 percent of the population, reported being unable to
15 find a regular family physician. Statistics also show that
16 Canada had many fewer physicians per capita in 2005 than
17 most other developed nations that maintain universal
18 approaches to health care insurance.

19 Canadians also, as the video points out, endure
20 very poor access to modern medical technologies. MRI
21 machines and CT scanners, considered now probably a basic
22 tool of medicine, are in short supply in Canada. Our
23 inventory stands at about 60 percent of the average of
24 universal access health insurance nations, and the services
25 provided by these machines are often subject to remarkably

1 long wait times.

2 The situation with respect to advanced
3 technologies that increase patient comfort and decrease
4 invasiveness, and perhaps provide small increases in, let's
5 say, survival, such as lithotriptors and the application of
6 interventional radiology, is even more dire for Canada ranks
7 near the bottom of developed nations. Canada is also very
8 slow to invest in medical technology, and many pieces of the
9 medical and diagnostic equipment that we do have in Canada
10 are outdated and in need of replacement.

11 One of the defining characteristics of Canadian
12 Medicare, and indeed Canada's shame, is waiting lists.
13 Canadians often wait months or even years for their
14 medically necessary care. In 2008, the median wait time for
15 orthopedic surgery, from mandatory general practitioner
16 referral to treatment by a specialist was nearly 37 weeks.
17 It was nearly 32 weeks for neurosurgery. And while the wait
18 times for cancer treatment were shorter at 4.6 to 5.8 weeks,
19 they were hardly what you might consider prompt.

20 Delays in the delivery of health care in Canada
21 also rank among the longest in the developed world. For
22 example, a recent study published in Health Affairs found
23 that Canadians, as compared to patients in Australia, New
24 Zealand, Germany, the Netherlands, the U.K. and the U.S.
25 were most likely to wait more than one month for elective

1 surgery, most likely to wait six days or longer to see a
2 doctor when ill, and most likely to wait two hours or more
3 for access to the emergency room. These lengthy waits not
4 only caused serious psychological and personal harm, but can
5 affect patient outcomes and indeed survival.

6 Canada's health care system is also a study in
7 decline. Once the home of one of the developed world's
8 highest physician-to-population ratios, Canada now ranks
9 23rd of 28 developed nations who maintain universal
10 approaches to health care insurance. And that decline is
11 firmly set to continue. Largely due to government
12 restrictions on physician training, Canada's
13 physician-to-population ratio is poised to decline in coming
14 years without a significant intake of foreign-trained
15 doctors. Similarly, wait times for health care in Canada
16 have grown markedly since the early 1990s. They now stand
17 at 86 percent longer than they were 15 years ago.

18 While the picture on the outcome side is a little
19 better than the picture on the access side, that picture is
20 by no means rosy for Canada. Canada's infant and perinatal
21 mortality rates, in fact, rank very poorly compared with
22 other nations. Equally troubling is the fact that these
23 rates have, in fact, been on the rise since 2000 or between
24 2000 and 2005, while they fell markedly in the average OECD
25 country.

1 Looking at several measures of mortality that more
2 closely measure the performance of the health care system,
3 itself, Canada's performance does rank among the top 10 OECD
4 countries. However, it remains behind a number of nations,
5 including Australia, Japan, Sweden, Iceland, Switzerland,
6 and France. I would also point out that Canada's
7 performance with respect to cancer specifically has been
8 found to lag that of the United States.

9 It is clear from the evidence that Canadians
10 endure poor access to health care services in spite of
11 world-class levels of health care expenditures. While the
12 specific reasons for this are manifold, all can be
13 categorized as an excess of government management and
14 intervention and a lack of private competition and
15 appropriate financial incentives for patients and providers.

16 Equally troubling is the fact that the solution to
17 these problems has proven elusive within the Canadian
18 framework. Governments across Canada have tried to attack
19 the waiting-time problem by announcing wait-time benchmarks
20 and selective wait-time guarantees along with large
21 increases in funding. Neither the benchmarks nor the
22 guarantees are what you might call ambitious at 4 to 8 weeks
23 for radiation therapy, to as long as 26 weeks for hip and
24 knee replacement, or lower urgency cardiac bypass surgery.

25 Similarly, administrative reshuffles including

1 implementing and then restructuring or eliminating
2 regionalization; governmental reviews, councils and panels,
3 and targeted funding initiatives have all proven just as
4 ineffective at resolved in Canadians' woes.

5 For some individuals, the status quo has become so
6 dire that they have turned to the courts for recourse.

7 Several cases currently before provincial courts provide
8 studies in what Americans could expect were they to adopt
9 the Canadian-style government-run health insurance system.

10 In Ontario, Lindsay McCreith was suffering from
11 headaches and seizures, yet faced a four-and-a-half-month
12 wait for an MRI scan in January of 2006. Deciding the wait
13 was untenable, Mr. McCreith did what a lot of Canadians do,
14 he crossed the border, and paid out of pocket for an MRI
15 scan in Buffalo. The MRI revealed a malignant brain tumor.

16 Upon returning to Ontario, he found the
17 government's system still refused to provide timely
18 treatment offering instead a months-long wait for surgery.
19 In the end, Mr. McCreith returned to Buffalo and paid for
20 surgery that may have saved his life. He's currently --
21 he's currently challenging Ontario's government-run monopoly
22 health insurance system claiming that it violates the right
23 to life and security of the person guaranteed by the
24 Canadian Charter of Rights and Freedoms.

25 Shona Holmes, another Ontario court challenger,

1 endured a similar harrowing struggle. In March of 2005, she
2 began losing her vision and experienced headaches, anxiety
3 attacks, extreme fatigue, and weight gain. Despite an MRI
4 scan showing a brain tumor, Ms. Holmes was told she would
5 have to wait months to see a specialist.

6 In June, with her vision deteriorating rapidly,
7 she went to the Mayo Clinic in Arizona, where she found out
8 that an immediate surgery was required to prevent permanent
9 vision loss and potentially death. Again, the government
10 system in Ontario required more appointments and more tests
11 along with more wait times. She returned to the Mayo Clinic
12 and paid for her own surgery.

13 On the other side of the country in Alberta, in my
14 home city of Calgary, Bill Murray waited in pain for more
15 than a year to see a specialist for his arthritic hip. The
16 specialist recommended a Birmingham hip resurfacing surgery,
17 a state-of-the-art procedure that gives better results than
18 basic hip replacement and would have allowed him to continue
19 with his active lifestyle.

20 The government bureaucrats, unfortunately,
21 determined that Mr. Murray, at 57, was slightly too old to
22 enjoy the benefits of this procedure, and thus said no. In
23 the end, he was also denied the opportunity to pay for the
24 procedure himself in Alberta. He's heading to court
25 claiming a violation of his Charter Rights as well.

1 These two legal challenges, the Ontario ones, are
2 joined, along with one challenge launched in British
3 Columbia in January by a number of private operators who
4 share a common goal: To win Canadians the freedom to spend
5 their own money to protect themselves from the all too
6 likely, and perhaps inevitable, failure of the government
7 health care system to provide care in a timely fashion.

8 They all find their footing in the landmark
9 Supreme Court ruling on Quebec health care insurance in
10 2005. In that case the Supreme Court of Canada, itself,
11 found that Canadians suffer physically and psychologically
12 while waiting for treatment in the public health care
13 system. And that the government monopoly on essential
14 health services imposes a risk of death and irreparable harm
15 to health.

16 The Supreme Court ruled, in fact, that Quebec's
17 prohibition on private health insurance violates Section 1
18 of the Quebec Charter which states that "every human being
19 has a right to life, and to personal security, inviolability
20 and freedom." That conclusion was based on the performance
21 of Quebec's government-run health insurance scheme.

22 The realities of what Canadians endure on a daily
23 basis are far from the paradise many believe to exist. To
24 the contrary, Canada's health care system is one of low
25 expectations cloaked in lofty rhetoric. It is a system that

1 fails Canadians on a regular basis. It is a system that
2 comes at the cost of pain and suffering for patients who
3 find themselves on long waiting lists with nowhere to go.

4 Americans would be well advised to look elsewhere
5 for their solutions.

6 MR. SAYLOR: Thank you. I wanted to note, one,
7 that you have a BA in Honors in Economics from the
8 University of Calgary, and also you have an MA in Economics
9 from the University of British Columbia. And you're quite
10 recognized throughout the continent for your articles and
11 your appearance on TV shows and talk shows. Thank you for
12 your testimony.

13 I'm 54 years old this year, and I -- it scared me
14 a little bit; I'm glad I'm not living in Canada.

15 Any questions at this time? Michelle --
16 Representative Brooks.

17 MS. BROOKS: I think everyone in this -- at this
18 table and in the general assembly, and -- we want our
19 residents to have affordable, accessible and quality health
20 care, and this does pose a problem.

21 And I thank you for your testimony because I'm a
22 firm believer that we need to have an objective and
23 comprehensive conversation in regard to what direction and
24 how we achieve more health care for our residents, while not
25 eliminating our quality of health care.

1 I have a couple of questions. One, in the
2 examples that you used in your testimony, are they an
3 average example of what happens in Canada, or are they
4 exceptions to the rule of what happens in Canada? Because,
5 again, I think we need an objective look at, is this the
6 norm or are these just cases that, you know, were pulled out
7 to show how terrible Canada's system is?

8 MR. ESMAIL: They are not necessarily exceptions.
9 The reason I'm bringing them up is these are the court cases
10 that are before the courts. These are individuals who have
11 actually gone to the length that they will take the
12 government to court and launch their constitutional
13 challenge in the hopes of seeing their Charter Rights
14 protected in terms of their right to life and security of a
15 person, or their right to life specifically.

16 They are not exceptions, though, in the sense that
17 Canadians do wait an awful long time for health care.
18 Stories of this nature are not at all uncommon in Canada.
19 It is true that in any health care system you can find an
20 anecdote, you can find someone who's had a disastrous
21 experience, who's been let down. The important question is:
22 What is the quantity of those disastrous experiences, and
23 what is the frequency with which we see these things occur?

24 It is remarkable in Canada to see how often we
25 find people in the newspaper and television -- or on the

1 television, rather, who have had these sort of experiences,
2 where the anecdotes reach the wait and regularity that they
3 do in Canada, you know you have a very real problem.

4 I also went into great lengths earlier in my
5 testimony to go through all of the data and information.
6 Remember, those are median wait times. So the median wait
7 time of 5.8 weeks for medical oncology or chemotherapy,
8 means 57 percent of Canadians actually wait longer than six
9 weeks. And, again, wait times of several months are not
10 unheard of and are not uncommon in Canada in the way you
11 might hope they would be.

12 So while these cases are really quite frightening,
13 they are the ones that have been mentioned in the media,
14 which is why I bring them up here; but it would not be hard
15 to go out into Canada and find other similarly harrowing
16 stories.

17 MS. BROOKS: I've had many conversations today. I
18 think that we need to look at this, as I say,
19 comprehensively. And we need to talk with the people that
20 have this system in place that the direction seems to be
21 going, and learn from their examples and, you know, compare
22 what we have in this country and what they have.

23 And I've talked to doctors from Canada --
24 emergency room doctors and also just residents from Canada,
25 to ask them what their experience in the health care system

1 is, and they share some of your concerns. The one emergency
2 room doctor that I spoke with said that you can wait in an
3 emergency room for eight/nine hours.

4 The question I had is he had talked about that
5 there is a 10-hour -- that is the longest you can wait; so
6 there's actually patients in ambulances outside of the
7 emergency room so that they don't go over that wait in the
8 emergency room. Is that accurate, or are you aware of that?

9 MR. ESMAIL: It depends on the Province. In
10 British Columbia, the government has set a target of
11 80 percent of patients have to be seen in the emergency room
12 within 10 hours. Now, often this means playing a little
13 game that you won't let patients in the door or you'll
14 classify "being seen" differently.

15 In the United Kingdom they had a similar target,
16 and essentially the hospitals did have to rename the
17 hospital -- rename chairs in the waiting room to be hospital
18 beds. And, therefore, as soon as you sat down, well, you
19 were in a bed, so you were under the target. These are the
20 games you end up playing in a bureaucratic system.

21 The reality in Canada is that the patient is not
22 the focus. The system is the focus, and the quote, unquote,
23 universality of the system is the focus. Patients were
24 being failed on a regular basis throughout the system. And
25 it's not just in the anecdotes and the examples you find,

1 it's in the hard data that you actually discover that the
2 Canadian health care system is quite poor.

3 I very much agree that we need to get away from
4 rhetoric, need to get away from the politics, both in Canada
5 and the United States. And we need to get away from the
6 anecdotal stories and the examples to talk about the hard
7 facts. And the hard facts are very clearly, Canada is
8 failing when it comes to medical technology; it's failing
9 when it comes to access to physicians; it's failing when it
10 comes to access to health care in terms of waiting lists.

11 It's getting worse in terms of outcomes in many,
12 many areas. Although I think we can credit our excellent
13 physicians, our very well-trained physicians, and the great
14 people in the health care system, with having avoided some
15 of the obvious negative consequences on the outcome side
16 that we might expect given this very poor access profile.

17 I often tell Canadians that the best way to
18 characterize the Canadian health care system, when you look
19 at the facts, is that it's a system that does a pretty
20 decent job of dragging people back from the brink of death,
21 but it treats them terribly in an inhumane process of doing
22 so.

23 MS. BROOKS: I've always been an advocate for our
24 residents to insure -- you know, we want our residents to
25 have quality, accessible and affordable health care.

1 And I have one other question for you: My
2 grandmother just passed away about a year ago at the age of
3 101. But in her 90s, she decided to climb up on a
4 stepladder and get something out of the cupboard and she
5 damaged her hip. So in her 90s, within just a day or two,
6 she had hip surgery. What would have happened to my
7 grandmother in Canada, and how would she have been treated?

8 MR. ESMAIL: The basic hip surgery would probably
9 still have been available to her. The issue with Mr. Murray
10 was that Birmingham hip resurfacings, which are a little
11 more advanced, were at the time limited to, I believe, it
12 was 55 and under. So he was just two years too old.

13 She would have been able to get the hip
14 replacement, most likely. Now, the issue, of course, is
15 that hip replacements are limited and access to them is
16 limited, so physicians will individually have to ration that
17 care. The administrative rules are not easy to track down,
18 and they're not very common across Canada; it's really left
19 to the physician's office.

20 She probably could have expected a wait of 40
21 weeks or longer. The median wait time in Canada for a hip
22 replacement is about 40-some weeks in 2008. Being elderly,
23 not having to go back to work, she most likely would have
24 waited longer than 40 weeks. It could have been well over a
25 year.

1 There are instances of individuals, because of
2 waiting so long, they have damage to their livers because of
3 the painkillers they have to take to get over the pain of
4 the hip replacement. So there may have been some risk of
5 damage to the liver from the painkillers or some risk of
6 addiction from the painkillers. But at the end of the 45-
7 or 50- or 52- or 70-week wait time, she probably would have
8 received that joint replacement.

9 But you can imagine the deterioration that takes
10 place over that time frame. And you can imagine what that
11 would mean for her to be able to get back to a healthy
12 lifestyle, to get back to being active, and enjoying time
13 with you, enjoying time with the rest of her friends and
14 family, and perhaps even surviving up to 101.

15 And this is one of those unmeasured costs of
16 health care that we don't recognize it. When individuals
17 wait very long periods of time, the likelihood that they'll
18 return back and re-engage fully in their lives is reduced
19 quite significantly. And, again, that was recognized by the
20 Supreme Court in their -- in their landmark 2005 decision.

21 MS. BROOKS: And that's the perspective that I
22 think that we need to bring into this conversation, is, you
23 know, my grandmother had that surgery within a day or two.
24 You just said that -- and she was in excruciating pain.

25 Now, residents across this country and across this

1 State, do we really want to change our system in such a way
2 that our grandparents, our parents, are waiting 40 weeks for
3 a hip replacement? And that's very concerning to me,
4 because I wouldn't have wanted my grandmother to go through
5 that. And that's the question, is changing to a system that
6 is less than what we already have, is that fair to our
7 residents?

8 Thank you very much for your testimony.

9 MR. ESMail: Thank you.

10 MR. SAYLOR: Representative Evans.

11 MR. EVANS: Thank you, Chairman Saylor. Thank you,
12 Mr. Esmail, for your testimony today and traveling the great
13 distance to be here.

14 My question centers around the nonsurgical
15 procedures. In this country, we have our federally-funded
16 health care clinics, which I believe do a magnificent job.
17 The Community Health Net is one example in Erie. I have
18 another federally-funded health care clinic in Linesville in
19 Crawford County.

20 The stimulus package in Washington is going to
21 direct some money to Pennsylvania for those clinics. I'm
22 glad to hear that news. About \$8 million, I believe is the
23 figure that will come to Pennsylvania to help our clinics.

24 In Canada, do you have a similar model for the
25 nonsurgical procedures, the routine health care issues?

1 MR. ESMAIL: It varies very much by province. It's
2 very much a federal -- it's very much a provincial system in
3 Canada, that's as a result of the Constitution.
4 Constitutionally, responsibility for health care policy and
5 health care delivery, as well as financing, rests with the
6 provinces.

7 The federal government is very much involved on a
8 financing basis. If they have an agreement with the
9 provinces, as long as the provinces live by the rules of the
10 Canada Health Act and whatever the Federal Health
11 Administrator decides the Canada Health Act says, the
12 provinces will receive funding for their health care.

13 We do have a clinic system in Canada. A lot of
14 the work is done in hospitals. There are clinics, however,
15 that do quite a bit of the nonsurgical work. We have some
16 limited contracting for the private surgical -- for surgical
17 services, rather, on an outpatient basis, as well, in
18 Canada. So there is a very similar structure to that.

19 We have a slightly more general
20 practitioner-focused health care system than some other
21 countries; although, that's quite difficult to deal with
22 when you have many Canadians who can't find a general
23 practitioner or use the sporadic care or the -- I'm sorry,
24 the occasional care provided by walking in the clinic.

25 MR. EVANS: I guess I wanted to also understand how

1 the turn-around time is, how quickly people are treated at
2 those clinics, and if it does help to ease your emergency
3 room traffic. You cited some long waits in the emergency
4 rooms.

5 And our feeling on our task force, that I've been
6 thankfully a member of for the past several years with
7 Representative Saylor's leadership -- and we had a piece of
8 legislation in Pennsylvania last year which would have
9 directed another \$25 million in our State to the clinics,
10 with the goal being to reduce the pressure in the emergency
11 rooms, thus lowering the cost of health care as one
12 component.

13 And I'm wondering, in Canada, if the clinic system
14 is, in any respect, helping to ease that burden on your
15 emergency rooms?

16 MR. ESMAIL: The simple answer is: Not really.
17 The wait times in Canada on the emergency room -- on the
18 emergency side are quite a bit longer than they are in the
19 other countries, and the evidence bears that out; but they
20 are, of course, quite a bit shorter than the elective care.

21 Our clinics very much work on the walk-in elective
22 basis, on the scheduled basis, where the waits aren't quite
23 remarkably long. After-hours care in Canada is pretty much
24 only going to be available in the emergency room. There are
25 a few walk-in clinics, of course, around the country that do

1 have after-hours care available. But if something happens
2 to you anytime after -- anytime outside of business hours,
3 you're most likely going to end up in the emergency room
4 because there's nowhere else to go in the health care
5 system. And a lot of that, again, relates to any number of
6 policy choices and decisions and financing decisions that
7 have been made over time in Canada.

8 MR. EVANS: That concludes my questions, Mr.
9 Chairman.

10 MR. SAYLOR: Representative Hutchinson.

11 MR. HUTCHINSON: Thank you. I also wanted to
12 explore something we hear a lot about.

13 You gave the examples of folks in Canada who get
14 fed up or want the care immediately, they travel to America
15 and get the surgery or whatever procedures they need. But
16 we also hear the other way, about the prescription -- folks
17 from here going there for prescription drugs.

18 I want your perspective on how that fits into your
19 system. Is it easier for Americans to get drugs in Canada
20 than it is for Canadians to get it there? What's the
21 comparison with costs, with availability and those kind of
22 issues on the prescription side?

23 MR. ESMAIL: We have a very interesting breakdown
24 in terms of the public and private sectors in Canada that I
25 think has to be understood when you look at the Canadian

1 system. Physician and hospital services are under the
2 public monopoly scheme, so you cannot have private insurance
3 or even private payment for physician in-hospital services
4 in most provinces in Canada.

5 Now, there are a couple of interesting exceptions
6 to that; but, generally speaking, the Canadian system does
7 not allow private purchase -- private purchase of physician
8 and hospital care. Pharmaceuticals are generally outside of
9 the health care system, unless delivered in the hospital.
10 Which means, as a resident of Canada, as a citizen of
11 Canada, my pharmaceuticals will be purchased under a private
12 insurance policy from a private pharmacy.

13 Now, they are regulated in terms of price for
14 on-patent pharmaceuticals across Canada. We have a national
15 regulator for that. We also have restrictions on what
16 pharmaceuticals will be available in hospitals through the
17 public health care system; and then we do fall behind other
18 countries in that.

19 And I can't pay for those privately. But I would
20 generally be able to walk into a local pharmacy, buy my
21 pharmaceuticals, and then I would ask for reimbursement from
22 my private insurance being provided by my employer; or I
23 would pay out of pocket. Which means that, of course,
24 pharmaceuticals are equally available to me, as they are to
25 an American crossing the border.

1 There has been some interesting work looking at
2 the prices of pharmaceuticals in Canada. Some folks have
3 found, in fact, that if you were to shop around in the
4 States, you could find just as good a deal, if not a better
5 deal here for many, many pharmaceuticals.

6 The other side of the equation is that we pay much
7 more for our off-patent generic drugs, so our generic drugs
8 are actually more expensive in Canada relative to what you
9 would pay here in the United States. And, again, there is
10 some government regulations that create that price gap for
11 us in Canada, and that actually sees our substitution rate a
12 little lower as well. But we tend to use more brand-name
13 pharmaceuticals than generics relative to what Americans do,
14 because the cost difference is just not as large in Canada.

15 MR. HUTCHINSON: Just a quick follow-up. You said
16 there's a regulated price on some drugs. Is there a
17 subsidization from the Canadian government, or does the
18 company eat that? How's that go?

19 MR. ESMAIL: Well, the companies have a number of
20 rules that they have to follow in terms of pricing from the
21 patented-medicine pricing, or the PMPRB, and then they
22 measure the rates of growth of the pharmaceuticals.

23 Now, some of the rules on that price control --
24 and this is more the strength of my colleague, who deals
25 with pharmaceuticals. But some of the controls on the

1 pricing for brand-name patented pharmaceuticals, in fact,
2 have a follow-on effect for the prices that we actually pay
3 for generic pharmaceuticals once the drugs are off patent.

4 So there are a number of policies that actually
5 give us higher generic drug prices in Canada; but, again, it
6 is a Canadian regulation that we have certain regulated
7 prices for patented drugs in Canada. And, again, within the
8 hospitals, that would all be funded by the provincial
9 governments through the public health care program.

10 Outside of hospitals, unless you're a low-income
11 individual or under a number of public schemes that do exist
12 for segments of the population, it's really coming out of
13 your pocket or from your own private insurance, either
14 purchased privately or purchased by your employer as part of
15 your benefits package.

16 MR. HUTCHINSON: Thank you very much.

17 MR. SAYLOR: Representative Roae.

18 MR. ROAE: Thank you, Mr. Chairman. And thank you
19 for your testimony.

20 My question was partially answered when you were
21 addressing Representative Hutchinson, but I do want to get a
22 little bit more information. My question was going to be
23 is -- are there physicians that practice outside of the
24 government system? And I think you said, no, that
25 everything has to go through the government system.

1 What would happen if a physician wanted to be off
2 on their own, not participate in the government plan, and
3 just collect money from private individuals? Is it just not
4 customary, or is it actually illegal?

5 MR. ESMAIL: It depends on the province you're
6 looking at. For example, in some provinces, the physician
7 is not permitted to opt out. They are either in the public
8 system or they're not a doctor.

9 In other provinces, they're allowed to opt out;
10 but then there are restrictions on what they can price and
11 what they can and can't do. So in some provinces, you can
12 feel free to opt out and do your own thing as a physician,
13 but you can't charge a rate that's any different than the
14 public scheme, which eliminates the incentive to opt out,
15 because, of course, you get much more traffic under the
16 public system. It's a no-copay system, you can generally
17 fill your practice quite comfortably.

18 In some provinces, it's even more open than that;
19 you can opt out, you can charge what you want, you can run
20 privately, the patients are not reimbursable under the
21 public health care system. The market is still fairly small
22 in Canada, so we don't see a lot of that. The markets,
23 however, have grown quite a bit in the provinces of Quebec
24 and British Columbia.

25 In British Columbia, you see a number of private

1 surgical clinics, and they are able to provide private
2 surgery -- privately funded surgery to individuals, but by
3 flowing through a number of loopholes in the health care
4 system.

5 One of the loopholes is affectionately called
6 the -- affectionately called the Uncle George Rule. I can't
7 buy my own surgery, but any third party can. So what I
8 would do is -- for example, I would write you a check for
9 the cost of my surgery; you would write an equivalent check
10 to the private surgical center; and I get my private surgery
11 having never actually paid for it.

12 The other rule in play is the Medically Necessary
13 Game. The public health care system monopolizes medically
14 necessary health care. So the clinic will, then, ask you,
15 how long is your wait time in the public system; you'll
16 respond oh, 30 or 40 weeks. Clearly, that's medically
17 necessary, 30 or 40 weeks. So to do it in three weeks would
18 be medically unnecessary. And the government has sort of
19 allowed them to follow that loophole in British Columbia,
20 not in neighboring Alberta where we've actually locked down
21 on that rule. So there are a few games that are played in
22 British Columbia that allow individuals to buy their
23 surgery.

24 In Quebec, it's a little more open than that. I
25 can actually just walk into a clinic and buy my health care

1 and the government turns a blind-eye to it. The physicians
2 can be opted out, they can charge privately whatever the
3 market will bear in terms of their fees, and they have much
4 more flexibility.

5 The other issue, of course -- or the other
6 regulatory loophole is that as an Albertian, I cannot
7 purchase health care privately in the province of Alberta,
8 but I can purchase it privately in any other province in
9 Canada. Because the regulations are provincial, they apply
10 only to residents of that province and doctors of that
11 province, with the notable exception of the province of
12 Alberta, which actually has a regulation that requires
13 physicians not treat any Canadian privately.

14 So as a resident of Alberta, I can go to British
15 Columbia or to Quebec or Ontario and buy my health care
16 privately. Or I can cross the border to the United States
17 or go to Southeast Asia or the Caribbean for medical
18 tourism.

19 MR. ROAE: In the situations where physicians
20 cannot treat somebody privately, you know, regardless of
21 which province it's in, what would happen if a physician
22 would be caught doing that? I mean, would they just be
23 reprimanded, or would they go to jail, or would they lose
24 their license? What would happen?

25 MR. ESMAIL: It depends on the province. Again,

1 they probably would not lose their license; generally it's a
2 fine. In the province of Alberta, which I'm a bit more
3 familiar with, it's about \$10,000 for the first offense, and
4 \$20,000 for following offenses for having anyone treated
5 more quickly than they would have been in the public health
6 care system for money -- or done privately. Those penalties
7 were actually proposed in the province of British Columbia,
8 but were ultimately never ascended into law. So it is a
9 sizeable penalty that they will bear financially, which
10 gives them a very clear incentive to not do it.

11 For the private surgical clinics, I'm not -- I'm
12 not -- I'm not absolutely sure what the dollar penalties
13 are, but they can also run the risk of falling out with the
14 Health Minister and losing their private funding, or losing
15 their ability -- or their public funding, rather, or losing
16 their ability to operate. So it's very much an economic
17 disincentive for practitioners to not allow privately funded
18 health care to occur in those instances where it's regulated
19 by the provincial government.

20 MR. ROAE: Well, I'm glad you made us aware of that
21 aspect of your system up there. You know, if we move to a
22 system like that in the United States, I think people need
23 to realize that it may be against the law to pay for medical
24 treatment that the government's not going to do. If you
25 want to get something done better or done quicker, it would

1 be a violation of the law.

2 I don't think people in our country realize that
3 when everyone is talking about a government-run health care
4 system. Thank you, sir.

5 MR. ESMAIL: Well, thank you. And I think it is --
6 it is a very important thing to recognize in both Canada --
7 if you have two individuals in a family, an income earner
8 and a non-income earner, and they're both suffering from the
9 same ailment with the same wait time, the income earner
10 cannot pay for surgery privately in Canada. To get back to
11 work and supporting the family, they have to wait just as
12 long as a non-income earner. There is no option, other than
13 going to another province.

14 If you're in B.C. or Quebec, you have some options
15 available to you, though they're still quite limited, or
16 simply getting on a plane and going to the United States or
17 another country.

18 MR. SAYLOR: Representative Brooks has one more
19 question.

20 MS. BROOKS: Just to follow up on Representative
21 Hutchinson's questioning, you talked about private
22 prescription plans.

23 Can you talk a little bit about the cost of those.
24 And then, also, can you touch upon how the Canadian
25 government funds this health care system.

1 MR. ESMAIL: In terms of cost, I really can't speak
2 specifically to it. For most individuals who are employed,
3 it will be a part of your benefit package. And then that
4 means it's part of your total income and compensation, of
5 course. There are some subsidies in place or public plans
6 in place for individuals in a state of low income.

7 There is an insured population in terms of
8 pharmaceuticals across Canada, and it is also for dental
9 care.

10 MS. BROOKS: Can I stop you there.

11 MR. ESMAIL: Sure.

12 MS. BROOKS: What do you mean about there's an
13 uninsured population in Canada that don't have prescription?
14 That's the first I've heard.

15 MR. ESMAIL: There is a certain percentage of the
16 population that's small, and it's in the single digits; but
17 this percent of the population cannot afford or cannot get
18 access to the private drug plans and the private dental
19 plan. And so they don't actually have insurance coverage
20 for outpatient pharmaceuticals or pharmaceuticals outside
21 the hospital or dental care outside of the hospital. And,
22 of course, most dental is not provided in the hospital,
23 unless it is trauma or something quite serious.

24 So this -- this population will either be paying
25 out of pocket or seeking other options in terms of getting

1 their pharmaceuticals, or getting their prescriptions
2 filled, or getting into the dentist's office. Or they will
3 simply endure without, and perhaps make use of the health
4 care system more heavily.

5 Once they're in the hospital, their
6 pharmaceuticals are funded through the public system. So
7 they don't have to be concerned about in-hospital
8 expenditures; it's out of hospital that you have to be
9 concerned about. And it is an interesting breakdown in
10 Canada that the government will pay for the doctor who
11 writes the prescription, but they won't pay for the
12 prescription that's actually going to make you better at the
13 end of the day.

14 That comes out of your pocket or through your
15 private insurance. Unless, again, you're one of those
16 specific groups in a state of low income, or elderly, or in
17 some cases, who have access to a public drug plan.

18 In terms of financing the Canadian health care
19 system, it's general tax finance. Some provinces have a
20 poll tax in place, which is what they call a health care
21 premium. It's simply a head tax; it goes into general
22 revenues. Health care expenditures come out of general
23 revenues in all provinces. And the transfers from the
24 federal government are also funded through general revenues,
25 so it's a tax-filing system.

1 This, of course, means that individuals at a lower
2 rate of -- at a lower level of income will be paying less
3 for health care insurance; individuals at a higher level of
4 income will be paying much, much more. And we've done some
5 work on that and it shows that the premium for the lowest 10
6 percent of income earners in Canada is in the
7 hundreds-of-dollars range.

8 Effectively, when you work out what they're paying
9 in taxes and the percent that goes to health care, it's in
10 the tens-of-thousands-of-dollar range for those individuals
11 at the highest end of the income ladder.

12 MS. BROOKS: Thank you very much.

13 MR. SAYLOR: Thank you. Mr. Esmail, one thing I
14 did want you to clarify and correct, in case I'm wrong, is
15 since this is being broadcast and Americans don't know what
16 a charter is, when you refer to charter, am I correct,
17 you're referring to, basically, what we would call our
18 Constitution?

19 MR. ESMAIL: That's correct. I'm referring to the
20 Canadian Charter of Rights and Freedoms, which -- which
21 protects an individual's right to life under one of the
22 Charter, Section 7.

23 MR. SAYLOR: Very good. I thought people might
24 have some questions as they watch this as to what a charter
25 is; so it's really a constitution.

1 Okay. Thank you very much for coming and coming
2 all the way from Canada. We really do appreciate it. You
3 gave a great -- information to our committee. And we'll be
4 looking forward to utilizing that as we move forward.

5 MR. ESMAIL: Thank you for having me here, and it
6 was a great pleasure and honor.

7 MR. SAYLOR: Next on our testimony, we are going to
8 have a video conference with Mr. Richard Baker, who is the
9 founder of Timely Medical Alternatives/North America
10 Surgery, Inc. of Canada. And to introduce him, also, I
11 wanted to add that he is a -- he graduated with honors from
12 the Faculty of Commerce at the University of British
13 Columbia. And he's worked for such well-known companies as
14 Proctor & Gamble of Toronto, Merrill Lynch, Baker Lovick,
15 B.B.D.O, so on and so forth.

16 I also want to note that he's been on ABC, 20/20
17 moderated by John Stossell; as well as been interviewed
18 recently by Dan Rather on the national cable network
19 program, The Dan Rather Report.

20 Baker's company has been featured in the Wall
21 Street Journal, the LA Times, Smart Money Magazine, clipping
22 from Personal Finance, and U.S. News Report, and on and on.
23 I did want to make a note of a quote of Mr. Baker's, quoted
24 of saying, "The Canadian Health Act, which outlaws private
25 surgery in Canada, has caused more pain, suffering, and

1 death than any piece of domestic legislation in the history
2 of their country."

3 Mr. Baker -- would you please turn on your Mic.,
4 Mr. Baker. Okay. Go ahead, Mr. Baker.

5 MR. BAKER: Can you hear me clearly now?

6 MR. SAYLOR: Yes, we can.

7 MR. BAKER: I am pleased to be invited to talk with
8 you folks. I can -- I cannot begin to give you the data
9 that Nadeem Esmail, the numbers, the statistics, but I can
10 give you personal information about my clients who have left
11 the country and come to your country for urgently needed
12 surgery; in some cases, life-saving surgery.

13 And indeed, we have helped six people -- we've
14 been part of saving their lives by sending them out of their
15 own home country and sending them to the U.S. for
16 life-saving surgery.

17 Now, I'll wait for your questions. You ask the
18 questions, and I'll do my very best to answer them for you.

19 MR. SAYLOR: Representative Brooks has a question,
20 Mr. Baker.

21 MS. BROOKS: We're trying to get a balanced
22 snapshot or picture of the norm of health care in Canada,
23 not just the terrible stories or the good stories, but just
24 what is the average snapshot of health care in Canada.

25 So could you kind of provide us with some of your

1 expertise and what you've witnessed on an average of what
2 health care in Canada is like and what our residents could
3 expect here in the United States if we would convert to that
4 system.

5 MR. BAKER: Well, I think some of the testimony of
6 Nadeem Esmail was valid. There are people who get very
7 timely care, very good care in Canada. There are people who
8 die on waiting lists in Canada.

9 What does the average person expect? They would
10 expect anywhere from three months to a year and a half,
11 depending on where you live, for a hip or a knee
12 replacement; that's an average person. Now, if you live
13 outside of major cities, you're not going to get care
14 anywhere near as quick a fashion.

15 Is my sound coming out there?

16 MR. SAYLOR: We can hear you very well, Mr. Baker.

17 MR. BAKER: Can you hear me, I'm sorry?

18 MR. SAYLOR: Mr. Baker, we can hear you very well.
19 Continue. We can hear you, Mr. Baker.

20 MR. BAKER: So if you are under 80, if you live in
21 a major metropolitan area, you will get better care. If you
22 live in a rural area, if you're elderly, if your health is
23 compromised in any other way, you will wait an enormous time
24 for routine procedures like hip and knee replacement.

25 Let's take a province like Prince Edward Island.

1 If you get cancer in Prince Edward Island, there's only one
2 cancer drug that your oncologist can prescribe for you.
3 There are 25 generally recognized avocations -- cancer
4 drugs; prince Edward Island only makes one available to its
5 doctors. Happily, in British Columbia, where I live, you
6 can get 23 out of the 25. The other two are thought to be
7 too expensive to be handled by the province.

8 So if you live in Prince Edward Island, if you
9 happen to have the kind of cancer that responds to that
10 single drug that is covered, well that's great. But what if
11 it's any of the other 24 drugs? You are simply out of luck.
12 And the reason is they cannot afford, within the tax base to
13 provide 24 out of 25 drugs.

14 MR. SAYLOR: Representative Evans has a question,
15 Mr. Baker.

16 MR. EVANS: Mr. Baker, I wanted to ask you a
17 question about physician choice. Is there any room in
18 Canada if you're -- if you're going to undergo a surgery
19 such as a knee replacement, obviously, you want to be
20 informed as a patient as to who's going to be doing the
21 procedure.

22 If you would not care for the doctor, would not
23 personally choose a doctor being administered to you or
24 being assigned to you, do you have the authority or the
25 ability to move to another physician?

1 MR. BAKER: Theoretically, yes; in practice, here's
2 what's happened: You have waited, let's imagine, eight
3 months for a consultation with an orthopedic surgeon. You
4 have your consultation, and it does not go well and you're
5 not satisfied. You can proceed with the surgery, which
6 might be in another three months, or go back to the end of
7 the line and wait another eight months for a consultation
8 with another surgeon.

9 Now, not very many people feel that strongly that
10 they would abandon Doctor No. 1 and go to the bottom of the
11 list.

12 MR. EVANS: Thank you.

13 MR. SAYLOR: Dr. Baker, before we have a couple
14 more questions, the one I have for you is could give
15 the committee -- this is Representative Saylor. Could you
16 give us an example of just one of your patients who you've
17 helped out with trying to get surgery here in this country.

18 MR. BAKER: Absolutely. I can give you any number
19 of anecdotes.

20 Here's one that has stuck with me: In January of
21 2004, we were contacted by a man who said, my daughter went
22 deaf this month and she -- she went deaf in January; he
23 called us in July and said she had routine infections in her
24 ears. And she had drains put in her ears and one had fallen
25 out and she -- her infection had returned, couldn't hear the

1 teacher, so she was scheduled for surgery in July in
2 Children's Hospital.

3 And he said, what are you talking in July, this is
4 January, she can't hear the teacher in school, can she not
5 get in for this routine procedure faster than July. They
6 said, take it or leave it. He said, I'll take it.

7 So we were following his case. He got called in
8 mid July saying, I'm sorry, we've had to bump your daughter
9 until September. He said that's crazy, she'll be in 4th
10 grade in September, she still can't hear a word, and her
11 education is suffering, why can't she get in sooner. They
12 said, take it or leave it.

13 So he finally called us back again in September
14 and said, well, we just got word our daughter has been
15 bumped until next April, which would be 15 months after she
16 initially went deaf. So he asked if we could help; and
17 that's what we do for Canadians.

18 We got her in the next day to an ear, nose, throat
19 specialist in a nearby town in Washington State. The
20 specialist took one look in this little girl's ear, he said
21 this is a major situation, this child needs to see a
22 pediatric otologist. An otologist is somebody who doesn't
23 care about nose or throat; they just care about ears.

24 Well, the next day -- this is two days later -- we
25 got her seen by a specialist in Seattle. And he turned to

1 the father and said, let me get this straight, you've been
2 told to wait until next April for this little girl's
3 surgery. And the doctor -- the father said, yes, that's
4 true. He said, well, it's a lucky thing you didn't wait
5 until next April because if you had, she would be dead. She
6 has a massive cranial infection. He said, I'll do my best
7 to save her hearing, I can't give you any guarantees, right
8 now, my focus is on saving her life.

9 In fact, he saved her life. She lost all of her
10 hearing in one ear and half of the hearing in the other ear
11 for lack of access to meat-and-potato surgery; drains in the
12 ears, adenoid removals, tonsillectomy. That's the simplest
13 of all surgery, yet she was waiting -- can you hear me okay
14 now?

15 MR. SAYLOR: Yes, we can.

16 MR. BAKER: Okay. So the father came home, and a
17 couple of weeks later he called me and said, Mr. Baker, my
18 wife and I are in full accord, your star shines the
19 brightest in our heaven. And I went home that night dancing
20 on air; I helped save this little girl's life, and what a
21 great feeling that was.

22 I could tell you stories like this all day long.
23 I'll tell you one more that really, really illustrates the
24 situation here. Got a call from a woman whose myenteric
25 artery -- and that's the artery that goes from the heart

1 down to the bowel that helps a person digest their food.
2 Hers was 90 percent blocked and she'd lost 35 pounds because
3 she couldn't digest her food, she was vomiting on a regular
4 basis.

5 She had been to see a vascular surgeon about
6 having a bypass of this artery, and she had been booked for
7 a surgery. She got to the hospital, she was prepped. She
8 was lying on the operating room bed when suddenly they said,
9 sorry, we're going to have to bump you, you can't get your
10 surgery, something more urgent has come along.

11 She said, what could be more urgent than a person
12 who can't digest their food and was essentially starving to
13 death. They said, never mind, come back next week. She
14 came back the second week, seven days later; she was, again,
15 bumped.

16 Now, her surgeon, who was a wonderfully
17 compassionate man, said, look, Shirley, I cannot offer you
18 any guarantee you aren't going to be bumped next week or the
19 week after. You have, maybe, a week, maybe, two weeks, if
20 you're lucky, to live. You need to get your surgery
21 immediately. I suggest you contact Richard Baker with our
22 organization, Timely Medical Alternatives, and he will get
23 you your surgery in the U.S.

24 She contacted us the next day. We had her down in
25 Bellingham, Washington. She had an assessment. The next

1 day she had her surgery. They found three blocked arteries,
2 not just the myenteric surgery. The surgeon in Bellingham
3 said, Shirley, you were hanging by a thread. I don't know
4 how much longer you would have lived. But he was able to
5 stent this artery and the blood began to flow through again,
6 she began to gain weight, and unquestionably her life was
7 saved by leaving the country.

8 MR. SAYLOR: Well, it sounds like your company is
9 performing, almost like Mother Theresa, acts of kindness in
10 Canada.

11 At this point I'll ask Mr. Hutchinson for
12 questions, as well.

13 MR. HUTCHINSON: Thank you for your compelling
14 story. But I just have a question back to your earlier
15 illustration about the cancer drugs and the one drug allowed
16 out of 25 different ones.

17 Who actually makes that decision of which -- you
18 know, this is the cancer drug and these 24 are not? You've
19 mentioned that that is an economic decision, but who's
20 making that decision? If you could just elaborate on that
21 that a little bit.

22 MR. BAKER: Maybe Nadeem would have a better answer
23 for this than I, but my assumption is it's made by the
24 Ministry of Health. The Health Minister, he would have
25 guidance from oncologists who would say, here are all the

1 drugs, here is what they cost. Of all of them, you're going
2 to get the best bang for your buck with this one, No. 17 out
3 of 25. If you can only afford one, this would be my advice
4 to fund this one and not the others.

5 MR. SAYLOR: Thank you. Any other questions by the
6 committee? Mr. Baker, I want to thank you very much for
7 your testimony today and the first use of video conferencing
8 here with the Policy Committee. And thank you for your
9 cooperation and all you do for all of us.

10 MR. BAKER: May I make a closing comment?

11 MR. SAYLOR: You sure may.

12 MR. BAKER: I have said repeatedly that if the U.S.
13 adopts the Canadian health care system -- first of all, God
14 help you if you do. But from my own point of view and the
15 point of view of my fellow Canadians, where would people who
16 you are urgently in need of surgery go if they couldn't go
17 to Canada? If you had the same problems we had, where would
18 we send our clients?

19 At the moment we refer to the U.S. health care
20 system as Canada's other health care system. And without
21 access to an efficient well-running system, the Canadians
22 would have no place to go; and that's my concern.

23 MR. SAYLOR: Again, Mr. Baker, thank you very much
24 for your testimony. And Mr. Esmail is going to clarify a
25 couple of things, I believe, as well. If you want to come

1 to the Mic. so we can hear you better for the television
2 system.

3 MR. ESMAIL: Just with respect to the answer on
4 pharmaceuticals, Rich is quite right that the decision will
5 happen at the Ministry of Health. It will ultimately be the
6 Ministry of Health that decides which drugs will be covered.
7 The issue of how they arrive at which drugs are going to be
8 covered is a bit convoluted.

9 It starts at Health Canada, where they issue a
10 notice of compliance, which is, essentially, like an FDA
11 approval for Canada. The drug will then go to review by an
12 all-province committee, which virtually all the problems are
13 subscribed to, who will then do a pharmaco-economic
14 assessment and determine a cost benefit analysis of which
15 drug they think should be listed and which drug shouldn't.

16 And they'll shrink the list of drugs that have
17 been approved by Health Canada to a list of drugs that they
18 think the provinces should approve. The provinces will then
19 take their scientists and economists and physicians and redo
20 the analysis to shrink the list further to the drugs they
21 think they should approve. And from that much reduced list,
22 and province will ultimately make the decision.

23 It's not necessarily physicians who are making the
24 calls on the drugs; there are any number of economists and
25 scientists and others who were involved in doing the

1 cost-benefit analysis. And I think understanding is quite
2 critical as we hear a lot of discussion about having a
3 similar program enacted for the United States in Washington.

4 MR. SAYLOR: Thank you, again. Mr. Baker, I wish
5 you the very best.

6 MR. BAKER: Thank you.

7 MR. SAYLOR: At this point, again, on video
8 conferencing we're being joined by Dr. Devon Herrick --
9 Herrick, if I get his name correctly. He received his Ph.D.
10 in Political Economy and a Master of Public Affairs from the
11 University of Texas at Dallas with a concentration in
12 economic development. Dr. Herring also holds advanced
13 degrees in finance. He is a preeminent expert in the 21st
14 century medicine, including the evolution of Internet-based
15 medicine, consumer driven health care, key changes in global
16 health care and market, and is a health care economist.

17 Mr. Herrick, welcome. Can you hear us?

18 MR. HERRICK: Mr. Chairman and Members of the House
19 Republican Policy Committee and the Health Care Task Force,
20 I welcome the opportunity to share my views and look forward
21 to your questions.

22 Let me -- before I talk about some of the other
23 health care systems in OECD countries, let me first kind of
24 put this into context, give you -- give you some background.

25 There have been numerous proposals to cover the

1 uninsured, both federal and the state level. Prominent
2 plans bear much in common with a recent proposal in
3 Pennsylvania. Many of the prominent proposals and the
4 politicians and pundits have shied away from using words
5 like single-payer, government-run, or socialized health care
6 system because most politicians understand that few citizens
7 would put up with the sacrifices resolved. But, however,
8 there's a very real fear that we could wind up with a
9 government-run health care system by default.

10 All of these proposals generally call for an
11 individual mandate where everyone must have health coverage,
12 at which employers would be responsible for covering a
13 portion; of course, they would pass that onto workers in
14 lieu of wages. All of these proposals would expand
15 eligibility for programs like the state children's health
16 insurance program and Medicaid, as well as providing
17 subsidies to moderate income families.

18 Since three-quarters to about 90 percent of those
19 already targeted for expansion of public coverage already
20 have private coverage. Now, you could have approximately 60
21 of the population -- or excuse me, of the newly covered
22 under these plans, drop private coverage. In other words,
23 most of those proposals would have government inducements
24 for people to drop private coverage to get into public
25 health care programs.

1 The most controversial of the proposals currently
2 debated in Congress is the idea of creating a public plan
3 that would compete with private plans. You might call this,
4 Medicare For All.

5 Now, the big question would be, would this
6 Medicare For All plan, would this compete on a level-playing
7 field or would it rely on taxpayer subsidies and charging
8 below market -- or paying below market Medicare
9 reimbursements to get the advantage and crowd out private
10 coverage? According to a recent report from the Lewin
11 Group, which is a consulting actuary that scores a lot of
12 public proposals, this type of plan would probably pay
13 around 70 percent less than current private plans with pay
14 doctors and hospitals.

15 This competitive advantage over time would likely
16 result in a crowding out of private coverage. In fact,
17 Lewin estimates that 130 million people would probably join
18 this plan because maybe their employer dropped coverage, or
19 because maybe it's priced under the competing plans and you
20 have to pay taxes and so on.

21 If you do the math and look at 130 million people
22 joining a public plan, you add in the Medicaid, the S Chip
23 and the Medicare, you're talking about somewhere around 80
24 percent of the population would be in some type of
25 government-run plan; and that's not even including the

1 military and federal employees in the FEHBP.

2 So if we're talking about 83 percent of the
3 population having a program that is sponsored by government,
4 we could expect many of the problems we've already talked
5 about that I heard, again, Esmail talk about, as well.

6 What do we expect from this? This type of
7 dominance by a public plan would be similar to what we see
8 in many areas of Europe and the OECD. For example, if
9 there's only one big government payer, it has the ability to
10 rise and carry in numerous ways. For example, it was
11 already mentioned, ration by waiting is common, skimping on
12 costly treatments, bottlenecks in terms of diagnostic
13 equipment.

14 As was mentioned early, around 827,000 Canadians
15 are currently waiting to either see a specialist for a
16 consultation or waiting for a treatment that's been
17 prescribed by a specialist. In 2007, the average wait was
18 around 18 weeks across 12 specialities and 10 provinces. I
19 think it dropped a week by 2008.

20 In Britain, around 1.8 million people are waiting
21 to see a specialist or waiting for an inpatient or
22 outpatient treatment. As was mentioned earlier, diagnostic
23 equipment and imagining equipment is also in short supply.

24 The United States has around 34 CT scanners per
25 million Americans; there's about 12 in Canada and eight in

1 Britain. The U.S. has 27 MRI machines per million, compared
2 to around 6 million in Canada and 6 million in Britain --
3 six per million in Britain.

4 About two years ago, I read a report in the
5 Canadian Medical Association Journal that stated there were
6 only something like thing three PET scanners in Canada that
7 were available in the public sector for use by Canadian
8 Medicare. The other scanners were either in the private
9 sector, where they cannot be used for Canadian Medicare, or
10 they were at universities for research. This compares to,
11 probably, more than a thousand of these scanners in the U.S.

12 These are the latest and greatest machines for the
13 diagnosis of cancers and serious conditions like that.

14 And, of course, that and, also, reduced access to
15 some of the most -- the latest costly cancer treatments is a
16 leading cause of why cancer mortality is much higher in the
17 OECD countries and Canada than in the U.S.

18 For example, I have some figures here: U.S. women
19 have a 63 percent chance of living five years after a cancer
20 diagnosis compared to around 57 percent for European women.
21 For men in the U.S., it's around a 66 percent chance of
22 living five years after a cancerous diagnosis, compared to
23 around 47 percent for European men. 90 percent of American
24 women survive breast cancer, compared to 79 percent of
25 European women. But if you look at individual countries for

1 individual cancers, it gets much worse.

2 For example, breast cancer mortality is 52 percent
3 higher in Germany than in the U.S., and it's 80 percent
4 higher in the United Kingdom. About 99 percent of U.S. men
5 survive a diagnosis of prostate cancer compared to only
6 about 78 percent of European men. So, if you look at the
7 United Kingdom, in Britain the prostate cancer mortality is
8 604 percent higher than in the U.K. and the U.S., and 457
9 percent higher in Norway than the U.S. And the mortality
10 rates show colon/rectal cancer among British men and women
11 is about 40 percent higher.

12 And if you look at Canada, again, the U.S. fares
13 better, although, not quite as big a contrast as in the U.K.
14 Breast cancer mortality is around 9 to 10 percent higher in
15 Canada; prostate cancer mortality is around 184 percent
16 higher in Canada. Colon cancer mortality among men is about
17 10 percent higher in Canada than in the U.S.

18 Also, in the U.S., we have better access to a lot
19 of drugs to treat chronic conditions. For example, more
20 than half of Americans who can benefit from taking
21 medications for high cholesterol are currently receiving the
22 drugs. By comparison, if you look at the ratio in Holland,
23 it's around -- it's just over one-third. Only about
24 29 percent of the Swiss and just about a quarter of Germans,
25 and less than a quarter of those in Britain, and maybe 17

1 percent of the Italians receive these drugs.

2 You have to look at preventive care. Around 90
3 percent of American women have had a mammogram. The rate
4 falls to less than three-quarters for Canadian women.
5 Nearly all American women have had a PAP smear; this is only
6 about 90 percent of Canadian women. More than half of
7 American men have had a PSA test for prostate cancer; this
8 falls to only about 16 percent of Canadian men. Nearly
9 one-third of Americans have had a colonoscopy, with only
10 about 5 percent of Canadians.

11 So you wonder -- we've heard various stories today
12 about lack of equipment, treatments that are slow in coming,
13 people waiting in pain. So if this is true, why would
14 people tolerate these conditions? Well, it's something that
15 we sometimes call the politics of medicine. Most people
16 tend to be healthy. In fact, about -- you know, the rule of
17 thumb is that 20 percent of your population consumes about
18 80 percent of your health care resources. This suggests
19 that about 80 percent of the population is in pretty good
20 shape.

21 So if health care spending is dominated by
22 government, then it only makes sense for a shrewd politician
23 to target health care resources to where most people and the
24 most voters are. Well, since most people are healthy, the
25 way they do that is they tend to target resources to those

1 that really just need primarily care at the expense of the
2 20 percent of the population that is very sick and in need
3 of very intense care.

4 I think this is a cruel aspect of government-run
5 health care systems that most people did not really
6 understand.

7 And at this point, I will now take any questions
8 you may have.

9 MR. SAYLOR: The only question I have on this
10 whole -- all the statistics you presented us, from your
11 experience or your knowledge -- and, maybe, I'm going beyond
12 what you can tell us -- is who does have the best system in
13 the world as far as health care concern right now?

14 I mean, it sounds like the United States based
15 upon what you're saying; but is that really true? Are there
16 other systems better than what we have here in the United
17 States? Hold on one second. Would you turn your Mic. back
18 on; we missed the answer.

19 MR. HERRICK: I'm sorry, I didn't realize it had
20 gone off.

21 If you're talking about the U.S. health care
22 system, we do spend a lot of money and we do get a lot of
23 benefit for that money. We have access to very costly
24 treatments. And our longevity mortality of those above 65
25 does bear out that this makes a difference.

1 But if you're looking at how we can better spend
2 money, we do waste a fair amount of money. In fact, on
3 average, can say about 30 percent of health care dollars are
4 wasted under our system.

5 If we're looking at, maybe, a different model of
6 health care, I would be interested in looking at how the
7 Swiss do their health care system. They have personal and
8 portable health care. It is entirely private insurance.
9 Much of it is paid for through people at a worker's job, but
10 they can go from job to job and keep the same insurance.
11 And oftentimes, the contracts are not renewed every year,
12 but, in fact, longer term, maybe every three years.

13 They do spend more than other areas in the OECD,
14 but yet they do spend less than we do and they seem to have
15 a pretty good quality health care system.

16 MR. SAYLOR: Any other questions? Seeing none,
17 Dr. Herrick, I want to thank you, again, for testifying
18 before our health policy committee. And thank you, again,
19 for all the information you provided us.

20 MR. HERRICK: You're welcome.

21 MR. SAYLOR: Next is Steve Fisher, President of the
22 Northwest Association of Health Underwriters. I just want
23 to make note, also, that Mr. Fisher is an agent with -- and
24 I want to get this right -- Byham's --

25 MR. FISHER: Yes.

1 MR. SAYLOR: -- Insurance Services, Inc.,
2 Meadville, here in this region, since 1996.

3 Prior to joining Byham's, he spent 10 years
4 helping and develop and administer two managed care
5 companies and served as vice president of marketing for
6 both. Mr. Fisher is, also, an approved instructor and
7 teaches continuing education classes for the Pennsylvania
8 Insurance Agents. He is serving, of course, his second term
9 as president of the Northwest Association, or Chapter; and
10 he is a recent recipient of the William Wetzel Excellence in
11 Public Speaking Award for the National Association of Health
12 Underwriters.

13 Mr. Fisher.

14 MR. FISHER: Okay. I also want to welcome Ray
15 Doreian with me -- or Doreian, he's going to be speaking
16 after me. He's with Health Underwriters, as well, out of
17 the Philadelphia area. So -- and you'll see a difference in
18 his accent.

19 Mr. Chairman, Honorable Representatives, Ladies
20 and Gentlemen of the audience, I do want to begin by
21 thanking you for holding this hearing in Edinboro; we
22 appreciate that. And we appreciate being invited to take
23 part in something as important as health care.

24 For the record, as you said, my name is Steve
25 Fisher. And I am the president of the Northwest

1 Pennsylvania Chapter of the National Association of Health
2 Underwriters, or NAHU. Our association is made up of
3 insurance producers like myself, who specialize in meeting
4 health insurance needs of individuals and employers.

5 I, personally, have 25 years of experience in this
6 industry. And as you said, 10 years of that was on the
7 administrative side; so I've seen it from both sides. The
8 majority of our clients are in the manufacturing business,
9 but many of them are also in the health care industry and
10 have had a number of conversations with me over the past few
11 years.

12 Our association, meaning NAHU, we do believe that
13 all Pennsylvanians and Americans should have equal access to
14 care. The fact of the matter is, though, that we already
15 do. Everybody has equal access to care. The question comes
16 into more of who pays for that care; will it be the
17 insurance company, will it be the individual, or will it be
18 the government. So -- but we already have care, which is a
19 little bit different from what you've seen on the
20 presentations today.

21 Many of the public have a misconception that if we
22 have a government-run program, single-payer, universal, that
23 it will be free or will be significantly less in cost; and
24 that's not really the case.

25 I've had the privilege to serve on three different

1 national committees that have dealt with health care, and
2 we've studied about a dozen countries around the world to
3 see how they were doing it. Some of this is what you've
4 seen today. The PowerPoint presentation that you have in
5 front of you, is a result of one of those. It's the three
6 myths of the single-payer presentation. And that's shared
7 hundreds of times across the country, so feel free to look
8 at that. It has all the speaker notes and everything else
9 on it.

10 And what we also found out was that the high cost
11 of health care is having the same impact on every country,
12 regardless of who they are and what type of system that they
13 have.

14 What I found most interesting is that the citizens
15 in many of these other countries, in fact, 25 out of 26 that
16 were surveyed, felt that health care reform was a major
17 issue that they had to look at in their countries. What was
18 most interesting is many of them said that they need to have
19 a system more like what we have in the United States where
20 we're saying we need what they have. So, basically, I said
21 what my grandparents told me must be true, and that's that
22 the grass is always greener on the other side.

23 I will admit that our current system does have
24 some problems. But I think that rather than just simply
25 replacing it, we need to look at what we have and seeing how

1 we can work with that and improve it. And as a member of
2 NAHU, I can assure you that NAHU and all of our members,
3 we're excited about health care reform, but we want to be a
4 part of that. And we want to assist you and your staff
5 along the way anyway that we can. Use us as a resource. We
6 have 20,000-plus members across the United States and we're
7 willing to help you out with this.

8 Like Ray is going to talk about and like other
9 agents that are in our industry, I'm in front of employers,
10 employees, and individuals every day discussing their health
11 insurance needs and health care that they've received. Many
12 of these people initially indicated that they would be
13 interested in universal coverage or single-payer based on
14 the satellites that they heard. But once we started talking
15 in detail and they found out more information, they all of a
16 sudden decided that maybe it isn't what people are proposing
17 it to be and that really wasn't of interest to them.

18 If I asked them how much an office visit or a
19 prescription or an emergency visit cost, usually they'll
20 just respond with their copay; well, it cost me \$10 or it
21 cost me \$20 or \$50. They really do not have any clue as to
22 what the real cost of health care is, and that's what the
23 insurance companies end up paying. They really don't have a
24 clue, especially heart surgeries or any of those.

25 How will any of this will change under a

1 single-payer system? Unless we can find a way to control
2 the escalating health care costs, we will not be able to
3 provide affordable health care under any scenario;
4 regardless, again, whether it was private or government.

5 New oral oncology drugs -- and you heard them
6 talking about some of the new drugs. Some of these new
7 drugs have a price tag of \$10,000 to \$40,000 per month.
8 That's almost half a million dollars per year for one
9 individual for one drug. And the question is, how will you
10 pay for that?

11 In some of these foreign countries, they actually
12 allocate drugs based on postal-code lotteries. They'll draw
13 what we call a ZIP code, that's the area that first gets
14 access to that drug. What they found was that Realtors love
15 it, because everybody, all of a sudden, wants to move to
16 that area; so homes become quite pricey. Again, that's
17 something that I don't think would be accepted here in
18 Pennsylvania or any other place in the United States if we
19 went to postal-code lottery for some of these new drugs.

20 My concern is very similar to the experiences that
21 we've heard today in the testimonies. And that is that if
22 we adopt a single-payer, we'll quickly realize the need to
23 ration care to avoid finding additional funding solutions.

24 European countries have already experienced this
25 problem. No country's system is able to keep up with the

1 high cost of health care; and, especially, when you're
2 looking at an aging population. We want the latest
3 technology, the latest drugs, and the medical expertise
4 that's available.

5 In December of 2006, the Heritage Foundation and
6 the Galen Institute invited five European health policy
7 experts to explain to Congressional staffers in Washington,
8 D.C. how the European health care system worked.

9 And here's a few of the comments that they made --
10 you've heard some others today, but Britain's Stephen
11 Pollard warns Americans, "Do not listen to the perennial
12 siren voices with call for a single-payer system in the
13 U.S." Americans would never tolerate the rationing of care
14 routinely experienced by Europeans. "It would be the
15 ultimate irony if... the U.S. were to embrace such a
16 fundamentally flawed model" as a single-payer system, "at
17 the very time when Europeans are discovering competition and
18 choice."

19 Sweden's Johan Hjertqvist -- if I pronounced it
20 right -- says that data shows how poorly European systems
21 respond to consumer needs. And we've heard that today in
22 the testimonies.

23 And then according to Dr. Alphonse Crespo of
24 Switzerland, "Citizens always wind up paying for health
25 care, either through taxes, insurance premiums, or

1 out-of-pocket costs. It is only an illusion to think
2 'government' pays the bills through single-payer systems."
3 And we've heard today, they don't; either they ration the
4 care, you're paying out of your pocket, it's declined.

5 The fact of the matter is that we already have two
6 single-payer systems here in the Unites States; and they're
7 Medicare and Medicaid. Late last year, I had the
8 opportunity to attend a meeting with Congressman English,
9 which he presented slides to us on the Healthy Americans
10 Act. And we were joined on the phone by Senator Bob
11 Bennett, a Republican from Utah, who co-authored this bill
12 with Senator Ron Wyden, a Democrat from Oregon.

13 One of the slides that they showed us -- and I'm
14 going use their terms -- said that Medicare is \$34 trillion
15 in the red and Medicaid is \$30 trillion underwater; that was
16 about September of last year. I was just in D.C. about a
17 month ago, and one of the people that spoke with us said
18 Medicare is now closer to \$44 trillion in the red.

19 I'll close with two questions. First, how can you
20 assure us that a single-payer health plan will not
21 experience the same tax issues and rationing that is being
22 experienced throughout European countries and Canada? And
23 second, what will you do to avoid the massive debt
24 experience by Medicare and Medicaid?

25 And, again, thank you for providing me with this

1 opportunity to testify before you.

2 MR. SAYLOR: Steve, thank you. It's interesting, I
3 think, that I keep telling people that I run into and they
4 talk about the clips, and that's the problem, is I think
5 people hear, well, everybody is going to have insurance.
6 And that sounds all well and good; but when it gets to who's
7 paying for it, how much you're paying for it, and more
8 importantly, what kind of care are you going to get out of
9 it and how long you're going to wait to get that care.

10 I always like to remind people that it's like
11 anything else, that it's always great until you see what's
12 really happening to you. And I think that the one thing as
13 Americans, I think -- I think we're one of the most
14 compassionate people in the world. And I think we're
15 horrified to see what's happening in other countries; and we
16 keep saying to ourselves, well, that won't happen here,
17 we'll put a better system in.

18 And it seems like a lot of countries who have
19 national health care, or universal health care, or
20 single-payer, none of them seem to fix it and none of them
21 have found a better system than what we had. So it's
22 interesting, in -- as health underwriters and as health
23 insurance agents, I think the concern -- or the question I
24 had for you are as -- around the country, here in the United
25 States alone, what exactly have been experiences, any horror

1 stories that you've seen, similar to those that we've heard
2 to today from Canada, or England, or elsewhere?

3 And I know later Mr. Doreian -- do I have that
4 right -- is going to testify and talk a little bit about
5 Australia. Can you -- is there anything similar here in
6 this country, that you're aware of, at least?

7 MR. FISHER: Yeah. Actually, it's just the
8 opposite. One of the things that -- we were just at a
9 Capital conference; that's our annual convention, it's down
10 in D.C. with health underwriters, it was about 800 of us
11 that were there. And one of the things that we were talking
12 about is we don't hear their stories.

13 We hear significantly other ones. And Ray and I
14 were talking about this earlier, that we know of people that
15 have had claims that are \$500,000, \$800,000, \$1 million,
16 where they pay virtually nothing out of pocket. And they're
17 able to go right through the system and they don't think
18 twice about it.

19 You know, they might complain that their insurance
20 premiums went up a little bit. And you say, didn't you have
21 that open-heart surgery and those other things last year;
22 yeah, but the insurance paid it. I mean, I don't understand
23 why my rates are going up, I only spent a few hundred
24 dollars out of pocket. It's not that big of a bill. It is.

25 And the fact of the matter is we hear more

1 positives. And that's the one thing that we were actually
2 asked in Washington D.C. A number of the offices that we
3 met with said start providing us with more information on
4 the positives. So we're actually capturing those stories
5 across the United States of all the positive stories of what
6 our current health insurance system has done for people and
7 how they're able to get right in and get the care and get it
8 taken care of without the long delays.

9 MR. SAYLOR: Okay. Representative Evans.

10 MR. EVANS: Thank you, Stan. Steve, thank you for
11 being here this afternoon.

12 Are you familiar with the legislation that was
13 passed in Massachusetts, in that Commonwealth, and how it's
14 affected their state? Do you have any information for us
15 that we should consider as Pennsylvania is approaching that
16 legislation in that direction by the current administration
17 here?

18 MR. FISHER: It's funny because HealthAmerica just
19 had a broker meeting yesterday for agents up in Erie, and
20 they showed the average cost was highest in Massachusetts
21 right now than it was in the other states. And that's
22 because of the guaranteed issue and the system that they
23 have.

24 When that was first put into place, they
25 drastically underprojected what the costs were going to be

1 and they've had to make adjustments since then. And it
2 is -- it's the most expensive state right now for providing
3 health care.

4 MR. EVANS: So what type of feedback are they
5 getting from employers and individuals there that -- you're
6 saying the premiums are higher there than other places in
7 the --

8 MR. FISHER: The cost of providing the care is
9 higher there. New Jersey is not that far behind. And I use
10 New Jersey because that's probably the closest to what
11 Governor Rendel has been talking about here.

12 New Jersey started their health care reform in
13 1992. They went with a guaranteed-issue program, community
14 rating; portable, so that if somebody loses their job, they
15 can take the coverage with them. And they also went with
16 a 75-percent medical loss ratio, where Governor Rendel was
17 talking about an 85 percent.

18 75 percent says that 75 cents of every dollar paid
19 in premium has to be paid in claims or gets refunded, or
20 credited back, or rates reduced, or something. New Jersey,
21 actually, just raised theirs to 80 percent, and there's talk
22 of raising it higher.

23 What they found was that their rates were getting
24 extremely high in the New Jersey area. I'm going to use the
25 individual market as an example, versus the group, because

1 these are the ones that are published on their website. If
2 you go to the New Jersey Department of Insurance, for
3 somebody to buy individual health care like we could buy
4 around here in our area here, Direct Blue or one of those
5 plans, again, it doesn't matter what age you are, the rates
6 are the same.

7 A family of four, five, six, whatever, but a
8 family buying a plan with a \$2,500 individual deductible,
9 \$5,000 family deductible, with co-insurance of another
10 \$2,000, that family has a risk of \$7,000. Their cheapest
11 premium on an individual group -- or on an individual
12 basis -- now, the cheapest premium is \$34,000 a year, the
13 most expensive is \$148,000; so between \$3,000 and \$12,000 a
14 month in premium. I don't know of any plans in our area
15 that even come close to that, but that's what reform has
16 resulted in.

17 When it started, it was real low. It continued to
18 creep up. And New Jersey said that those rates are
19 justified and they're proved because the claims have
20 justified them needing to be that high. The only people
21 that are buying into it are the ones that are extremely sick
22 and have the money to pay for it. The general public can't.

23 So they're actually making changes in that now.
24 They're looking at going to medical underwriting. They feel
25 that they can probably drop that family rate down to about

1 \$1,200 a month by including medical underwriting, which
2 we're talking about taking away some of those. So I think
3 we have to be very cautious with that, as far as a state.

4 MR. EVANS: Thank you.

5 MR. SAYLOR: Representative Brooks.

6 MS. BROOKS: What do you think some of the cost
7 drivers are on why our health care costs are escalating so
8 quickly? And, also, what are your thoughts or ideas on how
9 to decrease those costs?

10 MR. FISHER: First of all, people have to become
11 more educated on the cost of health care; what all is
12 involved with that.

13 I think back to -- you're familiar with Vantage,
14 you're from this area. I was with Vantage when it first
15 started, it was known as Horizon; we brought in the first
16 PPO. We had \$5 office visits, prescriptions were \$1 for
17 generic, \$2 for brand.

18 The insurance company that was underwriting that
19 found that the office visits quickly didn't go up, but
20 didn't quite double -- well, it went up about 63 percent
21 because it was a \$5 copay. People didn't think twice about
22 going back a second time. There was so little impact on the
23 individuals that we saw utilization continue to climb, and
24 that's still the case today. We've made it too easy for
25 people to access the care. That's one of them.

1 You know, the fact that everybody knows that we
2 have to do something with tort reform, because they say that
3 at least 50 percent of the tests that are done aren't
4 medically necessary. It's defensive medicine. So they're
5 running these additional tests or higher-cost tests; and we
6 have to do something about that. But the consumers have to
7 get more involved.

8 I mean, I think that we're doing some of the right
9 things, moving with deductibles and co-insurance. We're
10 bringing insurance back to what it was when I first started
11 the business, you didn't have copays. And so people are
12 thinking twice about it. HSAs, with the real high
13 deductibles, if people don't have money right now to pay a
14 \$1,250 or a \$2,600 deductible before they go on an office
15 visit or get a prescription, that's not going to help them;
16 but when they still have a copay, it's \$25 or \$50 for a
17 specialist, or ER copay goes up a little bit, I think that's
18 okay. It makes them a little bit more aware of the cost
19 when they're a consumer.

20 But we have to take away the cradle-to-grave
21 coverage that is virtually little out of pocket; make them
22 be held a little more accountable on it. That's happened
23 with employers shifting premiums the way that they have.
24 But what's happened as well is some people say I can't
25 afford my share of the premium and they drop their coverage,

1 and that doesn't help us.

2 MR. SAYLOR: Representative Roae.

3 MR. ROAE: Thank you, Mr. Chairman. Thank you,
4 Steve, for your testimony.

5 In our current system right now, I don't know the
6 exact number, but it's about, what, 80 percent of the
7 citizens have health insurance now, whether it be through
8 work or Medicare or some type of government program; the
9 20 percent that don't have insurance, they still have health
10 care. That's a statistic that you hear people say, that
11 20 percent of the population has no health care.

12 And that's not really true. They don't have health
13 care insurance, but they do have health care. The hospitals
14 are not turning them away -- you know, they are getting
15 care.

16 Now, that being said, rather than tipping over the
17 applecart for the 80 percent of the population that have
18 health insurance, what would be the best thing to do for
19 that 20 percent?

20 MR. FISHER: Well, first of all, that 20 percent is
21 kind of a distorted number because many of those insured
22 they show already have some type of government program
23 available to them that they don't sign up for, for whatever
24 reason, pride or whatever is the reason is they don't sign
25 up.

1 Another large percentage of that population has
2 incomes of over \$50,000 that chooses to self-fund their
3 risk. We hear that everyday when we talk with them. They
4 say instead of paying \$1,000 a month, I'll put it in the
5 bank; they forget to put it in the bank or they use it for
6 something else. A large percentage of it is temporary
7 uninsured. My son graduated in December and he came off the
8 insurance, and we got him a different individual plan while
9 we were waiting to see if he got one through work. So a lot
10 of those are short-term uninsured.

11 They say that only about 20 percent of the
12 uninsured population is uninsured on a long-term basis.
13 And, you know, when you look at that, it represents about
14 9 million people in the United States, which is about 3
15 percent of our overall population. So, again, do we want to
16 disrupt that applecart for the rest of the people to try to
17 do something for those 3 percent.

18 I think, again, it comes down to education and
19 helping these people understand what programs are available
20 out there for them. I can tell you, we do have problems.
21 I've had a lot of people -- and other agents in the room
22 will tell you they've had the same thing, where we've got
23 individuals that want insurance. They'd come in, they'd
24 fill out the health applications, they're willing to pay for
25 it, and they get the client because they have health issues,

1 whether overweight, or whether it's a recent surgery they've
2 had, or something else.

3 So I do think that we need to look at the
4 high-risk pool, something that we can work with insurance
5 companies and have the government work with them and say
6 let's find a way to take care of these people. You know,
7 we'll take part of the risk for you on those; they do need
8 to have coverage. Again, they want it and nobody will take
9 them.

10 MR. ROAE: I come from a background in
11 property/casualty insurance; I worked at Erie Insurance for
12 14 years. And I just couldn't imagine a system where, you
13 know, most people for auto insurance, you know, they buy in
14 the voluntary market and they buy from Erie Insurance or
15 State Farm or Allstate or whoever, and there's a very small
16 percentage of the population that ends up in an assigned
17 risk type of a involuntary program.

18 And it seems like that's something that we can do
19 with the health care, too, rather than taking what's working
20 for the -- you know, most of the people and trying to start
21 over with something different. It's just kind of scary if
22 you think about, you know, trying to do that with any other
23 type of service or product.

24 I hope we don't go down that road, but I do hope
25 that we can find a solution to make insurance more

1 affordable; but that being said, you know, everybody is
2 going to have to pay. You said in your testimony that a lot
3 of people aren't really talking much about the cost of
4 everything. Well, some of the people that are paying
5 nothing now, they don't have insurance now; if there is a
6 government system, they're going to have to pay something.

7 I mean, seemingly, everybody is going to have to
8 pay something, and everybody should pay something, but it
9 should be done a way that people can afford. But it
10 shouldn't be done in a way that takes away all of our
11 choices.

12 MR. FISHER: Well, we heard that from the Dean
13 based on income as to what they're paying for their health
14 care from the hundreds to the tens of the thousands of
15 dollars.

16 I'm not a property casualty agent, but you
17 mentioned auto insurance. We were talking about how many
18 people are uninsured on health; but how many people are
19 uninsured on auto, and they're supposed to be having that.
20 They're supposed to buy that, and they still don't, for
21 whatever reason.

22 MR. ROAE: Right. There's a State law that you
23 have to have auto insurance.

24 MR. FISHER: Right.

25 MR. ROAE: And only 90 percent of the people have

1 it and the other 10 percent don't, even though they're
2 violating the law. So I guess even if there's some kind of
3 a law you had to have health insurance, maybe everybody
4 wouldn't buy that either. I don't know.

5 MR. FISHER: And the way that they lower their auto
6 insurance premiums is they increase their deductibles, they
7 change their coverage on there; it's really no different
8 from this. And we tell people let's look at your auto
9 insurance. If your auto insurance was covering your oil
10 changes and changing your tires and changing your brakes
11 when they're needed, changing everything like health
12 insurance does, auto insurance would be unaffordable because
13 we'd be taking care of all the maintenance on it.

14 That's what we're really doing with health
15 insurance, we're taking care of the maintenance.
16 Unfortunately, a high, high majority of the population
17 doesn't do anything as far as maintenance -- preventive
18 maintenance. We have to educate them more and try and get
19 more involved with preventive care.

20 And I think that that's part of what Ray will talk
21 about, too, is the preventive care will help us avoid some
22 of these larger claims down the road.

23 MR. ROAE: All right. Thank you, Steve.

24 MR. SAYLOR: I did want to make a note that in
25 Pennsylvania back to President Clinton, as well as now the

1 Secretary of State, Senator Clinton, has noted that
2 Pennsylvania is the best state in the nation when it comes
3 to health care. We only have roughly 92 percent of
4 Pennsylvanians insured with health insurance. So it's good
5 to be leading the pack in this country with that. Also, at
6 this point -- Representative Brooks, one more question, yes.

7 MS. BROOKS: Thank you for being here. I wanted to
8 ask you for the residents that don't have health care, what
9 are some of the situations that they would run into if they
10 became ill, that our system that we currently have would not
11 cover or would not pay for?

12 I'm aware that the emergency room has to treat
13 them, the hospitals cannot turn them away. But what are
14 some of the services that would not be provided to them if
15 you did not have health care?

16 MR. FISHER: Generally, I think they can find the
17 service eventually. They may not find it's their first
18 choice, but they will find it. I was just talking with an
19 individual yesterday who did not have insurance and they had
20 a baby and they got a very expensive bill.

21 And he's saying, you know what, this is
22 ridiculous. I was talking to somebody, who told me what was
23 covered by their insurance, how little it paid, because they
24 saw the Explanation of Benefit Form. He said, the hospital
25 charged me the full amount, the doctor charged me the full

1 amount. And what his comment was is I'm going to go back to
2 them, I'm going to say look, I know this is what the
3 insurance paid you, I'm willing to pay you that, will you
4 accept it; because if not, let's set up a payment plan where
5 I'll pay you \$10 a week or something until I'm paid off
6 because I'm not going to pay you the full charge.

7 And there is a huge difference when you're looking
8 at it. Again, there's other factors that go into those
9 reimbursements, and a lot of it's on volume and those other
10 issues as well.

11 They talked about consumers having transparency
12 and being able to see pricing, so that if they don't have
13 insurance, they can go out and find the best price. The
14 best price isn't necessarily the best choice. You know,
15 I've told people, if you look at it -- we have a thing
16 called PHC4, the Health Care Cost Containment Council. It's
17 very confusing when you try to look at it, and understand
18 it, and see the severity indexing and the ratings between
19 hospitals and maybe this patient just had this condition,
20 somebody else had multiple conditions.

21 If you're going on price, are you going to look at
22 what that hospital is charging, or are you going to look at
23 their average outcomes, or are you going to look at
24 re-admission percentages there, because maybe the
25 higher-priced hospital has the best outcomes and maybe

1 that's how they're being reimbursed by the carriers.
2 They're getting paid a little bit higher because they're
3 doing a better job and people aren't going back two or three
4 times.

5 So the people that don't have the insurance, I
6 think they can find the care, I think they can shop for it.
7 Generally, they're going to negotiate a payment plan with
8 them. Saint Vincent just yesterday, I think it was, or the
9 day before, they're increasing now to 350 percent of the
10 federal poverty level. Anything -- anybody that's in that
11 income range or below, they're willing to write-off their
12 bills if they can't pay for them.

13 That's a significant amount of money, 350 percent
14 of federal poverty level.

15 MS. BROOKS: Let's use an example: A person that
16 does not have health care and needs a hip replacement, we
17 heard in Canada that they -- a Canadian could wait 40 weeks
18 or -- to -- for that hip replaceable. In this country, if a
19 person did not have insurance, how would they be treated for
20 that hip replacement?

21 MR. FISHER: They would be going to some surgeon
22 and talking with them and explaining their situation and
23 trying to negotiate how to make a payment plan on that; or
24 seeing if there's any assistance they could get from the
25 State or somebody else to pay for that coverage.

1 But they're not -- I don't think it's going to
2 delay their care that much. They're going to be able to
3 just go and negotiate it. Generally, the surgeons aren't
4 going to do it for free.

5 MS. BROOKS: Right. Well, and I think the
6 comparison that needs to be made is in this country we have
7 the option to go and at least make payments; in Canada, you
8 do not have the option. Yes, that person has health care,
9 but they're waiting 40 weeks for that treatment.

10 And I think that has to enter into the discussion,
11 which would be what our residents prefer to have, is you
12 have the option to have your treatment or your hip
13 replacement in a few days, or you live with the pain for 40
14 weeks and then you may be bumped for another six months,
15 nine months, and you still don't have your treatment.

16 So I think that's part of the decision or the
17 discussion that we need to have.

18 MR. FISHER: I agree. I mean, you heard that.
19 Rick Baker was talking about where a surgery was all of a
20 sudden delayed, and then you wait longer again. Here, you
21 do have that choice. You don't have to wait eight months to
22 see if you're going to be seen at that point. You can go
23 out and start talking to somebody right now and say I have a
24 procedure scheduled over here eight months out, but can you
25 get me in a little bit sooner, or how can we work this out

1 to get me in quicker.

2 MR. SAYLOR: My last comment, Steve, and we'll get
3 to Mr. Doreian, is that I find it amazing that we want to
4 trust government with our health care system, when it can't
5 even manage when we give them our dollars for our retirement
6 and Social Security. Ask seniors citizens of this country
7 how good a health care or how good of a pension system they
8 have that they pay into, and what Americans pay into for
9 America -- you know, whether it's a -- I talk to kids in
10 high school all the time what they're getting taken off
11 their paychecks and they're not happy, and they're just in
12 high school.

13 And I remind them that it will get a lot worse
14 once they get out of high school and have a full-time job,
15 right now, just trying to pay for college. So it's
16 interesting that we want to test our life, our health, and
17 well-being to government when, at least, right now the
18 government is on the side of the taxpayers. If we disagree
19 with something -- if you disagree with the health care
20 you're getting or your insurance company's judgments, you,
21 at least, can come to your State Representative. You can go
22 to somebody in government, the Insurance Commissioner,
23 whoever.

24 Once the government is running it, there is nobody
25 to appeal to. You're already dealing with the highest power

1 you can go to. And that's what people don't understand, I
2 think, is the fact there is a system. Is it perfect, no;
3 but as we've seen today, it's far more perfect than what
4 anybody has. We just need to find some ways to make our
5 system a little better.

6 MR. FISHER: Getting back to something
7 Representative Brook said, is how do we help lower the cost
8 and how do we make it more cost effective.

9 We're fortunate in this region; we do have an
10 organization known as Vantage. And like I said, I was
11 involved way back then; I'm old. But when they started, it
12 was some hospitals that got together and said we're smaller
13 hospitals. We can't compete with the bigger hospitals at
14 the same level; we don't have the same buying power, et
15 cetera. So they got together and said, let's work on this.
16 They were able to form joint purchasing programs, more
17 hospitals have come in.

18 But I think back to when we were hearing about the
19 MRIs and things in Canada. At one point with the Vantage --
20 with the mobile MRIs, Vantage had three of them at that
21 time; that was more than all of the Province of Quebec had.
22 And that was just Vantage here in Northwestern PA that took
23 and shared those with other hospitals, but they saved
24 millions of dollars for health care in this region by
25 working together -- that's hospitals throughout the region

1 working together on trying to find ways to improve the
2 quality of care, the cost of care, and everything else.

3 And I think if we saw that throughout the State,
4 it would be great.

5 MR. SAYLOR: Moving on to Mr. Ray Doreian. Mr.
6 Doreian is the President of The Trinicor Corporation.
7 Please proceed, Mr. Doreian.

8 MR. DOREIAN: Thank you, Mr. Chairman.

9 Mr. Chairman, Honorable Representative, Ladies and
10 Gentleman, thank you for the opportunity to present
11 testimony to you concerning the performance and viability of
12 one existing single-payer health system.

13 As a 26-year resident of the great Commonwealth of
14 Pennsylvania and a licensed professional in the field of
15 health insurance since 1972, I concur with the desire to
16 insure that every Pennsylvanian has access to the finest
17 health care in the world; the U.S. Health Care system.

18 Several recent efforts to replace this system with
19 a so-called single-payer system need to be met with the
20 facts of the abject failure of single-payer system, from
21 patient delivery to cost control. I'm here today to provide
22 you with first-hand testimony regarding the Australian
23 single-payer health care system.

24 Firstly, it's failure to deliver quality health
25 care to me, to my Australian family, and to my Australian

1 friends. And secondly, the ongoing fiscal situation and the
2 need to ration, will limit service to that nation's
3 citizens. Consequently, the real crisis is in the system's
4 method of rationing care to control cost, denial, or delay
5 of services. This crisis has generated a call for choice
6 between the government and the private system.

7 But to begin, let me share some examples of life
8 inside the Australian single-payer system and care denial
9 that has taken place and is taking place:

10 Firstly, during January 1983, my five-year-old
11 son, Ian, experienced a medical emergency in Australia.
12 Ian, being smacked in the head with a cricket bat, knocked
13 off his feet, he was in a daze on the ground with an
14 expanding golf-ball sized bloody lump on his forehead.
15 Quickly applying ice to the lump, we drove him -- drove him
16 to the local hospital ER, making sure to keep him from
17 dozing off. Proceeding to the emergency room intake desk,
18 where we were instructed to sit in that line, which upon
19 inquiry was, the line to see the intake nurse, the one to
20 whom we were speaking, upon asking, we were informed that
21 the wait to see the nurse, to whom we were speaking, would
22 be another two and a half hours.

23 At that point, we inquired, what happens then,
24 which the nurse responded that if I deem it serious, you get
25 to go to that line, pointing to a line of people seated in

1 an adjacent waiting area. Inquiry as to the anticipated
2 wait in the second line produced, when the doctor arrives,
3 it shouldn't be any more than a couple of hours, maybe three
4 at most.

5 Fortunately, we learned of a nearby doctor who was
6 going to see us privately for cash. This doctor inspected
7 and dressed the injury and provided us with overnight
8 instructions. The next day follow-up visit was completed
9 without incident, noting that should Ian have needed an
10 x-ray, this cash doctor was also able to get us past the
11 hospital's intake system. Otherwise, the Australian
12 single-payer health system would have involved two lines
13 again on the next day, hopefully with a scheduled
14 appointment in three or more weeks, for an x-ray if it was
15 determined after those two inspections.

16 Secondly, my stepmom was diagnosed with cancer in
17 1992 by a government health nurse. At that time, the nurse
18 practitioner determined that Mom's localized nose cancer was
19 not sufficiently serious to warrant further evaluation by
20 specialized personnel. From that time, Mom was seen by the
21 nurse practitioner and a medical doctor and was supplied
22 various home-health aids, wall and bath rails and hospital
23 bed and things, and other things as her condition
24 deteriorated.

25 Then, in 2002, another government doctor

1 determined that Mom was sufficiently sick enough to warrant
2 examination by a cancer specialist. Following the cancer
3 specialist's examination, she determined that the cancer was
4 too far along for remedial surgery and Mom was placed on
5 bedrest and an increasing Morphine regimen to arrest her
6 pain.

7 Along with that, my stepsister had resigned her
8 position to take care of Mom as the government insurance
9 support system can no longer afford to keep this patient
10 past the extended care facilities. Now, in her seventh year
11 of palliative treatment, Mom was moved to a terminal
12 facility in early 2007, where she will complete her life.

13 Thirdly, Ken, a high-school classmate. Now, this
14 high school sociology teacher and professional Australian
15 Rules football player was diagnosed at age 51 with
16 cardiomyopathy by a government health doctor in 1993.

17 Due to his extremely good physical condition, he
18 was not considered a candidate for heart transplant, as the
19 doctor said to Ken and his wife, Jill, Ken is not sick
20 enough for a heart transplant. Ken died eight months after
21 this diagnosis leaving Jill and their three children.

22 Fourthly, John, another high school classmate died
23 of cancer at 65. John was a teacher and in excellent
24 physical condition. When diagnosed with lymphoma in 2003,
25 the doctor told John and his wife, Carol, John is too well

1 to consider surgery. However, by 2005, they were advised by
2 a cancer specialist that John's cancer was well advanced
3 into his lymph system, too far advanced for surgery. He was
4 on palliative drugs until his death on the 9th of
5 April 2007.

6 My sister Rosalie, who is a special needs -- was a
7 special needs teaching supervisor and her husband, John, a
8 professional fireman, are both disabled and unable to
9 continue working not on Workers' Compensation. Their
10 situation will be covered later.

11 Sixth, and finally, the doctor appointed to me
12 used penicillin to treat sinus infections to the degree that
13 I was poisoned with large, watery blisters over my entire
14 body. As a consequence, I am acutely allergic to penicillin
15 and it's derivatives. My recovery from this condition came
16 through a private doctor known to my grandmother, to whom
17 she paid cash for this doctor to attend to me.

18 I talk and e-mail my family in Australia and my
19 friends frequently. When we talk about what's going on, I
20 always get an earful on health conditions. They constantly
21 marvel at how much better things are in the U.S., especially
22 regarding waiting times and approvals not being needed for
23 medical procedures; by bureaucrats, that is, and with their
24 single-payer system.

25 April the 24th, just a few days ago, after

1 mentioning to my sister that I was going to be with you on
2 the 30th, her response was, don't they know it can't be done
3 without private cover -- that's personal health insurance --
4 do they have their heads in the sand, there's no money to
5 pay for it. Have they looked at the other socialized
6 systems; they're all failing.

7 Now, let us take a brief overview of the system
8 from a fiscal viewpoint. Around 1983, the cost of basic
9 health care costs in Australia and custodial care through
10 the single-payer system are so large that the states were
11 federally mandated to take over a larger share of the cost.
12 This is the same type of effect as we've experienced with
13 Medicaid. These unfunded mandates required the seven states
14 to provide funding to continue the federally-directed health
15 insurance program.

16 The result was that the states could not maintain
17 the structure and custodial care was virtually eliminated;
18 witness our issues with long-term care. Even though the
19 government allowed individuals to purchase private health
20 insurance for access and increased benefits, the Australian
21 system reached a breaking point in 1999 when the national
22 legislature realized the government alone could not fund the
23 government-mandated health system.

24 In 1999, to help solve the funding crisis, the
25 Australian government legislated that all individuals aged

1 30 and older must purchase basic coverage private health
2 insurance. This private health insurance provides for
3 100 percent cost coverage for the government mandates
4 through private insurance industry contracts. In this
5 fashion, the private insurance industry became the
6 government's third-party administrator and its funding
7 mechanism for the health care claims of all Australians aged
8 31 and above who are private health insure enrolled
9 individuals.

10 By definition, this is the heavy-user cost group
11 with its increasing utilization. Private health insurance
12 permits its enrollees to see any provider in Australia for
13 health or medical services not covered by the government's
14 health insurance system with a big caveat, depending upon
15 the type of private health insurance that you purchase, the
16 pre-existing conditions of a resident of one state may be
17 covered in another state.

18 Otherwise, except for emergency care on a very
19 limited basis, the pre-existing conditions of a government
20 health insurance specific state resident covered in any
21 other state. For example, an individual not covered by
22 government health insurance with a pre-existing condition
23 vacationing in another state can only receive limited
24 emergency care. Any care for an injury deemed to be
25 attributable to the pre-existing condition is covered with

1 the cost of treatment paid out of pocket by the patient, who
2 must file for cost recovery in their state of residence.
3 Elective or non-elective surgeries for conditions involving
4 the pre-existing condition are only covered by the state of
5 residence, with the above out-of-pocket and reimbursement
6 provision in place. Again, the patient's state of residence
7 is the key.

8 Therefore, in reality, there are two separately
9 funded health care systems in Australia. The first is the
10 government health insurance system for all individuals who
11 are age one day to age 30 and 364 days, and also for
12 individuals aged 31 and above who do not own private health
13 insurance.

14 The cost of this government health insurance
15 program is paid for by a medical tax, which is paid by each
16 individual. Additionally, for those individuals aged 31 and
17 above who do not purchase private insurance, cannot purchase
18 their own private insurance, an additional annual medical
19 tax is paid by a tax levy; 5 percent per year compounding
20 annually to 35 percent maximum.

21 The second funded health system is the private
22 health insurance system for individuals aged 31 and above
23 that qualify for and purchase private health insurance. The
24 cost of the insurance is borne by the purchaser and the
25 government, who provide a 30-percent tax rebate of the base

1 premium cost amount for the government health mandated
2 coverages.

3 It will be noted that these two systems, the
4 government system and the private system, provide the care
5 and the cost of care for extremes in the marketplace.
6 Government health insurance provides for the statistically
7 lowest cost users, the under 31-age group; private health
8 insurance provides for the majority of the statistically
9 highest cost users, who are the over 31-age group. Noting
10 that the benefits in the private health insurance system
11 exceed -- they don't match, they just exceed, the private
12 government health -- excuse me one moment.

13 However, please note that government insurance
14 also provides the extreme cost users, those individuals who
15 do not qualify to purchase private health insurance at the
16 time of application. The cost of this unknown risk places
17 an increasingly extreme burden on the government funding for
18 government insurance.

19 As noted, my sister Rosalie, a retired teacher,
20 and her husband, John, fall into this last category.
21 Rosalie, a former shot-put champion, suffers from
22 debilitation of her back, knees, and hips from the demands
23 of training and competition. John, a professional fireman
24 since high school, suffers from many years of rescue and EMT
25 missions that have left him with a serious back injury.

1 Consequently, with their pre-existing conditions,
2 neither Rosalie nor John qualified for private insurance
3 when it was mandated. Also, due to the unspecific injury
4 claim period, they are determined no claim for
5 Workers'-Compensation-type injuries since they have no
6 specific injury date of conception.

7 As a result, their income tax burden has been
8 increased by an additional 5 percent a year, which topped
9 out at the 35-percent rate in addition to the normal income
10 tax burden. Incidentally, my cousin -- my classmate, John,
11 who had the cancer, pay that tax burden until the time of
12 his death.

13 In summary, therefore, based upon these
14 experiences and others, I submit that the Australian
15 single-payer health system has failed. I say this because
16 the Australian government, after eliminating the private
17 health industry -- insurance industry in the 1970s and
18 putting Medibank/GHI, which is now called Medicare, in place
19 in Australia in 1975, as the only health care system through
20 to 1985, and allowing individuals to purchase private health
21 insurance for access and increased benefits.

22 Then beginning in 1999, the Australian government
23 required persons to purchase private health insurance to
24 obtain their own treatment providers and share the cost of
25 health care private insurance; noting that 33 percent of all

1 the health expenses covered by private health insurance, of
2 those, 28 percent are to obtain quick attention, 21 percent
3 to choose their own doctor, and 20 percent to have a
4 dentist.

5 They divided the risk pool into two segments; the
6 under age 31, and the over age 31. And then they mandated
7 the requirement for persons age 31 and above to purchase
8 health insurance or suffer additional confiscatory taxation
9 of persons who do not or unable to purchase private health
10 insurance; that is the 5 percent yearly up to 35 percent
11 additional tax.

12 The Australian's single-payer system salvation has
13 only been the ability of the Australian private health
14 insurance industry to take care of a significant majority
15 segment of the most costly portion of the population, while
16 government health insurance provides for the shrinking under
17 age 31 population, noting that the Australian birthrate is
18 below 2 and is not population sustaining.

19 As a conclusion -- in conclusion, any move to
20 adopt a single-payer system in the Commonwealth of
21 Pennsylvania should reflect upon the longest-running,
22 single-payer system in the similar autonomous and
23 increasingly market-driven based economic system in
24 Australia; it's Australian cousin, really.

25 At the moment the issue is choice, per the

1 attached quote, "Australians should be able to choose either
2 private health cover or Medicare to ensure a more efficient
3 and fair system and help reduce public waiting lists and
4 health care costs, a health care economist from The
5 Australian National University has proposed."

6 Thank you very much for the opportunity to testify
7 before you.

8 MR. SAYLOR: Representative Brooks has a question.

9 MS. BROOKS: Do you feel that fundamentally this
10 country can confer or transition to a health care system
11 such as yours without having the negative impact of the
12 cases and statistics that we've heard about today and
13 maintain our quality of health care that we have in this
14 country?

15 MR. DOREIAN: You just answered the question for
16 me, Representative; no. To maintain the quality, to retain
17 the investment in medical research, to continue to have the
18 same level of ongoing advancement that we experience -- or
19 and we enjoy -- that's really what -- we enjoy and we expect
20 the best care when we go to hospitals. If the hospital
21 doesn't service you, you go to another hospital.

22 The answer is, yes, it would -- no, it would not
23 happen there. If -- let me start again. It will not happen
24 here if we go to that kind of system. We will not have that
25 quality, we will not have the access options, we will not

1 have the additional consultation options, we will not have
2 -- you name it, we could go on and on. But that -- we will
3 not have it.

4 MS. BROOKS: And I feel that's the fundamental
5 question to this discussion is do we convert to a different
6 health care system where statistically we show that you wait
7 months upon months to see a doctor; we do not have that in
8 this country. You wait perhaps years for perhaps what's
9 known as the simplest surgery in this country such as hip
10 replacements or hip surgery, there's no real choice for
11 doctors.

12 Right now, we do have -- although your health
13 insurance plan keeps you within that network, there are
14 times the capability for a patient to have a choice of their
15 doctors. Wherein these systems, there is no real choice, or
16 you go to the back of the line and wait another seven,
17 eight, nine months to see that doctor if you've decided you
18 want to see another doctor.

19 You have accessibility to, perhaps, only one
20 medication if you have cancer, yet if that medication is
21 known not to help the type of cancer that you have. And
22 there is a lack of advanced diagnostic equipment in those
23 health care systems where, really, we are advanced in this
24 country.

25 So I think that's the fundamental question we need

1 to enter into this discussion is do we trade the quality of
2 health care that we have in this country for what other
3 countries have, because I think there's this -- for some
4 reason there's this theory that we can take the best of
5 health care for the system that you come from and we're not
6 going to have unintended consequences of the negatives of
7 the statistics of what has been mentioned today.

8 MR. DOREIAN: It does seem that way,
9 Representative. It absolutely seems that there's the
10 thinking that we can chance the system without consequence.
11 I do not believe that is possible.

12 In addition, I think one of the things that maybe
13 is underneath the radar screen in terms of my Australian
14 experience, doctors there are required to limit the patient
15 care that they give. What does that do? That controls the
16 cost. So in terms of cost control, if you delay care, if
17 you limit care, or you deny care for a period, you can drop
18 the cost. Outcomes are not the issue. You know, here in
19 the United States -- and I'm a U.S. citizen, proud to be
20 one, okay, we're interested in outcomes, we're interested in
21 what happens -- what happens when.

22 And we want to -- I hate to say it, in one sense,
23 we want it now. But I'm glad we want it now, because that's
24 who we are.

25 MS. BROOKS: I think about when my daughter was

1 four years old. And for months upon months, you know, she
2 had this bruising. And the doctor -- you know, she was a
3 four-year-old little girl, well, we ended up having blood
4 work for her. The blood work came back, we were still in
5 the hospital waiting for that blood work; we had two hours
6 to get her to a children's hospital. That is how sick she
7 really was.

8 We had two hours to get her to a specialist. And
9 in this country, we were able to get her there, and the
10 specialist was waiting at the door for us. And I think
11 about what would have happened to my daughter in a health
12 care system such as yours; and that is the question, I
13 think, we all need to ask ourselves.

14 MR. DOREIAN: I have cried many times over my high
15 school friends and the loss of their lives. They were not
16 sick men. They were not sick men. They had -- one had a
17 bad heart; one had cancer that was in recovery. My stepmom,
18 she just had a little bump on her nose. She could have had
19 treatment; she's dying today.

20 MS. BROOKS: Thank you.

21 MR. SAYLOR: Representative Evans.

22 MR. EVANS: Thank you, Stan. I wanted to ask,
23 since we're on the Edinboro campus here, I do get many times
24 during the year correspondence from students who no longer
25 can be on their parents' coverage and they fall into that

1 hole, I guess, at age 18 until they find a job.

2 What can be done, in your view -- I don't expect
3 you to speak for the entire insurance industry, but what
4 weakness do we have in our system that allows that to
5 happen, and how can we possibly protect college-student-aged
6 individuals who are bare on coverage and many times don't
7 have access to the ability to pay a premium at all?

8 MR. DOREIAN: I'll speak to that from two points of
9 view, if I may, Representative; thank you for the question.
10 At the present time in Pennsylvania, there's a proposal to
11 expand coverage up to age 30 in a family policy. That's a
12 policy that the Association is standing with and it will
13 support that.

14 On the other issue, if that were not available,
15 there is very inexpensive health insurance available for
16 younger people -- let's just focus on those two issues.
17 There's two groups of population, those who are insurable
18 and those who aren't, okay. Those students who are
19 insurable, it's very inexpensive. I just insured the son of
20 a client who just graduated college, and I think he's --
21 this is in Philadelphia. His premium is a very
22 comprehensive plan, it's about \$180 month.

23 Now, that's not a lot of money -- no, I beg your
24 pardon \$90 a month. That's not a lot of money for
25 comprehensive coverage. You know, I think if I was in the

1 student's shoes and didn't have income, I'd be putting the
2 squeeze on dad. But the issue is a lot of those, unlike we
3 were, generally speaking, kids are going to live forever.
4 They know that; they're not going to get sick, their friends
5 are not going to get sick. When one of their friends get
6 sick, when the kid comes down with something, that's when
7 they want insurance. And, you know, we all learn by
8 experience, and I'm sure that that's the same there. So
9 that child this uninsurable or has some issue, okay?

10 There's a lot of full-time students that can't be
11 kept on a parent's policy. There are -- there is the CHIP
12 program, there's all kinds of programs in the State which
13 will provide insurance for those particular individuals. So
14 there's no -- I have no hesitations to say that coverage can
15 be found for them -- the insurance companies can be found
16 for them. And as we've heard earlier today in other
17 testimony, in the event of emergencies, they can present in
18 a hospital. They can get care; they can get cured. The
19 matter of who pays for it is a different issue, but they can
20 get care.

21 MR. EVANS: I appreciate your comments. I do think
22 there is an inherent problem and we are seeing a shift from
23 the traditional students that attend on a full-time basis by
24 a number of factors. The cost drivers are by the fact that
25 they may not have a relationship with their parents, their

1 parents may be deceased; these are factors we're going to
2 have to look at. And I do believe that it is something in
3 the law that we should take a look at in Pennsylvania to
4 expand it up to age 30 because of the fact that it is a
5 low-risk group, and I don't believe that it's going to add a
6 tremendous amount of money to insurance costs.

7 So it's something we have to be sensitive about,
8 and I think that the previous determination of a
9 nontraditional student, I think, is now becoming the norm
10 rather than the exception. You see people who are displaced
11 workers who are coming back, who are raising a family,
12 trying to attend school; and for those people to be without
13 any coverage, I think, really is a crime.

14 And I'm hopeful that people that are viewing this
15 program, if they're able to see this on PCN and other
16 places, that if they are without insurance coverage, you
17 know, contact their State Representative, wherever it may
18 be. I know my office does help direct individuals to some
19 of the low-cost programs that are out there, some of the
20 State programs that are out there. But that's one area of
21 the population, I think, that we have to remember is very
22 dramatically affected. And God forbid that any of those
23 students without coverage get in a catastrophic accident,
24 they're looking at bills that really can't be repaid in a
25 lifetime.

1 With that being said, thank you, Mr. Chairman.

2 MR. SAYLOR: I want to thank both you gentlemen for
3 being here. And, I guess, my comments would be, it seems to
4 me, from what I've heard from you gentlemen and others, is
5 that as we ration care -- and that seems to be what's going
6 on in these single-payer systems. I didn't hear today,
7 particularly as Mr. Esmail and others have testified, that
8 areas that are poor or areas that are lacking already in
9 health care, which are many times in this country, the rural
10 areas and, of course, the more poverty areas of the country,
11 maybe in the cities, that it has helped either of those
12 regions; it seems like it's even worse, maybe.

13 So it doesn't seem like it's a solution for the
14 poor, and it doesn't seem like it's a solution either for
15 those who are living in very rural or desolate areas. I
16 guess my concern is maybe it even gets worse in this country
17 because we already have those problems in our rural areas;
18 we have those problems in our cities with dentist and doctor
19 shortages; and we truly are suffering in this country, and
20 hopefully we're making some progress, with the shortage of
21 nursing.

22 And my concern is when you start
23 having government-run things, you start fixing prices, which
24 means we start fixing the salaries of what doctors and
25 nurses can make, and that's really the free-enterprise

1 system. And if we're going to discourage people, like
2 doctors, from going into the field and other people in the
3 medical field, there's a host of people -- I think it's one
4 of the leading growing areas in this country in job creation
5 is the health care field, I think we're going to see a lot
6 more of a shortage, because, you know, Americans have that
7 ingenuity of really solving problems.

8 And I think the biggest concern we need to do, as
9 we talk about in here, Pennsylvania, as we have 8 percent
10 uninsured. College students are part of that, others that
11 choose not to buy insurance, but maybe can afford it. And
12 I've talked to some of them, which is interesting. I'm
13 amazed, I've talked to some people that are near 40 years of
14 age making well over \$150,000 and has no health insurance; I
15 was shocked. I have some constituents that came in to see
16 me, and they actually would like a government program. And
17 I was taken back by that.

18 But in the end, I want to thank you for coming
19 today. Hopefully, this is going to educate some people and
20 educate us, as well as we move forward. As Representative
21 Evans talked about, there are some things that we have to do
22 to fix it. We have to help those students; we have to help
23 those who don't have health insurance in the private system.
24 But the single-payer system doesn't seem to be the way to
25 go, but there a lot of things we're going to look at.

1 In fact, next Wednesday -- this coming Wednesday,
2 we, the Policy Committee, are going to have a public hearing
3 on the Massachusetts Insurance Program. So we're getting to
4 hear more testimony from people from Massachusetts and
5 others as to exactly what's going on with their health care
6 system in Massachusetts.

7 So, again, thank you very much for coming. Any
8 other comments?

9 MS. BROOKS: I think we all agree that we do have
10 challenges and obstacles regarding health care in this
11 country, and we need to address those challenges and
12 increase accessibility. And we do have challenges,
13 especially in the rural areas. But how do we do that and
14 still maintain choice for our patients, maintain quality in
15 our health care, but still make it better? And I think
16 that's the question that we need to answer.

17 MR. SAYLOR: Thank you, gentlemen.

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19 (Hearing concluded at 3:23 p.m.)
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