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### **Backgrounder – Response to BC Throne Speech**

On February 14, 2006, British Columbia's Lieutenant-Governor Iona Campagnolo read the speech from the throne, highlighting the priorities of the province's Liberal government for the next session. The speech raised eight health policy-related questions making the future of health care its main focus.

The BC government's rhetorical questions on health care are a clear indication of its intentions to pave the way for private for-profit health care in BC based on a false assumption that public health care expenditures are out of control.

Before addressing the questions raised in the throne speech, it is important to stress that public health care expenses have not been unsustainable in BC. Data from Statistics Canada and the Canadian Institute for Health Information reveal that the province's real GDP per capita rose by 7.3 per cent between 2001 and 2004 while public health care spending increased by only 1.1 per cent.

The following are the Council of Canadians' responses to the questions raised in the BC Throne Speech.

**What does the principle of “universality” mean when some citizens have special access to services and surgical options that others do not have, for lack of extended or private insurance? Or when only a handful of provinces even offer catastrophic drug coverage?**

Universality means that all citizens must be covered under a public health insurance plan, which pools the risk among all citizens and leads to lower costs. According to this definition, BC's Medicare is universal. If there has been “special access to services and surgical options” in BC and other parts of Canada, it is due to the lack of political will to ensure coverage of these services and surgical options by public insurance.

**What does the principle of “accessibility” really mean, in light of existing access to primary care, surgical care, or extended care across Canada?**

Accessibility is defined in Section 12 of the Canada Health Act: Insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. No one can be discriminated against on the basis of income, age, and health status. This is the principle that the Copeman Health Clinics have run afoul of, since requiring block fees to access its physicians clearly discriminates on the basis of income.

Access to primary or surgical care exists under BC Medicare. Wait times are a problem that needs to be addressed. Promising solutions exist within the public system, without the involvement of the private sector.

One example is the Alberta Hip and Knee Replacement Project which, through a central assessment clinic, streamlines the referral process, decreasing wait times for the first consult from 35 weeks to six weeks, and wait times for surgery from 47 weeks to 4.7 weeks. This happened in an eight-month span in 2005, and it happened within the public system. Recent media reports suggest BC is now looking at a similar program modelled on the Alberta initiative.

**What does “comprehensive” and “portable” mean to Canadians, given the wide discrepancy in insurable services across our country? How should we define concepts like “reasonable access” to “medically necessary” services, so that the courts are not left to interpret them for us?**

Health care falls under provincial jurisdiction. Premier Campbell would be one of the first provincial leaders to be up in arms if the federal government tried to draft a detailed list of services that would provide a uniform basket of publicly insured services from province to province.

But the problems affecting the principles of comprehensiveness and portability are real, and there is discrepancy in insurable services across Canada. It is up to premiers to negotiate services for the betterment of their constituents.

**Does it really matter to patients where or how they obtain their surgical treatment if it is paid for with public funds?**

This is a key question. The resounding answer is: Yes! It does matter!

There is a big difference between private for-profit and public/private not-for-profit clinics. In private for-profit clinics there is a 10-15 per cent overhead that would have to be paid for with taxpayers' money, be compensated for by lower wages for nurses or support services staff, or by cutting corners in medical procedures.

Using public money to fund for-profit clinics will cost much more than using public money for public or not-for-profit clinics.

**Why are we so afraid to look at mixed health care delivery models, when other states in Europe and around the world have used them to produce better results for patients at a lower cost to taxpayers?**

There is strong evidence that European models are not better or more cost-effective than Canada's. The advocates for European models often ignore important factors. In the case of France, for example, they rarely mention that the average annual salary of a physician is around CDN \$65,000. If BC physician wages were that low, public health care expenditures would be about 10 per cent lower for the same services.

In Germany, 70 per cent of the costs of the public health insurance are paid for through employees, and only 10 per cent through taxes. It is mandatory for an employer in Germany to pay 6.75 per cent of the gross income of each employee in payroll taxes, even for laid-off or fired employees. As for the United Kingdom, the waiting list problem has not been solved. On the contrary, the problem has worsened.

**Why are we so quick to condemn any consideration of other systems as a slippery slope to an American style system that none of us wants?**

Canada, unlike European countries, has signed the North American Free Trade Agreement (NAFTA). Paving the way to a parallel private health care insurance and/or delivery system could have major consequences for Canada. Allowing a parallel private for-profit insurance plan and private for-profit clinics could open the way for U.S. Health Maintenance Organizations (HMOs) to set up shop in Canada. European countries that do not have the same trade ties with the U.S. do not face the same risks.

**And why shouldn't we build our health care system on a foundation of sustainability? Are we really ensuring that the health care entitlements we enjoy as Canadians will be there for our children and future generations as our population ages?**

Everyone wants a sustainable model of health insurance and delivery, for now and for future generations. There can be many ways to ensure sustainability. Increased private involvement in health insurance and

delivery is not the solution because it will lead to inequality and contravene the principles of The Canada Health Act.

Profit is not the cure for British Columbia's health care system. Governments and citizens will have to set aside erroneous assumptions, quick fixes and rhetoric and move towards rebuilding the public health system. Innovative public solutions exist right here in Canada.