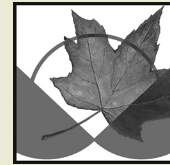
BC COMMENTARY

a review of provincial social and economic trends



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SPECIAL HEALTH CARE EDITION

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Help us celebrate the CCPA's 10th anniversary in BC!

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From the Editor

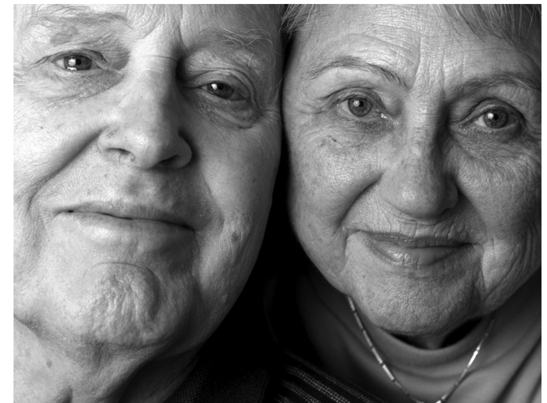
Let's Talk about Health Care

By Marc Lee

Last September, the BC government launched its "Conversation on Health Care." It will last almost two years and will feature forums around the province that ask people what they would like their public health care system to look like in the future. One might think that people are getting consultation fatigue, the results of which can be seen in numerous tomes written on health care in recent years, including the National Forum on Health (1997), the Romanow Commission (2002), the Senate's Kirby report (2001), and in the BC context, the Seaton Commission (1991).

Nonetheless, it is hard to argue with opportunities for democratic discourse, especially given health care's role as a core element of our social fabric and as the largest single item in the provincial budget. The trouble is one of motives: the BC government seems all too keen to implement private health care options wherever possible.

The Conversation's opening remarks included a highly misleading figure projecting that health care would consume 71% of the BC budget by 2017. But the numbers were tortured to make their confession. Health care expenditures were assumed to grow at 8% per year, even though they have grown by less than half that amount since the Campbell government came to power (the single largest annual increase was 6% in 2005/06, just before the last election). Similarly, revenues are assumed to grow at only 3% per year in the future, even though they have grown by 7% per year since 2001/02.



The government essentially assumed that health care is unsustainable, and then concluded that it is unsustainable. Misleading assumptions aside, the government's figures are measuring the wrong thing — what matters is the share of our total income we spend on health care, not the share of the provincial budget. BC currently spends about 7 cents out of every dollar of income (GDP) on public health care. If we continue to do that in the future, we can maintain our current system and even have some left over to expand services, as long as economic growth is reasonable.

Democratic dialogue must begin with an informed citizenry. Consider this issue of *BC Commentary* an act of intellectual self-defence against the claims of a well-heeled lobby that wants to expand private health insurance, care and delivery. We try to put back on the table the real issues that British Columbians need to be talking about — in the official Conversation and around the dinner table. The articles in this issue draw on many contributions the CCPA has made to health care policy, a list of which can be found at the back. •

What's in the Basket? Public vs Private Health Care

By Marc Lee

Health care is a large and complex sector of about $12 billion per year in BC government expenditures plus $5 billion in private expenditures. To a great extent, BC's Conversation on Health Care is about whether more of what is in the public realm should be delivered privately, or conversely, whether private services should be brought under the public umbrella. In essence, it is about how we want to pay for health care: together, through our taxes, or individually, out-of-pocket.

Just as the Chaoulli decision is facilitating private options in Canada, more and more sensible people in the US are looking to Canada as a model.

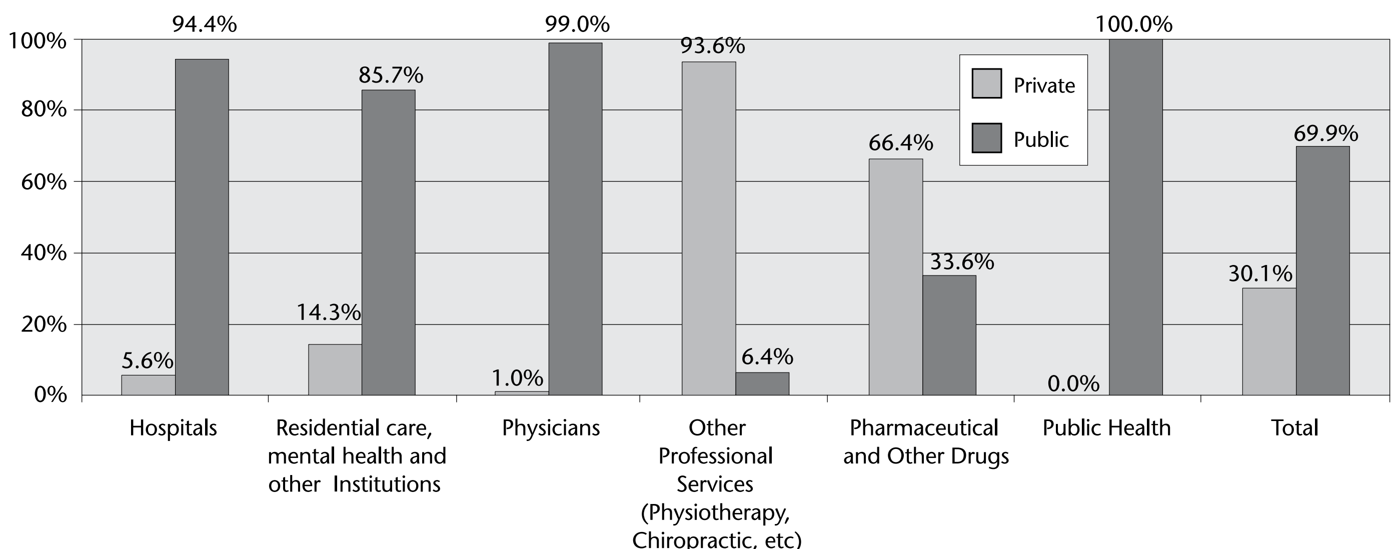
Public health insurance began many decades ago with coverage for hospitals, then later, physician services. These two areas remain the core elements of public health care, and are covered by the *Canada Health Act*, which sets out five principles that provinces must uphold in order to get federal funding, and contains provisions that ban extra-billing by physicians and user charges by hospitals.

Over time, public health care has expanded to partially include home care, long-term care, pharmaceutical drugs and other services. But coverage varies a great deal across the country because these services are provided at the discretion of provincial governments. These services may be subject to co-payments and deductibles, or may be means-tested. And they are subject to change, as has been the case in BC, where supplemental health care services such as physiotherapy, chiropractic and massage therapy, and routine eye exams, were de-listed from the public plan in 2002.

Private health insurance can supplement the basic health care services provided by the public system. Many employers provide this coverage (to varying degrees) for prescription drugs, vision care, dental care, and other services. Those without private insurance must pay out-of-pocket or go without. The private insurance sector in Canada resembles the US model of health care.

The public-private split is significant in the context of last year's "Chaoulli decision" by the Supreme Court. It ruled that, in Quebec at least, excessive waiting times for surgery in the public system could justify individuals with sufficient

Figure 1: BC Public and Private Shares of Total Health Care Expenditure, by Use of Funds, 2005



Source: Canadian Insitute for Health Information, National Health Expenditure Trends, 1975-2005, Tables D.2.10.1 and D.3.10.1

money to purchase private insurance to end-run the public system. This ruling has been claimed as a victory for private health care (interestingly, conservatives refrained from their usual cries of intrusive "judicial activism").

Just as the Chaoulli decision is facilitating private options in Canada, more and more sensible people in the US are looking to Canada as a model. Economist Paul Krugman points out that in the US system, "government pays directly or indirectly for more than half the nation's health care, but the actual delivery both of insurance and of care is undertaken by a crazy quilt of private insurers, for-profit hospitals, and other players who add cost without adding value. A Canadian-style single-payer system, in which the government directly provides insurance, would almost surely be both cheaper and more effective than what we have now."

The path forward is more accurately described as a matter of choice for provincial governments — whether to reform the public system so that the private option is not necessary, or to accept a greater role for private operators. In fact, there is good reason to believe that the scope of public health insurance should be expanded, not reduced. Lengthy reviews of the health care system going back to the 1990s agree on the broad parameters of a modern and progressive health care system:

Primary care

Primary care is widely seen as the appropriate entry point to the health care system to better coordinate overall care for patients. Primary care proposals include movements towards multidisciplinary teams, physicians paid by salary rather than fee-for-service, and a community health organization model that would provide 24-7 service, emphasize public health, and support chronic disease management.

Community health care

Reform proposals call for a model of home care services encompassing mental health, addiction services, post-acute care, palliative care, and care for frail seniors. These services would be integrated with primary care centres. Better access to residential and home care would also take pressure off the more expensive acute care system.

> "When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to recognize and revamp the whole delivery system — and of course, that's the big item. That's the thing we haven't done yet. —*Tommy Douglas*"

Prescription drugs

A national program should be introduced and would include measures to control costs: bulk-purchasing; use of cheaper generic versions; development of a national formulary; and, more comprehensive coverage for essential drugs. In the 2004 federal-provincial negotiations on health care, Premier Campbell proposed that the federal government take over the arena of Pharmacare from the provinces.

Public health and prevention strategies

Policies include promoting healthy living and combating items that increase health care costs such as tobacco and junk foods, while implementing measures such as handrails for frail seniors. For a cancer strategy, it means tightly regulating thousands of toxic chemicals in the environment. This framework also recognizes that there are socioeconomic determinants of health, the most pressing of which is poverty.

Public coverage should also encompass areas that are currently the preserve of private insurance, such as dental and vision care services and other supplementary health therapies. Only three-fifths of people are covered in some form by a private health insurance plan. For the remaining two-fifths of the population, those without any coverage, they have a simple choice: pay up or go without. And the data show that the majority of those without coverage simply do not get the care they need. Over a quarter of adult Canadians did not seek needed dental care in 2004 because of cost.

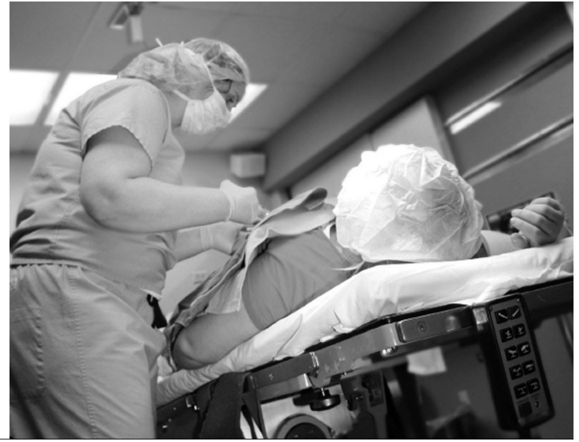
These reforms are supported by many health care professionals. Yet, the term "health care reform" is often hijacked by those who want a much greater role for the for-profit sector, a "solution" that is neither equitable nor efficient. The real challenge for health care is implementing progressive reforms that would make Tommy Douglas's vision of an integrated public system a reality. It is a vision that needs to be reiterated in the Conversation on Health Care. •

The term "health care reform" is often hijacked by those who want a much greater role for the for-profit sector, a "solution" that is neither equitable nor efficient.

Cost Escalation and Private Health Care

By Colleen Fuller

We have long known how unsustainable the cost of prescription drugs is, and now British Columbians are becoming increasingly familiar with the soaring costs of for-profit surgery and the insurance premiums that go along with it. Here is a taste of life in that market — and what we could expect more of if we sit back and watch it grow.



Premiums for private insurance are now increasing at more than double the rate of inflation — far more rapidly than the cost of public expenditures.

Across B.C. there are now 70 surgical clinics, including 23 providing outpatient general surgeries on a for-profit basis. This means each clinic must yield a satisfactory return on investment to its shareholders.

The international experience with private surgical facilities, however, is that they tend to charge much higher prices for the same surgery in a publicly-funded hospital. The *British Medical Journal* reported in 2004 that the National Health Service was charged 47% more for hip replacements performed in private surgical clinics than for the same procedures provided in public hospitals. In 2002/03, a coronary bypass operation cost an extra 91% in a private clinic in England compared to a non-profit hospital.

The experience in Canada is similar. For example, hip replacement surgery in a non-profit hospital in Alberta last year cost a reported $10,000. Hip replacement surgery in a for-profit clinic, according to Timely Medical Alternatives (which facilitates access to the clinics), can cost up to $21,780. In Canada's public hospital system, knee replacement surgery, according to the Canadian Institute for Health Information, averages $8,002 compared to between $14,000 and $18,000 in a private surgical facility.

Most of the outpatient surgery in Canada is done in non-profit hospitals, but for-profit clinics are waging an aggressive campaign to capture a larger share of the "market." Zoltan Nagy, the vice-president of the Canadian Independent Medical Clinic Association, has suggested that between $10 billion and $40 billion is invested annually in for-profit surgical clinics.

Private surgery clinics go hand in hand with private insurers by enabling those able to pay the premium to jump the queue. As Nagy says, "There are very few people who can afford to pay out-of-pocket for a $40,000, $50,000, or even $100,000 procedure. But when you have insurance that would cover it, that's a whole different story."

Today, just over 30% of all health expenditures are paid for outside of the public health insurance system. This is roughly split between direct out-of-pocket payments and private health insurance (mainly under workplace plans that cover "extended health" services). For covered workers, these benefits are included in calculations of every employer's total payroll package and are, in effect, wages paid in the form of insurance premiums.

Very few Canadians obtain private insurance on their own because they cannot afford the premiums — and, increasingly, neither can employers. It is worth noting that because premiums are a tax deduction for corporate employers, this amounts to a subsidy on the order of $5 billion to the private insurance industry.

Yet, premiums for private insurance are now increasing at more than double the rate of inflation — far more rapidly than the cost of public expenditures. This is leading many employers to introduce higher co-payments and deductibles or to cancel extended health plans altogether.

The experience of Canadians with private insurance is precisely what led to the establishment of a universal medicare program. The 1964 Hall Commission recommended public health insurance precisely because it avoided the high administrative costs and gaps in coverage that characterized private insurance at the time. And not much has changed in the world of private insurance since that historical victory for Canadians. •

Private Emergency Clinics: Cure or Cancer?

By Margaret McGregor

In early December, the Minister of Health reached a deal with the False Creek urgent clinic owner Mark Godley to publicly fund services offered there. Clinic owners claimed that the clinic would help solve the problem of crowding of our hospital emergency departments by seeing patients who might otherwise go to the hospital. So will it?

The Godley clinic has clearly said they will only see the 'walking wounded' — or 'low complexity' patients — not those coming in by ambulance or needing admission to hospital. Yet, a recent BCMA policy backgrounder identified the real cause of emergency department crowding as prolonged boarding of in-patients. These are patients who are sick and need to stay in hospital for treatment. However, due to the lack of available acute beds and staffing shortages, they have no place to go. They therefore lie in emergency departments — sometimes for days — until a bed opens up.

BC now has only 1.8 acute care beds per 1,000 population — 55% below the 2.75 recommended by the B.C. Royal Commission in 1991 and substantially less than the rest of Canada which has 3.0 beds.

The BCMA also called for immediate implementation of overcapacity protocols to redistribute admitted patients throughout the hospital. We cannot expect our emergency departments to transform themselves into in-patient wards every time there are no beds upstairs, while at the same time continuing to provide good emergency care.

Better bed management and discharge planning, and improved co-ordination of care between the hospitals and community to reduce the number of 'bed-blockers' (patients who are medically stable but unable to be discharged due to functional decline) are also short-term solutions. Ultimately an expansion in the number of acute care beds, to accommodate the 'surges' of sick patients when they come, will make the biggest difference to the problem of hospital crowding.

The Godley clinic won't solve our ER problems, but it will allow clinic owners to get taxpayer-financed returns for their ten million dollar investment. One potential downside of this is "over-servicing" — where providers who are remunerated based on the number of services provided (essentially "piece-work") and need to bring in returns on their investment, are motivated to do unnecessary things or "over-servicing" their patients.

The clinic will also have to attract health professionals, technicians and nurses from the hospital setting, most likely by offering higher salaries to work there. This will worsen the shortages of these professionals in our hospitals.

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False Economies in Health Care

By Seth Klein

There is a false economy underlying many of the ideas we hear for health care reform in BC, in that many of these changes do not actually control or save costs, but simply shift costs onto individuals, families and, in some cases, employers. They are not in fact about saving money — just changing who pays and how we pay, and the result will be a loss of both efficiency and equity.

» When Victoria scaled back Pharmacare coverage four years ago, this move did nothing to reduce drug costs. The fact that we heard no public complaint from the major drug companies about these Pharamacare cuts is perhaps the surest proof that these reforms do not mean lower drug expenditures overall. Rather, they merely shift drug costs onto individuals and employers.

» The 2001 decision to end Medical Service Plan coverage for supplementary therapies (such as massage and physiotherapy and chiropractic care) also represents both a cost-shift (onto individuals and workplace benefit plans) and a potential false economy. These therapies are an important means by which many people manage chronic pain. If they go without treatment because of rising out-of-pocket costs, the result may be lost days at work (which harms the public treasury) and/or injuries, with the resulting impact on the acute care system.

» A significant share of acute care patients are only there because of a lack of long-term, rehab or community services. When government fails to adequately invest in community care, it loses a vital early warning system — people who can regularly monitor the health status of vulnerable and frail clients, and intervene if a client's situation deteriorates. In doing so they avoid more costly admissions to the acute care system.

Public Solutions to Health Care Wait Lists

By Michael Rachlis

Waits for care are the biggest political issue facing Canadian health care. Federal and provincial governments have agreed to set limits on wait times for major surgeries and treatments, but conceded that these limits would be targets rather than guarantees. This is welcome news for Canadians already on long wait lists. But, despite years of debate on the issue there is still little discussion of making more efficient use of existing resources and facilities.

Meanwhile, the operators of private clinics and their supporters have seized upon the Supreme Court's Chaoulli decision, which struck down a Quebec ban on private insurance for Medicare-covered services. They are aggressively developing for-profit clinics to sell services to the public sector and any individual who has the cash to jump the public waiting lists.

Before going down this road, however, Canadians would do well to consider public sector solutions to the wait-times problem. Two such reforms are readily available.

The enemies of Medicare have used the legitimate public concern about delays in the system to peddle ill-advised policies such as for-profit delivery and private finance.

First, the public system should shift as many minor procedures and low-risk elective surgeries as possible (e.g., hip and knee replacements) to short-stay, public, specialized clinics. It has been widely — and wrongly — assumed that the only such clinics are for-profit businesses. In fact, Toronto's Queensway Surgicentre, a division of the Trillium Health Centre (a public hospital), is the largest not-for-admission surgical centre in North America. And in Manitoba, in 2001, the government bought the Pan-Am Clinic from its private sector owners.

Evidence from both Queensway and Pan-Am suggests that public sector delivery is superior. These clinics achieve the benefits of specialization and innovation normally ascribed exclusively to the private sector, while reducing overall administrative costs and providing broader societal benefits.

The second new public sector approach to health-care waits is through queuing management practices that are already used to maximize flow in such diverse areas as air traffic control and manufacturing. Rather than thinking of every wait list as a capacity or resource problem, we need to look at delays through the "lens of flow."

Canadians tend to assume that, if there is a wait for health care, there is not enough of it. Yet, most waiting is not due to lack of resources. For example, many breast patients have to wait for a mammogram, then wait for an ultrasound, and then wait again for a biopsy. The Sault Ste. Marie breast health centre reduced the wait-time from mammogram to breast-cancer diagnosis by 75% by consolidating the previously separate investigations. If a woman has a positive mammogram, she often has the ultrasound, and sometimes the biopsy as well, on the same day.

We could also eliminate waits for doctors' appointments. Family doctors often have delays of four weeks for appointments. The wait is typically shorter just before vacation and longer thereafter, but overall it is fairly stable. A doctor's capacity may be close to meeting demand, but he or she is servicing last month's demand today while postponing today's work until next month. If doctors could clear their backlogs, then theoretically they could go to same day service.

The Saskatoon Community Clinic serves over 20,000 patients. In 2004, patients faced a four-to-six-week wait for appointments. The centre temporarily increased resources to clear its backlog, re-designed some of their care pathways, and now provides same-day service.

The enemies of Medicare have used the legitimate public concern about delays in the system to peddle ill-advised policies such as for-profit delivery and private finance. They may claim that private clinics will deliver faster care at a better price, but the peer-reviewed literature demonstrates that for-profit care tends to cost more while, if anything, providing inferior quality services.

Let's not add private problems to our health care system. We already have the public solutions at hand. •

Controlling the Cost Drivers: The Case of Drugs

By Armine Yalnizyan

The power of single-payer systems could be used more effectively in our procurement systems, particularly in drug programs. Prescription drugs are the fastest-growing cost driver in health care spending, on both the public and private side. The provinces all have different ways of addressing the rising costs of drugs. Their policies also influence costs for private insurers.

The following techniques have an impact on the development and pricing of new patent drugs, as well as on the share of the generic drug industry in the market for prescription drugs. These measures would help control drug costs.

Generic substitution

All of Canada's provincial drug plans have a policy to cover only the costs of a generic drug in place of a patent drug if they are basically, or chemically, the same. The effectiveness of this policy has been somewhat blunted by changes to patent law that limit the use of compulsory licensing (where generic manufacturers are licensed to produce a drug under patent; the patent-holder is paid a royalty, but their monopoly is ended).

Reference-based pricing

In a system introduced in British Columbia in 1995, the province controls what it will pay by grouping drugs that treat the same condition and are deemed to be therapeutically equivalent, whether they are chemically the same or different. The plan limits payment to cover the full cost of the least expensive alternative, or the "reference" drug in a therapeutic class. Doctors can prescribe a more expensive drug, but if patients covered by the public plan opt for that choice they must pay the difference between its price and the reference price.

Direct price controls

At the federal level, the PMPRB (Patented Medicine Prices Review Board) sets price controls on the wholesale prices of new patent medicines coming onto the Canadian market. Generic drugs are not covered by its mandate.

Bulk purchasing

In general, Canadian governments do not use economies of scale to push for better deals in supplying drugs, even when they are on public formularies and known to be dispensed in huge and rising quantities every year. Everyone essentially pays the retail cost for every pill, even when hundreds of millions of pills are dispensed annually. Some hospital groups and large pharmaceutical retail chains have figured out the benefits of bulk-purchasing, and both Saskatchewan and Ontario have attempted price-volume contracts with pharmaceutical suppliers, with varying degrees of success; but this remains a limited option. In contrast, in the United States, although unit prices are higher, large insurers such as the Veterans Administration are more likely to strike price-volume deals. •

In general, Canadian governments do not use economies of scale to push for better deals in supplying drugs.

CCPA-BC's 10th Anniversary Fundraiser Gala Dinner with

NAOMI KLEIN and host Bill Richardson

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The Decline of Community Health Services in BC

By Marcy Cohen

Community health care refers to a continuum of services available in local communities, which are designed to maintain or improve the health and functioning of vulnerable populations such as frail seniors, people with disabilities, post-acute patients, and people with chronic conditions. These services include home nursing, home support, community mental health services, assisted living, residential care, and other community-based services.

A good home support system helps to identify more serious problems as they emerge and ensures that people can live independently in decent and healthy conditions.

These services support people to remain in their own homes and communities, by providing them with some help with daily living such as cleaning and medication management, or to receive higher levels of residential care if required. There are numerous research studies showing that a comprehensive and coordinated approach to the delivery of community health services will take pressure off the hospital system. By providing care focused on prevention and early intervention, it is possible to avert health crises and reduce the need for more expensive emergency or in-patient hospital services.

Unfortunately, this system has been in steady decline, and is now in a significant degree of chaos. This is the result of a long-standing lack of investment by successive provincial governments, and of deep cuts and reductions in access made since 2001.

During the 2001 provincial election campaign, the current government promised to address pressures in the hospital system by building 5,000 new long-term residential care beds by 2006. In reality, between 2001 and 2004 the government closed 2,529 residential care beds, while creating only 1,065 assisted living spaces. This leaves BC with more than 1,400 fewer beds than there were in 2001. And again in 2005 there were about 250 fewer long-term care beds than there were in 2004.

While the government points to the thousands of new beds it promises to build over the coming years, many of these will be assisted living spaces, not residential care. Residential care includes 24-hour nursing supervision and can accommodate the needs of the very frail elderly. Assisted living, on the other hand, provides a more limited number of services to seniors who can still direct their own care. Assisted living is a good option for those seniors who can live semi-independently, but it is not appropriate for an elderly person with, for example, dementia or significant mobility challenges.

Even closer to home, reduced access to publicly-funded home support means frail seniors and people with disabilities are being left without the basic supports needed to monitor their health and postpone (or avoid) the need for residential or hospital care. The number of people receiving home support dropped by 24% between 2000/01 and 2004/05, and the number of service hours dropped by 12%. This decline continues a trend that began in the mid-1990s. However, since 2001, reductions in access occurred at the same time as both residential care and hospital beds were cut.

Home support services have shifted dramatically to clients with higher needs, and have become more narrowly focused on medical tasks. The public system provides less and less of the daily living services that focus on prevention and maintenance, such as meal preparation, shopping, housekeeping and social contact.

Moreover, a good home support system acts as the eyes and ears of health care. It helps to identify more serious problems as they emerge and ensures that people can live independently in decent and healthy conditions. This can reduce overall health expenditures and should be part of the solution to BC's shortage of long-term care facilities and overcrowded hospital wards.

Lack of adequate community health services means seniors and their families are forced to pay

Continued on page 11

Mental Health Services and Social Policy in BC

By Marina Morrow

BC has been seen as one of the leading provinces in Canada in mental health care reform and in the development of active recovery models of treatment for people with mental illness. These models recognize the importance of providing a range of hospital and community-based services and the critical links between income, employment, housing and mental health. Unfortunately, in recent years BC has strayed from this path.

In 1998, a new mental health plan proclaimed BC's commitment to enhancing mental health care throughout the province. The plan pledged increases of annualized funding for mental health services including supported independent living beds, residential care resources, and increases to staffing and training for community-based services. A key goal of the plan was to work towards comprehensive, integrated mental health services. One promising development in this regard was the establishment of a Mental Health Advocate, the first position of its kind in Canada, to help monitor systemic problems with the mental health care system.

When the current government came to power in 2001, one of its first actions was to eliminate the position of the Mental Health Advocate and the protected envelope for mental health services that previously ensured that money allocated to mental health would not be used for non-mental health related services. The government reduced staff in the Adult Mental Health Division of the Ministry by 70%, thus radically altering its policy and leadership capacity. During this time the government also instituted deep cuts to social welfare services and legal aid. To date, little attention has been paid to the combined impact of cuts and policy changes to social services and mental health care.

Although since 2001 the government has instituted some changes that positively impact people with mental illness (such as a modest increase in supportive housing units), the cuts and negative policy changes appear to outweigh these benefits.

For example:

» In BC we do not have comprehensive, accurate data of the numbers of people with mental illness who are homeless and/or under-housed and therefore do not know the full extent of poverty amongst people with mental illness.

» Changes to eligibility criteria and the complexity of the application process for both basic income supports and disability benefits have made it virtually impossible for people to successfully apply for benefits without the help of an advocate.

» Advocacy mechanisms for the meaningful participation of consumers in treatment decision-making and policy development have been badly eroded.

» Community-based mental health services continue to be under-funded and active recovery models are under-valued in the overall system of mental health care.

» Housing for people with mental illness that conforms to federal best practices standards is extremely inadequate and wait lists are unacceptably high.

» Housing, especially in Vancouver, is often provided in unsafe locations and outside of a therapeutic environment.

» Employment supports in the province are geared primarily toward people without mental illness. Further, support for innovative models that actively promote consumer empowerment through meaningful activity is lacking.

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Little attention has been paid to the combined impact of cuts and policy changes to social services and mental health care.

An Aging Population and the Sustainability of BC's Health Care System

By Marc Lee

One argument you are likely to hear in the Conversation on Health Care is that public health care is unsustainable because our population is aging and seniors use a disproportionate amount of health care services. But before we hit the collective panic button, let's take a look at the facts.

While population aging has put upward pressure on health care costs, its impact is relatively small. Over the past decade, it has accounted for annual cost increases of just under one percent, and projections indicate that it will be only slightly higher in the future. If we take other cost pressures, such as inflation and population growth, into account, BC needs to increase health care spending by just under five percent each year to maintain current service levels for an aging population.

BC currently spends about 7 cents out of every dollar of income (GDP) on public health care. If we continue to do that in the future, we can maintain our current system and even have some left over to expand services, as long as economic growth is reasonable.

The good news is that the economy will also be growing, and what matters is the size of health care expenditures relative to our total income (or GDP) — not the share of the provincial budget. As long as the economy grows faster than health care expenditures, our current system is sustainable. Even if BC's economic growth rate (nominal GDP) averaged four percent per year — well below historical norms — the additional cost of maintaining current services would be small: an additional penny per dollar of income by 2031.

The bulge of seniors is expected to peak around 2031, and will be declining thereafter. So we have lots of time to gradually respond to the challenges posed by an aging population. This includes a restructuring of health care services, such as enhancing home care and residential care so as to take the pressure off the more expensive acute care system. We should also emphasize prevention and population health initiatives to reduce the overall incidence of ill health.

A final element related to health care spending is that the suite of services we call health care has expanded over time. A typical British Columbian today receives about one-and-a-half times the amount of health care services as his or her predecessor of thirty years ago.

If future economic growth rates remain consistent with those over the past quarter-century (5.7 percent per year), we actually have scope to expand health care services. On the ground, this could mean more long-term care beds, more comprehensive drug coverage or public dental insurance.

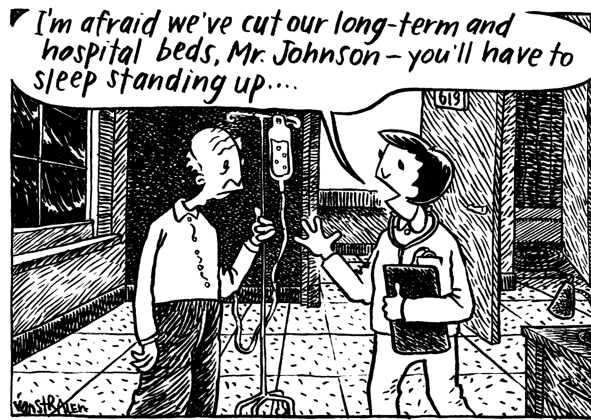
The expansion of health care services is also intertwined with the bigger issue of technology. The real financing challenge comes from advances in technological possibilities, broadly defined to include pharmaceutical drugs, new surgical techniques, new diagnostic and imaging technologies, and end-of-life care.

New technology almost always increases total costs, even when it reduces the cost per procedure. An example of this is knee and hip replacements, where waiting lists have been a major concern. In response, the BC government has dramatically increased surgeries, at rates well beyond what population growth and aging would require. Yet, waiting lists are still an issue because the advent of less invasive (and less risky) surgical techniques has increased the number of people who can have such surgeries. Compared to 1990, today's 80-year-old is twice as likely to have a knee replacement.

Another example is end-of-life treatments. Dying has become very expensive: research has found that one-third to one-half of a typical person's lifetime health care costs come in the final year of life. This raises ethical dilemmas, particularly when technology can prolong life by days or weeks, but with little or no improvement in health status or quality of life.

These technological challenges can be addressed most efficiently and equitably in the context of a public system. A thorough process of health technology assessment is required to ensure that new technologies provide benefits in accordance with their costs. Public policy initiatives could also be implemented to better control drug costs, through greater generic production, bulk purchasing, and an expansion of BC's successful reference drug program.

That's the "conversation" we really need to have.



The good news is that the challenges facing public health care are not demographic time bombs beyond our control.

The good news is that the challenges facing public health care are not demographic time bombs beyond our control, but technological issues that, while profound, are suitable to a public process that is well within our control. It is not the number of seniors that is the problem, but finding a rational framework to ensure we spend our health care dollars as effectively as possible. •

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The Decline of Community Health Services in BC

for care privately or provide it themselves. Those who cannot afford to pay or who do not have families to support them often go without any care until they are admitted to an emergency ward in crisis. This is happening across the province, and is resulting in increased wait times and back-ups for acute care — as several health authorities now acknowledge.

Exactly how much this is costing the health care system remains unknown. We do know that housing seniors in acute care beds costs many times more than it does to house them in residential care or to provide them with services at home. It is time to go back to the drawing board, look at how these services could be enhanced, and the impact that would have on waiting times for emergency and other hospital services. •

Continued from page 5
Private Emergency Clinics: Cure or Cancer?

It is true that the clinic will provide another place to go for "low complexity" patients needing urgent care. However two of our smaller hospitals — UBC and Mt St Josephs — already provide excellent urgent care services and may well be under-utilized. If there was a need to expand such services, then encouraging the "walking wounded" to attend these facilities and expanding their hours is likely to be a more accountable and sustainable option. •

Continued from page 9
Mental Health Services and Social Policy in BC

The BC government continues to focus mental health care funding on acute care and hospital-based care rather than much-needed services based in communities. Indeed, community-based organizations have suffered cutbacks and are increasingly overwhelmed with new requests for service. This in turn has tightened the mandates of mental health teams such that only those people with the most serious forms of mental illness are able to access support systems.

The government has ignored its responsibility to develop a comprehensive mental health strategy for the province that establishes the provision of income, employment and housing supports to people with mental illness as part of comprehensive mental health care provided by the Ministry of Health. The province has lost sight of active recovery models and is letting a preoccupation with cost-containment guide decision-making, rather than the values reflected in 'best practices' for the care and support of people with mental illness. •

CCPA Resources on Health Care

Available for download at www.policyalternatives.ca

Is BC's Health Care System Sustainable? A Closer Look at the Costs of Aging and Technology by Marc Lee, November 2006.

Community-Based Mental Health Services in BC: Changes to Income, Employment and Housing Supports By Marina Morrow, Silke Frischmuth and Alicia Johnson, August 2006. A publication of the Economic Security Project (ESP).

Getting Better Health Care: Lessons from (and for) Canada by Armine Yalnizyan, July 2006.

From Support to Isolation: The High Cost of BC's Declining Home Support Services by Marcy Cohen, Arlene McLaren, Zena Sharman, Stuart Murray, Merrilee Hughes & Aleck Ostry, June 2006. An ESP publication.

Public Solutions to Health Care Waitlists by Michael Rachlis, December 2005.

The Pains of Privatization: How Contracting Out Hurts Health Support Workers, Their Families, and Health Care by Jane Stinson and Nancy Pollak and Marcy Cohen, April 2005. An ESP publication.

The Hidden Costs of Health Care Wage Cuts in BC by Marc Lee and Marcy Cohen, April 2005.

Continuing Care Renewal or Retreat? BC Residential and Home Health Restructuring 2001-2004 by Marcy Cohen and Janice Murphy and Kelsey Nutland and Aleck Ostry, April 2005.

Democratizing Public Services: Lessons from Other Jurisdictions and Implications for Health Care Reform in BC by Marcy Cohen, March 2005. An ESP publication.

Fair Pharmacare? A Backgrounder on the Government's Changes to BC's Pharmacare Program by Sylvia Fuller, April 2003.

Paying for What Works: BC's Experience With the Reference Drug Program as a Model for Rational Policy Making by Alan Cassels, March 2002.

Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care by Donna Vogel and Michael Rachlis and Nancy Pollak, November 2000.

Policy Options for Progressive Health Care in BC: Proceedings of a CCPA-BC Workshop on the Future of Health Care by Marc Lee and Seth Klein (editors), May 2000.

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BC COMMENTARY

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