

**Envisioning Progressive Health Care Reform
Speech to the Canadian College of Health Care Executives,
BC Lower Mainland Chapter**

By Seth Klein, BC Director, Canadian Centre for Policy Alternatives
May 24, 2002

Good morning, and thank you all for this invitation. Our Centre has been deeply involved in debates regarding the preservation and improvement of public health care for many years, and I'm pleased to have this time to share some of our policy ideas and recommendations with you -- an organization that is likewise committed to both the efficient and equitable provision of quality health care to all Canadians.

Let me start by saying a little bit more about the CCPA. We are a non-profit public policy research institute committed to social and economic justice. When I'm asked to say in a sentence what it is that we do, I say we produce and promote research aimed at challenging the TINA phenomenon -- TINA being an acronym for the prevailing message, immortalized by Margaret Thatcher, that "there is no alternative." It is a claim we hear, in one form or another, all the time. For example, if I were to put the central message out of Victoria these days into a sentence it would be "we're sorry, these cuts will be painful, but we have no choice." Likewise, we frequently hear the assertion that we wish we didn't have to open up our public health care system to private corporations, but rising costs give us no alternative.

We believe that good public policy is always about choices -- that there are, in fact, alternatives. We've been making that case since 1980, and in 1997, opened our BC Office in an effort to bring more balance to public policy debates here in our province.

What I'd like to do in the time I have with you this morning is this: First, I'd like to address what we see as some of the risks and challenges to public health care, particularly in light of the changes being imposed by the new provincial government. Second, I'd like to outline the main planks of what we see as a progressive alternative agenda for health care reform. I'd also like to address some of the options for reform that are in the mix that we believe are wrong-headed (some of which John has just proposed), and explain why we view them as misguided. And finally, I'd like to close with some thoughts about your role, as leaders in the health care field.

The Challenges

I don't envy the task you face as health care executives, particularly here and now in BC, given the tidal wave of change you are being asked to manage.

I would submit that there is a false economy underlying much of the current round of health care reform in BC, and that many of these cuts (I'm sorry, "changes"), don't actually control or save costs. They simply shift costs onto individuals, families and in

some cases employers. They aren't in fact about saving money -- just changing who pays and how we pay. The result will be a loss of both efficiency and equity.

Indeed, False Economy and Cost Shifting are two key themes that characterize so many of the cuts currently originating from Victoria.

For example, cutting Pharmacare may not save the health care system money, nor will it reduce drug costs. The fact that we have heard no public complaint from the major drug companies about these Pharmacare cuts is perhaps the surest proof that these reforms won't mean lower drug expenditures overall. Rather, they merely shift drug costs onto individuals and employers. Moreover, they risk increasing hospital costs.

The evidence from Quebec is telling. A study by Robin Tamlyn and her associates published in the January 2001 edition of the *Journal of the American Medical Association* looked at what happened when that province raised the cost of prescriptions for those on social assistance and the elderly from a nominal two dollars to twenty-five percent of the total cost per prescription. The result: fewer patients took the drugs they were prescribed, resulting in increased adverse effects and more visits to expensive emergency rooms.

The government is pleading poverty, claiming that BC's public plan covered a larger share of drug costs than in any other province. That is true. But what they fail to mention is that overall per capita drug expenditures (public and private combined) have been lower in BC than in any other province. The fact that we have chosen to pay for more drugs collectively is saving money. Governments can control costs through bulk purchasing, and other cost-containment strategies (such as the Reference Drug Program). In contrast, if the share of expenditures borne by the public system decreases, Pharmacare will lose influence over drug prices.

The early decision to end MSP coverage for supplementary therapies (such as massage, physiotherapy and chiropractic care) also represents both a cost shift (onto individuals and workplace benefit plans), but also 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.

And there are more false economies embedded in the health care restructuring announced last month.

For example, according to recent estimates by the Ministry of Health, about 13% of acute care patients are only there because of a lack of long-term, rehab or community services. Therefore, the decision to decrease the number of long-term care beds, and to merely maintain current funding for home support, will mean more pressure on the acute care system, which as you all know, is already under great stress. Given demographic trends, there is a clear need for more long-term beds. "Assisted living" spaces, while desirable,

are no substitute. Assisted living is appropriate for some at some stages, but cannot replace long-term care.

Given this, the plans tabled by the health regions on April 23rd to reduce the number of acute care beds are simply not realistic, particularly given the fact that the number of acute care beds available in BC has already dropped by almost 40% over the past 10 years (well in excess of what was recommended by the Seaton Commission in 1991, and without the needed commensurate investment in community care). BC now spends less per capita on hospitals than any province except Saskatchewan, and the latest cuts haven't even started.

Another example: With increased contracting-out of various services will likely come a decrease in quality. Lower wages are associated with poorer training and higher staff turnover. Estimated cost-savings from contracting-out rarely include the costs of administering and supervising contracts, which continues to be borne by the public system. And what is saved in lower wages generally goes to the shareholders of the private firm offering the service, leaving no real net savings to the public.

Another example: When health boards cut school-based eye and hearing testing, what kind of higher costs will we subsequently face dealing with more complicated problems?

The costs of restructuring itself, and the severance pay this restructuring will require, is going to consume millions of public health dollars. And as you know, the academic management literature in the US and Canada has raised questions about whether downsizing (public or private) actually saves money without sacrificing quality. Frequently, the resulting disruption and dumb-sizing carries its own costs.

Another example: When rural hospitals close, and access to maternity care and other services is lost, it sets in motion a domino effect. Rural communities will find it more difficult to recruit and retain physicians (who rightly want to practice the full spectrum of care, which requires hospital support). The literature tells us that when women must relocate to give birth, they experience more adverse outcomes. All this means that more people will be coming to Vancouver's specialty hospitals to give birth or for other acute care needs. Yet the largest employment cut in percentage terms announced on April 23rd is to the new Provincial Health Services Authority. This leg of the health care system is planning for a reduction in services, but what is unfolding in the regions is at odds with this plan.

These are all false economies. The plans outlined by the various new health authorities last month don't square. They are not realistic. All propose off-loading onto other points of the overall system. But something will have to give. As a whole, the plans do not compute.

Other challenges you face stem from broader public policy changes.

For example: The Liberal tax cuts.

It needs to be said that, to the extent that much of the current dislocation, disruption and downsizing in the health care system is driven by an alleged need to cut government costs -- this fiscal imperative is a self-inflicted crisis. None of this hardship needed to happen. It is almost entirely the product of the reckless tax cuts delivered last summer -- a public policy choice with very real consequences. The Liberals campaigned on the promise that tax cuts would generate so much economic activity that they would pay for themselves, and no spending cuts would be needed. Our Centre was among the few voices disputing this view, but most voters came to believe this assertion. They don't anymore. Even the government's own budget shows that the tax cuts won't come close to paying for themselves.

In its early days in office, the government blew a hole of over \$2 billion in the provincial budget. The spending cuts and the health care freeze are merely about paying for those tax cuts. They are the other shoe dropping. This is important context for the debate on health care reform.

The re-making of our province is being justified by the twin false claims that BC's government spending was out of control, and that our taxes were among the highest in the country. Neither assertion is supported by the facts.

The notion that we cannot afford our public programs -- that BC has been living beyond its means -- is simply untrue. Before any of these latest cuts, BC government spending relative to GDP (the size of the economy) was already the third-lowest in Canada, and peaked in 1991. BC's public service was already the second smallest in the country (measured as the number of total public sector employees per capita). True, health care has become a larger share of the provincial budget, but much of that speaks to the cuts to all the ministries outside health and education over the past 10 years.

Neither does the evidence support the claim that BC taxes were "uncompetitive." Even before last summer's tax cut, the vast majority of British Columbians paid either the second- or third-lowest taxes in the country. And overall government revenues relative to GDP were already the third-lowest in the country.

In combination, the tax and spending cuts will surely result in greater inequality. We are witnessing a transfer of income from the poor (who disproportionately depend on public programs), to the wealthy (who disproportionately benefited from the tax cuts). Moreover, most people's tax cuts are being quickly consumed by escalating medical premiums, pharmaceutical costs, child care costs, user fees and tuition, etc.

These trends will have an impact on health care. Why? Because the research on the determinants of health is clear. The empirical evidence connecting poverty and inequality with poorer population health and increased health costs is unequivocal. Poverty is the greatest health hazard, and the leading killer. We face a real problem here -- and you face a real challenge as health care managers -- because the policies of the new provincial government will increase poverty and inequality. The cuts to welfare and the diversion of

social housing funding to "assisted living" will put more pressure on the health care system, just as you are being told to do more with less.

Bad Reform Ideas

Before talking about what a progressive reform agenda would look like, let me spell out what it isn't, because there are a number of bad policy prescriptions being bandied about.

Bad idea #1: User fees

The basic false premise behind this idea is that, if people are charged a modest fee for service, frivolous usage will decrease, and a new income stream will open, thereby saving the overall system money.

The core problems with the idea are these (and I'm drawing heavily on the work of UBC's Robert Evans here): 1) doctors have much more influence over usage than do patients; 2) The theory behind user fees (or co-payments) is that, under the law of supply and demand, consumption will decrease when the price increases. The problem, however, is that, generally speaking, we demand health care not because we want it, but because we need it, or believe we need it; 3) The research indicates that patients are poorly equipped to tell the difference between necessary and unnecessary treatment; 4) The research on user fees tells us that those who are primarily sensitive to user fees are the poor (who also tend to have higher health care needs), and that when facing user fees, they may avoid needed as well as unneeded care. If, however, one tries to build into the system a threshold to exempt low-income people, the added administrative costs may wipe out any hoped-for savings.

Here again the false economy theme emerges. User fees may prevent people from pursuing preventative care, leading to higher demands on the acute or chronic care system down the road. And as the Tamblyn study out of Quebec showed, some low-income people and seniors stopped taking necessary drugs when facing higher fees, leading to adverse health outcomes and an increase in visits to costly emergency rooms. A recent Manitoba study on asthma drugs had similar findings.

A major new study out of the London School of Economics, drawing on evidence from the US, Sweden, Ireland and France, concluded that user fees may indeed deter frivolous use of health care, but that they also deter people from seeking necessary or appropriate treatment, particularly among the poor.

Consider this simple fact: it is that part of the health care system that is fully public -- hospitals -- where spending has remained most stable (there has been no change in spending on hospitals relative to GDP since the 1970s). In contrast, the part of the health care system that has experienced the greatest increase in costs is drugs, which is largely private, and where large user fees are the norm.

Bad idea #2: Privatization (by which I mean turning to for-profit delivery, not non-profit)

This approach fails the tests of both efficiency and equity. It fails the efficiency test because so much money is lost to administration, duplication of service, marketing, fragmentation and the loss of system-wide coordination, and, of course, to profits (with shareholders expecting 10-15% rates of return).

Privatization also fails the test of equity, not only because low-income people cannot afford insurance, or because those with precarious employment do not have employer plans, but also because those with chronic or, increasingly, genetically-predisposed problems, will face prohibitive premium costs. As it currently stands, Statistics Canada data indicate that in 1999, only 53% of Canadians were covered by supplementary medical insurance. Broken down by gender, only 47% of women are covered compared to 59% of men.

But what about the Alberta model? Namely, public funding but private delivery (be it private clinics or private hospitals). Throughout the debate over Bill 11 in Alberta two years ago, Premier Klein insisted the Bill would not violate the Canada Health Act because the funding will remain public and the procedures will be available to all. So, what's wrong with that? What's wrong with private delivery if the funding is still public?

Well, a number of things:

There are lots of things the private sector does well -- it makes exciting computer games, produces food and clothing (although not without disturbing evidence of exploitation and environmental damage), builds homes (although again, not for everyone and not without the occasional leak), it services appliances, and it makes a pretty good donut. But the private sector doesn't do health care well -- and the research evidence on this from around the world is unequivocal.

A key difficulty with all these private options is that with health care, unlike with conventional commodities, there exists an imbalance of information.

Kevin Taft and Gillian Stewart, in a book published by the Parkland Institute, our sister research institute in Alberta, explain the problem this way:

If you go to Tim Horton's for a donut, and you get a stale donut, it does not matter that you are not a master baker, you will know it is a stale donut and you can say "this is a bad donut -- I want my money back."

But if you have a splitting and persistent headache and you go to see your doctor, and he or she says, "you need an MRI," who are you argue? How do you know a strong pain-killer won't do the trick? The imbalance of information means we are incredibly dependent on doctors to control costs.

Now, what happens if that doctor making the diagnosis is working at a private hospital? Now, inevitably, the doctor is in a conflict of interest. Why? Because the best interests of the patient and the public system may be at odds with the interests of the institutional shareholders who own the hospital and want a high rate of return, which means prescribing the most expensive form of treatment -- so long as the public is picking up the tab -- driving up health care costs.

The key is that private hospitals are inevitably less efficient than public ones. Why? Think of it this way:

Say we have \$100 in public health dollars. If that is directed towards a private hospital, right off the top there are institutional investors who demand 15% rates of return (the profits). Investors also demand growth of about 15% annually, leading to more built-in pressure to drive up costs. Then there is the fact that private sector top executives generally command salaries much higher than in the public sector. Then there are the private costs of marketing, processing claims, corporate expansion and take-over strategies, and low and behold, if you're lucky, the \$100 you started with is now only \$70. What's more, while you might have been able to care for three people with the original \$100, now you only have enough to care for two -- so waiting lists go up (not down).

That's why, according to a recent issue of the New England Journal of Medicine, "For decades, studies have shown that for-profit hospitals are 3-11 percent more expensive than not-for-profit hospitals; no peer reviewed study has found that for-profit hospitals are less expensive." Similar studies have come to similar conclusions regarding for-profit nursing homes and home care.

Numerous studies undertaken by academic institutions in the United States [from John Hopkins, Harvard, University of California, University of Texas, and from Australia] show that the drive for profits lowers the quality of health care and compromises patient safety:

A 1999 study by Johns Hopkins Medical Institutes and Harvard Medical School, for example, discovered that patients with kidney disease who went to for-profit dialysis clinics were 20 percent more likely to die and 26 percent less likely to be placed on a transplant waiting list within 18 months of starting dialysis. The study also found that for-profits employed fewer staff than their non-profit or public counterparts.

The study's authors concluded that the higher number of deaths were associated with an emphasis in for-profit clinics on controlling costs and maintaining high patient volumes. Another study, this one published in the August 2001 issue of the American Journal of Public Health, found that for-profit nursing homes were cited for deficient quality 46.5% more frequently than their non-profit counterparts. This study, conducted by the University of California and Harvard University, analyzed data from government inspections of 13,693 nursing homes during 1998, a figure that represents virtually every nursing home in the US. Higher rates of severe quality problems in which patients were

harmed were also attributed to for-profit nursing homes, where staffing levels by licensed nurses and nurses' aides were found to be significantly lower.

For-profit and not-for-profit hospitals were compared in a study published in the April 2000 edition of the *Journal of General Internal Medicine*. The study was conducted at the University of Texas, and showed that among 15,000 patients, those cared for in for-profit hospitals were two to four times more likely than patients at not-for-profit hospitals to suffer adverse events such as complications following surgery or delays in diagnosing and treating an ailment.

According to health economist Dick Scotton of Australia's Monash University, the efficiencies of the private sector "are always illusory." Commenting on Australia's experiment with privatization, Scotton told the *Toronto Star* in March 2000, "Governments think they will save money [from privatization]. But the private operators always bid low -- then they threaten to go into bankruptcy and the contracts have to be restructured." His arguments are borne out by studies from both the United States and Britain.

Bad idea #3: P3s (Public-Private Partnerships)

I'm speaking now primarily about capital projects. This again is an unnecessary solution to a false problem. At its root, the issue with P3s is simply about who holds debt. Any time a capital project is to be undertaken (in the public or private sector), the money almost always must be borrowed. But governments, mainly because of the success of groups like the Fraser Institute, fear taking on debt. With P3s, they leave that task to a private firm, and then they simply lease back the services on an annual operating basis. The private firm takes on the debt, and the debt stays off the government's books.

The government is still paying for the capital costs, however, only the financing costs are built into the annual rents. The irony is that private firms always face higher financing costs than do governments. The credit ratings of any private firm are lower. So fear of debt leads to government paying higher financing through the private sector over time.

The recent report by forensic auditor Ron Parks into the proposed P3 for a new Abbotsford hospital puts the lie to the notion that these schemes save money. Even the PriceWaterhouseCoopers feasibility report Parks was assessing had the cost savings very low over 30 years, but as Parks pointed out, even these modest gains were based on a number of questionable and sensitive assumptions, which if proven illusory would mean no gain at all, or worse.

But beyond the money issue, there are issues of accountability. In the event of a problem with the project or service, who is responsible -- the public authority, or the private firm? And to whom will the private firm feel its principle responsibility -- the public or its shareholders?

The experience with the Private Finance Initiative in Britain is telling. According to the *British Medical Journal* and other reputable British publications, PFIs -- or public-private partnerships -- in Britain have been plagued by shoddy construction standards and huge

cost over-runs, which have siphoned funds away from patient care services. The BMJ also noted that costs for these private facilities are 18 to 64 per cent higher than conventional public hospitals.

Bad idea #4: Medical Savings Accounts

This is similar to the private voucher system the Fraser Institute and others propose for education. It involves some or mostly public funding, and then individuals are free to shop around to various providers. Private advocates like it, because it opens the door to unlimited private delivery, with the associated profit potential. But it raises many questions. In particular, what happens to people whose health care requirements exceed the money available in their MSA accounts? It is an approach that discriminates against the sick and old and poor, who face high health costs.

This approach is also incredibly and unnecessarily complicated. It is a clear case of the cure being far worse than the ailment.

MSAs did not help Singapore. Their health spending in fact rose dramatically under MSA until 1993. It was then brought under control through a variety of other more interventionist strategies, such as restrictions on technology in public hospitals, price caps on services, bed reductions, and tighter controls on the number and mix of physicians. Professor James Hurley, an economist at McMaster University, estimates that if MSAs were introduced in Canada, health costs would in fact increase, as the government struggled to pay for the basic accounts for low-needs Canadians, the premiums for catastrophic illnesses for those with serious problems, and the administration of this new complex system.

A progressive agenda for reform

At its heart, the health care experience in Canada provides a valuable lesson for many areas of public policy. Namely, that despite its short-comings and stresses, we have built something very impressive. And we have proven that in some cases -- health care being one -- services can be provided both more equitably and more efficiently when we provide them together -- collectively through our taxes, rather than privately and individually.

Our system recognizes that health care is not a commodity like any other, but a right to which all should have access regardless of ability to pay. Public health care has become central to our identity, and for good reason. It represents a shared commitment to care for one another, and to pool risk across society and across each of our life cycles, in recognition of the fact that none of us knows when serious illness will strike. Should we be paying for Jim Pattison's health care needs (as those who would have us undo universality always ask)? Yes. But we should pay for the overall system through a progressive income tax system tied to one's ability to pay. It's administratively simple, and it's fair. And it is that progressive income tax system that is currently being undermined by both the federal and provincial governments.

But that said, of course the system can be improved. We do need reform. We could use and coordinate health care resources more effectively. We can take pressure off the acute care system and do much better with respect to preventative health care. And we look to you to provide good management and leadership, but without throwing in the towel on the ideals of public health care and taking us down the road of increased privatization.

I don't see this government tackling the real health reform challenges with the potential to control costs, and frankly, neither did the previous government. They didn't adequately invest in Community and Continuing Care (as our Centre documented in a study two years ago called Without Foundation).

So what are the components of a true progressive agenda -- one that will actually control costs, rather than simply shift costs?

There is a better way. Here's our prescription:

1) Increase health care funding. Perhaps stating the obvious. This is required from both federal and provincial governments. While it is true that more money alone will not fix our health care system, lack of funding guarantees greater stress. The federal government needs to fully restore and enhance health funding transfers to the provinces. This should take the form of a specific and targeted health transfer (separate from other social and educational transfers), so that the provinces cannot redirect these funds for other purposes.

There is a disturbing level of crisis rhetoric these days about the unsustainability of public health care spending. The reality is that public health spending in Canada, relative to GDP, peaked in 1992. The key point is that health spending is driven mainly by need -- the only question is whether we want to pay for it collectively or privately.

2) Keep the health care system public. Stop the slow growth in private for-profit delivery. I've said enough on the merits of this already.

3) Bring in a Community and Home Care Act (CHCA). As health care delivery moves increasingly into the community and people's homes (which is, by and large, a good thing), the Canada Health Act is not being enforced, and that means privatization. The Canada Health Act only applies to hospitals and doctors services. We need new legislation to ensure continued public or non-profit delivery and universal accessibility.

4) Build new public long-term care facilities and invest adequately in home care. There is a clear shortage of long term care beds, and that shortage is increasing quickly. Without adequate investment in new facilities, long-term care patients will increasingly take up acute care hospital beds, and our emergency rooms, in turn, will remain clogged with acute care patients.

5) Move away from paying doctors primarily on a fee-for-service basis. This is critical for controlling costs, as doctors working on a fee-for-service basis have an incentive to see too many patients for an inadequate period of time, too frequently, and to order unnecessary procedures. (This is particularly true in BC, which spends a larger share of its health care budget on doctors than any other province.) Doctors on salary can take the time needed for each patient, and do not face the same incentive to "over-doctor". Every major federal and provincial inquiry into our health care system and its financing has identified fee-for-service as a major barrier to improving medicare's efficiency. This is not to say there is no place for fee-for-service. It may make sense for some services (births, for example) to be remunerated on a fee basis (we need to compensate people for getting out of bed in the middle of the night). The point here is to get the right mix. And contrary to popular perception, many doctors would prefer being on salary (with better income security and enhanced personal lives).

6) Move towards multidisciplinary, community-based, primary health care centres. This is not new. We all know this move is needed. Our health care system needs teams of professionals working together (on salary) serving their local communities (Vancouver's Reach Community Health Centre on Commercial Drive is a good model). Such centres can provide total care to a given population, and the centre's team can focus on the task of providing ongoing care, without worrying about their personal incomes. Many health care problems do not require the ongoing services of a doctor; they can be looked after by other (less highly-paid) professionals (nurses, physiotherapists, psychologists, counselors, nutritionists, etc.). We need to encourage everyone to establish long-term relationships with a family doctor/general practitioner, ideally based out of community centres (such as Quebec's CLSCs). We need people's first line of contact to be local health centres or GPs, not expensive emergency rooms or "doc-in-a-box" clinics that do not provide ongoing primary/family care. There is strong research showing that jurisdictions with multidisciplinary primary health care teams have healthier populations and lower costs. Professionals working with teams can also spell each other off and live more reasonable personal lives.

7) Bring in a public National Drug Plan and control drug costs. Drug costs are escalating more than any other component of the health care system. This requires repealing federal drug patent legislation (even if it means fighting off a WTO/NAFTA challenge). BC's Reference Drug Plan is a good model, as it makes little sense to pay sky-rocketing fees for drugs with no evidence of improved health outcomes. It means tackling the problem of physician over-prescribing with doctor education, good patient education, and a reigning-in of direct-to-consumer marketing. A national public Pharamcare plan will also greatly assist in controlling drug costs through bulk buying and more effective negotiating with drug companies. Perhaps we should consider a new federal Crown corporation to produce generic drugs.

8) Provide adequate resources for the Provincial Mental Health Plan. De-institutionalization has left too many mental health patients out in the cold. These patients still need adequate housing, incomes and support, and the on-going care of mental health

practitioners. The Provincial Mental Health Plan talks about integrating acute and community mental health services, to create a continuum of care. That takes money.

9) Give health care workers and patients a greater say within the health care system. Working in the health care system is stressful, and too often encountering it as a patient is even worse. Less hierarchical workplaces would be a good start. There is a growing literature indicating front-line workers with more autonomy and support functioning in more democratic workplaces experience decreased injury rates, take less sick leave, and deliver better patient care. We need reform, and both workers and the public will be more willing to go along for the ride if they are included in the policy-making and governance process.

Let me say a little more on this one. We all know the system needs reform. But when you are embarking down that road, it really helps to have the people in the system as allies. The management literature on this, as you know, is very clear. When change is imposed from on high, you get stress and burnout, poor morale, lost productivity and poorer quality service. Effective reform means respecting the knowledge of front-line workers. As a new study from the Canadian Policy Research Network notes, good reform needs accords with those in the system, to bring them in as allies. I think BC's 1993 Health Accord was a helpful model -- it said to workers in the system "We all know change is needed and that we need to move more health care into the community. But you need not fear change, because we will provide job security and retraining." I'm sure the accord had its faults, but it's a good model. Unfortunately, this government is moving in the opposite direction, and against all the expert advice. They have alienated all those in the system and made them into opponents, not allies.

10) Last, but certainly not least: Tackle the determinants of health and adopt a comprehensive anti-poverty strategy. That means rethinking tax cuts for those who need it least, and budget cuts for the programs low-income people depend on. If our governments declare war on poverty, child poverty, homelessness, and unemployment, health care costs will come down. More non-profit housing, not just for poor seniors and people with physical and mental disabilities, but for the thousands of other low-income people on waiting lists, is the most pressing need. Tied to this recommendation, we need to put more money into prevention and wellness, not just illness. That means tackling the causes of cancer and heart disease, not just the acute emergencies. It means dealing with environmental and food safety issues. It means better working conditions, and fostering healthier lifestyles.

Another way is possible. We can afford progressive reform. Our Centre outlined a different direction for BC -- a workable alternative strategy -- in a document we released in February called Towards a Solutions Budget for BC.

We called on the government to scale-back its tax cuts; keep the tax cut for the bottom two brackets (which the Liberals clearly ran on), but abandon the upper-income and most of the corporate tax cuts delivered by surprise last summer. Some of this money could then be directed toward a modest increase in spending.

This would have a number of positive outcomes. First, it spares us all the unnecessary pain of the spending cuts. Second, it would allow the government to honour its contracts, and to help the most vulnerable with a \$200 million increase to the welfare budget (as one should expect during an economic downturn). And third, because public spending keeps more money in the BC economy than upper-income tax cuts, this Solutions approach would provide four times the job and economic boost than would the Campbell/Collins plan.

Our Solutions approach stands in stark contrast to the message track from Victoria. We can still afford to take better care of each other. There is nothing inevitable about the spending cuts.

Your role

So finally then, what of your role as leaders in this debate? In short, we need you to speak out. I know this is hard. I know you are facing what seems an overwhelming task. But, as with local school boards and college and university boards, we need you to be more than managers of needless downsizing. You must be vocal. You must defend your patients, your workers, your professional integrity, and the public interest.

I must tell you that I was distressed watching the communications fiasco on April 23rd, and not just by the substance of the cuts. It is not your job to defend these cuts on behalf of the provincial government. We need you to defend the system.

In communities like Nelson and Kimberly, doctors and public health care workers, and community leaders are joining with their communities in sounding an alarm about what these cuts will mean. They are fighting, collectively, for their communities. That's good leadership.

If the new performance measures that the government is proposing are setting the public system up for failure -- if they cannot be realistically met within the context of the restructuring and cuts underway -- then we, the public, need to hear that, now, from you.

Much is at stake. The livelihoods of your workers. The viability of a number of interior communities. The lives of some of your patients. And, because of the trade agreements to which Canada is a signatory -- the NAFTA and the GATS (the WTO's General Agreement on Trade in Services) -- many of the privatization initiatives currently being contemplated could be locked-in. Meaning, if we find they were a mistake, the compensation we would have to pay to private transnational firms under these agreements would make the cost of rethinking these decisions prohibitive.

If you cannot speak out alone, then speak collectively, through organizations like this College (which has a mandate to engage in public policy debates). If changes underway are unsafe, it is the duty of your college, along with the college of physicians, nurses,

midwives, etc. to intervene. But, if you share some or all of the concerns I have outlined this morning, then speak.

Good luck, and thank you.

Canadian Centre for Policy Alternatives, BC Office
1400-207 W. Hastings St., Vancouver, BC V6B 1H7
Tel: 604-801-5121, Fax: 604-801-5122
www.policyalternatives.ca
ccpabc@policyalternatives.ca