Is public healthcare dying?

Supreme Court ruling to usher in a wave of change

pro Universal coverage must not have wait lists

BY BRIAN DAY, MD

The Supreme Court of Canada has now affirmed the right to protect one's health. The likelihood of more court challenges across the country is low because governments will revise their provincial laws to conform to the Court's guidelines. One can't imagine any provincial government arguing in court that it's acceptable for suffering and dying people to languish on wait lists, unless they live in Quebec. The current Canadian system is ranked 30th in the world in efficiency and third in cost. We can do better. In evaluating the implications of the Court decision, let's examine some facts.

The largest recipient of private healthcare funding will be public institutions. Healthcare will see an additional $12-40 billion a year in non-tax investment. In Britain, public hospitals receive over a billion dollars in private revenue. Like the orthopedic hospital in Cuba (which generates a yearly profit of $20 million US by treating non-residents), Canadian hospitals will be able to engage in entrepreneurial activity and use the profits to care for their own citizens.

End our brain-drained system

Government policy created the current manpower shortage. Over 20 years ago, governments were persuaded to stop training doctors because they generated over-utilization of services. This led to a doctor shortage but, despite this, rationed operating room time forces half of recently trained orthopedic surgeons and neurosurgeons to leave Canada each year. A 2004 McMaster University study showed that just under half of new nursing graduates obtained full-time work.The Court's decision will increase capacity, reverse the brain drain and increase the workforce.

Private clinics don't serve the rich. Most patients who are treated at centres like the one where I practice are low income working-class citizens. Every year, private centres remove 50,000 patients from public wait lists in British Columbia. The "rich" often leave Canada for treatment, while others with influence jump queues in the public system. Centres such as ours spend less on management, yet are more productive. Our salaries consume 30% of gross revenue compared to 70% in public hospitals (despite the fact that we pay our nurses more). Market forces and competition will make public hospitals more efficient. It's been stated by those who don't understand hospital global funding that private centres extract revenue from the public sector by "cherry picking." If 1,000 patients leave a wait list and pay for the surgery in the private sector, there's a net saving to the government of 1,000 x (cost). The public hospital can then utilize the freed up resources.

Canadians will soon experience European-style healthcare, which delivers universal coverage with a difference — no wait lists for the rich or the poor. Those who support our system (i.e. the two million patients waiting for healthcare, with some dying while they wait) must now go elsewhere to preach their blasphemy. Soviet-style medicine has been ruled illegal. Since the only country that now has such a system is North Korea, I wish supporters of traditional Canadian medicare a pleasant journey and a long stay.

Brian Day, MD, is Associate Professor of Orthopedic Surgery at UBC and Medical Director of the Cambie Surgery Centre in Vancouver. He was an intervenor in the Chaoulli case and has organized a major health summit, "Saving Medicare — Strategies and Solutions," to be held in Vancouver on November 11-12, 2005 (www.cimca.ca/conference.html).

con The myth of private healthcare

BY PAUL SABA, MD

The recent Supreme Court decision to allow access to private health insurance covering medically essential services severely undermines publicly financed healthcare.

First, the goal of medicare is to ensure universal healthcare for all. There is a core of essential services that are deemed necessary for the health of Canadians regardless of their financial means. This allows access to essential services to the poor and rich alike. The argument put forward by proponents of private insurance is that, "if you can afford to pay for it, why not?" The problem is that opening a "third way" to essential services with private healthcare would have a deleterious effect on the public system.

Second, there's the myth that private access to healthcare will free up lines in the public sector. There are two problems with this argument. First, the number of physicians and nurses is limited. If they're working in the private system, how can they operate on "public" patients? Another argument is that many surgeons are restricted from operating because of limited time available in public hospitals. These obstacles exist because of government restrictions that are causing the backlogs. Wouldn't it be better to allocate more time to doctors in the public system rather than encourage them to operate privately where financial incentives will dissuade them from treating public patients? A patient of modest means was recently advised that she would have to wait more than six months for a colonoscopy in the public system. But, if she was willing to pay $400, the procedure could be done in several weeks through a private clinic. Similar scenarios are repeated for patients who need ultrasounds, CT scans and MRIs. In Quebec, which has the most private imaging services in Canada, waiting times in the public system are the longest.

Models of practice can't be matched

Some cite France, Sweden and England as models for a parallel private system. But there are many other factors that play a role in their quality of care. Most European countries have more physicians per capita. In Sweden's case, only a few private hospitals provide specific care for selected patients. As for England, their government has invested heavily in public healthcare to ease long waiting times.

In fact, we live in North America where the United States, private health industries and the Free Trade Agreement are strong influences. If the private sector opens up, our governments would be forced to subsidize the private hospitals and clinics or face lawsuits. In the end, the public would finance those benefiting from private healthcare.

Finally, who could afford private insurance and who would benefit? The premium for standard Blue Cross health insurance in New Hampshire for someone aged 50 with a family and maternity benefits is around $2,000 US per month ($24,000 per year). If an employer contributes half of those payments an individual might get a break. But how many companies want to pay for spiraling health benefits today? General Motors recently laid off 25,000 employees, citing "poor car sales and increased healthcare costs."

Some believe that healthcare is a right that must be available to all, regardless of financial means. The biblical story of the Good Samaritan exemplifies that value. Otherwise, healthcare is simply a commodity that must be bartered for on the open market. PE

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