

**SUBMISSION TO THE
COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA**

by the

**British Columbia and Yukon Territory
Building and Construction Trades Council**

April 12, 2002



Abstract

British Columbia and Yukon Territory Building and Construction Trades Health and Welfare Plans are being forced to take up the medical insurance burden abandoned by the provincial government. Changes by the B.C. government in the last 3 months to Pharmacare, Extended Health Coverage and Medical Service Plan Premiums, will increase costs to BCYT-BCTC Health Plans by an average of 14% this year. Construction unions affiliated to the Building Trades, like many other private and public sector unions across the country, will be forced to take these increased health care costs to the bargaining table. Bargaining concessions by employers on this issue will raise the cost of doing business.

Some of the country's most influential business leaders have repeated their strong advocacy for universal medical coverage. These leaders have said that Canada's public health care system represents an "important competitive advantage" in attracting international investment, as it is a major factor in keeping Canadian labour costs down to some of the lowest levels amongst OECD countries.

This submission argues that no government program is sustainable if the government itself diminishes into insignificance. Medicare is sustainable and contrary to the media manufactured myth; costs have not been skyrocketing. The federal and provincial governments must put public health ahead of private health care lobby groups that aim to destroy our country's Medicare and make a profit on illness.

Introduction to the Cuts

The dismantling of Medicare has already started in British Columbia. In November and December 2001, the Campbell government announced that supplemental service under the Medical Services Plan (MSP) would soon end (i.e. Eye Exams, Physiotherapy, Massage, Naturopathy, Chiropractic Treatments and Non-Surgical Podiatry Services). On January 1st, 2002 government subsidies for these supplemental services were completely chopped for those not on premium assistance (i.e. those with incomes less than \$24,000).

Pharmacare subsidies have also been cut. Pharmacare deductible limits for those under age 65 were raised to \$1,000 (from \$800). The government will continue to provide a 70% subsidy on the next \$1,000 spent on prescription drugs. The 100% subsidy for annual drug expenditures over \$2,000 remains unchanged for the moment. Seniors, who previously had 100% of their drug costs covered (a dispensing fee of up to \$7.60 had to be covered by seniors up to an annual maximum of \$200), will now have to pay \$25 per prescription up to a maximum of \$275. Pharmacare will still cover 100% of the cost of drugs over the new limit.

Without making any changes to the level of benefits of their Extended Health Plans, BCYT-BCTC affiliate unions will face cost increases in the range of 16% to 19% to make up for the Campbell cuts to supplemental services and Pharmacare.

In BC, policies of the Gordon Campbell government have forced Building Trades trustees who oversee Extended Health Plans to review the sustainability of the coverage offered by their plans. To meet this challenge trustees have chosen from a number of unpalatable options. In the past, if there was no deductible for using supplemental services, trustees have decided to introduce a \$25 charge. If there already was a deductible trustees may have decided to increase it (i.e. to \$50 or \$100). Another option may be to reduce the amount covered by the Plan (i.e. 100% coverage would be reduced to 85% and 80% coverage would be reduced to 70%). In the case of Extended Health Plans our union members are paying the cost of the government cutbacks out of their own pockets.

Changes to Extended Health Care Plans are just the beginning of the new reality in BC. As of May 1, 2002 Medical Service Plan premiums will jump by 50%. The premiums are currently \$36 per month for singles, \$64 for couples and \$72 for families. In just over two weeks from now these premiums will jump to \$54, \$96 and \$108. The additional cost to BCYT-BCTC affiliate unions is expected to be approximately \$6.75 million per annum.

BCYT-BCTC Affiliate Union	Additional cost to Health & Welfare Plans as a result of MSP increases on May 1, 2002
Bricklayers	\$90,000
Boilermakers	\$450 - 500,000
Cement Masons	\$80,000
IBEW Locals 230, 1003, 993, 258	\$480,000
Electricians	\$520,000
Ironworkers	\$500,000
Labourers	\$1,160,000
Operating Engineers	\$2,100,000
Painters	\$435,720
Plumbers	\$700,000
Sheet Metal Workers	\$704,000
Teamsters	\$948,000
Tilesetters	\$30,000
Total	\$8,247,720

To make matters worse, dental charges have recently risen by 3% and life insurance premiums by 1%. The cost of the Health and Welfare Plans will be hard hit by all of these increases.

Skewed Statistics Used to Sell MSP Cuts

To sell these costly changes to the public the BC government has embarked on an orchestrated dis-information campaign. The province wants to paint a picture of spiraling costs and crisis in health care in order to build support for dismantling Medicare and off-loading costs on to users.

When Gordon Campbell's Minister of Health, Colin Hansen, announced the cuts to Pharmacare he justified the move by saying that BC had higher per-capita contributions to provincial drug plans than any other jurisdiction in the country. This is simply not true.

The chart below shows that while BC contributes the highest **percentage** on drugs the overall per capita expenditures are the lowest. Both Ontario and Quebec pay more than BC, per capita, on prescription drugs. BC's low drug costs are largely the result of our referenced based drug system. BC avoids paying for costly new drugs that are just as effective as less-expensive existing drugs. The newer "me-too" drugs are marketed as major breakthroughs but only have minor therapeutic advantages for few people.

Provincial Comparison of Prescription Drug Expenditures

Province	% Private	% Public	Total Per Capita Expenditures	Total Public Per Capita Expenditures
Alberta	61.2	38.8	\$321.89	\$124.89
B.C.	43.7	56.3	\$284.86	\$160.37
Manitoba	54.8	45.1	\$328.32	\$148.07
N.B.	72.4	27.6	\$381.68	\$105.34
Nfld.	57.4	42.7	\$292.36	\$124.83
N.S.	63.1	36.9	\$344.30	\$127.04
Ontario	60.6	39.4	\$416.49	\$164.09
P.E.I.	73.1	26.7	\$371.13	\$ 99.01
Quebec	52	48	\$379.55	\$182.18
Sask.	55.4	44.6	\$324.45	\$144.70

Source: Canadian Institute of Health Information, *Drug Expenditures in Canada, 1985 to 2000*. Comparisons in the table are for the year 2000

It is interesting to note that BC has managed to keep the annual per capita cost of drugs to the lowest level in the country, despite the fact that we have the highest percentage of citizens over the age of 65 (13% of the province's population). Alberta's per capita cost for drugs is \$37.03 higher than in BC even though seniors only make up just 9.6% of that province's population.

Dis-information about the cost of Medicare has been a constant theme in the debate over the future shape of health care in Canada. I don't want to take up too much of the Commission's time on the point. I will however pause for a minute to address those "chicken littles" whose constant cry is "the sky is falling".

Expenditures on health care in Canada remain at 9.5% of GDP, more than 4% lower than the USA (at 13.6%). Public expenditures on health care are extremely low for a country with a universal state health. Less than 70% of the total spent on health care comes from Canadian governments (in Sweden and the UK the state expenditures make up over 83% of the total spending). In fact, Canada placed 21st, when compared with other OECD countries, which was amongst the lowest level of public sector health care financing in the OECD group.

Finally, health costs are not spiraling out of control. What is happening is that government participation in the economy as a whole is declining. In the 1980's government represented 16.4% of the GDP. Today it is at 11.3%. Provinces are correct when they point out that health care costs have risen from 35% of all expenditures to 40% today. What the provinces don't say is that when

calculated as a proportion of provincial revenues, health care costs have remained constant over the last 5 years, at 32.5%.

The media and some provinces have whipped up hysteria without pointing out that they have slashed government expenditures in all other areas, by about \$22 billion – almost the same as recent tax cuts which have disproportionately benefited those with incomes over \$100,000. Viewed over the last 6 years health costs are not growing. Statistics from the Canadian Institute for Health Information shows that provincial health care spending on health has remained constant; at about 6% of the entire Canadian economy over the last 6 years. Researchers from the CIHI also make clear that the small increases in the last few years are due to inflation, and not increases in utilization or an aging population.

Medicare Makes Canada an Attractive Place to do Business

Medicare is one of the single most important incentives for business to locate in Canada. KPMG recently released its most up to date report on capital cost comparisons facing investors among the G-7 countries. The study measures labour, transportation, utilities, taxes and other fixed overhead costs for capital investment ventures. The report, **Competitive Alternatives**, rates Canada as the most attractive site for international investment. Canada's cost index was 85.5, which represents a 14.5% cost advantage over the United States (US = 100.0). Canada was followed by the UK (at 86.9) and Italy (at 88.6).

The single most important factor in the cost advantage for Canada is labour (across all cost model operations). While wages account for the bulk of labour costs Canada did not offer the lowest salaries. Italy, France and the UK all had lower salaries than those found in Canada. What made labour costs so low in Canada was the minor cost of health and welfare plans and other benefits.

Labour cost model comparisons for the metal components industry give a good snapshot of Canada's competitive advantage thanks to Medicare. In the following chart we see that the total cost of statutory plans and other benefits is just \$715. This compares with equivalent costs of over \$1156 in the US.

Labour Cost Model – Metal Components
(Competitive Alternatives – KPMG)

	AT	CA	FR	GE	IT	JP	UK	US
Location sensitive costs								
Salary/wages	2,738	2,601	2,420	3,170	2,155	4,668	2,491	3,416
Statutory plans	529	255	1,045	581	762	636	222	377
Other benefits	770	470	582	1,768	409	1,103	608	779
Total Stat. Plans & other benefits	1,299	725	1,627	2,349	1,171	1,739	830	1,156

According to **Competitive Alternatives** author Mr. Stuart MacKay, Canada's universal health care system "is a significant factor" in keeping private benefit costs down (*Globe and Mail, February 12, 2002, B10*).

Mr. MacKay confirmed his comments to the *Globe and Mail* in a telephone conversation with research staff at the BCYT-BCTC. According to Mr. MacKay, an overall comparison for all industries shows that Medicare saved Canadian business an estimated 8.5% on the cost of labour when compared with the U.S.A. (*phone conversation, February 19, 2002*).

The competitive advantage for investment in Canada is not lost on our own homegrown businesses. In fact the CEO for the Toronto Dominion Bank, Mr. A. Charles Baillie, has gone out of his way to defend Medicare from a business perspective. In an address to the Vancouver Board of Trade on April 15, 1999, Baillie said, "Canada's health care system is an economic asset, not a burden, one that today, more than ever, our country dare not lose." Baillie goes on to say, "Let me be as clear as I can be. To set aside our single-payer, publicly funded universal health care system would not simply be a moral error. It would be a grave economic error as well. The fact is, the free market efficient and desirable as it is, cannot work in the context of universal health care." (www.tdbank.ca/tdbank/tdtoday/speeches/15apr99).

The “senior voice of business on national and global issues” the Canadian Council of Chief Executives has also come to the defense of Medicare. In a memorandum for Prime Minister Jean Chretien, September 7, 2001, the council said, “The important competitive advantage once provided by Canada’s public health care system has been seriously eroded.” The memorandum goes on to say that the council will be an active participant in the on-going discussions on the reform of Medicare (www.ceocouncil.ca).

The final endorsement from prominent business organizations backing Canada’s Medicare comes from the Conference Board of Canada. While arguing for the need for reform and debate on the future of health care in Canada, the Conference Board of Canada has acknowledges that Canadians “see health care as a key underpinning of their quality of life, and they want the system protected.” (C.B.C., Performance and Potential 2001-2001, p. 104).

Further, according to a report in the Globe and Mail, a more recent report from the Conference Board states that “Any policy debate on the future of the health care system of Canada should recognize not only medicare’s symbolic value to individual Canadians, but also its economic contribution to the competitiveness of Canadian businesses vis-à-vis the United States,” (Globe and Mail, February 12, 2002, p. B10).

Solutions

I understand that the Commission would like to hear from presenters about proposed reforms and mechanisms to ameliorate Medicare. I want to begin this segment with a disclaimer. While I believe I have outlined and documented the important competitive advantages afforded by the Canadian health care system, I admit that I am not an expert on health care economics. There are many others from the health care sector and academics with an expertise in these matters. Never the less, I will endorse solutions, which have been proposed by some of these experts. Solutions for Medicare that best meet the interests and needs of construction workers.

One of the most common solutions advocated by the proponents of the crisis in health care, is for government to de-list certain health services now covered by Medicare, and to have private insurance schemes or patients pick up the bill. As outlined at the outset of this paper, British Columbians are already feeling the pain of the first round of de-listing of services formally provided by our provincial medical services plan. The result is additional costs for the Health and Welfare Plans of our affiliate unions, totaling more than \$8 million. These cuts are not necessary given the truth about government subsidies for medicare. The fact is that medicare costs are not “spiraling out of control.” The consequence of de-

listing of services is that unions will be going to our employers and looking for changes to our collective agreements, which mitigate these new taxes. In the end it will impact negatively on the cost of labour with serious repercussions for attracting new offshore investment capital into the country.

The issue of user fees comes up again and again in the debate. Construction workers are a proud breed. Many retired construction workers refuse to seek medical treatments unless they absolutely require attention. User fees for construction workers are simply not necessary. We don't need an added deterrent to the medicare system. A submission by the Tommy Douglas Research Foundation to the Standing Senate Committee on Social Affairs, Science and Technology affirms that "study after study has shown that user fees do not reduce health care costs, do not eliminate inappropriate care, but rather people who can't afford the fees (the less healthy), end up getting less care and for those who can pay (those who are more healthy) get more care." Given the substantial evidence to rebut the so called "funding crisis" in health care, Dr. Bob Evans, health economist at U.B.C. has classified health user fees issue as the "zombie" of health policy; a dumb idea that has been discredited again and again but just won't die! (p. 7)

I want to just touch briefly on one other solution which has received endorsement from many quarters and which the BCYT-BCTC also supports.

We support the recommendation of the Mazankowski report to consider putting doctors on salary. We also support an increased role for nurse practitioners and 24-hour community clinics to take the pressure off emergency wards.

I want to thank the Commission for providing us with the opportunity to make a submission.

Respectfully submitted,

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