Hey buddy, can I bum a cigarette?

I guess this isn't an unusual request from a stranger. However, I don't smoke and have been told I am healthy-looking (liars). Also, when I was asked this question I was walking toward the physicians' entrance at my local hospital. I could have been a visitor but I did have a stethoscope around my neck. The individual making this request was leaning against a No Smoking sign.

One of my health authority's initiatives was to make all of their facilities smoke-free zones. Admitted patients with nicotine addiction are now offered nicotine replacement, and staff who smoke are forced to go elsewhere. I applaud this health-driven decision, but unfortunately it hasn't quite had the intended benefit. Previously, patients and staff would smoke in the designated smoking areas thereby keeping all of the smoking-related garbage and smell in one spot. Now, with no clear direction the smokers have to be more creative and sneak a ciggy wherever they can. This has led to the hospital grounds being littered with discarded cigarette butts, packages, and wrappers. Since the bus stop isn't considered hospital property many of the truly addicted huddle together in this kiosk. Those wanting to actually catch the bus now must choose between secondhand smoke and standing in the rain.

One of the less rule-oriented populations is the collection of unfortunate patients with psychosis admitted to the psychiatric ward. These nicotine-addicted unwell individuals escape out the nearest exit, which, you guessed it, is the physicians' entrance. There they can linger under the No Smoking signs asking for handouts once their own supply is diminished. I have to admire their creativity, because they often fashion their own smoking area by pulling out wheelchairs and transport chairs, creating a nice comfy circle in which to socialize while they smoke. They mark their turf with garbage, blankets, chairs, and other items. As a result the arriving physicians are greeted by a cloud of smoke and patients requesting handouts.

It is reasonable for organizations to declare their properties smoke-free. However, most facilities don't have visitors who are kept there for days on end without the opportunity to leave. Smoking isn't illegal, and you could argue that for some nicotine-addicted psychotic individuals that removing their ability to smoke leads to conflict and interferes with their care. In contrast, narcotic addicts are offered risk reduction activities such as methadone maintenance, safe injection sites, and needle exchanges.

For the health of the non-smokers and care of our hospital, perhaps it is time to revisit having designated ventilated smoking areas. I'm not saying we should make it easy for people to smoke. Heck, we could make the room a giant treadmill, making patients walk while they get their fix. We could also cover the walls with anti-smoking slogans and have nicotine replacement dispensaries at the entrance. I am sure that better minds than mine can come up with some sort of compromise, as the current system isn't working as intended.

In the meantime, to cover my hospital parking fees, I have started selling packs of smokes at a 50% markup. If you can't beat them—charge them.

—DRR

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A healthy constitution

"The government was set to protect man from criminals—and the Constitution was written to protect man from the government" —Ayn Rand

The above quotation forms the basis for the current constitutional challenge of the Medicare Protection Act by six plaintiffs: the Cambie Surgery Centre, three children, and two cancer patients. The 2005 *Chaoulli* decision, which legalizes private health insurance in Quebec, was rated one of the most significant legal decisions in Canadian history. The forthcoming case will surpass it in importance, since it will be argued under the Canadian Charter of Rights and Freedoms alone and will impact other provinces.

Canadian governments impose penalties that limit a citizen's right to reduce pain and suffering. In Ontario, the Orwellian-sounding Commitment to the Future of Medicare Act can issue fines of $10 000 to $25 000 if patients or corporations expedite their care. Similar legislation in BC has been passed and awaits only proclamation to become law. In Alberta, a clinic that violates the legislation by allowing a patient access to private care can be fined $100 000.

Canadians have the freedom to spend their money on gambling, cigarettes, and alcohol. Yet of all countries in the world, we alone outlaw a citizen's right to purchase health care for themselves or for a loved one. Even the most authoritarian governments on Earth have no such prohibitions.

The potential benefits of more private sector involvement in our health system are documented in the world literature. French government data show private hospitals there perform 60% of all surgery, are 30% to 40% cheaper, and have fewer complications and deaths. Increased privatization in Lombardy (Italy) led to the creation of one of Europe's best health care systems as private competition stimulated efficiencies in the public system. In England, following government reforms, patients became empowered and now choose from over 350 public or private hospitals nationwide for procedures from bunions to heart and cancer surgery. Waiting lists have shrunk and standards have risen, as patient-focused funding and increased private sector involvement have been introduced. Patients now access NHS websites that reveal facilities and providers with poor outcomes. The recent report about avoidable deaths in some large public NHS hospitals was a direct result of policies that include accountability and transparent reporting of quality and outcomes in all institutions.

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For more information

Contact Jessica Cavers at jcavers@bcma.bc.ca or 604-638-2891

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www.bcma.org/health-awards

In Switzerland, health spending is similar to that in Canada (11.4% of GDP), yet they have 50% more doctors, three times as many CT scanners and PET scanners, and no wait lists for specialists, MRIs, or surgery. They have 500% shorter waits in emergency rooms. Paradoxically, in Canada, the lowest socioeconomic groups have the worst access to care and the worst health outcomes. This is the opposite of the original goal of our system.

Peer-reviewed studies have revealed fewer complications after appendectomy in private hospitals and reduced complications after delivery of a baby in private rather than public hospitals. Hip replacement surgery has been shown to be more efficient when carried out in private hospitals.

A recent report from Saskatchewan by Janice Mackinnon (who served as Premier Roy Romanow's NDP finance minister) confirms that the private sector is more cost effective than the public system. BC experience confirms this. In a Newfoundland government study comparing public and private nursing homes, the for-profit institution was 23% less expensive, provided equal care, and was as good or better on quality of life indicators. Injured workers are among the 60 000 patients a year treated at private clinics in BC. WorkSafeBC has saved hundreds of millions of dollars annually through expedited care. Statistics on outcomes in private facilities show they offer a safe option. Housing patients in private rooms, as opposed to room sharing, leads to reduced infection rates (including life threatening superbug infections) and preserves privacy and confidentiality. Patient satisfaction rates in BC private institutions greatly exceed those in public hospitals.

Worldwide, medical tourism is a $160 billion a year industry. Each year, 3 million patients leave the US for treatment abroad. This "trade" is not available to Canadian hospitals because of political issues and draconian laws that deny Canadians options and choices.

There are no large private hospitals in Canada, and the potential massive revenue from participation in this market would be available to public hospitals that presently close operating rooms in the afternoon and on weekends. This would lead to more jobs for doctors, nurses, and other health workers. This could become one of Canada's biggest industries. Success in our litigation will open up this market for Canada.

The 2005 *Chaoulli* decision was supported by most Canadians (CMA poll) and a vast majority (83%) of physicians. In a 2012 Ipsos Reid poll, 76% of Canadians thought they should be able to buy private insurance for treatments outside the public system. Governments have not acted because modern politicians have forgotten the meaning of leadership. They have delegated power to a massive health bureaucracy that is interbreeding and self-propagating at an extraordinary rate. Germany spends less than Canada and has a hybrid public-private system, without any wait lists. Canada has one public health bureaucrat for every 1400 citizens. That is 11 times as many as in Germany (one per 15 500).

One cannot expect bureaucrats to support the introduction of a hybrid public-private health system embracing competition, choice, and accountability. They would never organize the downsizing and elimination of many of their own jobs. That is why we have resorted to asking the court to liberate Canadians from what amounts to medical enslavement. Governments should confer and protect rights rather than eliminate them. We are asking the court, on behalf of BC patients suffering on wait lists, to grant the same rights that were granted to Quebec residents by the Supreme Court of Canada. We hope that our litigation will (to paraphrase Dr Arnold Aberman) lead to the decriminalization of medical acts between consenting adults. **—BD**

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