Submission to the Nova Scotia Law Amendments Committee on the Insured Health Services Act - November 28, 2012

Dear Committee Members, I would like to thank you for this opportunity to comment on this important and progressive piece of health legislation.

My name is Bill Swan. I wear many hats. Among them, I am the Deputy CEO of the International Health Economics Association and a well-controlled severe asthmatic who Co-Chairs the National Asthma Patient Alliance. I will speak briefly from both viewpoints.

Principles of the Canada Health Act

From a health economic viewpoint, the act should entrench the principles of the Canada Health Act in the body of the legislation. It is an established legal principle that legislative preambles state intent, but are in no way binding.

It is critical that our legislation do more than simply establish intent, it must also ensure that the health system remain, as much as possible, a single-payer universal system. Any wiggle room may ultimately be used to undermine the principles of our health system and allow continuing privatization of the health care system. No legitimate research exists to support this ideology. To paraphrase noted Canadian health policy expert Raisa Deber, "if we can't afford public care, we sure as ***heck*** can't afford private care."

Moving the principles to the body of the act will effectively eliminate this potential risk. This can be done simply by amending Section 2 of the Bill on page 2 to list the five basic principles of "public administration", "comprehensiveness", "universality", "portability" and "accessibility" after the clause "that satisfies the eligibility criteria for federal funding under the Canada Health Act".

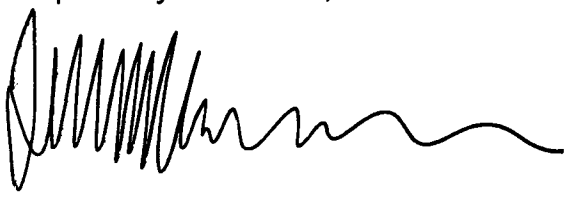
Patient Engagement

Patient-oriented care and its synonyms have become de rigueur of late. Yet more often then not the focus is on the provider and payers in the system with patients excluded entirely from the process. Yet the untapped expertise of the patient is largely unrecognized as a source of valuable input, reflection and reform.

As such - while much broader patient engagement is a long-term goal - a change in the composition of the Appeal Board would be a start. The composition of the Board should be more flexible and include other health providers depending upon the issue at hand (e.g. if it is an issue involving prescription drugs, a pharmacist should be included. Most importantly, rather than including only one lay-person, at least one bona-fide patient representative should be part of the Board.

This could be done by amending Section 39(1) to include a "(d) a provider other than a physician, dentist or optometrist" and "(e) two lay persons including at least one insured patient who is not a provider".

Respectfully Submitted,



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