Access to health care was a prevalent topic during the Conversation on Health. Issues raised on this topic included: access to primary health care and clinics; specialists; emergency departments; acute and long-term care facilities; and ambulance services. Here is a selection of what British Columbians had to say on the topic of access to health care.

Primary Health Care and Clinics

Access to primary health care was a prominent topic during the Conversation on Health. Participants discussed primary care suggesting that most often doctors are the first point of contact, or gatekeepers to the public health care system. They also suggest that this contributes to long wait-times and delays in receiving medical care. Other participant concerns include: a lack of doctors and availability of their services after hours; long wait times; and a lack of incentives for doctors to attend to non-urgent needs such as preventative care. To improve access to primary health care, many believe that Government needs to give patients more choice on the types of primary health care providers they can access as well as educating and attracting more primary health care providers and looking at their scope of practice. There was also considerable support for both expanding the role of complementary medicine practitioners and promoting multi-disciplinary clinics.

The majority of participants support multi-disciplinary clinics to improve access to primary health care, although the details related to the operation of these clinics are widely debated. Suggestions include: walk-in clinics that are open 24 hours a day and seven days a week; mobile clinics, especially for rural communities; clinics that specialize in a community defined care need such as diabetes or cancer; and stand alone surgical clinics that are dedicated to one speciality such as orthopaedics. Some participants raise concerns about walk in clinics and the continuity of care and preventative care that these clinics deliver. Others emphasize that the focus should be finding alternative ways to access primary health care within the existing system. They suggest this may include providing more community support services, increasing the scope of practice for certain health care professionals, and expanding the role of the BC NurseLine.
Access to Specialists

Discussions on access to health care often include some discussion on access to specialists. The common view is that the wait-times in moving from primary care to specialized care are too long. Many participants suggest that this is due to inefficiencies in the referral system. One example often cited is having to see a general physician for every referral to a specialist regardless of whether it is for an initial or follow-up visit. Others voice concerns related to receiving faster access to specialists through emergency departments, placing limits on the number of surgeries that surgeons can perform, and having a burdensome process for general physicians to follow when referring patients to specialists. Participants provide many recommendations, including: enabling patients to have direct access to specialists through a self-referral process; allowing other health care professionals such as physiotherapists, chiropractors and naturopathic doctors to have the authority to refer patients to specialists; and extending the time period for when a referral is required.

Efficiencies need to be encouraged. For instance, re-referrals to specialists for continued monitoring of a condition that required their expertise is a waste of health resources. The specialist should keep the relationship with the patient until it is no longer needed.

– Online Dialogue, Vancouver

Emergency Departments

The topic of emergency departments was very popular during our consultations. Many participants are concerned that there are a lack of alternatives to emergency rooms. Others focus on the issues of poor patient flow and mismanagement, staff shortages, a lack of beds, and funding cutbacks. The fundamental issue for many is that emergency departments are over-used and congested.

Emergency departments are loaded down with admitted patients and the staffing is depleted to the point that they cannot give good care to these patients and have no space or resources to examine or treat the Emergencies that come in.

- Online Dialogue, Errington

Some participants emphasize supporting a shift in the public perception of emergency care and re-defining urgent and non-urgent care. Others suggest establishing benchmarks for emergency room wait times or expanding triage capacities. Many support bolstering the staffing infrastructure by allowing professionals to work within their full scope of practice and providing in-hospital training as well as providing suitable alternatives that have diagnostic equipment.
Acute Care Facilities

The majority of participants advocate for more funding and resources for the acute care system. Many believe that the reduction of acute care facilities and beds over the last 20 years has placed considerable pressure on the acute care system and has contributed to staff burnout, long wait-lists, and poor quality of care. They also believe that these pressures make emergency departments the default for care, which contributes to overcrowding and congestion in emergency care.

*The shortage of acute care beds is a primary factor for emergency department overcrowding which has become a significant patient safety and quality of care concern in British Columbia.*

– British Columbia Medical Association, Submission

Long-Term, Residential and Extended Care Facilities

During our consultations, there was strong support to build more long term, residential and extended care facilities to accommodate the current, as well as future needs of the elderly. Participants widely agree that British Columbia needs more long-term care beds in both rural and urban communities.

Many participants voice concerns related to specific long-term and residential facilities that are located in their community. The underlying theme of these concerns is that community facilities need more resources. Many recommend increasing long term care facility intake and stopping the closure of long term and residential care facilities. Other suggestions include increasing bed capacity and providing the resources to help local communities take care of geriatric and palliative patients.

Ambulance Services

Many participants feel that ambulance crews are doing a good job, but that there needs to be faster access and increased availability of ambulance services in British Columbia, especially in rural communities. A common concern is the lack of resources in staff, crew skills and ambulance fleets (including air, ground, and sea). Some suggest that this lack of resources does not make the field attractive to new recruits. Many believe staff are not compensated fairly, particularly for being on-call, and that the system does not efficiently use the knowledge and skills of existing staff. This is seen as contributing to inefficiencies in the dispatch process and negatively impacting the quality of patient care and response times. Participants also raise concerns that complex care patients are often transferred over large distances and suggested these
inefficiencies increase the time it takes to get rural patients to tertiary centres. Many discussions focus on the current centralized/regionalized model, which some suggest increases the demands on the system. They also suggest that there is not a corresponding increase in resources or expansion of scope of practices to meet these demands. Participants recommend providing ambulance crews with assessment training to avoid transporting patients to hospitals if possible, and giving more authority to paramedics to treat patients in the field.

Conclusion

The majority of participants believe that changing the way we think about health and health care is fundamental to improving access to care. To do so, most want Government to support a health care model that responds to patient needs. They also want a system that gives patients a number of ways to access different types of health professionals and health services. Many believe that access issues can only be resolved by shifting the public perception of emergency care, providing alternatives to emergency departments, and alleviating pressures on the acute care system.
Access

This chapter includes the following topics:

Demand Management  
Primary Health Care and Walk-in Clinics  
Specialists  
Emergency Departments  
Acute Care  
Long-Term and Residential Care  
Ambulance Services  
Comments on Specific Communities and Facilities

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including:

Innovation and Efficiency; Primary Health Care; Health Care Models; Health Spending;
Demand Management

Comments and Concerns

Access to Health Care
Public Expectations on Accessing Health Care
Choice and Coverage
Sustainability
Information and Public Education

- Comments on access to health care:
  - British Columbians overuse health services because they do not have any other options.
  - The health care system does not promote individual accountability, especially in terms of using health care services appropriately.
  - Our system has turned into a patient drive-through, due to the inefficient one symptom or issue per doctors’ appointment system.
  - Treating petty ailments in the public health system blocks up services that should be available for those that truly need them.
  - Pharmaceutical advertisements on television and in magazines are terrifying people (especially older more vulnerable people) and are leading to increased burden the health care system beyond capacity.
  - Unnecessary tests are a strain on the system.
  - Using the health care system unnecessarily clogs up the system and causes long waits for people who really need the care.
  - Delisting health services such as physiotherapists, chiropractors, naturopaths and massage therapists limits access to appropriate care.
  - Just providing funding does not get to the root of the problem of access to care. We need to focus on accountability, staff retention, appropriate staffing, innovative scheduling, respect for workers and ongoing education.
• A study on the social isolation of older people showed that the more knowledge, engagement and involvement they had with their health care, the more they tended to seek appropriate treatment from an appropriate health professional.

• Most seniors do not have enough choices or control over their health care. Those that do, have it because they have the money.

• British Columbia has a very open-ended system whose cost is driven by unbridled and uncontrolled input. Input is the desire of the public to access care, and the output is the capacity of the doctor to see and serve the public.

• Canada has equal access to health care without discrimination.

• The current system takes care of cancer patients effectively and efficiently.

• Canada has one of the finest health care systems in the world if you can access it.

• Generally, the care given in British Columbia is excellent, but we need to increase access to medications and diagnostic tools.

• I am generally pleased with the service I have had from all areas of health care. I am healthy and have not needed the system often, but when I did it was there.

• One of the biggest problems is access to the system including primary care access, access to laboratory results and public consultation on access to health care.

• There is a bias in the system about who gets treatment based on geography, demographics, and so on.

• The bulk of our votes and decision making happens in highly dense populations where density driven decision-making models actually work and make sense. However, these models do not fit if you are in other less densely populated areas of British Columbia, like Dawson Creek.

• Public and policy debates often focus on questions of wait-times, but it is clear that geography, cultural differences, cost, knowledge base and other factors are important barriers to achieving appropriate access.

• My daughter and I spent three weeks in the children’s ward of a hospital and we were treated very well. We were given a private room and both had a proper bed and three meals a day.

• The system works well and is accessible for certain special interest groups, but not for the common person.

• Access is limited due to awareness, cost, support and political engagement.
- The current health care system will treat life and death type afflictions, but those that are suffering from non-life threatening situations are treated without urgency.

- Equal access has to be traded off against both quantity and quality of care. Equal access means access to services that are fewer in quantity and poorer in quality than are available in most other Organization for Economic Co-operation and Development (OECD) countries and the United States. Canadians have equal access to getting in line, but they do not all stay in line.

- The current system of having a single payer is fairest, as need, not ability to pay is what gets you to the front of the line.

- Health care is a necessity like clean water and should be accessible to all.

- If the Government could only provide one service to its citizens, then it should be health care. There is nothing more important than access to state-supported, free health care. Not only should this be guaranteed, but we should be moving forward with a free dental and drug plan.

- The current funding model for dental care widens the gap between rich and poor. The poor tend to have worse dental health and it is exacerbated by our policy decisions. In general, the Government needs to make policy decisions that could lessen the inequities in health not widen them.

- There is a lack of operating facilities especially for joint replacements.

- There is concern about equal access to health care as British Columbians already pay for health care services. Those who can afford it go elsewhere, so they must effectively pay more.

- British Columbia has a good children's hospital system.

- In discussing health care, too often the assumption is that all British Columbians have equal access to extended health benefits either through their employers, unions or government sponsored plans such as that provided to clients by the Ministry of Employment and Income Assistance. Unfortunately, this is not the case.

- If our facilities cannot handle the number of suspected cancer cases, then should we not be proactive and co-ordinate a system with other provinces and countries to provide the tests and surgery needed?

- Perhaps we need to help pay costs (reasonably) for tests and so on in order that we all receive timely care.
• **Comments on public expectations on accessing health care:**
  
  - People have been convinced that there is no need to put up with a minor ache or irritation if it can be remedied by a drug or treatment.
  - People expect everything for free.
  - One doctor comments that he has a six month wait-list for cancellations for which he feels he is the brunt of public frustration. He feels that the general public should take on some responsibility and stop looking at health care as free.
  - People need to understand that everything is not free and not every illness requires surgery.
  - The barriers to reform are the unrealistic expectations that we have given the public. The public has a poor understanding of what the system is and what it can deliver.
  - Societal expectations of health care are becoming unrealistic.
  - We have to stop treating health care as an all-you-can-eat smorgasbord where there is no physician and consumer accountability for resource use.
  - The public sees primary and preventive care as a visit to the doctor for a quick fix.
  - British Columbia has a very generous and high quality health care system. However, our system is simply overtaxed by unreasonable expectations that are far beyond anything ever envisioned for the general public.
  - There are over 20 million visits to family physicians offices annually in the province. That is a big shift from the past when we had lower expectations of our health care system.
  - It is part of today’s culture to expect and ask for too many tests and prescriptions.
  - The system has failed us for many reasons. The biggest problem is that most Canadians expect service for nothing. Wake up Canada and pay for your services. Let us not become like the United States, but at least be like the Europeans and pay more for what is needed.
  - I have worked and paid taxes since I was fifteen years old. It is my right to expect that there will be public health care available should I need it.
  - It is sad to be aging and have something that you have invested in all your life, like health care, not be available when you need it.
• **Comments on choice and coverage:**

  - If the customer cannot choose on the basis of who is best and what it cost, it will always cost too much. It will never be as good as it can be and there will never be enough of it. A customer is defined as one who makes the choice and pays the bill. In health care, the customer is the patient, family, caregivers, and people around the patient, but it is also the referring physician, the Ministry of Health, Ottawa, the voters, and the political side. There are disparate customers and they all need to be satisfied.

  - There can be universal health care, but it should be prioritized. If we want other countries to look at Canada as a model for health care, then we have to build customer choice into the system. Decades of social experiments with equality-for-all have failed in dozens of forms.

  - If services are to be provided for all, then not all services can be provided.

  - Whatever you do, the public needs to know for sure what services are covered and what services are not. It should be the same for all.

  - Lack of access is a bigger cost driver than medications and human rights. We do not want to make a choice between money and time or wait-lists.

  - If the goal is to optimize the health of both the individual and the population, then we need to radically change how health services are designed and determine our options and priorities. This includes making choices about what we are not going to fund so that we can start moving the funding upstream.

  - Where or how surgery is obtained does not matter as long as quality of care is assured.

• **Comments on sustainability:**

  - In order to create a sustainable health care system we must reduce the demand for services placed on the system. This is particularly critical as the baby boomers enter the system.

  - The system is costing too much so we need to peel away services.

  - People are waiting too long for services such as surgery and the most urgent case is not necessarily the next case. We can do much more to make our system the best it can be for those who need it. Sustainability has been redefined to mean meeting the customers' service needs.

  - Global aging and longer life expectancies put pressures on our health care resources.
• Comments on information and public education:
  • People do not know where to go to get tests and treatment other than hospitals.
  • We need to do more to encourage seniors to use health care services other than their doctor’s office.
  • People do not know where to go for primary health care.
  • The 24 hour BC NurseLine is an extremely useful, but poorly advertised service.
  • Many people are uninformed and/or uneducated on what health services are currently available.
  • Translated health care brochures have mistakes and do not reach their intended audience.
  • Some television advertisements incorrectly direct people to their doctors when other health care providers would be more appropriate.

Ideas and Suggestions

Access to Health Care
Clinics and Access to Health Care
Choice and Coverage
Sustainability
Information and Public Education

• Ideas about access to health care:
  • Build a dynamic health care system that is responsive to the needs of British Columbians in place of the existing rigid system we have today.
  • Avoid unnecessary examinations and tests.
  • Set health care priorities through consultations with a panel of qualified health care professionals.
  • Use trained consultants to conduct a provincial health care review and make recommendations for improvements.
  • Integrate population health and acute care management to improve patient services.
  • Focus on prevention and increase coordination between home support, home nursing and primary care to manage demand and avoid use of more expensive long-term care and hospital services.
  • Increase resources to care for patients in communities.
• Have a seniority clause in health care where those people that have lived and worked all their lives in British Columbia are first when it comes to treatment.
• Increase access to medications and diagnostic tools.
• Provide services closer to home.
• Allow for freedom of choice.
• Focus on access to physician care and services and continuity of care both on and off reserve.
• Support an Open Access or same day appointment approach, which increases opportunities to address health concerns by phone and email.

• In the United Kingdom the root cause of delay was variability and high utilization, so the British Government proposed some short term strategies to optimize its current capacity such as reducing steps and queues, using first in, first out principles, planning discharges, maximizing skill use, pooling capacity and stopping rework. In the longer term, the British Government’s goal is to plan for a system with no queues, which includes measuring and shaping demand, planning capacity and reducing variation. These strategies are at the core of their plans to achieve their next target.

• Follow the New Zealand approach to reduce wait-lists by introducing clinical prioritization for elective surgery. In this case, if the patient does not meet certain criteria, then they do not qualify for publicly-funded treatment. This strategy is based on three fundamental principles: clarity, timeliness and equitable access to assessment and treatment. For clarity, patients know whether or not they will receive publicly-funded elective assessment or treatment to provide certainty on their plan for care. For timeliness, if a patient is deemed eligible for publicly-funded services then a request for access to a doctor is responded to within ten days and assessment or treatment within six months. Equitable access to assessment and treatment means similar access for similar need, based on transparent, consistent and systematic criteria.

• Close the open door and introduce a system of personal responsibility. Otherwise the enormous demand for health care will overwhelm the system and bankrupt the country.
• Improve availability to tests to catch cancer early and improve mortality rates.
• Focus on improving outcomes versus cutting costs - get better value from what we spend by assuring appropriate use and adherence. The right intervention for the right patient at the right time.
Canadians want everything that modern medical science can offer and to have it delivered equally and quickly. We have to tell patients and the population that this is impossible.

Start a primary care pilot project that is dedicated to surgical procedures to eliminate wait-lists that is publicly owned and funded.

**Ideas about clinics and access to health care:**

- Establish more specialized short stay surgical clinics within the public system.
- Establish alternate practice settings such as mobile clinics, clinics in group homes for developmentally disabled, private hygiene clinics, visits to the home for home-bound patients, and visits to children’s facilities and daycares.
- Establish Centres of Excellence for orthopaedics, cardiac care and so on.
- Reframe the idea for having a 24 hours seven days a week clinic to providing a responsive primary care system, which could be achieved by increasing: same day access, the number of people who actually have an identified primary care provider, and the ways and mechanisms for accessing primary care such as phone, email, group visits and extended hours.
- Create a centre for specialists so that all specialists are used effectively and patients do not wait one year for treatment.
- Create stand alone clinics that focus on one group of procedures such as joint, knee, hip, eye, back and so on.
- Create and support stand-alone public clinics that are specialized and focus on short stays. These clinics are geared for low-risk elective surgery, allow for better patient flow, increase efficiency and ultimately have shorter wait-times. They also achieve the efficiency benefits of specialization and innovation often ascribed exclusively to the private sector, while maintaining the public sector advantage of low overall administrative costs and broader societal benefits.
- Support one-stop, multidisciplinary pre-surgery centres to consolidate as many services as possible under one roof.

**Ideas about choice and coverage:**

- The state of Oregon has a list of 85 to 90 procedures that have been established as priorities for the health care system. The higher on the list, the more of a priority that condition is. Establishing a list like this for British Columbia could settle issues such as what is and is not covered, as we cannot provide every thing to everyone.
• There should be mandatory minimal health care services available for everyone regardless of location. Services above this mandatory minimum should be reasonably defined locally.

• Subsidize all new medical procedures and all new medications that are not currently covered by the Medical Services Plan on a graduated net income basis: the lower the income, the greater the percentage of subsidy.

• Guard publicly-funded services to ensure health care for all.

• When the health care system was set-up, it was to cover high hospitalization costs that people could not afford. We have to go back to that goal and examine the things that have been added, which are now burdening on the system.

• Define what is medically necessary and provide that to everyone.

• We need to establish a public body that sets the criteria for decisions concerning when highly expensive medical interventions will be made and when they will not.

• Until everyone has basic health and dental care, no one should get extra care or treatment.

• **Ideas about sustainability:**

  • Identify long-term elements that put more demand on the health system and then prevent and manage those elements.

  • Do health care planning that emphasizes:

    a. demand management including primary care, health promotion and prevention, proactive planning, and efficacy review;

    b. network development including internal processes, bridging processes, case management, best practices and triage; and

    c. human resource management including seasonal flexibility, staff retention and recruitment, staffing models, and education and training.

• **Ideas about public information and education:**

  • Encourage people to use the BC NurseLine and the British Columbia Health Guide.

  • Advertise the BC NurseLine more. For instance, send fridge magnet's with the BC NurseLine to everyone.

  • Find a collaborative solution that gets health care professionals get together to feed information to the BC NurseLine.

  • A dial-a-nurse line should be available 24 hours seven days a week.
• Provide more information to public on how to use the health care system appropriately.
• Provide more outreach programs to target those that overuse health care services.
• Produce public information campaigns on some basic life threatening situations to help educate the public on when they need to call 911.
• Teach first aid and basic health care in schools.
• High school students should learn about how the health care system works, how to stay healthy and how to access health care services.
• Support injury prevention and safety education such as the use of seat belts, child car restraints and bicycle helmets to decrease emergency visits and hospital admissions.
• Improve how we estimate wait periods and provide patients with frequent updates.
• Require that doctor offices have videos on patient etiquette and information on what services the doctor can and cannot provide, as well as other ways to obtain those services. Patients could watch these videos while in the doctor’s waiting room.

**Primary Health Care and Walk-in Clinics**

**Comments and Concerns**

*General Practitioners and Access to Primary Care*
*Walk-in and Community Clinics*

• **Comments on general practitioners and access to primary care:**
  • The shortage of general practitioners restricts access to primary health care and preventative care. It also breaks the continuity of care for too many British Columbians.
  • We cannot book appointments with our doctor unless we are willing to wait a week and can get time off work to go during office hours.
  • Limitations on the numbers of patient visits per day for family practice clinics results in general practitioners restricting their office hours. As soon as the doctor’s allotted 44 visits are over, the doors close because there is no point being open and working for free.
● It is so difficult for the public to get a family physician that more and more patients are forced to go to walk-in clinics for their care. If there is no access to a walk-in clinic, the emergency room becomes their default health care provider.

● Most doctor offices are akin to assembly lines, where patients have 12 minutes maximum to state their case and get an intelligent response.

● It is not right that patients can only discuss one problem per visit to the doctor.

● It is perceived as multi doctoring when a patient meets with a number of doctors in order to identify which one they wish to stay with.

● Family doctors spend too much of their day refilling prescriptions, doing basic check-ups on healthy people, talking about the weather and writing referrals.

● Medical Doctors are the only entry point to the health care system because the services of other health professionals are not covered.

● At one time general practitioners and nurses would have attended to non-urgent needs. Today, the general practitioner service delivery option is withering because Medical Services Plan policies have made it less attractive for doctors and they have failed to reward those who may be willing to work evenings and weekends.

● Patients with no family doctors are 3.5 times more likely to end up in an emergency room.

● People do not tend to access primary care physicians after hours. Emergency room data supports this analysis, showing that the peak in demand for low urgency care is during daylight hours.

● Most repeat visits are for the most common conditions such as the common cold and generally do not require a physician’s attention. Instead, nurses could perform simple diagnostic measures and direct care over the phone.

● Too many visits to the doctor are more for social reasons than medical reasons.

● Many patient visits are unnecessary. For instance, many family physicians will call back patients into the office to discuss lab results, which were negative. This is a waste of health care money and causes unnecessary emotional stress for the patient.

● There is absolutely no incentive for patients to not visit their family physician. In fact, many family physicians encourage more visits because that is how they are paid.

● Making an appointment to get a laboratory requisition for on-going and routine blood work for patients with a chronic condition is wasteful.
• People do not want to have to take two or three hours off work when they have to go see a doctor to get a simple thing done.

• Under our present system, physicians are motivated to ask for return visits because they are limited in what they can charge for a visit and therefore are inclined to have the client return again at another time. This is inefficient in terms of office overhead, Medical Services Plan payments to physicians, and often paid lost employee time in the work place. Unnecessary return visits are wasteful in terms of travel time, gas consumption and other inefficiencies.

• The current method that we have to access our own physician is excellent. We are never turned away and when critical situations arose our physician acted in our best interests in an expedient manner.

• People seek primary care at hospitals rather than through doctors, public health nurses or mental health nurses.

• Too many patients are admitted to hospitals that could otherwise be treated in the community.

• Some people contact the BC NurseLine, go to a walk in clinic, and then the next day go to their regular physician to see if the physician agrees with the prescription that they got from the walk-in clinic. We need to discuss how to integrate services to deal with issues like this and reduce the duplication of services.

• The current structure of the health care system results in gaps in service coordination and lacks the flexibility to respond to these challenges.

• Primary health care is not available on weekends.

• There is no connection or co-ordination between the BC NurseLine, emergency departments or walk-in clinics.

• The suggestion of having 24 hour clinics near hospitals sounds great, but activities have to coordinated between the two organizations. There is no use going to the clinic first and then being referred to the emergency department if doctors in emergency do not trust the clinic's diagnosis.

• Primary health care is not available when people need it on weekends and evenings.

• There is lack of funding for preventative health care and alternative health care professionals.

• There is a lack of incentives to provide after hours care.
British Columbia has done some innovative things like the BC NurseLine, but the NurseLine does not have the authority or experience to make diagnoses.

There is a lack of communication between physicians and other health care professionals.

We are not utilizing public facilities to their fullest potential due to staffing shortages.

There is too much segregation of medical staff and patients.

Protocols require a range of diagnostic tests before patients can get to the equipment or tests that their doctor thinks they actually need.

**Comments on walk-in and community clinics:**

- Walk-in clinics may leave emergency rooms for real emergencies but they do not actually provide quality primary healthcare.

- Walk-in clinics take the easy issues leaving the general practitioners with the more complex issues that take more time to deal with.

- Walk-in clinics have a group of doctors and they are often open 24 hours seven days a week. But there are problems with these clinics such as continuity of care.

- Walk-in clinics create an attitude amongst the physicians that they do not have any real investment in you as a patient.

- People sometimes go to more than one doctor in different walk-in clinics until they either get the answers they want to hear or get the prescription they want to take.

- Walk-in clinics do not include enough diversity of health practitioners.

- Walk-in clinics are not being utilised to their full capacity.

- There is a perception that people will get better care in emergency departments than walk-in clinics because in the emergency department patients can get all of their tests done at once, have access to specialists and get admitted if required.

- Walk-in clinics do not employ a diverse enough range of health practitioners.

- There is scope of practice and turf protection issues with walk-in clinics.

- Walk-in clinics tend to close early because of having already met their quota.

- The quota system for doctors in walk-in clinics curtails the usefulness of walk-in clinics.

- There are not enough community clinics.

- Walk in clinics have not met their purpose of decreasing emergency room visits.
• Walk-in clinics are replacing general practitioners. Government has not fully considered the impact of this change in health care delivery.

• Walk-in clinics that are open 24 hours seven days a week will not work unless people accept the fact that unnecessary visits are a drain on resources.

• The care at walk-in clinics provides no emphasis on prevention.

• People are suggesting 24 hours seven days a week walk-in clinics with no specificity of what that really means. For instance, the number of emergency room visits and non-urgent clients generally increases when people come home from work until about 10:30 pm and then they drop after 11:30 pm at night.

• If we have 24 hour private clinics close to hospitals, who would pay for these clinics? There is concern that the cost would fall to patients and that most patients could not afford this.

• Continuity of care is an essential part of good primary care. However, 15 per cent of Canadians, and likely the same percentage of British Columbians have to depend on episodic care from walk-in clinics, because they are unable to find a family doctor who will take them as patients. If all these 'orphan' patients were young and healthy it may not matter much, but they likely represent a cross-section of society from the very young to the very old and from the healthy to those with several chronic conditions.

• Walk-in clinics that are open 24 hours seven days a week are not a good idea. Rather the focus should be on providing responsive primary care that people want. This may mean all night doctor phone lines, increasing same day access to someone’s own physician or team member, or emailing the doctor or a walk-in clinic with a concern. We need to increase the ways to ask the question and extending the available time to actually access a live person.

• Walk-in clinics are a waste of money. Investing in community health care would be a better use of money.

• An increasing number of newly graduated general practitioners are choosing to work shorter hours in walk-in clinics to provide brief, episodic care. Complex health problems are difficult to address in these clinics as compared to more traditional medical offices where physicians get to know their patients and their patient’s personal circumstances, sometimes over many years. The Government has attempted to direct funding to more comprehensive care, but this measure may take some time to achieve results.

• Walk-in clinics are a licence to print money for the doctors. Because they are free, the public drop in for every minor issue that comes up.
• The advent of walk-in clinics has only added to the distress of the system. One can go to any mall or shopping center and find a drop in clinic very handy. It is free so why not check out that sore finger or sore throat or whatever. Once in the clinic the doctor is obliged to send the patient with something such as an X-ray requisition, a lab requisition or a prescription.

• Centralized non-urgent care clinics struggle to respond to demand in an efficient way. There are sometimes long waits and at other times when walk-in traffic is low professional resources are ill-used.

• Walk-in clinics provide quick fixes, but are ill equipped to follow up complicated cases and provide poor continuity of care. This often results in patients returning to hospital emergency departments or a family physician for re-examination and re-testing.

• We already have walk-in medical clinics in most urban areas of British Columbia. The challenge is that many people going to emergency wards with colds, flu, sprains and other non life threatening health issues instead of using these clinics.

• Public walk-in clinics are good value for money.

• Walk-in clinics work well. Locums and part-time doctors often staff them, which is a good use of resources.

• Walk-in clinics provide a temporary solution for those unable to secure a family physician.

Ideas and Suggestions

Walk-in and Community Clinics
Reducing Emergency Room Usage
Family Practice
Community Health Care Clinics and Centres
Role of Health Professionals in Primary Care
Primary Health Care Practices and Models

• Ideas about walk-in and community clinics:
  • Provide more walk-in clinics that are open 24 hours seven days a week.
  • Provide more multi-disciplinary walk-in clinics that emphasize prevention.
  • Have more Nurse Practitioners and physician assistants at clinics to help screen patients.
  • Connect 24 hours seven days a week clinics and pharmacies at hospitals.
• Exempt walk-in clinics from the quota system. Pay physicians until the end of their shift.

• In Sparwood, people can accept that acute care facilities are not located in the region. However, there is strong need for 24 hours seven days a week staffed facility. This is important because mining draws a young labour demographic with young families to the region so there needs to be more care close to home.

• Implement a franchised system of private 24 hours seven days a week medical centres in every city in British Columbia.

• Provide 24 hours seven days a week pharmacies to fill prescriptions written by walk-in clinic doctors.

• Provide high class first aid station 24 hours a day.

• We do not need clinics open for 24 hours seven days a week, but we do need a clinic provided for peak periods. Locate clinics for peak periods in the hospital itself where the hospital and the clinic can share triage.

• Allot a space in every hospital to accommodate a group of doctors in a clinic environment and then pay them a salary.

• Standardize the services available at walk-in clinics.

• Move day surgeries and less complicated procedures out of hospitals and into clinics.

• Provide access to diagnostic equipment at walk-in clinics.

• We need stand alone clinics dedicated to one specialty such as orthopaedics.

• Create Centres of Excellence that specialize in community defined needs, such as diabetes.

• It would be much better to divert if heart failure patients to a weekly community clinic in which health professionals such as nurses, dieticians and pharmacists could advise them on nutrition and other issues important in monitoring their health.

• Provide more primary care options in rural communities through walk-in clinics.

• Follow the Swedish model for walk-in clinics.

• Consider the Masset Health Centre model to increase services at clinics.

• Government should offer funding to the owners of existing walk-in clinics for extended hours.

• Increase the use of mobile clinics.
• Offer free or reduced square foot rental to independent walk-in clinics.
• Provide more multi-media information about clinics aimed at different ethnic groups.
• Put signage on bus routes to advertise walk-in clinics.
• It is good to have clinics available through the public health care system, especially in light of the shortage of doctors.
• A walk-in clinic using Nurse Practitioners to assess or triage and assign a patient to either the emergency room or to the clinic for service is a great idea.
• The British Columbia Government should subcontract the non-urgent or less urgent medical conditions to 24 hours seven days a week medical clinics.

• Ideas about reducing emergency room usage:
  • Attach 24 hours seven days a week clinics to emergency departments.
  • Educate the public on when to use the emergency room and when to use a 24 hours seven days a week walk-in clinic.
  • Support more private 24 hours seven days a week emergency facilities such as the False Creek Care Centre in Vancouver.
  • Have 24 hours seven days a week clinics with doctors or Nurse Practitioners that would act as a triage center to deal with patients and refer to emergency if needed.
  • Train paramedics in the Canadian Triage and Acuity Scale to determine whether a patient could go to a clinic or if it is a true emergency case.
  • A community clinic system would help solve emergency problems. Ensure the community clinic fits in with the vision of the community by studying the growth and demographics patterns.
  • Augment emergency departments with a separate out-patient clinic. Operate these clinics the same way that family physicians operate their own clinics. This means that doctors could bill the Medical Services Plan in the same way as any other walk-in clinic with a Medical Services Plan card.
  • Have staggered hours for clinics to help with emergency overload.
  • Support models such as that found in Kamloops where a group of physicians formed a non-emergent, after hour walk-in clinic to try and help decongest the emergency room at the Royal Inland Hospital.
  • Give triage nurses in the emergency room the authority to turn people away that do not need to be in the emergency room.
• Have a specified triage nurse assess patients who enter requesting services and have a walk-in clinic on site at the hospital to divert non-urgent patients. Doctors who were on salary and could work in both the emergency room and the walk-in clinic.

• Only treat certain medical issues at emergency departments, such as severe bleeding, heart attack, severe burn, stroke, or industrial/road accident. Walk-in clinics close to the hospital could handle all the other issues.

• Extend the Wound Clinic formula to at least the two big hospitals that have overloaded and overcrowded emergency departments. This formula includes specially trained emergency nurses who first assess a patient and send the true emergency cases to the doctors, and treating less serious cases themselves.

• Restructure the business model for clinics so they are a precursor to emergency room services.

• We should be able to get referrals from walk-in clinics or general practitioners for specific machines in emergency departments and then to be sent back to the original doctor with the findings.

• An integrated team of nurses, nurse practitioners, pharmacists and doctors could solve many of the so-called emergencies that appear at the emergency department.

• Provide urgent care clinics next to emergency with mental health practitioners on site.

• Open as many ambulance stations as possible as first aid post. In large metro areas, have ambulances designated as first aid posts situated in high call volume locations to treat the walking wounded.

• Ideas about family practice:

• Create an environment where family practitioners can profitably exist to serve patients in a proactive health care model.

• Facilitate a renewed interest in family practice and expand the role of Nurse Practitioners.

• The family physician gets to know you and your family members and can see health patterns because they have your health history. This is so important in obtaining correct diagnoses.

• Get rid of the old family doctor system and replace it with centralized clinics with good computer-based record keeping.
• **Ideas about community health care clinics and centres:**
  - Use our local community health centres more effectively.
  - Have 24 hours seven days a week community health centres where people could access primary health care practitioners plus emergency care for minor things.
  - Ensure all communities have a clinic.
  - Provide more community clinics along the lines of REACH and MidMain Health Clinic, both in Vancouver.
  - Provide urgent care at community health care centres and private medical centres.
  - Expand community services to deal with more issues.
  - Support community clinics where there is care available around the clock from a multi-disciplinary team of health care providers.
  - Real progress has been made on reducing wait times in emergency departments in several Canadian jurisdictions by using community clinics. In Sault St. Marie, members of the community health centre uses emergency services just one fifth as much as the rest of the population does.
  - Provide a health van with a public health worker that can triage at shopping malls and other public places.

• **Ideas about the role of health professionals in primary care:**
  - Encourage the use of Nurse Practitioners to help shift the current public perception that they have to see a physician.
  - Encourage the use of multi-disciplinary teams.
  - Use doctors for initial reviews of patients rather than emergency department staff.
  - Increase the number of house calls from all health professionals such as doctors, nurses and Nurse Practitioners.
  - Allow others to be gatekeepers for the health care system, not just the general practitioners.
  - Encourage more telephone consultation for the doctor/patient relationship, particularly when there are long distances to travel for ongoing consultation with specialists. In this case, the specialist would still get paid, but at a lower rate than in person visits. A bonus side effect would be savings on transportation and the environment.
• Pay physicians to make house calls. Perform more procedures to be in the patient's home to reduce the pressure on hospitals, clinics and care facilities.

• Stop one problem visits to doctors. Patients need more time at the doctor's offices to talk about issues and get more information about services.

• Encourage the role of midwives. They keep labouring women at home longer thus preventing unnecessary intervention in hospitals.

• Give naturopathic doctors the same privileges as medical doctors to lighten their load.

• Make it mandatory for doctors that work in a walk-in clinic to get hospital privileges.

• Provide onsite translators or require second languages for nursing staff.

• **Ideas about primary health care practices and models:**

  • The British Columbia Medical Association should be responsible for rotating medical doctors so that they can handle the normal and/or excess patient loads.

  • Consider the long term connection to primary care as practiced in the Kaiser Permanente non-profit model in the United States.

  • Consider the model in the United Kingdom that uses something called see and treat, which says that the most senior person will deal with people much more quickly.

  • General physicians should receive a greater fee for service so that additional visits are not the means of insuring adequate salary. A fair fee for service review could perhaps solve the present practice of return visits to achieve sufficient time with the physician and save the time and effort of all concerned.

  • Give incentives to physicians to keep their clinics open on the weekends and/or have extended hours.

  • Introduce user fees for walk-in clinics and doctor office visits to cut down on unnecessary visits with exemptions for low-income individuals or families.

  • Take the therapy to the patient such as long term care patients receiving IV treatment by creating treatment teams that travel to the patients. This is better than moving the patient multiple times in an ambulance.

  • Provide more incentives for new medical graduates to work in northern communities in British Columbia and in clinics not paid via the fee-for-service model.
• The Children’s Hospital has a much better system. The patient sees every necessary practitioner in one visit.

**Specialists**

**Comments and Concerns**

Access to Specialists  
Referrals to Specialists  
Efficiencies  
Accountability

• **Comments on access to specialists:**
  
  • Specialists can refuse a consultation with a patient, which can delay treatment.
  
  • The availability of specialists and certain procedures should not be regionally limited.
  
  • If a specialist does not care for the questions that a patient asks, then they can advise the family physician that they will no longer see that patient.
  
  • It is stressful to wait months for a specialist to interpret test results when they may be especially concerning.
  
  • Pensioners should not have to wait to see a specialist for their problem. They should be looked after instead of being left on medication while their condition worsens.
  
  • There is up to a two week wait in hospital to see specialist, but patients arriving in the emergency department see a specialist immediately.
  
  • It is physically, mentally and emotionally stressful for a patient to try and convince their doctor that an appointment with a specialist is necessary.
  
  • There are too few specialists in British Columbia.
  
  • It is very difficult and expensive to see a specialist for women’s health issues such as early onset menopause
  
  • Specialists are available, but there is a long wait.
  
  • The number of unnecessary visits from patients only seeking reassurance is staggering. They see it as their right to see a specialist whenever they want.
  
  • Nurse practitioners refer to specialists at much higher rates than family physicians do.
• **Comments on referrals to specialists:**
  
  • General practitioners are hesitant to refer patients to specialists because they want to keep the patient’s treatment within their own practice.
  
  • General practitioners do not spend enough time with patients to make a proper diagnosis as they are inclined to refer them to a specialist.
  
  • Patients are sent to specialists unnecessarily. Often a family physician could have dealt with the issue at a much cheaper cost to the system.
  
  • Centralized referral clinics centred in public facilities have reduced waiting times for key procedures.
  
  • People must make an appointment with their doctor every time that they want to see a specialist. This now requires the Government to pay for the appointment plus the cost of a letter to see a specialist.
  
  • Specialists are asking doctors to cease their referrals in order to spend more time in the operating room.
  
  • Most doctors now refer patients with anything other than basic problems to specialists, causing increasingly long wait lists. The family doctor does not have the time, nor are they paid, to be the old fashioned doctor that was able to solve a host of problems.
  
  • Jurisdictions that allow patients self-referral privileges must deal with abuse of the system. For example, some people want to see a specialist when a general practitioner could have dealt with the issue. Also, patients may seek out the advice of numerous practitioners and specialists until they hear a diagnosis that they feel is correct.
  
  • The process of referral to a psychiatrist is wasteful and ineffective. Even if a patient is diagnosed as having mental health issues, they need a referral from the Ministry of Children, Families, and Development or the Adult Mental Health department to visit a psychiatrist.

• **Comments on efficiencies:**
  
  • The wait-time between primary care and specialized care is long, drawn out, and very expensive.
  
  • There is a lack of communication between primary care physicians and specialists for diagnostic screening and testing.
  
  • The amount of unused and underused surgical capacity in British Columbia hospitals, even in daytime hours, vastly exceeded the number of additional hours
physicians said they needed to eliminate waiting lists for some key elective procedures - hip and knee replacements and cataract surgery.

- Specialists require the patient to return multiple times when they could have dealt with the issue at hand on the first visit.
- The paperwork required for specialist consultations is burdensome.
- Only specialists can order medical Resonance Imaging (MRI) exams. It is challenging to receive these tests due to specialists’ long wait lists.

- Comments on accountability:
  - We do not give family physicians enough training or authority to try and diagnose ailments, so instead they send people to specialists who in turn order tests and send the patient back to the family physician.
  - Too often, specialists offer inadequate advice during follow up appointments.

**Ideas and Suggestions**

- **Access to Specialists**
- **Referrals to Specialists**
- **Efficiencies**
- **Accountability**

- **Ideas about access to specialists:**
  - Provide quicker and easier access to specialists.
  - We should consider dentists as specialists that everyone needs to see twice a year.
  - Have all specialists in the same building where the population warrants this kind of set-up.
  - Australia increased operating room utilization 5.1 per cent by reducing the number of last minute cancellations.
  - Return to specialist services in Nelson, not just Trail, until a new hospital located in a central area.

- **Ideas about referrals to specialists:**
  - After an initial assessment by a specialist, there may be a requirement for follow-up appointments. These appointments should not require referral from a family physician.
  - Reduce the amount of referrals necessary for provider services.
• People should have direct access to specialists through a self-referral process.

• If a specialist requests a patient to get an annual test, then the patient should not have to go back to the general practitioner to get an annual requisition.

• Allow people direct access to health care providers such as nurses, dieticians, physiotherapists and specialists without a referral.

• When a doctor refers a patient to a specialist, that referral should stay valid for the duration of the treatment.

• Allow patients to have access to a specialist for one year without a further need for referral from a physician.

• If a patient has a chronic medical condition, they should not have to visit their general practitioner first to get a referral.

• Screening tests should be available to anyone on a self-referral basis with a reasonable fee.

• Specialists should maintain a relationship with the patient until their services are no longer needed.

• If a patient has seen a specialist in the past three to five years, then they should be able to book their own appointment with that specialist without referral.

• People should be able to book an appointment with a specialist over the phone and not have to go through a doctor.

• Provide more education to general practitioners regarding referral practices.

• Stop charging referral fees for access to specialists.

• Encourage general practitioners to consider other alternatives before referring to a specialist.

• Give physiotherapists, chiropractors, and naturopathic doctors the authority to refer patients to specialists.

• When being referred to a specialist, the patient’s complete medical history should be available.

• Raise the quota for general practitioners to make referrals.

• Allow family practitioners to refer patients with mental health issues directly to a specialist.

• Encourage doctors to refer their patients to specialists, as some doctors may be reluctant to lose their patients business to specialists.
• **Ideas about efficiencies:**
  
  • Increase the length of time that a specialist has with each patient to reduce the need for repeat visits.
  
  • Doctors need to learn which specialists are available and ensure that the chosen specialist is appropriate for their patient case.
  
  • Hold a case conference between patient, patient support, general practitioner, surgeon and oncologist in the presence of a serious disease to develop plans and discuss available alternates.
  
  • Only specialists can order Magnetic Resonance Imaging (MRI) tests. Grant general practitioners the authority to order these tests too.
  
  • Second opinions should be required in order to reduce unnecessary surgical procedures. This may cut down on the large number of caesarean procedures being prescribed.
  
  • Mammography clinics should book follow-up appointments with patients when the results of their exam require a re-check within six to twelve months.
  
  • Ensure that specialists hire appropriate staff to meet their workload needs.
  
  • End the requirement for a patient to be present when a phone call would suffice. Let the doctors charge a fee for the call rather than hold up clinic time with useless re-referrals to specialists.
  
  • Replace individual specialist wait-lists with service category wait-lists.

• **Ideas about accountability:**
  
  • Require surgeons to provide information to patients about the options for surgical care in British Columbia.
  
  • Improve the bureaucracy so pertinent information passes between doctors and specialists faster.
  
  • Complaints about specialists should go to the Provincial Government not the College of Physicians and Surgeons, who have a vested self interest.
Emergency Departments

Comments and Concerns

Access to Treatment in Emergency Departments
General Physicians and Emergency Departments
Overuse and Misuse of Emergency Departments
Staffing Emergency Departments
Impacts of Congested Emergency Departments
Beds and Resources in Emergency Departments
Costs and Efficiencies

• Comments on access to treatment in emergency departments:
  • The health system is great at providing emergency care when the situation is life threatening.
  • The triage system is going well; we are doing the right thing.
  • The care we get in emergency rooms is good. If it is a real problem, then the emergency staff take you right in.
  • The emergency department is working very efficiently, particularly for true emergencies. Once the patient sees an emergency room physician, the care is good and the problem is usually fixed.
  • Why can a person obtain faster and often much better emergency care for their dog or cat from a veterinarian, than one can receive at a hospital emergency wards?
  • The nursing centre in Courtenay is a good example of how to deliver services in the community as an alternative to people going to emergency ward during the day.
  • I was taken to an emergency room in China by ambulance with food poisoning and was treated by a doctor, nurse and technician within two minutes after arrival.
  • There is ageism in emergency departments.
  • Patients may languish for many hours in emergency and then be moved or admitted to a floor where there are several empty beds.
  • Emergency departments are getting worse especially Surrey Memorial.

• Comments on general practitioners and emergency departments:
  • Physicians use the emergency room as an office.
• Family doctors should not be able to use emergency rooms as their locum when they are not available, nor should they encourage their patients to go to emergency in order to jump the queue and get surgery quicker.

• One participant writes that their family doctor would not take their visiting grandchild because they were not the child’s patient, so they had to take their grandchild to the emergency room.

• Doctors can only admit patients to the hospital through emergency departments, they cannot admit directly to any unit.

• Patients are sent to emergency rooms when they are unable to see primary care physicians in a timely manner.

• Doctors are telling their post-operative patients to go to the emergency room if there is a problem, but then the emergency room does not understand the situation.

• People are going to the emergency department instead of going to a family physician.

• There is seldom a time in emergency rooms when the waiting room is not filled with the elderly and those needing sutures or a bone set. Thirty years ago people would have gone to their family doctor for suturing, eye exams, rashes, sore throats and strains or sprains. Nowadays, family doctors are too busy to do these or other traditional tasks (like home visits). And with so many women in the work force, we no longer have a cheap supply of caregivers in the community for our elderly.

• Great numbers of seniors are coming into emergency rooms because doctors do not visit care facilities.

• Seniors in long term care have no access to physicians during off hours. Often long term care facilities have to send seniors to the emergency room for attention.

• **Comments on overuse and misuse of emergency departments:**
  
  • Funding cuts to rural hospitals put pressure on emergency departments.
  
  • One of the problems is the closure of the emergency rooms in some of the smaller hospitals. The concentration of emergency care to just a few hospitals ensures that there will be unacceptable wait times and potential for disasters.
  
  • There is an increase in emergency room visits because there is a lack of ongoing support for people with chronic conditions, an increase in seniors’ health needs, a lack of coordination of services for seniors and inappropriate use by some.
There are a lot of elderly females in emergency departments because care providers do not know where else to get help for them.

Elderly patients with complex healthcare needs and disease management go to emergency departments because they have nowhere else to go. We need an infrastructure where these types of patients can be housed for two or three days in an environment that is only for them.

Too many elderly people end up in emergency because they are having a scared or lonely moment.

Elders increasingly show up at emergency departments when their families cannot cope any longer.

There are too many patients with non-emergency issues in the emergency room.

There is a general lack of understanding of when to use emergency room services.

Overuse and misuse of emergency departments is actually a public awareness and education issue.

Information on alternatives to emergency departments is not available or advertised.

Some people are using emergency rooms and walk-in clinic visits for problems that could be solved by the patient if they were better informed about how to take care of minor health care situations.

Artificial regional divisions create congestion in emergency rooms.

There are not enough community resources for families to look after their elders. As a direct result, emergency rooms are backlogged with elders waiting for acute care beds.

There is misuse of ambulance services in an effort to jump the queue in the emergency room or short circuit triage.

Welfare recipients use ambulances because they are free and ambulances transport to hospitals, not to doctor offices.

Walk-in clinics send people to emergency for things that perhaps they could do such as stitches.

If the emergency room will not turn you away and the Care Point medical clinic will charge you $50, where do you think poor people go?

People think emergency is free and go there.

Emergency rooms are misused because of cultural expectations of how end-of-life should be managed.
Triage does not have authority to turn those patients away who have minor injury or illness.

We need to stop using our emergency rooms as overflow for social services that have been cut or no longer exist.

There is an increased use of the emergency room by persons diagnosed with psychiatric disorders and substance use, which is overwhelming staff.

Emergency doubles as first point of contact for homeless, sex-trade workers, mental health and low income individuals, because there is nowhere else to go.

Some mental health patients are discharged from hospital too early so they end up going back to emergency, which ends up costing the tax payer more. This is due to pressure placed on psychiatrists and nurses to discharge mental health patients to make room for new admissions from emergency departments.

Much of the costs for emergency services and ambulances may be due to addictions. People with addictions need to be placed in long-term recovery centres. There need to be more and improved counsellors and the counselling services. These services cost money but would reduce the costs incurred in emergency.

A third of emergency room patients have no fixed address (those with mental/drug addiction) and can be better served by specialized treatment centres. Another third of patients is over 65 years old with complex medical issues that could be better served by properly equipped extended care facilities. The remaining third are there for what emergency rooms are designed for, healthy individuals who have an unanticipated health crisis or trauma.

People without health care coverage are likely to be served in emergency rooms rather than walk-in clinics.

Emergency rooms are administering ongoing care rather than short term emergency care.

Parents with young children need more counselling about childhood sniffles and communicable diseases, rather than running to emergency care.

Many musculoskeletal complaints end up in the emergency room when they are less urgent or non-urgent conditions. One of the most common musculoskeletal complaints in emergency departments is back pain.

There is a concern that new immigrants to Canada use the emergency department because they do not know the alternatives or feel safer in the emergency department rather than a walk-in clinic.

People go to emergency rooms to get their prescriptions free.
The problem is not that too many people are carelessly using the health care system or the emergency departments because most people who seek help need it. The problem is that the capacity has been exceeded.

Too often there are patients such as people with Multiple Sclerosis who must go to emergency to get steroids intravenously when they have an exacerbation. Why cannot this service be done in a clinic under a doctor’s care?

There is concern that many single mothers without family support are using emergency, as they have no one to call and share their concerns.

Nurses on the BC NurseLine seem to be afraid of litigation and therefore tell many people who call that they should go to the emergency department.

The emergency department is not the issue. It is a throughput problem where demand is exceeding supply and there is no where to go.

People use emergency departments as walk-in clinics.

Cuts to acute care lead to increased demands on emergency rooms that now have to provide some of these acute care services.

Emergency room overcrowding is due to inpatients.

Government literature indicates that emergency visits increased significantly more than the population increased between 2001 and 2005. However, there is no indication as to how many visits result from no other medical assistance being available; therefore leaving the emergency ward as the only choice. It can safely be assumed that many emergency visits are not emergencies and are a result from a shortage of doctors.

Emergency room congestion has nothing to do with the running of the department so building new emergency departments is not the answer.

Inappropriate use of emergency has been an issue for over 20 years. Past initiatives to address this issue include better triaging, user fees and fast tracking.

A recent report has outlined that 25 per cent of all Emergency Department visits are unnecessary and could have been avoided if the patient simply undertook common-sense self-care measures or a visit to the drug store for over the counter remedies such as cough syrup, aspirin and vitamins.

There has been constant pressure from the Government to reduce visits to the emergency room. The patient and staff are constantly asked whether the visit is necessary. That decision can only be made by the patient before they present. It depends on their medical experience, education and insight.
• **Comments about staffing emergency departments:**
  
  • Staff in emergency rooms use up too much of their time answering repeated questions.
  
  • Emergency departments in hospitals are understaffed.
  
  • There is not enough emergency room staff. For example, at Langley Memorial there is only have one doctor on in emergency at night time. This is the same amount of doctors we had 20 years ago and our population has increased, so you can imagine the wait.
  
  • There is lack of communication between staff in emergency departments and patients as staff do not have time to explain things to patients.
  
  • There is an issue with liability for volunteers in emergency departments.
  
  • Emergency departments are loaded down with admitted patients. The staffing level has been reduced to the point that they cannot give good care to these patients and have no space or resources to examine or treat the emergencies cases that do come in.
  
  • By law, once you walk into the door of a hospital a doctor has to see you.
  
  • Emergency physicians are trying to decompress emergency rooms, but at the same time most of these physicians are only paid until they reach a certain threshold of patients. So the incentive for emergency physicians is to see as many patients as possible, while at the same time we ask those physicians to keep emergency departments for emergency cases only and to decompress patients so they can focus on the more acute patients.
  
  • People with cancer problems need to be triaged better by someone who understands cancer. They need some way to be flagged as a cancer patient rather than wait for an hour for triage, and be exposed to others in waiting room.
  
  • The triage system in emergency departments is inappropriate. There is an absence of staff at triage stations, superficial medical cases going to emergency rooms, understaffing of Emergency Physicians and an inappropriate ratio of physicians to nurses and beds.
  
  • Emergency room health care professionals are facing burnout because they are bearing the brunt of an angry public.

• **Comments on the impacts of congested emergency departments:**
  
  • When the emergency room is full there is a problem with prioritising patients.
• Waiting in the emergency department for a long time can lead to more serious health issues and higher costs.

• Patients exposed to gruesome injuries while waiting for care in emergency departments raises safety issues.

• Emergency room wait rooms are uncomfortable, especially for clients who may want or need to lie down.

• Emergency rooms cannot cope with the volumes of patients, the waits are unacceptable, and seeing patients on gurneys in hallways is insulting and undignified to those relying on our health care system to care for them in a dignified and appropriate manner.

• The inability to receive reasonably prompt emergency care in hospitals is a serious concern.

• One participant questions how overcrowded emergency rooms actually are, as they have seen an emergency room physician's time being wasted while he examined a toddler's red marks only to diagnose mosquito bites. They have also seen a very elderly senior citizen coughing up blood while waiting to see the emergency room physician who was occupied in dealing with a convulsing drug abuser presented to him by paramedics who picked up the drug abuser off the street.

• Emergency departments are overcrowded.

• Comments on beds and resources in emergency departments:
  
  • Finding beds to transfer admitted emergency room patients to is a problem. There are often no available beds so transfer to in-patient setting is blocked.
  
  • There is concern that most of the patients in beds in the hallways are elderly people.
  
  • There is a lot of frustration of having for a long period of time for medical attention in emergency rooms.
  
  • Emergency does not have enough diagnostic equipment available and the equipment it does have is not utilized fully.
  
  • With the closure of the University of British Columbia Emergency Department in 2003 the volume and level of acuity went up at St. Paul's Hospital and the Vancouver General Hospital. This necessitated hallway stretchers which were lettered "A" through "J" in the hallway just outside of the emergency room at the Vancouver General Hospital. In uncountable occasions many critical patients were in those stretchers because they could not get a bed inside the emergency
room. Furthermore, on one occasion I had to insert a central venous catheter in one of the family waiting rooms to resuscitate a patient going into renal failure with fluids. He was about to get a bed in the emergency room but this was taken by another patient having an acute myocardial infarction (heart attack). It would have been hours before getting a bed on the ward. He may have died before then. (He ended up surviving, getting the surgery he needed and leaving hospital). The beds in the emergency room were not full of people with non-urgent conditions. They were either admitted patients that could not get a bed on the ward because the ward was full of patients that were waiting for non-existent long term beds in the community.

- Beds in emergency departments are used as acute care beds.
- There is recent evidence published that refutes the notion that non-urgent patients tie up beds in emergency departments.
- There are no acute hospital beds in emergency.

**Comments on costs and efficiencies:**

- There is no incentive for emergency rooms to limit non-emergency use and therefore try to be more efficient.
- Basing hospital funding on each fully processed emergency room patient that is treated in less than 10 hours would only lead to mistakes and rushed decisions.
- Emergency rooms are not efficient and do not have access to patients medical histories.
- There is concern about budget management for emergency departments and that some emergency issues are considered to cost the system less but in fact they will end up being very expensive. For example, non-urgent patients waiting for long periods of time may be less expensive in financial terms, but they are actually very expensive in other terms such as using up nursing resources.
- Patients should be able to get their medication administered at the emergency room and should not be pressured to administer it at home.
- If you take the average cost of a patient in an emergency ward, then you are considering the person who came in with terminal contusions and the person who came in with minor ailments. If the costs are not separated for different levels of care required then you are grossly overestimating what it may cost to look at somebody in the emergency room.
- I would be happy to pay the going rate for professional private health care rather than wait for hours in the emergency room.
Ideas and Suggestions

Access to Treatment in Emergency Departments
Availability and Misuse of Emergency Departments
Emergency Department Staffing
Beds and Resources in Emergency Departments
Costs and Efficiencies

- Ideas about access to treatment in emergency departments:
  - A person should not be able to walk off the street for emergency care. A clinic located in the proximity of the hospital should do all the triaging and refer patients to a non-emergency 24 hour clinic if possible.
  - Pass legislation to limit use of emergency rooms to 911 ambulance emergency calls only. Send all other minor cases to local walk in clinics or local storefront emergency services operated by local general practitioners.
  - Provide triage outside hospital emergency rooms like the Canadian Army model.
  - Provide suitable alternatives to emergency departments that have diagnostic equipment.
  - Use aggressive monitoring of patient needs for queuing for treatment.
  - Change the way that the health care system treats emergency departments as a backup.
  - Establish benchmarks so that patients do not stay in emergency departments for more than a few hours.
  - Provide geriatric assessment in emergency departments.
  - Advertise and market alternatives to the emergency department that are based on patient needs.
  - Have patient advocates in emergency rooms.
  - Bring children to emergency through a different area and separate out problematic patients.
  - Provide ways for greater use of telephone consultation before going to emergency to reduce the number of emergency visits and to help people know what to expect when arriving at emergency.
  - Government’s one-size fits all solution for emergency departments and after hours care in rural communities does not work. Look at publicly funded alternatives that relieve pressure on emergency departments such as walk-in clinics and secondary diagnostic centers.
The emergency room should not be the entry point into the health care system. 

Put seriously disabled and chronically ill patient needs first on the priority list. 

Provide intravenous therapy in walk-in clinics instead of the current practice of having to go to the emergency room to have it done. 

Have an infant and child clinic connected to paediatrics in the hospital to free up room in the emergency departments. 

Have a gerontology clinic attached to the emergency department. 

Designate hospitals or care centres for the elderly. 

Provide comprehensive, longitudinal and holistic care at the community level with extended hours provided. 

Admission to the emergency ward should be by ambulance or by a doctor’s reference. 

Implement a numbering system for each patient to help track patients. 

Have a first aid room at each hospital and major shopping centers taking enormous pressure off our over crowded emergency rooms. 

Encourage the establishment of both private and public emergency clinics for non-life-threatening injuries. 

Provide more respite care in home so families do not leave their family member in the emergency department, as they do not have any other choice. 

Solutions to the emergency room problems need to be proactive, not reactive. 

We need legislation to protect the hospital from any potential liability for the one in a million chance that an urgent case is referred to a clinic by mistake. 

Fund nursing centres and public health units to provide emergency services from 7:00 am to 11:00 pm to take pressure off the emergency department. 

Emergency departments should have many separate units such as a trauma unit, a stroke and cardiac unit, a mental health unit and an isolation unit. 

Provide services like a library, food vendors and video rental in emergency rooms. 

Build a new facility for emergency department issues in Castlegar and elective surgeries in Trail. 

As one enters the emergency room, it could be the triage Registered Nurse’s responsibility to assess the patient and determine the level of urgency. For instance, level 1 is you are dead and require immediate intervention (like CPR) and level 5 means that you can sit in the emergency room all day and live to see
another day. In this case, patients need to be advised that they are a level 5 and will have the choice to remain in the emergency room and be charged a user fee or they can leave and see their physician the next day. Sounds risky as we are then relying upon the triage nurses judgment but it has to start somewhere.

- The room layout of waiting rooms in emergency rooms should allow for small grouping instead of one long line of chairs or benches. Patients need to be able to lie down if they need to.
- Implement a five-part strategy to reduce Emergency Department waits and incorporate it into the performance agreements with Health Authorities:
  a. Implement a maximum length of stay (6 hours from time patient enters the door) and wait time benchmark for admission to hospital (within 2 hours after the decision to admit) in every emergency department in British Columbia;
  b. Adopt overcapacity protocols province wide.
  c. Expand triage capacity immediately for emergency departments experiencing volume beyond their physical plant capacity, using portables if necessary;
  d. Create regionally based pools of Emergency Department physicians and General practitioner’s with Emergency Department experience to provide float coverage in demand overload situations; and
  e. Introduce urgent care centres (with access to lab and x-ray services) that are in close proximity (or in hospital) to emergency departments that are routinely overcapacity.

- Ideas about availability and misuse of emergency departments:
  - Consider a third strike system, which gives the option to the medical centre to give a fine on the third strike.
  - Give hospitals in British Columbia the right to refuse those people who do not have medical emergencies.
  - Follow the 911 model in France that has in home acute care to prevent emergency admission.
  - Government needs to establish a maximum emergency department length of stay benchmark of less than six hours (from arrival to emergency department exit).
  - Government needs to require that all admitted patients must be transferred out of an emergency department to an inpatient area within two hours following a decision to admit.
• We need definitions for what constitutes urgent and non-urgent care. Otherwise it is like we asking patients to make the judgements of a triage nurse when deciding whether or not to go to the emergency Room.

• Offer more services for homeless people who end up in emergency.

• The public needs to take some responsibility for clogging up emergency rooms.

• Look at the reasons why people are using the emergency room and not walk-in clinics. One example of this was in the Royal Hospital London that studied why there was escalating attendance at emergency for minor complaints. Results showed that one immigrant community in particular went to emergency because they did not feel that the doctors at the walk-in clinics were professional because they were not wearing white coats.

• Many emergency visits are unnecessary. If the patient had to pay, then they might be more prudent in the use of the service.

• People who abuse emergency care should be billed for it.

• Track an individual's use of emergency services and charge those people who abuse emergency room services.

• Survey the self inflicted ailments like drugs and alcohol that end up in the emergency room to see if there is need build a separate clinic for these cases.

• Encourage new immigrants to use doctors and clinics instead of the emergency department.

• Do not give out free medicine in the emergency room.

• If someone shows up at emergency for a non-emergency have the nurse make an appointment for a non emergency clinic or pay a higher rate.

• Introduce a surcharge for people who use the emergency department. People on social assistance could have a determined number of visits per year without a charge or more if they have serious medical problems, as authorized by their physicians.

• Support a shift in public perception of emergency care to go to a community health centre first.

• Provide a user-friendly information package to all households listing common maladies that frequently result in a visit to the emergency department and other pertinent information.
• Educate people about:
  a. emergency use and overuse;
  b. when to go to a physician and when to go to emergency; and
  c. types of minor ailments that can wait for medical treatment.

• Ideas about emergency department staffing:
  • We need better support for emergency staff.
  • Listen to emergency staff.
  • Allow the use of Nurse Practitioners to clear backlogs of non-emergency cases in emergency rooms.
  • Call in extra staff when the emergency room is busy.
  • Use volunteers in emergency departments.
  • Have alternative health care providers in emergency rooms.
  • Emergency room staff and use of resources needs to be more versatile.
  • Chiropractors are highly trained in musculoskeletal complaints, and have a lot of experience in diagnosis and treatment of back pain in particular. Emergency departments should have a chiropractor on staff so that emergency room physicians have more time to see patients with urgent conditions.
  • Give patients attending the emergency department a choice to be treated by a Nurse Practitioner within one or two hours, or they can wait for longer to see a doctor.

• Ideas about beds and resources in emergency departments:
  • Provide new resources and proper utilization of resources to get patients out of the emergency room.
  • More beds in emergency departments.
  • Have appropriate supplies ready for use in emergency rooms such as vomit bags.
  • Spend more time and resources on cleanliness in emergency wards.
  • Instead of closing hospitals dedicate them to chronic or urgent care to take pressure off emergencies.

• Ideas about costs and efficiencies:
  • Improve the efficiency of admitting repeat patients to the emergency room and/or hospital by improving patient medical records.
• Provide more training to ambulance staff so they can determine whether or not to take the patient to the emergency department.

• Educate the public about costs and alternative services to help prevent utilization of high emergency department costs.

• Remove the limits on how many patients a doctor can see in a day and allow the doctors to set their own limits to cut down on the number of people in emergency departments.

• Consider a combination of public and private funding to help overcrowding in emergency departments.

• Bill doctors for the full cost of using the emergency department for a procedure that could logically be done in their office.

• Send a letter to patients attaching a bill that demonstrates the cost of their visit to the emergency room.

• Amend the Canada Health Act to allow user fees. Waive the fees if it is a real emergency.

• Eliminate health care premiums like Manitoba did, where everyone has a health care number and can go to any clinic or doctor, but they are unable to visit emergency for minor ailments.

• Emergency room funding should be part of global funding.

• Adopt new technology and use different ways of powering the emergency department.

**Acute Care**

**Comments and Concerns**

- Access to Acute Care
- Acute Care Bed Shortages
- Health Human Resources
- Acute Care Administration and Management
- Costs and Efficiencies
- Transferring Patients

- Comments on access to acute care
  
  We have to stop using hospitals as hotels to get diagnostics done. We have to stop using our hospitals as residential care facilities. We need some checks and
balances in place to ensure that hospitals are for there intended purpose, which is acute care.

- When physicians become frustrated with patients that they are having difficulty treating, which is often the elderly who have multiple medical and social issues, physicians admit these patients to acute care because they do not know what else to do.

- The historical expectation that hospitals should continue to provide over night health care for non acute and preoperative care is gradually shifting. We are beginning to accept what the research for years has shown, that it is better to convalesce at home.

- In many cases, the weaker and more debilitated patients eventually die in an acute hospital bed when all they needed was a care home and to be involved in some form of activity, rather than lying in a hospital bed for two to five months.

- Comments on acute care bed shortages:
  - There are not enough beds for the detoxification of patients addicted to drugs and alcohol. More beds for detoxification purposes would relieve pressure on emergency rooms.
  - Bed shortages create bottlenecks in all the major centres of British Columbia.
  - According to a survey, Kelowna General has 87 less beds than it did in 1990. Considering the population increase over the past 17 years, this statistic reflects terrible administration.
  - My father waited more than four months in Memorial Pavilion for an acute care bed in a nursing home when the Gorge Road Hospital was closed. The Vancouver Island Health Authority knew that beds were needed for the residents of the Gorge Road Hospital and also for all the new admissions from the community, but still it stayed closed.
  - Seniors and acquired brain injury patients are the most difficult to place and spend months in acute care beds, which is the worse possible place for them. The activity restrictions escalate their behaviour and they disrupt patients.
  - The traffic on the Sea to Sky Highway can add to the pressures on acute care beds if there are any more accidents.
  - The significant reduction of residential care beds in British Columbia has placed considerable pressure on the acute care system as more people residing in acute care beds wait to be placed in residential care facilities. This, in turn, has backed up emergency departments in hospitals and resulted in serious emergency department overflows. Greater overall system costs are also incurred by the
shortage of residential care beds, as acute care beds are much more costly than residential care beds.

- British Columbia has a relatively low number of acute care beds. That shortage of beds means that most British Columbia hospitals frequently operate at unsustainable occupancy rates of higher than 90 per cent, a level at which hospital overcrowding and bed crises are inevitable. The highest priority construction project in health care should be the creation of new acute and long term care capacity.

- We need more chronic care beds so that we can use our acute care and our emergency department beds for the purposes for which they were intended.

- The population has doubled, but acute care and long term care beds have closed.

- The current acute care bed shortage has a significant impact on emergency room waiting times, critical care capacity and surgical cancellations. The result is a system that has failed to provide for even the most critical needs of British Columbians.

- There are not enough beds or placements, but what we do have currently in the system is working well.

- The acute care system does not have enough of the following:
  a. publicly funded beds;
  b. acute, recovery and long term care beds;
  c. transition beds where patients are held prior to proceeding to the next level of care;
  d. available staff;
  e. facilities and operating rooms;
  f. appropriate beds and therefore level of care;
  g. beds for assisted living, complex care and social living;
  h. community support that creates more demand for acute care and beds;
  i. immediate availability of treatment facilities;
  j. special care beds such as beds for wandering and dementia patients;
  k. transportation to and beds for detoxification centers;
  l. specialized staff for acute care beds;
  m. child or adolescent psychiatry beds; and,
  n. acute care beds for those with developmental delays;
Patients are being admitted to the hospital with one ailment and then leaving the hospital with another ailment. This is because a lack of beds leads to dangerous overcrowding which leads to the cross-contamination of diseases.

When the hospital in Fort St John was built it had three times as many beds as it does now, yet the population has increased by at least four times since the hospital has been built.

There is a giant shell game happening in Prince George, where the status of buildings has changed, but there are no new beds.

There are not enough available beds in major centers in British Columbia such as Prince George, Vancouver and Victoria. In addition, there are not enough staff members in the receiving hospitals to treat the patient.

The lack of beds negatively affects post-hospital care and monitoring. It also causes other problems for patients, such as staying for days in emergency rooms, geriatric patients filling beds and the splitting up of couples and families.

Operating rooms cannot be used because there are not enough beds available in the hospital.

There are too many cardiac patients that are kept in hospital so that they do not lose their bed for bypass or angioplasty surgery. We should allow these patients leave the hospital on day passes, without being discharged so that they lose their place in line for surgery.

Patients often wait a long time for their surgery to be scheduled, but it can be cancelled at the last minute because of a shortage of beds. For example, after seven months of waiting and preparing for surgery, although the patient, the surgical team, the operating room and the nurses were ready for the surgery, there were no beds in the hospital for recovery. These types of dry runs are a waste of taxpayer dollars, not to mention the frustration that this situation creates for all involved.

Acute care beds are plugged up with those needing acute care and there are no community services for patients to access. As a result, people rebound back and need intermediate facilities for respite care and long term care beds.

The single biggest problem facing our hospitals is the fact that so many acute care beds are taken up by chronically ill and elderly patients.

We have had a reduction in our in-patient acute care beds and in our long-term care beds. So now we have seniors at home, but we have little or no home support service available. This leads us to the more expensive options of care for seniors, which include putting them in emergency departments and acute care
beds. Meanwhile, surgeries have to be done on patients that need those acute beds. Nobody has a sense how this impacts families and communities.

- Wait lists for surgeries, specialists and emergency rooms are exacerbated by bed and equipment shortages.
- Discharging patients too early leads to recidivism, but there are not enough beds for convalescence.
- Inadequate numbers of beds force patients to face inhumane conditions.
- How long can someone lie in bed with a broken bone on morphine while they wait to have a bed open up so they can have surgery?
- Many people have had to sleep for two to four nights in a hallway awaiting surgery.
- It is simply not fair for a person who lives a healthy lifestyle to waste time waiting for a bed that is taken up by somebody who chooses to live an unhealthy lifestyle, while both people are paying the same amount of money for care, or lack thereof.
- There is a concern that neonatal patients have to get care outside of British Columbia because of a lack of beds.
- Patients are inappropriately placed in beds because of the backlog in the system.
- British Columbia's acute and long-term care sectors have insufficient capacity to meet current and future demand. For example: Since the 1990s, there has been a steady reduction in the number of acute care beds per capita in the province. British Columbia has only 1.8 acute and rehab beds per 1,000 population. This is 35 per cent below the 2.75 that is recommended by the British Columbia Royal Commission and significantly lower than most Organization for Economic Co-operation and Development (OECD) countries. From March 2002 to March 2004, 1,279 hospital beds were closed, which is a 19 per cent reduction in capacity when population increases are taken into account. Between 2001 and 2004, there was a net decrease of 1,464 residential care beds, even after accounting for new assisted living units. As of January 2006, British Columbia had 5.8 publicly and privately funded medical resonance imaging machines per million residents, below that the numbers of Alberta, Quebec, New Brunswick, Manitoba and PEI. All provinces except for Alberta and Ontario had higher numbers of publicly and privately funded cat scans than British Columbia.
- British Columbia does not have enough adolescent psychiatry beds or acute care beds for those with developmental delays. This population actually regresses and does horribly in a general psychiatric hospital environment. We need more appropriate acute care options for these populations.
• A shortage of acute care beds forces hospitals to discharge patients faster and this limits the amount of teaching and preparation that can occur before a patient is sent home to live with their condition. Home care does not adequately replace the in-hospital education a patient should get.

• The Government shut down care homes for the elderly all over British Columbia and now there are elderly people in acute care beds instead of care homes.

• **Comments on health human resources:**
  
  • Bed shortages lead to staff burnout, extra overtime costs, greater patient load and sicker patients.
  
  • There is a nursing shortage not a bed shortage. Two beds are closed on our unit not because we do not have the nurses to care for them.
  
  • I believe the main cause of long wait lists is the fact that doctors cannot get enough access to existing beds.
  
  • Many beds are closed because we do not train enough registered nurses.
  
  • Beds and wards in hospitals around British Columbia are closing because of staff shortages.
  
  • There is a lack of staff including nurses, administration and technicians, especially during peak season.
  
  • Health care staff is overworked and patients are delayed in receiving treatment.

• **Comments on acute care administration and management:**
  
  • Changing the rules around bed assignments confuses staff and patients.
  
  • British Columbia has the lowest bed-to-patient ratio in the country.
  
  • There should not be anymore hallway care.
  
  • It is a problem when people are told by their doctor that they need to be in the hospital, but the hospital kicks people out because there are no beds.
  
  • There are too many surgery cancellations because there are no beds.
  
  • Hospital administration has come up with a hallway nursing protocol, which implies that there is no intention of fixing the bed shortage problem.
  
  • We have an acute care system that is bursting at the seams, where acute patients often occupy beds that are allocated to long term care. We are not doing enough to move the acute care patients out of these beds.
· The Province needs to be careful because when the baby boomers are gone it will need less hospital beds, in the same manner that we need less schools today.

· With hallway beds, there is no privacy for the doctor, patient or family to discuss personal treatment.

· Too much office space is being set aside for hospital administration when there is such a problem with space for beds.

· There are people occupying beds that do not need hospital care, but the Government does not provide them with other places to go.

· There is a constant push to shorten the length of stay of patients, but outpatient rehabilitation in communities is inadequate so patients ultimately return to acute care.

· **Comments on costs and efficiencies:**

· Hospital beds are being used for the infirm because of a lack of institutional beds. This causes patients to become less active, less able to take care of themselves and it ultimately costs the health care system more in the end.

· While hospital occupancy is over 100 per cent, hospitals are funded based on the premise that only 75 per cent of the beds will be full at any one time.

· People may check into acute care to avoid extended care fees.

· It is cheaper for government to get patients out of the system because beds are expensive.

· Acute care and acute beds can be quantitatively measured in funding dollars received; however, measuring preventative care where care is more qualitative is not so easy. We need to develop a means to measure prevention so that it can receive the same attention as acute care and beds do now.

· **Comments on transferring patients:**

· There is concern that patients needing beds in intensive care units (ICUs) are transferred to different institutions because there are no intensive care unit beds at the hospital that performed the surgery. It is traumatic and painful for patients to be transported back and forth between intensive care beds in different hospitals.

· There is a concern that it is nearly impossible to get an emergency transfer due to a lack of specialists as well as bed shortages.
• Patients are held at local hospitals until a transfer can be arranged to another hospital, but often there is a shortage of beds at the receiving hospital so the patient gets worse and may die while waiting.

• Bed closures in the Vancouver region affect all other regions because outlying regions send patients to Vancouver for specialized care such as cardiac and orthopaedics.

• Emergency patients wait far too long for specialist care while rural doctors are on the phone to the British Columbia BedLine, looking for a hospital with an available bed.

Ideas and Suggestions

Access to Acute Care
Acute Care Bed Shortages
Acute Care Administration and Management
Health Human Resources

• Ideas about access to acute care:
  
  • Implement a robust primary care strategy to decrease long term demand on acute care system.
  
  • Provide transitional guidelines for acute care settings.
  
  • If we built the required facilities to meet this provinces long term care nursing needs, it would free up so many acute care beds in our hospitals that our hospitals would be able to function as they should.
  
  • Opening up closed schools as extended care facilities would free-up some hospital beds for acute and short term stays.
  
  • We need geriatric activation units across British Columbia to get the weak and debilitated elderly out of acute care beds (they do not meet rehabilitation unit criteria).
  
  • Implement mandatory province wide coding for acute care admissions.
  
  • When a person’s health starts to go downhill, they want to know that the right help, beds and equipment will be available when they need it.
Ideas about acute care bed shortages:

- Stop closing acute care beds and increase funding for discharge planning.
- A designated transition unit with sufficient beds would make the current allotment of acute, long-term and palliative beds more effective and efficient.
- Direct our tax dollars to build more long term health care beds and nursing homes, which will in turn free up acute care beds and in the long term be a much more cost effective way to spend our tax dollars in health care.
- Expand acute care bed capacity, as we are only operating at two-thirds of the Seaton Commission’s recommended number of acute rehabilitation beds per thousand. We have to look at our emergency departments, operating rooms, long term bed capacity and most of all, the whole issue of multidisciplinary care.
- Reinstate the acute care beds at Delta Hospital.
- If we closed all the beds used for abortion, then there would be more beds available to everyone.
- We need more funding for beds and equipment on the Lower Mainland.
- Increase beds and services across the province.
- Provide more triage beds and standards.
- Provide more transitional beds for seniors.
- Provide more labour, delivery and postpartum care suites as well as nursery and pediatric facilities.
- Provide more specialized beds so patients are not in the inappropriate bed for the area of care required.
- Provide more rehabilitation and convalescent type beds and care to reduce congestion within hospitals and emergency rooms.
- Establish more chronic care beds to open up more acute care beds.
- Provide more beds in emergency departments.
- We need more in-patient beds for child and youth mental health.
- For the short term we need more operating rooms, hours and more hospital beds.
- Re-open hospital beds to the numbers that existed in the year 2000 and publicly fund acute care hospital beds.
- Provide more neonatal beds in British Columbia so mothers do not have to be separated from their newborns or sent to the United States to give birth.
• **Ideas about acute care administration and management:**
  
  - Have a provincial centralized electronic booking system for tests and procedures. This would increase efficiency and keep track of how long people have been waiting and what beds are available.
  
  - Establish maximum wait times for beds for those patients that are admitted to hospitals through emergency departments.
  
  - Protect designated beds such as those for surgery, cardiac care, general care and orthopaedics.
  
  - Surgery wait lists and recovery beds must be coordinated.
  
  - We need to cap the number of hallway beds allowed in the emergency room.
  
  - The BedLine does not work and ties up ambulance crews who are needed elsewhere.

  - Transfer the geriatric non-critical patients that are taking up acute care beds and get them into appropriate long term care beds.

  - **Health Authorities should commit to renewable five year plans that include:**
    
    a. **target rates of utilization (per age/gender standardized population) for acute care services;**
    
    b. **bed targets (based on funded beds per population) for each clinical service provided in a Health Authority; and**
    
    c. **strict guidelines that all acute care hospitals in British Columbia not exceed an average occupancy rate of 85 per cent to allow for surge-capacity situations.**

  - The shortage of acute care beds is a primary factor for emergency department overcrowding which has become a significant patient safety and quality of care concern in British Columbia. The British Columbia Medical Association recommends setting a provincial benchmark for total emergency department length of stay that is measurable and linked to an accountability framework for performance assessment.

  - While health authorities agree that more beds are needed, they are not necessarily required in hospitals. For example, health authorities could investigate the expansion of services at existing facilities such as expanded elderly care facilities rather than moving the elderly to the emergency department for treatment.

  - Prioritize patient needs so that the greater the patient’s need the higher priority it is for them to get a bed.
• Base bed management on recognizing that patients have different needs at different stages of life.

• There is a need to prioritize care according to patient need not just the needs of special interest groups such as the WorkSafeBC.

• We need criteria for wait lists for beds such as severity of illness and family and work responsibilities. For example, whether or not you will lose your job if there is not a bed available for you to have a procedure versus a retiree that may have more time.

• First take a look at how available beds are currently utilized before directing financial and staff resources to increasing the number of beds.

• Quality control would ensure that there is more attention given to the reform of primary care beds.

• Address the problem of patients who over-stay in hospital beds. We need better bed utilization practices including effective discharge criteria.

• Fund beds in areas with bed shortages and where occupancy is over 100 per cent.

• Accelerate the creation of areas of excellence in each of the major hospitals in order to create efficiencies.

• **Ideas about health human resources:**

  • As a priority, carry out human resources planning to staff the 5,000 bed strategy.

  • Provide incentives to interns to discharge patients on time so that beds are available to other patients.

  • Post operative beds need to be funded to support good nursing care.

  • All beds should be converted to electric three position beds so nurses do not have to run to a room six times a day to crank a bed up or down.

  • Although more beds are clearly needed, simply opening more beds is not a viable solution, as there are not enough nurses to staff these beds. There is a shortage of nurses, but there is also a long wait list for students to enrol in nursing school. To train more nurses now, go back to on the job training for nurses.
Long-Term and Residential Care

Comments and Concerns

Long-term and Residential Care Facilities
Long-term Care Bed Shortages
Facilities in Specific Communities

• Comments on long-term and residential care facilities:

  • Hospitals are treated as long-term care facilities because there is a lack of alternatives, resources and education.

  • Long-term care patients strain hospital staff in short-term facilities.

  • Bureaucratic decisions have resulted in the demolition of many long-term care facilities without plans to rebuild facilities, such as the closure of Saint Mary's Hospital.

  • I firmly believe that our hospitals and emergency rooms are overcrowded because there are not enough long-term care facilities available for our aging population. We all know that a hospital bed costs much more than long-term care and it is a waste of tax dollars to keep patients inappropriately in a hospital bed.

  • The Interior Health Authority has closed extended care facilities in anticipation of private facilities filling this void. Our hospitals are over run with seniors who now have to depend on emergency facilities for their needs.

  • Patients do not receive the attention and care that they would have gotten in a long-term care facility while they are waiting in a hospital bed. This means that recovery is delayed or does not happen due to neglect.

• Comments on long-term care bed shortages:

  • There is a shortage of residential care beds so patients are placed in already overcrowded emergency rooms.

  • We were promised 5,000 more long-term beds, but instead we lost 3,000 long-term care beds.

  • Long-term care patients remain in acute care beds and the Intensive Care Unit is crowded.

  • Too many long-term care beds are closed and replaced with supportive housing.

  • There are adequate long-term beds available, but they are closed because they are inadequate or not up to today's standards.
• We cannot transfer patients out of the emergency room because beds on other floors are filled with patients waiting for placement to a long-term care facility.

• I recognize that the Government is taking steps to create more extended care beds to move patients requiring long-term care out of hospitals; however, this appears to be happening at a slow pace. I urge the government not to be distracted by the media focus on individual incidents relating to emergency room waits.

• We need to create more long-term beds. It is the elderly who tend to most be languishing in the hallways because there is nowhere for them to go. This is where the major backlog is being created.

• There is concern that the Government of British Columbia promised more long-term care beds but is not providing them rather it is focusing on providing assisting living buildings.

• Families naturally want loved ones nearby when institutional care is required. However, bed availability for the most part usually means that someone must die for a vacancy to occur. The preferred care facility cannot always be provided upon the immediate request of a family, as someone else would have to be moved out for that to happen if a bed is not available through the death of a resident. Those people that complain that they cannot immediately move their loved one into the care centre of choice must understand that an alternative location may be the only answer in the short run. An alternative would be to care for the loved one at home rather than drive the extra miles to an alternative facility. Most people are not willing to do that and some complain loudly and gain media support. So seniors end up in hospitals rather than long-term care facilities and then end up using all of the available beds.

• Comments on facilities in specific communities:

  • We need more hospital and long-term care beds in the Cranbrook Regional Hospital. This hospital now serves all of the East Kootenays, which includes approximately 80,000 people, but it was only built to serve approximately 20,000 people.

  • Long-term care beds have not increased in Kamloops despite the fact that those who need them have increased. The backlog in the hospital exists because we have nowhere to put these people.

  • The Ministry of Health said that Trail needed more transition and respite beds. However, the community saw that only 11 residential beds were then funded in the area (10 to a private facility in Castlegar and one to Trail). Several community members with health care, engineering and cost analyst backgrounds proposed a
22 bed Transition Unit as a solution to our problem of up to 18 acute beds being occupied by elderly people waiting for assessment, transition to home, or care facilities. (We also had a problem with our elderly being sent out of town for residential care and then family unable to travel to visit because of the mountainous area). Transferring an adult day care program to the unit would have made the 22 beds economically feasible. The site was a former care home so amenities already existed.

- There are promises to upgrade the Kelowna Hospital, but this does not include increasing long-term and extended care beds.
- Patients from 100 mile house went to four different hospitals in need of an Intensive Care Unit bed. Why is the BedLine unable to identify where the available beds are?
- Masset is combining acute and extended community care.
- Burns Lake is adding transition beds to help transition from acute care to extended care.
- The Comox Valley Hospital has trouble finding beds for all of its patients.
- Increase the number of operational beds at Mills Memorial Hospital to be more in line with the numbers at other hospitals with regional responsibilities.
- Provide a recovery area at Dawson Creek Hospital for surgery patients, rather than sending patients home early.
- Do consultation and business planning to provide resources to rural and Northern British Columbia. Realize the differences in providing health care in these areas and that it costs more to deliver this care.
- Provide beds and build for growth in Fort St. John, one of the fastest growing northern communities.
- Increase beds in the Jubilee Hospital in Victoria.
- The immediate construction of a 1000-bed hospital in Surrey is needed.
- Build more primary health centres and long-term care beds in the West Kootenays.
- Provide more diagnostic services, and long-term and transitional care in Kelowna.
- Build another hospital in the Fraser Health Region because the Royal Columbian Hospital is overwhelmed.
- There are unacceptable wait-times due to bed shortages at the Royal Inland Hospital.
• The shutdown of the Sparwood Acute Care Center means that people needing those facilities now go to the Elk Valley Center. However, there are stories of people lining up in beds in hallways there, as they wait to be admitted to a room.

• There are issues finding space for new equipment within the Comox Valley hospital.

• Emergency rooms in Penticton General, Kelowna are overrun because beds have been too heavily cut.

Ideas and Suggestions

Long-term and Residential Care Facilities
Long-term Care Bed Shortages
Resources
Costs and Funding

• Ideas about long-term and residential care facilities:
  • Increase long-term care facility intake.
  • Stop closing long-term care facilities.
  • Reopen long-term care facilities that have been closed.
  • Put less stress on acute care by increasing the supply of long-term care and extended care beds and facilities.
  • Use existing but closed hospital beds for rehabilitation, convalescence, awaiting interim and long-term care beds.
  • Provide satellite services to senior centres or residential care facilities.
  • Use closed down facilities for other uses, such as community health and wellness centres.

• Ideas about long-term care bed shortages:
  • Increase bed capacity, especially for assisted living and residential.
  • Reopen at least 4,000 of the long term care beds that have been closed.
  • Plan, build and implement policies for the future now. This includes recognizing the aging population and addressing the lack of chronic care beds.
  • More chronic care beds for seniors would reduce the so called burden on the system by seniors.
• Government needs to fund more long-term beds so that major hospitals can discharge chronically ill people to the long term homes and free up the hospital beds for critical care patients.

• Open more publicly funded respite units, assisted living beds, long-term care beds, palliative care and extended care beds.

• Double the number of long-term care beds in communities.

• The Government has focused on increasing the number of assisted living units, rather than residential care beds. However, residential care beds and assisted living units are not interchangeable because of the differing care needs between residential and assisted living patients. Although Health Authorities are now building new residential care beds, they need to develop a longer term planning process for increasing home and community care capacity.

• **Ideas about resources:**

  • Increase resources to allow patients to remain in residential care versus being sent to emergency.

  • Help local communities to take care of geriatric and palliative patients and support long term care homes so these patients do not have stay in acute care hospital beds.

  • Utilize more ideas on the home care front in order to take pressure off the hospital system.

• **Ideas about costs and funding:**

  • The cost of respite and palliative beds is prohibitive for low income seniors. Put a system in place to help low income seniors such as setting a threshold for assistance based on either the Guaranteed Income Supplement or a certain minimum income level. Waivers are currently cumbersome and slow to be approved.

  • Instead of tax cuts, we should put that money back into opening the beds that were closed in hospitals and open the promised long term care beds.

  • Provide publicly funded support for home care services.

  • Build publicly funded long-term care beds in each community that provide proper care for each resident.

  • Provide funding for community education on spiritual and acute care.

  • Move costly non-emergency patients to community facilities.
Ambulance Services

Comments and Concerns

Administration and Dispatch
Human Resource Issues
Availability and Misuse of Ambulance Services
Costs and Funding

- **Comments on administration and dispatch:**
  - There is a lack in accountability for decisions that dispatch and ambulance staff make.
  - Ambulance service is too centralized. Dispatch and headquarter services are now too far removed from the communities they serve.
  - Ambulance services are not well organized and can be wasteful.
  - Turn around time for ambulance crews are lengthened or delayed, as drivers have to wait with their patients in the emergency rooms.
  - The cost of having ambulance crews stand by while their patient is waiting for a bed is unacceptable.
  - The wait-time for access to an air ambulance is too long. The British Columbia Ambulance Service only operates two air ambulances after 8:00 p.m. in all of British Columbia.
  - The dispatcher decides what cases get priority.
  - Ambulance services mails invoices to people many months after the service was used. In some cases bills are sent to collections agencies without the invoice first being sent to the patient.
  - Ambulance invoices are mailed out months after a patient’s death. This brings back painful memories to family members.

- **Comments on human resource issues:**
  - The paramedic’s scope is limited because physicians and nurses are no longer available to act as transport escorts.
  - The demand for ambulance services outweighs available human resources, crew skills and an ambulance service that contains air, ground, and see fleet vehicles. Patient transport is currently bottlenecked and it takes too much time to get rural intermediate and critical patients to tertiary centres.
The level of care that patients receive from ambulance attendants may be inadequate.

The British Columbia air ambulance service may only have about one-quarter of the number of crews that Alberta possesses.

The British Columbia Ambulance Service concedes that service has been challenged by labour shortages and a lack of skilled people, but that they will mitigate this challenge by mounting a recruiting drive. Why are they wasting money with a recruiting drive when there is already well-trained staff who wants to work?

The British Columbia Ambulance Service is the largest ambulance service in Canada and as they approach their 35th anniversary of they are still struggling to address staffing issues that should have been fixed in the late 1980’s and 1990’s.

Emergency or general duty crew are unable to meet their response time goals due lack of staffing and the geographic placement of stations.

Due to reductions in paramedical services, the public must rely more on other first responders. Firefighters, who possess only a first aid certificate, would be the primary source of care now as paramedic services are spread too thin.

When paramedics start they are paid two dollars an hour to be on-call and no more than 20 minutes away from their stations. Their pay does not go up until they receive a call out. Those operating in rural stations may only receive two or three calls a week.

- Comments on availability and misuse of ambulance services:
  - Ambulance services are abused to access emergency departments with a higher priority.
  - There is no reason why a patient’s family should have to drive them to a hospital for emergency or patient transfer reasons. Times of high usage should be taken into consideration so that there are no ambulances on standby during peak hours.
  - Seniors are increasingly calling on ambulance services. This is due to the assumption that they are granted faster entrance into emergency departments than if they were to walk in.
  - Ambulance services are rising but resources for this service are not.
  - There is too heavy reliance on ambulance services to transfer home care residents to emergency rooms.
  - There is no assistance when transporting patients out of the hospital.
• It takes five or more hours to get an emergency patient to specialist care due to a lack of ambulatory service.

• People may be abusing ambulance services by calling them to obtain a free ride into town. This abuse of the system is both costly and endangers those who are experiencing a real emergency.

• Ambulance drivers are not communicating necessary information to patients regarding process and protocol.

• The requirement of ambulance crews to direct all of their patients to emergency only increases the number of calls for ambulance service.

• **Comments on costs and funding:**

  • Closing hospitals leads to higher ambulance costs for the health care system and its patients.

  • Having to pay for ambulances makes this service inaccessible to those living on a lower income.

  • There is inadequate funding for ambulance services including:
    a. Lack of staff to service ambulance stations;
    b. Poor wages;
    c. Lack of training for staff; and
    d. Staff shortages in smaller communities.

  • There is too much transportation between major hospitals for different kinds of treatments. This shuffling around is not cost effective and is traumatic to the patient.

  • Seniors in residential and long term care facilities are forced to pay ambulance costs for transportation to their appointments.

  • The Greater Vancouver Regional District’s firefighting budget is roughly the same as the entire provincial budget allocated to paramedical services.

  • An ambulance trip costs $500.00; however the patient is only billed $54.00.
Ideas and Suggestions

Administration, Management and Dispatch
Human Resource Issues
Availability and Misuse of Ambulance Services
Costs and Funding

• Ideas about administration, management and dispatch:
  • Review the British Columbia Ambulance Service’s dispatch service.
  • Stop requiring that ambulance crews wait at the hospital until their patient is seen by a doctor, they should be able to leave to attend to the next dispatch call as soon as the patient is admitted.
  • Communications and dispatch services should be located in the most populated regional centres.
  • Adopt an ambulatory model similar to that being used in Alberta.
  • Heliports are not a routine part of a hospital emergency-ward in new facilities. Hospitals should be retro-fitted and reinforced to allow for the weight of a helicopter and a roof-top elevator to lower the patient directly to an emergency care area or operating room.
  • Merge police, fire and ambulance services into one emergency response resource.
  • Use global positioning systems (GPS) technology to better coordinate ambulances.
  • Ensure better communication between fire trucks and ambulances to prevent over-response.
  • Eliminate the overlap of emergency, ambulatory and fire services when being called-out to a first response situation.
  • British Columbia Ambulance Service management must set the criteria for the use of air evacuation helicopters.
  • Follow examples in other jurisdictions such as the United States where 911 calls can be made over the internet using voice over internet protocol (VoIP) technology.
  • Allow paramedics to access a patient’s electronic medical records.
  • Encourage ActNow measures to reduce the need for ambulance service calls.
  • Partner with communities to develop first responder programs.
  • Design and build smaller ambulances for transportation purposes only.
• Ensure that ambulances are in good running order.

• The ambulance service requires more stations and staff to achieve Emergency Medical Service industry accepted standards if they expect to improve patient outcomes which would ultimately save health care dollars.

• **Ideas about human resource issues:**
  
  • Implement an intermediate-level paramedic to substantially reduce transport times to tertiary centres.
  
  • Empower paramedics to treat patients in the field.
  
  • Give ambulance personnel the authority to deliver a patient to the nearest available treatment centre. Do not allow the patient to decide where they are to be delivered.
  
  • Make it mandatory that dispatchers have local geographic knowledge of their area of responsibilities.
  
  • Ensure that the right people possessing the right skills are the ones that are transporting patients between facilities.
  
  • Expand ambulatory scopes of practice. Centralize or strategically locate expert crews, or implement a combination of critical teams versus intermediate teams. Intermediate patients represent the greatest bottleneck so we need a solution that focuses on the transport of type of patient. These options require a change in the Emergency Health Act to expand the scope of practice to account for the appropriate skills needed to transport patients.
  
  • Ambulance attendants should have an on-line hospital connection.
  
  • Give paramedics the authority to treat the elderly in their own homes.
  
  • Provide the First Responder Certification Program free of charge or at a reduced rate to small volunteer departments.
  
  • Provide ambulance crews with assessment training so that they can avoid the transport of patients to hospitals when possible.
  
  • The new service at the Royal Columbia Hospital has hired full and part-time ambulance personnel to assist in emergencies and to relieve the crews who have to wait around.
  
  • Paramedic and ambulance crew should all receive the same level of training.
  
  • Training firefighters as first responders is beneficial. They are often the first to arrive at the scene.
  
  • Negotiate a new contract with ambulance service staff.
• Ideas about availability and misuse of ambulance services:
  • Increase ambulance service in areas that receive a huge influx of people in the summer.
  • In the event of arterial fibrillation, send a doctor and a nurse in a large van equipped with portable equipment and anti-arrhythmia medication. If these measures do not stabilize the patient in the home, then transport them to emergency room.
  • Investigate and encourage meaningful partnerships with local industry.
  • Implement a pilot project with the British Columbia Ambulance Service that would see a sedan passenger vehicle with one crew member and one social worker for all calls in the downtown core of Vancouver.
  • Use ambulatory patient vans in the place of regular stretcher ambulances to take patients to local clinics instead of emergency departments. This would have many benefits and could be coordinated using the British Columbia Ambulance Service’s Advanced Medical Priority Dispatch protocol.
  • Residents in some smaller communities do not mind which hospital they end up in as long as they arrive alive.

• Ideas about costs and funding:
  • Keeping ambulance crews on duty in rural areas would cost less due to being able to immediately administer care to those in need.
  • Additional ambulance and helicopter units are necessary, especially for highway traffic accident and collision victims.
  • Purchase more helicopters for the air ambulance service.
  • Increase resources in urban and metropolitan areas to reduce response times.
  • Require that all ambulances charge a fee that is well in excess of what a taxi might cost. Make the fee refundable after a doctor’s visit and confirmation of a true medical emergency. Add this fee to medical insurance premiums or take it off welfare checks.
  • Provide more funding and guidance for the Municipal Emergency Preparedness Program.
  • Provide more funding for extrication training programs.
  • Allocate more resources, funding and equipment to the British Columbia Ambulance Service.
  • Consider contracting out ambulance services.
Comments on Specific Communities and Facilities

Access to Health Care in Specific Communities
Access to Health Care and Specific Facilities

- **Comments on access to health care in specific communities:**
  - Campbell River needs a new facility and the Comox Valley hospital needs upgrading to sustain the growing population.
  - The Vancouver Island Health Authority voted to build a new hospital between Campbell River and Courtenay, but this will cost more money than it would to renew the existing Campbell River and Comox (Courtenay) hospitals.
  - There is concern that hospitals and facilities are being closed in the Vancouver area yet the demand to handle tertiary referrals from other areas in British Columbia continues to increase.
  - $25 million in funding was provided to the University of British Columbia Hospital for hip replacement surgeries, but no funding was provided for residents in the Interior of British Columbia.
  - New hospitals in Quesnel and Masset are good things.

- **Comments on access to health care for specific facilities:**
  - I am appreciative and thankful to be living in British Columbia as the wonderful medical staff at Vancouver General Hospital saved my life in 2002 with a smoothly run operation via a quick transition into emergency surgery.
  - I had a heart attack four years ago and an angioplasty procedure. I received prompt and excellent service in the cardiac ward at the Vancouver General Hospital.
  - There is concern about the food quality and need for expansion at the Kelowna Hospital.
  - There is concern about overcrowding at the Vernon Jubilee Hospital and Kelowna General Hospital.
  - They are building a new hospital in a hurricane zone near Massett and Port Clements.
  - The White Rock Hospital will be overcapacity soon and they have no plans as to how to deal with this flow of patients.
• There is concern about the quality and money spent on the hospital renovations in Revelstoke.

• There is concern about accessing the Trail Hospital in bad weather conditions.

• The operating room at the Oliver Hospital was closed, which makes residents go to the Penticton Hospital.

• Local residents argue that Deni House was safe and presented a petition to Government to keep it open. This facility was closed over concerns of its condition.

• Health authorities need to upgrade the Langley Memorial Hospital.

• There is concern that patients closer to the Langley Memorial Hospital have to go to St. Paul’s Hospital because there are no available beds at Langley Memorial.

• Prince Rupert Regional Hospital requires an adequate equipment budget as there is a service obligation to surrounding communities.

• The Vancouver General Hospital has a lot going for it such as its evolution as a major complex care centre and research hub. The creation of the Conversation on Health was itself an acknowledgement that there are choices to be made in the delivery of public health care. There are two paths that can be taken to move to the next level and continue to develop the Vancouver General Hospital as a world leader that generates advances in patient care for British Columbians, or, alternatively, to stall and lose momentum.

• There is concern over the closing of the Delta Hospital, as it was the only hospital had been supported by the citizens of the Ladner/Tsawwassen area.

• The Lion’s Gate Hospital in Vancouver has a very good garden for patients but it needs to be enclosed.

• The Sacred Dove Hospital has provided good service.

• There is concern that the St Vincent’s Hospital had an excellent hip surgery program, but the hospital was torn down to make way for a sky train.

• Wait-time in Kamloops has decreased due to new equipment and additional staff.

• People teaching about Type 2 diabetes at Burnaby Hospital are great, but there was a five month wait-list to get in the course.
Ideas and Suggestions

Access to Health Care in Specific Communities
Access to Health Care and Specific Facilities

• Ideas about access to health care in specific communities:
  • Provide another hospital to receive trauma patients in the Fraser Health Authority.
  • Fundraise for the Sunshine Coast hospitals through lotteries.
  • Give specialists in the Comox Valley more access to operating rooms.
  • Build a new hospital for the West End of Vancouver.
  • Do an analysis of the hot spots that need mobile attention in the Vancouver area.

• Ideas about access to health care for specific facilities:
  • Maximize the potential of the Vancouver General Hospital as a coordinated complex care center, as this hospital has the capacity to grow and already draws thousands of workers and patients to its precinct every day. It would also make the most of the potential to increase the interaction between specialists and researchers at this site.
  • Increase the size of the Royal Columbian Hospital to meet demands of a growing population.
  • Maintain the existing functions of the McBride and District Hospital, including emergency, acute and long-term care, laboratory, x-ray and outreach to the community.
  • Create a cardiac center for the interior of British Columbia such as in Kelowna.
  • Expand the St Mary’s Hospital including the emergency department.
  • Make a provision for a dental surgical suite at the Kootenay Boundary Regional Hospital with appropriate equipment and on-call staff.
  • Mount Saint Joseph Hospital should be kept open as a full service hospital and 24 hour Emergency room.