Health Care Models

Health Care Models was a major topic for discussion in the Conversation on Health. The importance of addressing issues related to health care vision and values, assessing our health care delivery system, managing change, encouraging the implementation of best practices, and moving towards patient-centred care were all topics for discussion. Here is a selection of what British Columbians had to say on the subject of Health Care Models.

Health Care System Visions

British Columbians expressed great passion about their vision of health. Most participants viewed health holistically, moving beyond a focus only on the health care system to a broader perspective on keeping populations healthy and considering the social and environmental factors that make this happen. Many participants believe that providing all Canadians with health care through a publicly funded system is a fundamental value that we must maintain, and some even call the public health care system a fundamental human right. Others put forward the view that the focus should not be on the funding, but on the health outcomes, however they are attained.

There was some agreement that health should be viewed from the perspective of a wellness care model, not illness care. Similarly, some participants feel that we do not pay enough attention to the whole person, and advocate for a holistic model of care that includes mental, emotional, physical and spiritual care equally. This was certainly a common theme in forums, and particularly in Aboriginal community forums.

Participants encouraged the Government of British Columbia to measure our success against health outcomes: how are we doing in terms of decreasing chronic illness? What about increased success of surgeries? Are we doing fewer heart operations? Do we live longer and healthier lives? These are the questions that participants feel would truly measure the success of our health care system.

Health therefore is both a complex social goal and a major enterprise in Canada, mostly now based in the public sector. While compassion and human rights lie at its base, there is also a need to see it in terms of social and economic benefits for whole populations.

- Pacific Health and Development Sciences, submission
The ideal role would be to keep people healthy as the first priority… The current cut and paste strategy of drugging and slicing our way to good health is not working.

- Email, White Rock

Assessing the Health Care System

There was no real agreement on whether there is a crisis in the health care system. Most participants argued that there should be some measure of change, but the extent of the change, whether whole-scale or minor, was a subject of debate. Many participants feel that Canada’s poor placement on the Organization for Economic Co-operation and Development (OECD) assessment of health care systems based on health outcomes is a sign that we need to dramatically over-haul the system.

Participants looked all over the world through the course of the Conversation on Health to find models that would help us achieve better health outcomes. There was no single system that offered solutions to the challenges participants raised.

There is a tendency in Canada for us to all pat ourselves on the back and say we ‘we have got the best health care system in the world.’ Well we can congratulate ourselves on that if we want, but I can tell you the OECD ranks Canada’s health care system at number 30, not number one. So we have some catching up to do.

- Provincial Congress, Vancouver

Change Management and Innovation

Most participants agree that change is both important and inevitable; it is the nature of the change that is at issue. Is it a profound change, or minor adjustments? There is no agreement on this, but most participants believe that we should be seeking a paradigm shift, a complete change in how we think about and deliver health care. Some participants believe that there are a lot of people left out of the mix, whose health care is substandard, and who cannot access the system as it is currently constructed. Others also suggest that, while it may be working now, the challenges down the road will make the system harder to access over time.

Participants are encouraging a move from a system of illness care to a system where healthy populations and preventing illness is the focus. This type of change may take many years, even decades. Maintaining focus on the change and the political will to proceed, sometimes through several electoral cycles, is very challenging. Participants talked about the need for courage and leadership to make these changes happen. Some British Colombians also explored some of the negative consequences of change:
there may be failures; some of the innovations may have unintended effects; and there may be significant resistance to the change that will make it difficult to maintain.

Participants encouraged the Government of British Columbia to make these difficult and fundamental changes to the system and to our approach to population health today. To make these changes, they look to other parts of the world where changes have been implemented successfully. In those circumstances, they say that taking action and reviewing that action using standard performance measures was key to moving forward.

British Columbians see financial investment in this change as critical to its success. They fear that there will be no desire to invest additional money in the short-term in order to achieve long-term goals. Many participants believe that this lack of investment will result in failure of any reform initiatives.

*Reform [like] this cannot be done overnight, it will take years of training, staffing and funding. Start now with a plan for a program that will ultimately meet the needs of the people of this province, complete with benchmarks and a reasonable timetable.*

- Email, Summerland

**Evidence-Based Decision Making and Best Practices**

Most participants believe that we do not take advantage of best practices, successes, evidence and pilot projects. They cited the lack of collaboration and communication within the system, the competitive behaviour between health authorities, and the lack of a clear structure to support the sharing and implementation of best practices as reasons for this failure.

Some participants want us to pursue more pilot projects to test innovative ideas, while others eschew pilots and ask that we start implementing good ideas immediately, adjusting them as we go. A number of British Columbians are frustrated, and suggest that we undertake pilot projects and never learn from them or implement them. Staff and patients may actually see success from a pilot project, which is later concluded with no sense of continuation, no evaluation and no ability to apply it elsewhere. Northern British Columbians are seeking out innovative solutions to address their geographical challenges. At our northern forums in particular, participants often expressed frustration about the waste of resources around pilot projects and the inability to implement any of the successful projects on an ongoing basis.
Participants want to focus on implementing evidence-based best practices, whether they are from British Columbia or around the world. They caution that you cannot simply pick a best practice from anywhere and import it to British Columbia. You must first look at the circumstances that made it successful in the other jurisdiction and determine whether that same environment exists here in British Columbia, or can be replicated. Regardless, it is important to develop strong performance management tools to monitor the implementation, make adjustments and determine its success over a pre-determined period of time. Lastly, participants believe that we need to nurture a culture of learning and change within the health sector if we are to embark on implementing best practices and moving from a culture of pilot projects to a culture of continuous improvement.

*I believe that no other country has a perfect system. If they did we could just be adopting it and we wouldn't be here today. So, I think we have a chance here, an opportunity now with this dialogue to develop a health care system that might be sustainable, not the current one.*

- Focused Workshop on Health Human Resources, Vancouver

**Patient-Centred Care**

One area of change that came up again and again was the focus on patient-centred care. For participants, focusing on the patient would begin the course of change within the system. While there is no common definition of what patient-centred care means, most participants agree on a few basic concepts. Within the health system, practitioners need to treat the patient as a whole person, not a single symptom or illness. That means giving the patient enough time in a check-up or treatment to properly assess their whole condition, providing the right health practitioners to understand that condition, and communicating with the patient about every aspect of their condition.

Another component participants agree on is that no two patients, even sharing the same symptoms, should be treated in the same way. Health practitioners need to approach each patient as an individual, listening carefully to that individual and valuing them as a contributing member of society, not just another patient.

Many believe health professionals need to operate as a team when they treat the individual. Specialists need to communicate with one another and understand the patient as a whole. The patient needs to hear the complete story of their condition and treatment from the team, not from each specialist or practitioner separately. Practitioners must also take the time to educate the patient about their condition and
treatment so that patients can be involved in their healing processes. Moving practitioners to a patient-centred and integrated care model means changing our approach to training and development, and even our current model of compensation for health professionals, particularly physicians.

Overall, participants believe that a move towards patient-centred care will fundamentally change the health care system and our approach to health, whether it is individual, family or community health.

*Our group chose client centered care and asked the question: how do we get there and what would it look like? …[C]lients are consulted to inform decision-making and planning and health care delivery at all levels. [T]here would be integrated access across multiple channels and there would be delivery system participants who are positive and collaborative… [T]here would be high client patient satisfaction, [and] health system navigation would be a priority. Patients would be empowered and more knowledgeable… Through technology, and the sharing of information, [integrated care] would become more accessible and to help people access services, they would have access to their health records. There would be incentives for patients and providers towards supporting a model of self-care. We would be putting health services where people go and there would be a values-based approach in training and institutional programs for providers.*

- International Symposium, Vancouver

**Conclusion**

Most participants believe that our concept of the health care system must change in order to support its sustainability but, more importantly, to support the citizens of British Columbia. A shift of focus to developing and maintaining healthy populations over illness care means a shift in investment. A system of patient-centred care requires that we train our health practitioners to work in teams and communicate with patients differently. Participants emphasize that replicating best practices from British Columbia and around the world takes time and investment, but will ultimately yield results. The kind of change participants are looking for is dramatic and foundational and will require time, adjustment, discipline and leadership to make it happen.

*There is no grand scheme, there is no master plan, there is no magic bullet that once identified will lead us to a perfect or nearly perfect health care system that will reign forever more in the province of British Columbia. Change is evolutionary and one never perfects it first time out. [W]e should expect to make mistakes and we should expect to learn from them and try to continue the process of building a better health care system.*

- International Symposium, Vancouver
Health Care Models

This chapter contains the following topics:

Health Care System Visions
Assessing the Health Care System
Change Management
Evidence-Based Decision Making and Best Practices
Patient-Centred

Related Electronic Written Submissions

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HEU Submission to BC’s Conversation on Health  
Submitted by the Hospital Employees’ Union

Submission to the BC Conversation on Health  
Submitted by Victorian Order of Nurses for Canada

Submission to the Conversation on Health  
Submitted by the BC Nurses’ Union

BC Conversation on Health A Partnership…. for Health Care or Wealth Care  
Submitted by the British Columbia Chiropractic Association

Shaping Health in BC – Observations and Suggestions  
Submitted by Pacific Health and Development Sciences

Recommendations for Better Health Care: Eye and Vision Care Services in British Columbia  
Submitted by the British Columbia Association of Optometrists

Submission to the British Columbian Conversation on Health  
Submitted by Life Sciences British Columbia

A Submission to the Conversation on Health  
Submitted by the Canadian Cancer Society

Maximizing Value for Health Care Investments  
Submitted by ABBOTT

British Columbia’s Conversation on Health  
Submitted by GlaxoSmithKline

Governance and Accountability in Health Services Delivery: A Submission to the BC Conversations on Healthcare  
Submitted by Tim Lynch

Re-organization of Health Care  
Submitted by John Living

Conversation on Health: My Views  
Submitted by Nancy Kenyon

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: Governance and Accountability; Innovation and Efficiency; Health Care Spending and Public Private Debate.
Health Care System Visions

Comments and Concerns

Health Care Vision and Values
Holistic and Client-Centred Approach to Health Care
Universal Public Health Care
Illness or Wellness Orientation of the Health Care System
Fragmentation of the Health Care System
Business Framework for Health Care

• Comments on health care vision and values:

  • Health is both a complex social goal and a major enterprise in Canada, based now primarily in the public sector. While compassion and human rights lie at its base, there is also a need to see it in terms of social and economic benefits for whole populations. The United Nations links health to human rights, as in the World Health Organization’s constitution: "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." However, the World Health Organization also promotes utilitarian concepts of health which portrays it as an investment, that is, health as a resource for everyday living and health as an ultimate purpose and outcome of society’s economic pursuits. No society anywhere has achieved health with equity without investing substantial amounts from public expenditures; virtually all nations failing to meet this human right are demonstrably deficient in related areas of public policy and financing.

  • The ideal role would be to keep people healthy as the first priority. The current cut and paste strategy of drugging and slicing our way to good health is not working

  • The public equates health care with hospitals.

  • The Province has a great vision and leads Canada in innovative thinking.

  • Government only thinks in terms of election timelines. In health care, we need an incentive to change to longer term visions and plans.

  • There should be a national perspective on health care to determine the vision and to identify sustainability concerns.

  • What values do British Columbians hold related to health and health care? These should be reflected in the health care system vision.

  • The British Columbia College of Family Physicians looks forward to being a partner with the Ministry of Health, Health Authorities, educational and licensing bodies and other professional disciplines in further developing a robust, efficient, effective, equitable, engaged health system.
• You need to focus on planning for 3, 5, 7, and 10 years out, and not simply on the period from election to election. We are preoccupied about the 5,000 beds and quite frankly that is not the right question to be asking. It is a political question, but it is not the right question from a planning point of view.

• The British Columbia College of Family Physicians looks forward to being a partner with the Ministry of Health, Health Authorities and other professional disciplines in further developing a robust, efficient, effective, equitable, engaged health system.

• What about health care delivered, in part, through the co-operative sector? The co-op engages the client more, which is key to successful health outcomes, and is a third way, different from public or private.

• There is considerable support, both in theory and in practice, from the experience in Emelia Romagna, a region of Italy, for the idea that social co-ops are the most effective way to deliver relationship services, that is, where the service depends heavily on the interface of the provider and client.

• Comments on a holistic and client-centred approach to health care:

  • Good health is when a person feels good inside and out, when they are able to live comfortably without a lot of physical or mental pain.

  • The social and cultural environment has huge impact on how people behave. The First Nations model in which aboriginals set their own community health goals has been successful because it takes culture into account.

  • British Columbia, more than other provinces, has begun to shift its thinking from that of a primarily institutional health care system to one whose vision includes public health and healthy communities. The regional role of the health authorities is a key to enabling programs and services to address the unique needs of the five different regions of the province. British Columbia is leading the way with respect to home and community care integration with hospitals, long-term care and other community agencies.

  • An integrated view of the health care sector facilitates the development of integrated health care policy; the role and contribution of pharmaceuticals; and, where appropriate, the factors responsible for growth in pharmaceutical expenditures.

  • Assessing the full value achieved from an increasing investment in the provision of new innovative medicines requires an examination of pharmaceuticals within the context of the broader health care system.
An integrated model of health care recognizes that the various segments of the health care system do not operate independently, despite sector-specific rules, regulations, management systems and budgets.

Component management frequently pits patient-focused providers against other stakeholders who are budget-oriented; fails to recognize the complex interactions of health services and health costs; leads to uncoordinated planning, management and delivery, resulting in lack of care continuity; lacks incentives to understand and treat the entire disease (providers can only affect events within a given setting or budget); reimburses disproportionately for the most expensive services in the most expensive settings; and, emphasizes treatment over prevention (sickness care versus health care).

- **Comments on universal public health care:**
  - Universal health care was not designed to cover all technical advancements and the numbers of seniors with which we are faced.
  - And, of course, I do not need to speak about our neighbours in the United States where every thirty seconds, someone files for bankruptcy due to serious health problems.
  - There is a lack of commitment to public health care by the Ministry.
  - The health care system cannot be coercive: we need to let people make their own choices. But all people regardless of age, gender or income will have to have the same rights, freedoms and choices.
  - What is the definition of a Canadian? It is an unarmed American with health care. I do think Canadians value that and I suspect they will demand more, and will continue to support a universally funded, universally administered health care system.
  - Medicare provides lower business costs and avoids health care bankruptcies, which benefits the economy. It ensures equality.
  - Fiscal considerations must not be allowed to stampede us into making changes to a comprehensive, almost universal, almost portable, accessible and publicly administered health system which works pretty well and only needs to be rounded out. A major rounding out I support, would be the inclusion of pharmaceuticals to some extent. Another would be the integration of mental health services more successfully into the general health portfolio.
• **Comments on illness or wellness orientation of the system:**
  - The current paradigm is a disease paradigm.
  - The current health care system is blindly and disastrously skewed toward allopathic medicine, encompassing extremely expensive medical technologies, expensive invasive procedures, and extremely expensive pharmaceuticals which in a very significant number of cases result in the patient not being healed as advertised or in fact creating worse health conditions for that person.
  - The system is illness-oriented and should be focused on wellness.
  - We tend to treat symptoms rather than the underlying causes of disease.

• **Comments on fragmentation of the health care system:**
  - The health care system has fragmented delivery focused on one treatment area at a time. It is a complex pathway in breast cancer treatment from diagnostics, to surgeon, to oncology, to post-treatment.
  - We are trying to do the same thing with separate disease silos.
  - The system is dehumanizing.

• **Comments on a business framework for health care:**
  - Things that work in private business do not work in health care.
  - Health care is a business.
  - The standard business model does not work. Health care is not like the automotive business or McDonald’s. It is about caring for sick and injured people not fattening the wallets of executives who have no knowledge of the business of health care other than the statistics and demographic tables. Put clinicians back in charge of things at every level. If they need management skills then provide them with those skills. At least they will spend the resources for the benefit of the patient.
  - Deliver health care through a business, not-for-profit model.
  - We must adopt the best of business models into the health care system: accountability, process improvement and measurements of results, best use of resources, efficient services, and the use of best practices.
  - There are also huge variations in practice, which in every other industry is a hallmark of poor quality. It would be a mark of terrible quality on the automobile assembly line if people were doing things differently, and using different sized rivets to put the cars together. But we do this all the time in health care.
• Our system is supply-driven rather than demand-driven; we fund process rather than outcomes.

• Doctors are currently paid on a fee for service basis which provides incentives for pushing people through the system rather than promoting healthy living. Physicians and the British Columbia Medical Association have the system locked up (no one can tell the doctors what to do). Is the physician the best gatekeeper?

• People who are not well educated in the health care profession are making long-term and significant decisions. These decisions are based on bottom-lines rather than on care, need, and sustainability.

• If the medical profession wants to practice as so many mechanics, then it should be expected, like mechanics, to have to compete for the general public's business. So far, no scheme presented has made provisions for the general public to shop around.

Ideas and Suggestions

Health Care Vision and Values
Holistic and Client-Centred Approach to Health Care
Universal Public Health Care
Illness or Wellness Orientation of the Health Care System
Business Framework for Health Care
Aboriginal People
Women

• Ideas about health care vision and values:
  
  • We have to shift from the current system to a future system that will use extensive bio-monitoring instead of episodic testing. It will emphasize education and coaching. Evidence-based decisions are the rule with electronic information flowing freely. Care is customized and the patient and family are active participants.
  
  • I see the future role of our health system would be to provide every person with an equal right to appropriate health care, not just adequate, which is the case now.
  
  • We need to come to the realization that health care is a necessity not a luxury. The health of the citizenry is a responsibility of the Government. It is the Government's responsibility to ensure that its citizens have clean air to breathe, clean water to drink, nutritious food to eat, adequate shelter for the climate and access to medical care on demand.
• The health care system needs to be re-designed according to the World Health Organization recommendations that three levels of health care exist. The first is where patients see low-level trained people, such as dieticians, kinesiologists and paramedical personnel for screening tests and simple health recommendations, and so on. In the second level come highly trained practitioners such as chiropractors, nurse practitioners, naturopaths, acupuncturists, and so on, who can deal with the majority of problems people face in a safe and inexpensive manner. In the third level patients see physicians. This only occurs in acute emergencies, or when there are problems that are not responsive to other treatment modalities. This will create a sustainable health care system that will benefit everyone including physicians, who are trained to deal with acute problems and not trained to deal with most chronic problems or most musculoskeletal problems.

• We need a paradigm shift to a preventative, qualitative, holistic approach which values all aspects of health to prevent a real crisis of sustainability.

• We do not believe there is a crisis but in order to have a healthier system we value a preventative, holistic approach which respects all aspects of health.

• We need a system anyone can access with no barriers.

• We need a product-line approach, including more macro managing of the system.

• Move outside the realm of allopathic medicine into the accommodation of a hierarchy of care. People need to be able to afford alternatives.

• We need a patient centered, integrated health care system, including alternative and complementary medicine.

• Government has to listen and learn that we need an economically, socially, environmentally-sustainable community-driven, publicly-funded, publicly administered and delivered, not-for-profit, wellness-focused system.

• We need the provision of culturally sensitive care for Aboriginal people.

• We need a health care system that can provide basic care, prevention, health promotion and accessibility within a set budget, allowing for differences.

• It is crucial to attempt to envision the long-term future. Focus on creating inexpensive medical technologies that can be self-administered. Envision a way in which not just Canada but the entire world can have good health care. Empower the poor worldwide to manage and finance their own health care.

• Look to other jurisdictions for improvements in delivery. British Columbia has a diverse geography, so one solution may not work for all parts of the Province. A management team could undertake this study.
• Model the system after the National health care system of the Netherlands, where hospitals, clinics doctors and insurance companies are all privately owned and operated and may compete on price.

• The research is there, we just need to make a decision on what suits British Columbia, then stick with it.

• There should be an overarching framework for health care.

• Focus on community care rather than acute care.

• We should assume that there will be a safety net for essential services. For non-essential services, we could consider other models of delivery. First we need to define what is essential. Alternate funding and delivery models should be defined for non-essential services.

• We need to look at demographic trends with an emphasis on immigration issues in order to identify the health trends.

• Let us not be afraid to take on some things that have worked in other countries. We do not have to try and reinvent the wheel every time we have a problem in Canada simply because we think it is the Canadian way to do things.

• Delivery models should promote patient responsibility, health care provider accountability and reciprocity between conventional and complementary health care, promoting patient choice.

• There should be equitable service and open access.

• Improve cultural sensitivities within the system.

• Extend the medical system to include mental health.

• We require leadership to set goals and not be diverted by interest groups.

• We require stronger federal and provincial coordination.

• Remove doctors from the apex of decision-making.

• There should be recognition and support for the not-for-profit system throughout the communities in British Columbia.

• Develop a system based on the understanding of roles and responsibilities allowing maximum utilization of the skills of practitioners, including nurses and nurse practitioners.

• If you design a system in which the customer can choose based on real value, the system will learn and learn rapidly. It will get better, faster and cheaper. We can take care of everybody.
• What if we redefine the clinician/patient interaction in terms of touches and also expand our perspective of what do we mean by touching a patient? Is it legitimate to manage a visit over e-mail? I am an oncologist, and one of the things that I enjoyed the most, because we used to have group visits for women who had actually been through breast cancer treatment, were treating those patients on the other side, who were doing well. I could bring in ten of them or so, see them over ninety minutes, have a little bit of time to spend with everybody, but the major part of the visit was that they got to talk to each other. And they learned far more about how to manage breast cancer from each other than they ever did from me. It also allowed us to stay in contact. That means we have to figure out how to pay for these things.

• So, what are the characteristics of successful systems? Well, it seems to me there are three. First, that every system that has dramatically improved access and/or quality is managed. The Canadian system is perceived as having overwhelming bureaucracies and a huge amount of management, which is not true. We actually tend not to manage as much as other countries. We have a very strong tradition of clinical autonomy. Secondly, the providers in the system consider themselves actually integrated parts of the system instead of independent contractors. Thirdly, accountability matters.

• It would be a good thing in health care if our health services were in part modelled on being learning organizations. The patient could learn things. The provider could learn things. The culture could change over time but in a less threatening maybe calmer way perhaps.

• Scale-up the very effective surgery wait-list projects so they are province-wide and cover all surgical procedures.

• Restore and enhance preventative home support services.

• Increase staffing and introduce multi-disciplinary primary care teams into residential care.

• Develop 24-hour, multi-disciplinary, community-based primary care.

• Increase housing and income support for vulnerable populations.

• Support the development of a national drug formulary.

• Really you look at the high level vision of where we want the system to be twenty years down the pipe, what values we want built into the system and the fundamental pieces that we want in place.
- I just wanted to say that today we have talked a lot about innovation, and I think that what we have to look at in health care is creating a culture that promotes innovation.

- Reduce the demand in health care services in the long term through investment in systems thinking, starting with the social, environmental and economic determinants of health for all people.

- We need to focus on adopting a prevention standpoint rather than a treatment perspective.

- **Ideas about a holistic and client-centred approach to health care:**
  - Shift from the medical model to a model where the person is at the centre, beginning with effective parenting, and focusing on wellness.
• Maintain the publicly-funded health care system with an emphasis on holistic, primary health care and disease prevention with greater accountability. How do we get there? Shift to a person-focus and recognize that we are individuals.

• Holistic health: treat the mental, emotional, physical and spiritual health equally.

• Train physicians in the client-centric model.

• **Ideas about universal public health care:**
  
  • We need to maintain universal health care.
  
  • Need a strong public system that focuses on prevention, flexibility, innovation and complementary medicine.
  
  • We need universal health care: in reality we now have a several tiered system.
  
  • We need a model that is publicly funded, but privately delivered. This would provide greater accountability and incentives.
  
  • I think it is fantastic that in this country no one buys their way to the front of the medical line. This is one of the most egalitarian systems I can think of and we are known world-wide for it. We should be proud of our system; and find a way to continue to support it, not take it apart.
  
  • Publicly fund the development of health care infrastructure.
  
  • Increase public investment in new post-secondary health care programs and in innovative projects to better utilize the existing health care workforce.

• **Ideas about the illness and wellness orientation of the system:**

  • We must focus on root causes of symptoms including poverty, mental health, and domestic issues.

  • Create a paradigm shift from the acute care medical model to a healthy lifestyle model. Rather than an illness focus for our health care system, create a health focus. This would require that housing, food, daycare, education, and culturally appropriate needs be considered and met.

  • Change from an illness model to a wellness model.

  • Acknowledge what patients say their most important needs are and help them meet them by appropriate referrals to traditional healers and ways of healing.

  • Try to imagine how to keep as many people as possible healthy in 2047.

  • We must move our focus from symptoms to causes, which will reduce long-term costs and create better health outcomes.
• **Ideas about a business framework for health care:**
  
  • Take the politics and the political rhetoric out of health care: every time we have an election, we get a new health policy. Alternatively there are no changes to health policy because governments are not willing to take risks fearing it will affect the next electoral outcome.
  
  • British Columbians want to see a plan that is multi-year, multi-dimensional and sustainable; a plan that maps out the future for our system rather than day to day balancing and band-aid fixes.
  
  • Operate the health care system like a business and market it to other countries for profit.
  
  • Replace the corporate model of health with a social one.
  
  • Eliminate public-private partnerships.
  
  • Eliminate privatization.
  
  • Reverse the North American Free Trade Agreement (NAFTA). Check the implications of the North American Free Trade Agreement (NAFTA) on our health care system.
  
  • Limit the multi-national control of health, for example by drug companies.
  
  • Consider running health care like a business. Operate on business principles. 21st Century expertise and knowledge to run and operate health care may require different skills and abilities to complement doctors’ and nurses’ expertise.
  
  • Health care is a value. Health care delivery should be a business.

• **Ideas about Aboriginal people:**
  
  • Develop and implement First Nations legislation that respects the autonomy of First Nations people and their title and rights within their territory.
  
  • Teach people that they have a purpose. Allow funds and resources to serve First Nations people in the system.
  
  • What we learn from Aboriginal communities can be used for the entire system. No community is well served by just a biomedical model.

• **Ideas about health delivery frameworks affecting women:**
  
  • The provincial government should fund women-only alcohol and drug addiction treatment services.
  
  • The provincial government should increase funding for mental health services for women.
• The provincial government should increase funding for women's counselling services including counselling for drug and alcohol addictions and post-partum depression.

• The provincial government should provide increased funding for programs that support immigrant women.

• The provincial government should support a universal and publicly-funded childcare system.

• The provincial government should increase supports for all mothers.

• The provincial government should provide businesses with incentives so they will promote family friendly policies which support women.

• The provincial government needs to restore funding to women’s centres.

• The provincial government needs to re-establish the Ministry of Women’s Equality.

• Provide funding and incentives to ensure that more female family physicians graduate from medical school so that they can provide the full range of care for women patients.

• Provide funding and incentives to ensure that nurse practitioners are fully integrated into front line primary care in British Columbia; women need greater access to nurse practitioners as primary care givers.

• Provide incentives to ensure that health care practitioners work in collaborative teams and that these health practitioner teams are informed about women's health care.

• Establish more community clinics.

• Increase funding for home care and support to enable women with disabilities and seniors to live in their homes.

• Increase funding for health care research that is centered on women's health.

**Outstanding Questions**

• Will the government tell the public its vision for health care and let the public comment on it?
Assessing the Health Care System

Comments and Concerns

State of the Health Care System
Cuba
America
Asia-Pacific
European
Other Health Care Reports
Comparing to Other Systems

- Comments on the state of the British Columbia health care system:

  - Most Canadians believe that the health care system in Canada is in a state of crisis and based on the discussions we have had today and the presentations we have seen, that financially, operationally, and symbolically, our health care system in Canada is in a state of crisis.

  - Canada came 30th in international health care, while the United States came 32nd, so we are not much better.

  - The level of care is not up to the promises being made.

  - The whole system needs to be changed, however changes must be cost effective and beyond minimal.

  - The system is not in crisis but there is room for improvement.

  - Acute care seems to be done very well and traditionally has been done well. Chronic care seems to be less well done.

  - Health care seems to be better elsewhere with more choice.

  - We have gotten a few perspectives from the public that are based on, with all due respect, their relative ignorance of the complexities they are dealing with and none of the isolated workshops that you have identified actually looks at the governance, the structure and the top end. Every time you get a small problem and you feed the issues back up, it leads you back up to something with how the structure of health is run, and we do not have those big pieces in place.

  - The system works for accidents and acute care, but is not effective for addressing chronic pain and staying healthy.

  - Romanow was good, but there was failure by government to follow up.

  - In terms of the old paradigm of health care issues and the politicization of those issues, I really believe we no longer have time for that.
• Success and failure of the system can be translated into a lack of trust in government, and the complexity of issues and problems with access and continuity of care.

• We often are not as culturally responsive in delivery models as we should be.

• If you are looking at Vancouver where sixty percent of our population is of Asian extraction now, then we need to also look at the role that Asian tradition brings into health care. Mount St. Joseph’s Hospital is a perfect example of a facility that has really tailored itself to amending its programs to that specific Asian population.

• First Nations and non-First Nations advisory groups look at things from different perspectives.

• The public health system is working, but cutbacks and privatization are creating problems.

• Health care should be in the hands of doctors not high paid executives. Hospitals do not need more money they just need experienced people making the decisions.

• The current system is designed to get the results we get. If we want different results then we need a different system.

• We need to manage client expectations.

• From my point of view, I think the Government is doing a great job managing our health care system and I support your plans for the future. I cannot think of any improvements to add to your present plans.

• The province has been progressive with the development of the British Columba Health Guide with the emphasis on individuals taking more responsibility for their own health but being appropriately supported by the health care system and health care professionals. The Guide’s focus on disease prevention and health promotion reflects the forward thinking that must happen across the country to ensure sustainable health care systems.

• This is a good system which is sometimes abused.

• Our system is better than other countries. Our basic system is good, let us build on it.

• We must start communicating the successes because there is a lack of a balanced view by the media.
• I am under the belief and understanding that the costs are escalating with the demographic wave that is approaching us. If we simply try to keep doing the same thing, add a few dollars and limp along, what we are essentially doing is putting the health care system itself on a waiting list, instead of getting to the root and dealing with the issue.

• The care, once received is very good.

• We have added, in the last few years, a whole generation to our life expectancy. We have the expectation to live almost a generation longer than our parents, and I think that is something that is truly remarkable.

• Generally the state of the system today is vastly superior than things were 20, 50 or 100 years ago, although things are degrading somewhat, due to costs and human resources.

• We do in fact have a strong health care system in Canada. Despite the challenges we face on a day-to-day basis it does what it is there to do.

• The vast majority of patients are receiving good quality care. Ability to pay is not a factor in receiving health services. Private insurance does not dictate health services and who gets what.

• The Conference Board of Canada came out and said that British Columbia has the best health care system in Canada. That is great news and something to celebrate.

• Service to the public by publicly-funded system is good.

• The health care system is not in crisis; it needs to be tweaked for efficiencies, not overhauled.

• I believe we have an excellent health care system. It does not get the credit it deserves.

• I have had occasion to use the Medicare system several times during my life; I have little reason for complaint. When I was young, poor people got care as a sort of charity and sometimes it was not very good care. The main point I want to make is that the system is not in nearly such bad shape as governments and people who make money out of sickness would have us believe.

• Unfortunately for me I am one of the many British Columbians who makes good use of our health system. I have multiple diseases and am in and out of hospital more than the average person. I have always been treated with the utmost of care and dignity and am very thankful for the system as I would not be here today if it were not for the great care.
• Why are we having so much trouble with our medical? When I used to live in Regina and when Tommy Douglas was the Premier he said, if the future politicians continued to follow the medical plan the way he set it up that everyone would continue to have quality medical care. Every where we look now there are waits and cutbacks. We need leaders who are ready to make the necessary changes.

• Comments on Cuba:

• I wouldn't want to live in Cuba and be attempting to practice free speech, but if I had to get primary care for what looks like $125 total spending per capita and have a pretty long life span, I would go to Cuba. It is a remarkable health achievement on value for money grounds.

• I strongly recommend that the Cuban system be studied. It is my understanding that their universal system, at a cost of around $ 600.00 per person per year, yields a life expectancy only slightly lower than that of the United States.

• Comments on the American system:

• There are a multitude of systems around the world that demonstrate that better care can be delivered at a lower cost. The worst example of the opposite is that land to the south that is often trumpeted as a beacon in health care delivery. I have worked as a physician in the United States for several years and when health became a personal issue I returned to Canada.

• The Health Maintenance Organizations (HMOs) are expensive, bureaucratic, and inefficient and certainly offer no solution for Canadians.

• In Canada, if a doctor finds melanoma, a surgeon cuts it out, then lets it heal for six weeks, then cuts out a bigger piece of the same area just to be sure. In the United States, if a doctor finds melanoma, a surgeon cuts it out, then lets it heal for 12 weeks, then sends you to the nearest bio-med lab for an ELISA TA90 blood test. If the blood test comes back positive, they do the second operation. If it comes back negative, no more operations unless a future test comes back positive.

• I have an acquaintance in Seattle who had an injury and received a Medical Resonance Imaging (MRI) within a few days. In Canada we are educated to believe that our health care system is superior to the United States. Is it?

• Some people are finally recognizing options other than the United States model.

• The absolutely poor, via Medicaid, and the very wealthy, via their own funds, are the only ones with decent coverage in the American health care system.
• As a person who grew up in the United States with many family and friendship ties to that country, I know with certainty that Canada’s public health care system is the envy of a vast number of Americans.

• Comments on Asia-Pacific examples:

  • Australia’s and New Zealand’s public hospitals are under funded and the equipment is outdated, because as more patients accessed the private facilities, the user numbers dropped in the public facilities and funding was based on user numbers. Not everyone could afford private care, resulting in a lower standard of care for those with a lower income.

  • Japan has one of the best medical plans. They call it social services and combines medical with retirement pensions and other things. For some reason Japan is doing better than Canada, at less cost. We would be wise to find out why and implement some of their solutions into our system.

  • (Australia) We’ve seen significant improvement in infectious diseases. Chronic disease, such as diabetes and heart disease continue to rise, but the rate of increase is actually slowing, which is an epidemiological way of saying we may be getting better. Some of this trend can be explained by the improvements in primary health care access for Aboriginal people in Australia.

  • Singapore has got very, very low Gross Domestic Product (GDP) expenditure and very low public expenditure, which is attractive to many governments, and yet has very good health outcomes and pretty good service access on average. Now the Singaporean system is founded on a particular Singaporean philosophy and that is that government will subsidize health care to make it affordable but Singaporeans able to do so must pay their share too. And so the Singaporean national health plan, which was founded in 1983, features minimal risk and is based on that idea of sharing responsibility with the state. There is minimal risk within the Singaporean national health plan and the medical savings accounts which form the back bone of the national health plan are designed specifically to be the property of individuals and the funding from them is counted as private expenditure. There are four distinct components to Singapore’s medical savings accounts and the first, or the back bone of the scheme is Medisave a scheme to which all workers must contribute. Medisave funds only hospital co-payments, nothing else. These accounts will earn interest and are part of a person’s estate upon their death. To protect accounts from being exhausted, there is a strict fee schedule that Medisave accounts simply will not pay hospitals beyond, and further to this, various high cost services found in other countries are not covered by Medisave. Next we have Medishield which is a voluntary scheme that pays for major or prolonged illness, but again with various services excluded. Third is
Medifund for those unable to meet costs. Fourth is Eldershield, which contributes toward the cost of care for the elderly. Now these same schemes are only a part of the funding mix in Singapore and a relatively small proportion.

• **Comments on European systems:**

  • It would appear that the present European models provide perfectly good examples of what we need to adopt in the way of health care. They have no waiting lists and cost no more per capita than our present system. In addition everyone still has access to their medical systems and there are no ongoing arguments about private versus public resources being used to meet the need.

  • The often cited mixed European models that provide better delivery at lower cost to the tax-payers are a myth for those un-informed. There, the very systems (Sweden and France) touted as solutions (because they happen to have some private hospitals) spend a considerable deal more from the public purse than we do. If these are served as best in the field, we should be increasing taxpayer funded health care options and not decreasing them. The reverse is simply illogical.

  • We should move in the direction of a European system as soon as possible and leave the pitiful ranks of the few countries that make it illegal for their citizens to seek health care outside of the government system (Canada, North Korea and Cuba).

  • I think our distance from Europe shelters us from the reality of their medical systems. Their systems are not perfect either and you rarely hear all the complaining when you live in Canada. When I lived in England for four months, people were constantly complaining about their mixed health care system and the news was full of stories about screw-ups, high costs, and waiting lists for procedures.

  • The National Health System: while the system is state, the standards are state, the money is state, increasingly, we are willing to use private providers where that makes sense. And by providers, I do not mean private insurance, but private providers who will do particular services, provided they meet our quality standards at our prices, and they are willing to share information and be part of our information systems and so on.

  • The United Kingdom model is destroying the National Health Care System there.

  • Not all doctors are happy with the changes in the United Kingdom because there are specialists surgeons who are out of work because they have no patients to operate on. But in general, the British Medical Association has supported it.
• The best health care system I have seen so far is the Swiss system. In terms of total expenditure on health care, Canadians spend almost as much as the Swiss do, yet the quality is nowhere near theirs. As a matter of fact, the Swiss government does not spend as much. The difference is in the private and public combination.

• Perhaps we can learn from some of the Scandinavian countries how to reward the various sectors of the economy in order to achieve the right mix of person-power for the vital needs of the general population.

• In France doctors are rewarded for convincing patients to quit smoking.

• In France, 10 or 15 per cent of wages go to health care. There are no waits at emergency, little or no waits for surgery, and so on. I think the French way is very equitable and fair. We may not be able to start at 15 per cent but we could start somewhere and add a little more every year with 15 per cent being the limit.

• Why these systems perform better as a whole is not such a complex question. France has 50 per cent more doctors per capita. How do they do it at roughly the same cost? French doctors cannot just pop across the border into a better paying jurisdiction like Canadian doctors can.

• The credibility of the report generated after the Premier's European mission is questionable.

• The Premier was over in Europe inspecting some of these excellent health care systems which seem to be a win/win situation for the patients as well as the doctors and countries involved.

• There was a study from Denmark, a country which implemented a universal program of seven days a week, twenty-four hours a day home care and home support which not only extended the quality of life for seniors, but also reduced healthcare costs.

• Comments on other health care reports:

  • The Romanow Report was a biased work arguing from a foregone conclusion. It put forth all kinds of tempting services without any realistic ways of paying for them.

  • I am disgusted with Romanow report as it only advised throwing money at the system and did not advise any system changes.

• Comments on comparing other systems:

  • British Columbia needs to look more into other provincial health models. In Maple Creek, Saskatchewan the residents have excellent rural access to medical
services via road and air. This could be a model for northern and rural British Columbia to work up to.

- We are going to have to have an approach which relates to the population that we have here. And we want to be very careful about plucking an idea almost out of thin air because it works in another society.

- What do citizens need to know about the health care system in order to build a good system?

- The British system at this point seems to be the model that is favoured for discussion, but certainly I think we need to open our minds to other possibilities as well. Innovation will not come from simply borrowing from a specific and single system which may or may not have been successful in other countries.

- A systematic review of 38 studies recently confirmed that Canada’s system leads to health outcomes that are favourable overall at less than 50% of the cost, when compared with the United States private for-profit system. However, perhaps more relevant is the World Health Organization’s landmark study in 2000 of health systems performances in almost 200 countries, ranking the United Kingdom in 18th place, Canada at 31st, and the United States at 37th. Most European countries performed better than Canada, while Australia’s performance (with similar socio-demographics) at 32nd place was virtually tied with ours. Several other countries also scored better than Canada, for example, Singapore and Japan. In our view, we should be prepared to study and learn from those systems which appear to be doing better than we are, and, while staying consistent with the core principles of the Canada Health Act, we should be more prepared to innovate, test and evaluate new approaches.

- There is a tendency in Canada for all of us to pat ourselves on the back and say that we have the best health care system in the world. Well we can congratulate ourselves on that if we want, but I can tell you the Organization for Economic Co-operation and Development, ranks Canada’s health care system at #30, not #1. So we have some catching up to do.

- The health care system in British Columbia is ranked number one in all of Canada, but British Columbians rank it eighth.

- We do not look enough at what is happening around the world.

- I have never heard anyone except critics of social medicine say that Canada’s health care system is the best in the world. By having all of us use the system, we assure ourselves that everyone gets the same attention. Nowhere in that attitude is the notion that we have the best care, the best education, or the best policies in the world.
• It is our view that health care quality and outcomes for British Columbia compare favorably with those of the United States and the other provinces. Clearly all Canadian jurisdictions must also collaborate with our neighbour to the south on issues of common interest, for example, environmental influences on health and communications regarding disease importation. However, the tendency to compare ourselves with the United States performance in health care and outcomes, while understandable, is misplaced. In terms of examining alternatives, it makes more sense to learn from the experience of other provinces, and also systems elsewhere in the world, for example Western Europe, that have proven better performers than the failing American model. To the extent that we look to the United States for systems design support or contracting, we must be sure that this does not threaten privacy. In the current American political environment, even its own citizens are losing trust regarding the invasion of privacy in the name of security.

• I think a single lesson we can learn right at the beginning is you just cannot do a tour of the world and cherry pick a few features that you think are wonderful and adapt them and adopt them holus bolus and expect them to work in this context. So context does matter.

• Some policies and practices are historically and institutionally and culturally rooted. So, for instance, you might think on balance if you were from Mars and if you looked at them all that the Netherlands or Germany had the best form of health insurance with these parallel, mandatory plural health insurance systems. But these were rooted in the old Bismarck social insurance developments of the 19th century. They grew up over time, and I do not think you could do that here even if you wanted to. It is just an entirely different model.

**Ideas and Suggestions**

*State of the Health Care System*
*Comparing to Other Systems*
*Other Health Care Reports*
*Information*

• Ideas about the state of the system in British Columbia and Canada:

  • We owe it to our fore-bearers and to ourselves to try and inventory what we do well and what we do less well. Look at the achievements of the existing system. The Canadian system is different from any other system in being focused on hospitals and doctors.
• Hire an outside consultant (non-government) to review the current system.
• We need to look more creatively at how we deliver health care, who delivers health care, where we deliver health care and the role of the patient.
• I think we need to do this on a province by province basis. I think each province is going to be completely different from other provinces. The solutions that may work in British Columbia, may not work in Quebec. And something that might work in Alberta is not necessarily going to work in Ontario.
• We need more understanding about cultural differences and its effects on health.
• A gender-based analysis needs to be built into the system itself, as a means of working towards women’s equality.
• A publicly funded insurance plan covering medicines as well as all the components of health is the only real solution.

- Ideas about comparing other systems:
  • Look seriously at systems being used by those countries that rank high in world ratings of health care.
  • Look at other provinces that are not crippled with this problem!
  • You recently returned from a European trip to understand how they do it better. Please start now to implement some of what was learned.
  • Of course we should be looking at delivery models throughout the world and adapting workable, efficient and universal components into our public system. We look at different models all the time in education but still focus our education system in a universal and public manner.
  • I am sure that somewhere in the world we can find elements that could make our system function better, but I believe many improvements can be implemented in a public and universal setting.
  • We need a definitive analysis of the various systems and models to make informed decisions about health care.

- Ideas about other health care reports:
  • The Mazankowski Report was far more realistic. That is what we should be adopting.
  • Implement recommendation made in previous reports including Romanow, Fykes, and Kirby.
• **Ideas about information:**

  - Keep the public updated with facts, not opinions.
  - The general public does not actually understand the system or how it works. Information is very media driven. People always hear the problems; they do not hear the good things.

**Outstanding Questions**

• Why did they not look at the Romanow report instead of holding this Conversation on Health?

• Why does Canada get a low rating from the World Health Organization?

**Change Management**

**Comments and Concerns**

[Rationale and Planning for Change](#)
[Stakeholder, Community and Public Input](#)
[Leadership and Political Will](#)
[Resistance to Change](#)
[Making Successful Changes](#)

• **Comments on planning and rationale for change:**

  - I believe that no other country has a perfect system. If they did we could just be adopting it and we would not be here today. So, I think we have a chance here, an opportunity now with this dialogue to develop a health care system that might be sustainable, unlike the current one. I do think that it will require a change in expectations and also an increase in expectations elsewhere.

  - The continued challenges can be viewed as the seed of the opportunity to work toward a re-structured system for health care that is comprehensive in its recognition of health outcomes. Alternately, it can be the stone of refusing to change and accepting continued higher costs and sub-standard outcomes. The clear choice of government is to lead health care re-structuring through its law making and organization of services. It is clear that the issue is not an inability to pay for health care, but the method of funding patient's health. In our view then, there is no alternative. The challenges remain to be addressed and resolved as in
previous reports. They must be the seed from which a new system can grow and develop.

- In New Zealand, despite the changes, the underlying institutions have remained unchanged. Quite depressingly, playing with structures has really failed to provide any profound improvements. None of the system reforms have really performed any better than the others and there were policy trade-offs with each of the reforms, meaning that none were properly implemented. And so, really, there are two lessons: first, that system restructuring probably should be avoided unless there is very strong evidence that the changes that you desire Simply cannot be achieved within existing structures; and second, there needs to be certainty that a reform with its associated costs, often large, will be worthwhile if the full aims are not achieved.

- If we do nothing, it is only going to get worse. Doing nothing and allowing the status quo to continue is not a solution. The way the numbers are trending up and the costs are escalating and our demographics are shifting, if we do nothing, things will get worse.

- There are broad similarities between our attitudes toward climate change and our attitudes toward health care change.

- Demand caused by aging populations, technology advances, and spiraling costs of delivery are making social and political solutions a challenge to muster.

- A recent survey reported that 45 per cent of Canadians believe that the health care system will fail to meet their needs within five years.

- Tough changes are necessary, whether or not they will be possible remains to be seen. Personally I am somewhat skeptical that we as a society will ever be able to attain a truly sustainable and universal health care system unless fundamental changes are made to both our expectations and methodology of providing health care.

- In my opinion, it is not the best approach to try to address issues and problems one by one. I think the difficulties are not individual but structural.

- Understanding the processes that need to be put in place and the structures to enable the outcome is critical. What frustrates me is that I am told to change, but there is absolutely no understanding of the change, no understanding of the people, the culture, the structure, the work process and what you actually need to put in place, and the time it takes to actually make things happen.
• **Comments on stakeholder, community and public input:**

  - How do we get the perspective of the client, patient, resident, family, community, nation, and the public? And how do we incorporate that into planning, delivery, evaluation, and all of the change management processes. What do they want? What do they need? In the alcohol and drug system, one of the things they do is have patient advisory groups. Once you have gone through treatment for your addiction, you can go on a patient advisory committee and give them feedback.

  - I suggest the interests of unions, nurses, and doctors, with their monopoly on the system, are unable to come up with a viable system due to their self-interest.

  - I am also worried that doctors, unions, administrators, and government will not show the creativity and flexibility necessary to implement structural reforms to make the best use of public dollars.

  - As a doctor my primary mandate is the treatment of patients and if a system, or lack of a system gets in the way of that, then I think as a physician it is my, and our, responsibility to help change that system and that is what we need to do.

  - Talking about the change through the Conversation on Health is a positive step.

• **Comments on leadership and political will:**

  - Talking about the whole health ministry itself and making a whole paradigm shift as to how services are delivered, are people expecting that this is going to take four or five years? The expectation in my view is that it should be a decade or more. The problem is you run up against is public expectations. You also have political timetables. You want to be able to go to an election saying you have accomplished something. You know what, sometimes it takes a lot longer to accomplish.

  - The other thing we talked about with regard to service delivery was the importance of political will, deciding what it is that we want to do, what is the best way to provide the services and how can that be done?

  - The period just prior to elections, be they federal or provincial, is not the best time to discuss health policy. The conflicting and misinformed viewpoints expressed about health care by competing politicians create a great deal of anxiety in the general public, leaving people perplexed, bewildered, confused and frightened. Furthermore follow-up media commentary usually adds to the confusion.

  - There is another risk that we do not talk about very often: it is the risk of other visions. You have people who have a particular thing that they want to sell, and they are really good at selling it and they get access to the Premier and the
Minister, and it just takes everything off the rails. It is the intellectual entrepreneurs of the world that can make this go sideways in a real hurry.

- If you are a Deputy Minister, you do not want to do anything that could curtail your career. If you are an Assistant Deputy Minister, you are not going to be doing anything that is going to curtail your career. So that is why the status quo just continues. So that is why it really has to come from the top with a directive for change.

- The British Columbia Medical Association has too much influence.

- The Government needs more courage to act.

- You learn very quickly the enormous value of preventive public health and education. We can learn from the developing world about extensive planning frameworks, which they use brilliantly to allocate resources and head in a common direction. Health care in most countries is bipartisan. You do not find it highly political in most developing countries. It is only the rich countries that use politics to destroy the longer planning cycle for health. Health is so complex it does not work well on an election cycle.

- **Comments on resistance to change:**
  - The system is not adapting fast enough.
  - The Canadian psyche is inflexible around the public health care model.
  - There is no mechanism for dealing with non-traditional demands or new types of demands.
  - There is a culture of entitlement, beliefs, expectations, and limited resources.
  - When you look at a system, the reason it is so hard to change is because there are some people for whom it works perfectly fine, thank you very much. How do you deal with that, because if it made sense for everybody there would be no reason to change it. There are some people for whom it is working but there are a lot more for whom it is not working. There is this concept that people really want things to be different but nobody wants to change. It is not being happy where you are necessarily, but the resistance can be a barrier.

- I know the culture is very challenging. We need to shake up the system. We have to shake it up and you have got to do it without alienating physicians or nurses or home care workers. But we have got to shake the system up and we are way too conservative in this. Culture shifts in response to things that happen, and the biggest things happen where you put the money.
• The white elephant on the table is what are we doing about our culture in health care? We talk about our lack of ability to innovate in Canada. What are we doing to have our physicians, our nurses, our health care workers, our politicians and our administrators change the culture? That is the biggest barrier in all this stuff. I honestly think that we can come up with all kinds of great ideas that would help people access this system, for example, consolidate clinical practice so that it is more standardized, or implement more value-based outcomes with clinical interventions. But we cannot seem to get there.

• When you think about the majority of the health care users being older people, they are the most resistant to change that might affect health care.

• If everyone could stop being so scared by the baseless fear-mongering, we could all just settle down and listen to new ideas.

• Change is tough. People do not change (especially when they have to give things up) voluntarily.

• I am an obesity researcher in the Vancouver area. I am originally from California and have spent the past five years in Montreal, so I am naturally drawing some comparisons between British Columbia and the other systems I have been involved in. Though there are clearly some serious issues that warrant attention, I must say that the climate for change here is impressive compared to what I have seen thus far in other locations.

• **Comments on making successful changes:**

  • Innovation is widespread in healthcare at various levels, and it is almost impossible to adopt an innovation that does not have an unintended adverse consequence, and I think we should be pretty up front about what those might be.

  • What I get scared about, is we will end up with a whole pile of investment in policy direction, and then we will step back and realize we have no difference in patient outcomes because we missed the essentials.

  • It seems to me that we have had a lot of change and a lot of it is quite disorganized. It feels like it is tinkering around the edges rather than getting to the core of the issues, and it is destabilizing the workforces. It is eating away at the morale, and we are sure going through a lot of people in terms of Chief Executive Officers (CEOs) and other administrators. The change is constant and unending, and I am not sure that it is making improvements. So I think the process of change is going to be important whatever we decide as a result of this.
• Stop making changes to health care. Time and resources are poorly used in making changes to health care.

• Is there a panacea? I think probably the answer really is no.

• The culture is changing from the bottom up instead of being dictated from the top down, and that is a very good thing. It may not be happening as fast as we would like, but it is happening. There are multiple cultures here: the public is one culture, the healthcare provider culture is another. Those cultures are changing, not necessarily at the same rates or at the same time, but they are changing.

• (United Kingdom example of changes to the National Health Service) To be successful, you need clear actions for successful delivery. Be absolutely clear what you are going to do and how you are going to measure it. Get your measurements right and then make sure you measure them and that they are evidence based. Focus on the things that we will deliver. We established something called the Modernization Agency in order to spread good practice. We were very clear that in making change happen and in spreading good practice you were involving individual staff members in different roles. It was also very important that you discovered best practice wherever it was. It takes an unreasonable man to make change, no doubt even better if it is an unreasonable woman. But the point here is this is not a voluntary activity. We were very, very clear that there were certain National Health Service standards and they were going to be delivered. It is about targeted support for high risk organizations. It is not the same everywhere. Some organizations are going to have more difficulty in making change and that may well be because of the population they serve, it may well be because of their history, it may well be because of historical use of resources, or geography, or whatever. What is important in making systemic change throughout the system is that you remember that there is a normal distribution of a bell curve and at the left hand end there will be the early adopters, the people who invent the good practice, you need to support them. There will be the people in the middle who are the ones who will move fairly quickly and with a bit of performance management will make change. But at the right hand end there will be the people who be lagging for whatever reason and you need to design processes to support them: it is not one size fits all.

• Government should clearly lay out the options to British Columbians and hold a referendum to decide the future of Medicare.

• Undertake an enterprise approach which includes all players in the health care system. This is underpinned by a risk management framework. We must start with a needs analysis which includes understanding the problem, and then develop a directional plan. The plan must be overseen by a governance
framework. A strong framework would include monitoring, evaluation, vision and values. The Ministry of Health Directional Plan would include a vision and be developed in collaboration with other Ministries, Health Authorities, stakeholders and other levels of government (including the public). Health human resource planning would be a part of the directional plan.

- Flexibility is something that has to be inherent in the system so that it has the ability to continue to move forward as time and years progress. To spend a whole lot of time developing a whole new approach only to discover that it is not very flexible and it cannot progress means that we will be faced with the same issue in another fifteen or twenty years from now and be having the same debate on how to change that system. It is key that the system has the ability to have some standard flexibility within it so it can continue to evolve.

- We are talking about re-doing our whole health care system: how it is funded and how it is set up. This is radical and involves all aspects of the system. It involves fundamental re-structuring. But a lot of our system works really well and we maybe do not have to change it. Maybe we just have to re-name it or put it in a different place or have it under the control of somebody else. It is about identifying the pieces that work well and the pieces that are not connected and integrated.

- There is a need to look ahead and plan, not just focus on crises.

- Government should look at the health implications of all Government policy.

- Use the existing delivery mechanisms to deliver better health care outcomes.

- We need vision, strategic planning, and leadership, including a blue ribbon or expert panel.

- We need to take a collective approach to addressing these issues, and to re-examine the processes, structures and institutions that came into existence a long time ago and served our purpose during that time.

- We must adapt to the future of health care and re-examine the future of health care every 10 years.

- Having worked in business, there is not a direct translation to health care. However this system is so wasteful it merits an external business and systems review. Not a Romanow-style report but a focus on the management structure, accountability and efficiency. We need lateral thinking and innovative solutions. This review must be external.
• My point of view is that it has to be fundamentally different than it is today and we need a Medicare renaissance in Canada where we go back to some of the roots of the advent of the Medicare system and examine what we have achieved. The system has evolved over time and it has become what it is today. Is that what we are trying to sustain, what it is today?

Ideas and Suggestions

Rationale and Planning for Change
Stakeholder, Community and Public Input
Leadership and Political Will
Resistance to Change
Making Successful Changes

• Ideas about rationale and planning for change:
  • Reform cannot be done overnight: it will take years of training, staffing and funding. Start now with a plan that will ultimately meet the needs of the people of this province, complete with benchmarks and a reasonable timetable.
  • What I would like to see you guys doing is some serious analysis of the countries at the top of the health care provider list from a service provisioning and cost basis. The world is a big place and there are lots of good models already in place for you to learn from and try to emulate. My suspicion is that some of the best are combinations of public and private health care!
  • Nothing short of a complete overhaul of our system will suffice. We need to get the other provinces and the Federal Government on side and get started on this painful but necessary journey.
  • Canadians need to be ready to absorb the changes.
  • Change the viewpoint that there is only one magic solution. People need to be open-minded.
  • Develop an interdisciplinary group to analyze data and make decisions.
  • Create social events to bring practitioners together and hold interdisciplinary conferences.
  • There is a need to focus on creating an environment for change that will move us to a model that is more patient-centric and more efficient.
• Health delivery solutions and changes are advocated without critical, lateral or 360 degree thinking and analysis. In particular without full consideration of the applicability of the local situation and local input. For example: As a student on a project to farm whitefish in the sub arctic, it was the plan to cut a hole in the ice and keep it open. The local Inuit walked by and said that it would not stay open. Every day they cut a hole in the ice and, despite all efforts, every day it froze. Another example: In the twenty-four hour general practitioner urgent care centers in the United Kingdom, patients rapidly learned that these centres offered the most convenient way to get seen and subvert the traditional but high quality family practice and chronic disease management.

• I think you have the opportunity to do it in a really structured way. Work on focused activities for improving care, so what the group does is come together and decide what they are going to work on and improve together. So they have big learning sessions and a big meeting where they discuss different ideas. They learn from other people. They might have a specialist or someone come in and then they decide what they are going to do for the next quarter.

• Ideas about stakeholder, community and public input:
  • Let Canadians take more responsibility for their health care model.
  • De-politicize the issues and involve everyone.
  • If any real change to the system is going to happen, the public will have to be involved. They will need to understand and support any changes. What can we do to help them become effective gatekeepers for the health care system?
  • Getting the vision has to be done with full input from the stakeholders. You have to engage them, but someone has to put it down on paper and then allow it to be massaged and built up to an end product so there is a buy-in process. It is not only getting the vision, but it is doing it in a collaborative way.

• Ideas about leadership and political will:
  • The political will is needed to see and act beyond one term of government.
  • The Minister and the Ministry must create the environment for culture change.
  • Identify and support charismatic leadership.
  • Change can only come from political fortitude and an intimate understanding of the source of the issues, not just a look at the symptoms as are so often brought to the public’s attention through the media.
• **Ideas about resistance to change:**
  - Provide incentives or funding for alternative delivery and training.
  - Create an implementation strategy that is flexible, has evaluation, leadership, and shared responsibility to bridge silos.
  - Encourage and recognize innovation. We do that a bit now in government, and there have been some awards given out in health authorities surrounding innovation. That promotes change. When you were accomplished, that inspires other people.

• **Ideas about making successful changes:**
  - We have to look at this globally, as well as short-term. As we look at long-term issues, sometimes those big issues immobilize us.
  - We need effective support for transformation: support what is working, change what is not, and know the difference.
  - Our system should apply some of ideas of the European health providers who seem to be able to provide a level of service comparable to ours without additional cost and without the horrendously long wait times.
  - Provinces should be given the freedom to try new ideas and processes, such as safe injection sites.
  - I think it is essential to change service delivery, because what we are really talking about is changing the system and the system is service delivery. I have 30 committees that I am on normally, but they do not actually help other than by stating the problem and getting some small actions. We are talking about actually doing it differently. And that is what Homeless Outreach is about, that is what integration on the ground is about and I do not mean one size fits all. If it is changing service delivery, it depends on the population you are reaching. So in a multi-cultural context utilizing agencies like SUCCESS and MOSAIC is I think a pretty important thing to do. For Homeless Outreach we were starting from scratch by creating a new way of doing it.
  - Moving from *status quo* to a preferred future is going to take money. You cannot really rob from the pot of money you have to maintain the *status quo* while you build the innovation.
  - There should be incentives, other than just financial, to encourage change within the new system.
  - A total systems approach is required: there are no quick fixes.
• Implement systemic or transformational change, not incremental change or tweaking.

• There is no grand scheme or master plan, there is no magic bullet that, once identified, will lead us to a perfect or nearly perfect health care system that will reign forever-more in the Province of British Columbia. Change is evolutionary and one never perfects it the first time out. We should expect to make mistakes and to learn from them and try to continue the process of building a better health care system.

• Let the system experiment, and even fail in trying to do all this. That is risk-taking.

• I’m intrigued by the word ecology: when you change the ecology, organizations adapt. At a healthy-province level, how do you get people more active so they are healthier? If we decided that, rather than build more highways for cars to move into more public transit, we would have people moving more, we would see a change in the health of the population in a number of ways without actually telling people how they have to change their activities. There would be fewer roads and more public transit. We would see a difference in health at a provincial level through public policy rather than driving down individual directives as to how you should do things. By changing some of the operating principles and allowing people to aggregate in innovative ways that are appealing to them in terms of organizing the health care system, the system changes out there. So you may get a community with 30 or 40 doctors and twenty decide to adopt this system. And what I have been hearing is that really very quickly, everybody else joins. And then they also get the community health services linking into that. It is not pushed down from the top; it is facilitating the opportunity. You change the ecology out there and people gravitate towards that. And dramatic changes are happening very quickly without central direction. And I think innovation is going to happen out there if we allow it and facilitate it. But what we find when we try to change people is that they react and they do not change.
Evidence-Based Decision Making and Best Practices

Comments and Concerns

Implementation of Best Practices
Evidence-Based Programs and Studies

Comments on implementation of best practices:

- There seems to be an inability to take successes from other health care systems (or other systems in general) and apply them. We do not adopt best practices.

- It will be our responsibility to seek out areas where cooperative research can take place. It is fundamental that this cooperation take place if the professions and the public are to make more educated and informed decisions concerning the most effective form of treatment. Today, the public continues to find itself faced with an overwhelming volume of information, often kept isolated or presented in a way that is far too often conflicting and confusing.

- I get nervous when people say pilot projects and I will tell you why. This is my jaded side. We have been piloted to death here. We have had more pilot projects and they never amount to anything even if they are successful. The research has been done out there. The studies have been replicated. I think implementing best practice is what we need to be doing. We have evidence now. What is in the way of implementing? We need to implement the evidence; we do not need more studies or pilot projects.

- We are a nation that is unable to generalize from success. That is our crippling problem. We are a pilot project country. Take a concrete example of primary healthcare: the model has been well described, but we never get there and the change is actually slowing down. Why is that? Because this is a matter that is negotiated with the British Columbia Medical Association instead of mandated by public policy. We negotiate everything in Canadian health care with an interest group. We never say, thank you, we have heard you. We understand, but this is the way we are going to do it. And it is not because we want to shove things down anyone’s throat, but at some point the public interest is clear and the interest group’s interest is clear and they do not match. And when they do not match, the public interest prevails, full stop.

- We have done so many pilot projects. They put a million dollars into a whole bunch of community developments last year, and they have evaluated it and demonstrated the results. We have received one-time funding in the British Columbia Healthy Living Alliance. We are going to start up a whole bunch of
programs and then what is going to happen in ten years? The intent of pilot projects is good, but they are almost an unhealthy diversion in the sense that they do not bear fruit in the long-term.

- Comments on evidence-based programs and studies:
  - There is a need to stop the advertising and impressions people get from studies and reports that are so-called scientifically proven. Then a month later another scientifically proven study reports the opposite.
  - (Aboriginal) Lack of mentoring support to develop evidence-based products and increase research report capacity.

Ideas and Suggestions

Implementation of Best Practices
Evidence-Based Programs and Studies

- Ideas about implementation of best practices:
  - Search out the best practices and have the intestinal fortitude to implement them regardless of vested interests.
  - Look carefully at the studies that have been done by the Senate, because the recommendations that have come forth are non-partisan and seek to find solutions, rather than seeking political gain.
  - Look in British Columbia first (the world comes to us now).
  - Develop innovation around a defined need.
  - Assign funding backed up by strong evidence-based information.
  - Match demand with access (both the type of care setting and the type of health care provider) across the continuum of services through prevention, resource management, trend analysis (demographic, age, ethnicity, gender, disease/health profile) and collaborative care models.
  - Planning surrounding best practices is not the work we do today. We must invest in learning environments and change.
  - Make sure it is evidence-based and has a real life application to any ideas for access.
  - We need to stop treating the application of new knowledge into the health care system as a project. To be sustainable, ongoing and long-term efforts and focus are required.
Recognize our best practices and resource them to spread them out in a useable format. Research entities need to be linked, smart, accessible, timely, and funded appropriately.

Release more information on positive experiences.

- **Ideas about evidence-based programs and studies:**
  - Create evidence-based and best practice programs.
  - Look at the model in the United Kingdom, namely, delivery councils, which are multi-disciplinary teams that operationalize various initiatives. These councils gather budgets from different levels of government to implement initiatives. While one level or delivery arm is the lead, delivery and operations are at the local level.
  - Research needs to be re-focused so it is not just about the current medical model, which is only a pharmacological model. Do not focus on technological solutions. Think outside the box.
  - We are committed to the current public health care system and to strengthening it to include evidence-based complementary medicine and preventative medicine.
  - Encourage behaviour change research.
  - We need more health policy based on health research which is evidence-based.
  - Make clinical phase three data public.
  - Implement a return to honest, factual scientific integrity to replace present public relations propaganda.

**Patient-Centred Model**

**Comments and Concerns**

**Defining Patient-Centred Care**
**Implementing Patient-Centred Care**

- **Comments on defining patient-centered care:**
  - This is a simple analysis that comes from the elders in our Aboriginal community: take care of the young children. Take care of the old people. Take care of the sick and the disabled. So in some ways, they understand and we all know that at each
age level, whether it is early childhood, or whether youth, adults or elders, they have different health needs.

- If we begin with the patient and their journey we can build a system that improves health care outcomes.

- Patient-centered care is more of a value-based approach rather than a technical way of actually providing the service. It is how the service is provided, not what the service is. I think no matter where you go in the health care system, people should expect that they are going to be respected and valued, and their rights are going to be considered. There is a profession that I think does this very well: dentistry. How many of you look forward to going to the dentist? Nobody does. But you know one of the things I have noticed over the past couple of years is how accessible dentistry is. I have a dental office in the little shopping centre near where I live. I have seen the dentist’s office in malls. They are very inviting places. You go in and you sit down, there are flowers and music. It is not austere and they make an effort to welcome you because they know you do not want to be there.

- Strangers not involved with the individual’s health care are making medical decisions on treatment.

- A one size fits all is a bad idea for health care as no two people react the same way to the same treatments. We should be paying for whatever treatment works best for individuals.

- **Comments on implementing patient-centred care:**

  - What usually happens is practitioners add an extra level of complexity, or import tools from the United States health system. All doctors have many examples of patients remaining in hospital for days or weeks longer than necessary not because of lack of resources but because of the complexity and complicated assessment system.

  - One of the assumptions is that people have the necessary information to actually be a part of their own care. We do not have clear roles and responsibilities. We do not have them defined in such a way that allows people to be involved in the system at all.

  - When a person is in the room, they need to be at the centre. Customer service means to treat that person as a customer or client, but how do we do that? We cannot provide everything to everyone, but neither can a business. They have to set their priorities. We are talking about how you value people. So you are a practitioner and somebody comes to you with an ailment or an injury and they are in distress. They are emotionally and mentally in another place. They may be angry, frustrated, worried, or fearful. But what we are getting at is that you
communicate that you value them: you are glad that they came and sought help from you. And if you cannot help them, you tell them that we want you to get well. Here is where you need to go and I will help you get there. It is a value-based approach: treatment and care in accordance with the patient’s values.

- Whether people are paying for that service or not, we are paying indirectly as tax payers and we do not need to be treated as if we are beggars or de-valued citizens, but that is how we are treated.

- I wonder how many people involved in this discussion are aware of the Canadian Association for People-Centered Health. The system we have now is primarily top down and is centered on the providers, not the people.

- What is the difference between what I am doing in my office every day and how that manifests itself in client-centric care? We do not even know what client centric-care is because we do not actually have the measures to know about it. I think one of the ingredients is that you create welcoming environments for people seeking health care. The provider acknowledges that you are an important person and you are nervous being there. So I am going to do things to calm you down and create a welcoming environment. I think a lot of our facilities are not welcoming. They are sterile, grey, and depressing places.

- The biggest thing that I found in the United States was not just that the on-the-ground care was better than I had here in Canada, but it was the education piece and how they let me know step by step what would happen and what I needed to do going forward.

- How do we create an informed population whose knowledge ranges from how you deal with your injury to when do you bring your child in when they have a fever. And how do we actually realign the economic interests so that we have the patient actually in the middle of this, rather than the provider.

- Demand is instinctual.

- In the United Kingdom, we look at patients as co-creators. Most of us as patients do not necessarily just want to receive wisdom, we want to be part of the solution. Actually talking about patients as consumers is fantastically important but they are actually consumers who want to be co-creators as well. So in terms of what we have done is we have tried to do a number of things there to shape demand so that it focuses much more on patients, personalization, prevention and so on.

- No process can be 100 per cent patient centered, otherwise every patient would have access to the total provincial budget if required to provide any health procedure that might improve the patient’s prognosis.
Ideas and Suggestions

Defining Patient-Centred Care
Implementing Patient-Centred Care

- **Ideas about defining patient-centred care:**

  - When we talk about patient-centered care, above everything, above any model of reimbursement or whatever, it is important to put the patient at the centre. That should be an overarching principle, prior to any discussion of models.

  - I would like to see a whole kind of patient self-care. The patient is in control of their health care, and managing their health care.

  - The patient is what we should be focusing our efforts on, and politicians, doctors, and pharmaceutical companies, should all come second. As leaders, we have to focus in on the patient: put the patient first.

- **Person-centered care pyramid:**

- **Ideas about implementing client-centered care:**

  - According to participants, all professionals need to be integrated and patients need to be empowered to utilize them. We need all practitioners working together for the best benefit of the patient. Further, outcome measures need to be patient-focused. A team approach would include choice for patients from a
wide array of professionals to achieve maximum health and wellness. However, no process can be 100 per cent patient-centered: efficiency, effectiveness and geographic location are all factors to be considered.

- Client or patient-centered care should be the vision of the health care system. To do this, the patient should be more informed on how the system works. Citizen-centered means those services that citizens need are provided in a coherent and consistent way across a holistic system: redefine the services that we should actually include, and then re-think that fundamentally.

- Create a culture of continuous quality improvement.

- Incorporate the patient into a high level of planning.

- Incorporate a seamless, customer-oriented system.

- Bring services to clients, rather than them having to go to services.

- One model does not fit all clients. Get flexible: tailor services to meet the needs of the person and the region.

- Empower people to be in control of their health through participatory care and provide feedback so patients can make informed decisions.

- Turn focus to client need across the care continuum, then the money will follow.

- Move to a more individual, patient-focus which looks at a patient holistically and Medical Services Plan coverage is determined based on what enables the patient to care for themselves.

- Consider and publicly fund the model from Alaska where the focus is on the patient and care is driven by the patient.

- How do we get there and what would it look like? We would need to have really clear definitions of client centered care. It would look like clients are consulted in decision-making, planning, and health care delivery at all levels. There would be integrated access across multiple channels and involve participants who are positive and collaborative. Technology would make services and information more accessible and help people access services and their health records. There would be incentives for patients and providers to support a model of self-care. We would be putting health services where people go and there would be a values-based approach in training and institutional programs for providers. Outcomes would be high client or patient satisfaction and patients would be more knowledgeable.

- Service delivery itself should be patient-driven as opposed to provider driven. It is not about what the provider brings to the patient, it is about looking at what the patient needs and then finding the right provider to bring that to the patient.