BC Nurses' Union submission to the

Conversation on Health
Single-payer publicly-funded, publicly-delivered medicare is the fairest, most effective way to provide health care services to our citizens.

By working to protect and improve medicare we are saying that health care is too fundamental to the well-being of our community to be treated as just another commodity to be bought and sold on the private marketplace, like luxury cars and big screen TVs.

Because we consider access to high quality health care services to be a fundamental right of citizenship, the cost of health care should be covered as a community responsibility through our taxation system, not through payments from individuals based on whether or not they can afford to make them.

Of course health care costs money. It’s just a question of who pays and how.

Despite government claims, spending on public health care is sustainable. The amount of spending by government on health care in BC has remained relatively constant over time as a proportion of the provincial economy. That’s the key factor in determining whether we can afford to continue to pay for it. Specifically, government health care spending consumes about the same portion of provincial GDP as it did 15 years ago – about 7 cents on the dollar. Contrary to some claims, the aging population is adding only minor pressures to this mostly stable picture (see Canadian Institute for Health Information, BC Ministry of Finance, *Is BC’s Health Care System Sustainable?* Marc Lee, Canadian Centre for Policy Alternatives, November 2006; *Carole Taylor's False Alarm*, Will McMartin, thetyee.ca, September 25, 2006).

We are concerned that government claims about “unsustainable” health care spending are deceptive, if not outright false. We reject the grossly misleading claims from the government that “if nothing is done”, health care “could consume 71 per cent of the provincial budget by 2017”. We are concerned that these claims are motivated by a desire to convince British Columbians to opt for more user pay, private for-profit health care schemes favoured by some in government, rather than an attempt to improve public health care.

Given the government’s misleading characterization of the sustainability issue, we cannot support the Premier’s stated intention to add the principle of sustainability to the Canada Health Act.
Finding ways to improve public health care means looking at the evidence of what works and what does not; it means a commitment to implement changes that will improve public health care, not to embark on reckless experiments that will make things worse.

It also means dropping claims about the superiority of “mixed public/private” European health care systems. These claims are made without reference to the rest of the European social program package — including income equality, generous social benefits, low post-secondary tuition and labour rights — that have no appeal to those advocating that these “mixed” systems be imposed in British Columbia.

Many of the points we make in this brief aren’t new. They’ve been offered frequently to the government during Conversation on Health events. They’ve been made many times in many places for many years before and during the current government’s terms of office. The key question is will the government listen?

### The Keys to Improving Public Health Care

1. **Directing resources and energy to improving primary health care.**
2. **Addressing the shortage of nurses, doctors and other health care providers.**
3. **Dedicating resources and coordinated management to reduce waiting times for surgery within public facilities.**
4. **Increasing services for seniors, such as home care, home support and affordable assisted living and long term care.**
5. **Controlling drug costs and implementing a national prescription drug insurance plan.**
6. **Addressing the social determinants of health such as quality child care, affordable housing and a safe and healthy environment.**

**I. Directing resources and energy to improving primary health care:**

Countless peer-reviewed studies have revealed that the key to providing more effective, affordable public health care is to improve the way we provide patients with care at their first point of contact, where they seek primary health care. (Roy Romanow, *Building our Future Together*, Report on the Royal Commission on Health Care in Canada, November 2002, page 115).

Despite much talk and considerable funding provided by the federal government, BC’s system of first contact or primary health care is still largely dependent on either fee-for-service physicians working as independent businesspeople in their own private practices or on physician-staffed walk-in clinics.

Physicians are providing this first contact care largely isolated from the knowledge and skills of other health care professionals such as registered and practical nurses, nurse practitioners, physiotherapists, social workers and dieticians.

There is no doubt patients in BC would benefit immeasurably if the provincial government led a transformation of primary health care away from independent
doctors’ offices to community health centres open 24/7, based on multidisciplinary teams of health care professionals, responsible and responsive to the communities they serve.

These centres have a proven record in helping prevent illness and keeping people out of hospital. (Dr. Michael Rachlis and Carol Kushner, *The Better Way to Health Reform*, BC Nurses’ Union, 1995). They have been touted as a critical reform to make medicare work as far back as the Hastings Commission of 1971, and again by Roy Romanow in 2002.

One of the tragedies of BC health care is despite all the re-organizations, restructurings, regionalizations, and “reforms” that have been implemented in the last two decades, few changes have contributed significantly toward improving the delivery of primary health care, beyond a few rather timid pilot projects.

An investment in community health centres would be one key positive allocation that could be made from the Ministry of Finance’s Health Innovation Fund for the 2007-8 fiscal year.

2. **Addressing the shortage of nurses, doctors and other health care providers:**

Now that the capacity to educate new nurses has been increased significantly in colleges and universities, the main contribution the government could make to address the critical shortage of health care professionals would be implementing workplace improvements that encourage mid-career professionals to stay working and attract those who have left back into their profession.

That means creating the conditions in which work is rewarding and satisfying and employees have the time and energy to enjoy leisure and family life.

For Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs), many of these matters are addressed in the collective agreement signed by the Nurses’ Bargaining Association with health employers in 2006. It’s critical the government maintain and increase its commitment to implement these provisions to reduce nurses’ workloads, increase front-line nursing leadership and support, and prevent workplace violence.

In addition the government should be aware that we will continue to advocate for set ratios of Registered Nurses to patients as the key method of ensuring controls over the workload burden. While government and health care employers may fear that ratios could force the closing of services during a nursing shortage when ratios can’t be met, the experience where ratios are required has been the opposite. In California and Australia the implementation of ratios of nurses to patients led to a dramatic increase in the number of RNs available for work, because many who had left the profession came back in, attracted by the prospect of manageable patient loads.
We also urge the government to improve the nursing work environment by adopting the “80:20” practice model where nurses devote 80 per cent of their working hours to direct patient care, while spending the other 20 per cent on professional development opportunities such as pursuing educational goals or mentoring other nurses. The nursing literature has established that the best practice conditions for patients and nurses prevail when nurses are in the workplace providing nursing care 80 per cent of their working hours, while spending the other 20 per cent on professional development and mentoring.

There’s another key issue to consider in working to keep and attract nurses by improving their work environment.

The policy of reducing the length of time that patients stay in hospital has resulted in only patients with the greatest needs for nursing care remaining in hospital. For nurses, the policy means there is less opportunity for breaks from the stress and intensity of caring for high need patients and less opportunity to provide patient education.

That’s why, for example, while we agree that public, not-for-profit urgent care centres should be established to take some of the burden off overcrowded emergency wards, these urgent care centres should be established as part of the hospital. They should not be set up as separate entities outside hospital walls, operated as private businesses by physicians or other health care entrepreneurs.

By keeping urgent care services as public, not-for-profit units within hospitals, emergency room nurses, who are continually confronted by difficult cases and challenging circumstances, would be able to rotate through relatively less stressful non-emergency urgent care settings as part of their job schedules, to relieve stress and the possibility of burnout.

Similarly, we are concerned about proposals by some health authorities to remove simple day surgical procedures to off-site clinic settings “so hospitals can concentrate on more complex cases”. In most instances, these proposals involve private, for-profit clinics which simply drain nurses and other professionals away from hospitals, exacerbating operating room staff shortages and leaving remaining staff confronting a never-ending burden of complex cases.

The government and health authorities must put all decisions through this critical lens: what will be the impact of those decisions on the work environment and on the ability of health authorities to keep and attract back the nursing staff needed to provide care to patients in the years ahead?
A survey taken by our union two years ago revealed a huge unused and underused operating room capacity in public hospitals throughout the province. Using information provided by the BC Medical Association, the report, which was provided to government, showed that the amount of unused and underused surgical capacity in BC hospitals, even in daytime hours, vastly exceeded the number of additional hours physicians said they needed to eliminate waiting lists for some key elective procedures - hip and knee replacements and cataract surgery.

Since then, the government and some health authorities have dedicated federal funding toward reducing wait times, and more operating room time is being provided.

Particularly noteworthy are the dedicated operating room resources for elective procedures at Richmond Hospital, UBC Hospital and Lions Gate Hospital. These projects followed the example set by the Alberta Hip and Knee Replacement project. The Alberta project demonstrated that through proper coordination of waiting lists and dedicated case management, waiting times can be reduced significantly within public facilities.

The key is for health authority medical leadership to assume the management of surgical waiting lists from individual specialists and surgeons, and to move patients through centralized referral clinics.

Through these projects centred in public facilities, waiting times for key procedures have been reduced dramatically.

The amount of unused surgical capacity in public hospitals that remains shows further improvements can be made by using public facilities.

There is no need to seek more operating room capacity from private, for-profit entrepreneurs. These ventures will cost the system more and drain our hospitals of scarce staff and resources.

Nor should the government be considering any of the so-called “payment by performance” or “payment by results” schemes being touted for hospitals by various advocates of for-profit health care.

These schemes would entrench in the hospital setting the volume-based fee-for-service system that has so badly served primary health care when applied to payments for physicians.

The idea of forcing hospitals to compete with each other and with private for-profit facilities for their funds and their patients is anathema to health care, an area of human activity that relies on teamwork, cooperation and coordination for its successes.

These schemes encourage cherry-picking of patients and procedures that generate the easiest revenue flow. They would destabilize the acute care sector by eliminating any certainty for budgeting or long term planning.
We remind the Minister of Health what Lord Nigel Crisp, the former head of Britain’s National Health Service, told him when he inquired about the success of “payment by results” during the Conversation on Health’s international symposium in June. Lord Crisp replied that things can go very wrong when the concept is applied to hospitals. He reported that the burden of paperwork has increased substantially, while setting and paying specific prices for specific hospital procedures doesn’t reflect the variability of needs for follow-up care or for dealing with complications. The scheme is hardly appropriate for treating mental illnesses.

Such schemes are not appropriate for improving medicare in BC. They would make current problems much worse.

Countless studies have proven that well-funded home care and home support can save the health care system considerable money by helping keep patients healthy and safe in their own homes and out of hospital. That’s especially the case for seniors and people with disabilities. (See Without Foundation, How Medicare is Undermined by Gaps and Privatization in Community and Home Care, Canadian Centre for Policy Alternatives, BC Government and Service Employees’ Union, BC Nurses’ Union, Hospital Employees’ Union, November 2000.)

Cutbacks in eligibility for personal care have been extremely short-sighted.

The Romanow Report called for an expansion of medicare to include home care, but little has been done to achieve this recommendation.

Similarly, the closing of thousands of long term care beds in British Columbia beginning in 2002 and the plan to replace many of them with rent supplements in private housing and assisted living spaces created a crisis in seniors’ care. (Continuing Care: Renewal or Retreat, Canadian Centre for Policy Alternatives, April 2005.)

Seniors need a variety of alternatives. Most would prefer to stay in their own homes if they could get help with some of their personal care needs. For others, assisted living is an attractive option. But most of the seniors who are so-called “bed blocking” in acute care hospitals are there because there aren’t enough complex care long term care beds, not because they can’t get a space in assisted living.

The other problem is the lack of registered nursing staff in long term care facilities. This limits the amount of nursing time available for residents on a daily basis. When a resident becomes ill, there’s limited nursing and medical attention available, necessitating frequent transfers by ambulance to hospital. The establishment of on-site infirmaries in long term care staffed by Registered Nurses assisted by visiting physicians — with at least one RN on duty around the clock — would go a long way to reducing the number of costly transfers to emergency rooms, and facilitate quicker discharges from the hospital back to long term care.
5. **Controlling drug costs and implementing a national prescription drug insurance plan:**

The cost of prescription drugs is a major source of financial stress and anxiety for many British Columbians. They can’t afford to cover the rising cost of pharmaceutical products out of their own pockets. Across Canada there’s a patchwork of coverage and co-payments provided by the various provincial drug plans.

Including prescription drug coverage in medicare was one of the key recommendations of the Roy Romanow report.

We acknowledge and appreciate the support given by the Premier of British Columbia for a national prescription drug insurance plan at the 2004 Premiers’ and First Ministers’ conferences. Unfortunately, since then respective federal governments have been allowed to drop the ball and there has been little progress.

Drug costs are one of the fastest growing components of health care spending. Coupled with pharmaceutical company patent protection and marketing control, this is one component of medicare that is truly “unsustainable”. But a national prescription drug plan would enable governments to bulk buy pharmaceuticals, thereby controlling prices, and provide all provinces with the expertise, pioneered by British Columbia’s Therapeutics Initiative, to assess the utility and cost-effectiveness of the newest, most expensive pharmaceutical products.

6. **Addressing the social determinants of health, such as quality child care, affordable housing, a safe and healthy environment:**

No discussion about ways to improve health care in BC would be complete without considering the social determinants of health. There is no better way to prevent illness and maintain a healthy population than to ensure everybody has access to adequate incomes, healthy food, safe drinking water, effective sanitation, affordable housing and quality, affordable child care. (See Andre Picard, *Sanitation Cleans Up as Top Medical Advance*, Globe and Mail, March 29, 2007.)

Programs to encourage income equality, such as an adequate minimum wage, decent rates for social assistance, rent controls, social housing construction, and good public pensions go a long way toward keeping people healthy and reducing demand on health care services.

Affordable housing is one of the key social determinants of health. As health care providers we believe that through protecting and building affordable housing we will ensure the health and well-being of those individuals most often disenfranchised in our communities.

We encourage the government to support and take action to implement programs improving the social determinants of health for all British Columbians.
The BC Nurses’ Union has addressed all the issues in this brief to governments at all levels for many years. This Conversation on Health is just the latest in a long line of consultations, formal or otherwise, in which we have participated. We are including several of our recent presentations as appendices here. As far as this consultation is concerned, the key question has always been: is the government prepared to take seriously what we and other groups seeking to improve public medicare have to say, and is it prepared to commit to carrying it out? Or has the government had its mind made up from the outset and constructed this “Conversation” as an elaborate and expensive public relations ploy to set the stage for whatever schemes for change it had in mind in the first place?

From the ways the government has set up the exercise and articulated the issues, we cannot be optimistic. But make no mistake. We will respond to any attempt to undermine public health care through more user-pay and for-profit privatization schemes with consistent, vocal and unrelenting opposition. The BC Nurses’ Union will continue to advocate for and uphold the highest standards of patient care under our public medicare system.

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- Control drug costs and implement a national prescription drug insurance plan.
- Address the social determinants of health, such as quality child care, affordable housing and a safe and healthy environment.

Conclusion: Will the Government Listen?
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