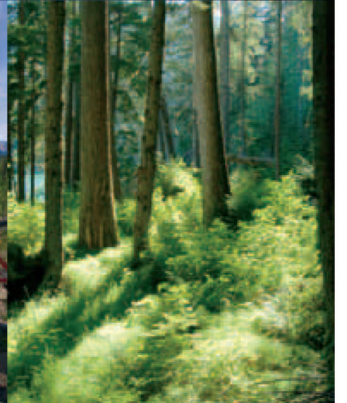
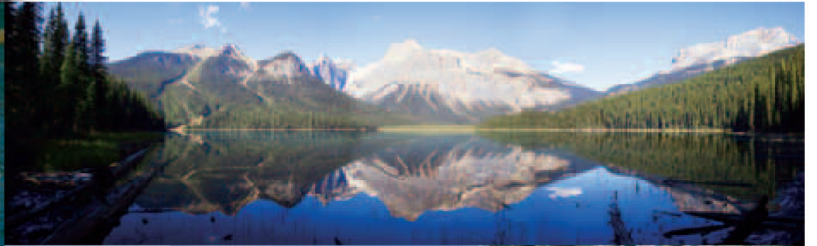


BC Physicians Speak Up



BC CONVERSATION ON HEALTH submission
JUNE 2007





PHYSICIANS SPEAK UP

**British Columbia Medical Association
Submission to the BC Conversation on Health**

June 2007



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**“When it comes to health care in Canada,
everybody wants progress but nobody wants change.”**

Gary Mason, Globe and Mail
March 6, 2007

PHYSICIANS SPEAK UP

British Columbia Medical Association Submission to the BC Conversation on Health

KEY RECOMMENDATIONS FOR BRITISH COLUMBIA'S HEALTH CARE SYSTEM

How do we better define the principles of the *Canada Health Act*?

1. The principle of **accessibility** needs to be strengthened through a commitment to maximum allowable waits for all surgical and diagnostic procedures as well as treatment in emergency departments.
2. The principle of **comprehensiveness** needs to be expanded to reflect the “core services” of today: medical, hospital, pharmaceutical, home care, long-term care and inpatient rehabilitative services.
3. The principle of **sustainability** must be added. Sustainability requires meeting clear and public standards for health human resources, infrastructure (including technology), clinical outcomes, and fiscal capacity.

How do we make our health system sustainable?

1. BC needs a practical and realistic approach to funding core services (as defined above). Full government funding for a broader basket of services is not sustainable, consequently, all core services should be subject to cost-sharing arrangements on a fair and equitable basis that ensures no one is denied care based on ability to pay.
2. BC should initiate pilot studies that support informal or family care givers as well as expand prevention activities in key areas such as tobacco use, obesity and vaccinations.

How can we improve health care delivery?

1. BC must act immediately to expand acute care bed capacity, emergency departments, operating rooms, and long-term care bed capacity. Health Authorities (HAs) must not exceed ongoing bed occupancy targets of 85%.
2. BC should support multidisciplinary care by removing existing barriers for incorporating allied health professionals within primary care physician offices while expanding the scope of chronic disease management activities.
3. Government should shift Health Authority funding to a mix of block and service-based funding to improve performance. HA performance assessment should be linked to patient outcomes in addition to expenditure targets.
4. Health Authority Medical Advisory Committees (HAMACs) should submit, on an annual basis, a public and independent report to the HA Board of Directors on clinical issues in the region.

INTRODUCTION - Open Letter from BCMA President

In September 2006, Premier Gordon Campbell launched the Conversation on Health. The challenge the Premier made to British Columbians was to have an honest and objective discussion about the challenges and solutions to ensure that our health care system will be there for us now and in the future. This process is an important endeavor.

The Premier asked three tough questions about our health care system:

- 1) What do the principles of the *Canada Health Act* really mean and how do we define them by law?
- 2) How do we ensure our system is sustainable for British Columbians in the long term?
- 3) How can we improve health care delivery to live up to those principles?

The BCMA in this document is providing answers that will take courage for government, health care providers and the public to implement.


Over the past fifteen years, physicians in BC have participated in many commissions and panels examining our health care system federally, provincially and locally. The reports and recommendations coming out of those endeavors are many. While we have made improvements in some areas, many challenges in the system remain unresolved, and in some cases become worse. This cannot continue for our patients. It is critical that we now start moving from discussion to action, and we must have the conviction to try something new.

Clearly, the most significant challenge facing our health care system is ensuring that people get timely access to care, whether it is on a wait list for surgery, in an emergency room, or in long-term care. British Columbians must have reasonable access to care when it is medically necessary. The problem is that this standard of care is not defined by government, either provincially or federally. That must change.

The success of the Conversation on Health will be measured not only by whether the subsequent changes improve sustainability, but also by whether the system provides care when people need it. This includes the need to ensure access to care for the most vulnerable members of our society. Therefore, a critical outcome of the Conversation on Health must be to implement practical changes that make realistic, objective and measurable improvements in access to care.

This BCMA submission provides practical short- and long-term recommendations to address key issues across the system. This document draws upon input from BC physicians and builds upon a decade of policy recommendations and submissions to provincial and federal governments by the BCMA.

This is not about what British Columbians want to hear, but about what they need to hear. There is no single or easy solution to the challenges in our system. It will take a multitude of targeted changes across the system and on the part of individual British Columbians to meet this challenge. It is about real solutions, and we need to start right now.



Geoff Appleton, MD
President

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SUBMISSION OVERVIEW

The BCMA's submission to the BC Conversation on Health is intended to provide recommendations on key issues in the system. In order to provide context for the discussion that follows, the first section will outline four key challenges that the health care system faces. The paper will then answer each of the Premier's three questions and will include a rationale for each recommendation. The Premier's questions are:

- 1) What do the principles of the *Canada Health Act* really mean and how do we define them by law?
- 2) How do we ensure our system is sustainable for British Columbians in the long term?
- 3) How can we improve health care delivery to live up to those principles?

THE CHALLENGE

The principles of the *Canada Health Act* were established in 1984, more than 20 years ago. In the ensuing two-plus decades, the health care system has undergone a significant transformation. Treatments are available today that could only be dreamt of in the eighties; information technology has resulted in better informed patients with higher expectations; health care delivery in BC has been reorganized under a regional structure; private diagnostic and treatment facilities are widely used and accepted; and the Supreme Court of Canada has issued a ruling that will have a direct impact on the issue of access.

In the midst of this new environment, the BC health care system is facing a number of key challenges that will continue to add pressure. These following four challenges provide the context for the discussion and recommendations that follow.

Challenge #1: Demographics

The growing and aging of British Columbia's population is well documented:

- It is projected that the proportion of seniors (65+) in BC will grow to 19.2% in 2020, from 14.2% in 2007.¹
- By 2030, nearly one in four British Columbians will be over the age of 65.²
- Seniors (65+) consumed approximately 44% of all BC government health spending in 2004, while only comprising of 13.7% of the population.
- In 2004, provincial health spending on British Columbians aged 1 to 49 was less than \$2,000 per person per year. There was a pronounced increase in per capita spending in the senior age groups, from \$2,153 for those between 50 to 54 years old to \$22,379 for those aged 90 years and more.³

Challenge #2: Chronic Disease

BC is experiencing a significant increase in the number of people with long-term or multiple conditions such as cancer, heart disease or diabetes. Chronic disease significantly increases costs and pressure on the system.

- 50% of the average family physician's workload is related to chronic conditions.⁴
- In 2004, cancer was the leading cause of death in BC claiming 8,401 lives.⁵ For 2007, an estimated 9,000 British Columbians will die from some form of cancer.⁶

¹ BC Government. *BC Summary Statistics*. 2007

² Premier's Council on Aging and Seniors' Issues. *Aging Well in British Columbia: Report of the Premier's Council on Aging and Seniors' Issues*. November 2006

³ CIHI. *National Health Expenditure Trends: 1975-2006*. 2006

⁴ Presentation to the Premier's Council on Aging and Seniors' Issues by Dr. Art MacGregor. March 16, 2006.

⁵ British Columbia Provincial Health Officer. *Food, Health and Well-Being in British Columbia. Provincial Health Officer's Annual Report 2005*. 2006

⁶ Canadian Cancer Society/National Cancer Institute of Canada. *Canadian Cancer Statistics 2007*. 2007

- Deaths from cardiovascular disease remain the second leading cause of death in BC. In 2004, 6,697 people died of cardiovascular disease, accounting for one-fifth of all deaths in the province.⁷
- 5.2% of British Columbians had diabetes in 2004. By 2010 it will be 7.1% – an increase of over 80,000 people in 6 years. Diabetes costs the health system \$750 million annually.⁸
- 4 out of 10 people with diabetes will develop complications such as blindness, kidney disease and cardiovascular disease, and/or may require amputation, all resulting in reduced life expectancy.⁹

Challenge #3: Capacity and Infrastructure

BC's acute and long-term care sectors have insufficient capacity to meet current and future demand. For example:

- Since the 1990s, there has been a steady reduction in the number of acute care beds per capita in the province. BC has only 1.8 acute/rehab beds per 1,000 – 35% below the 2.75 recommended by the BC Royal Commission,¹⁰ and significantly lower than most OECD countries.
- From March 2002 to March 2004, 1,279 hospital beds were closed – a 19% reduction in capacity when population increases are taken into account.¹¹
- Between 2001 and 2004, there was a net decrease of 1,464 residential care beds, even after accounting for new assisted living units.¹²
- As of January 2006, BC had 5.8 publicly and privately funded MRI machines per million population, below that of Alberta, Quebec, New Brunswick, Manitoba and PEI. All provinces except for Alberta and Ontario had higher rates of publicly and privately funded CT scanners per million population than BC (11.0).¹³

Challenge #4: Health Human Resources

British Columbia's shortage of health professionals is well documented. Although BC has expanded training programs for many professionals, the further impact in the coming decade will be significant. Consider the following:

- From 2001 to 2005, the total number of physicians in BC increased by 5.0%; however, the ratio of physicians per population increased only by 0.5%.¹⁴ Even with expanded training, physician supply in BC is not keeping pace with population growth and aging.

⁷ British Columbia Provincial Health Officer. Food, Health and Well-Being in British Columbia. Provincial Health Officer's Annual Report 2005. 2006

⁸ British Columbia Auditor General. Preventing and Managing Diabetes In British Columbia. 2004

⁹ British Columbia Provincial Health Officer. Food, Health and well-Being in British Columbia. Provincial Health Officer's Annual Report 2005. 2006

¹⁰ British Columbia Royal Commission on Health Care and Costs. Closer to Home. 1991

¹¹ M. Cohen et al. Continuing Care Renewal or Retreat? BC Residential and Home Health Care Restructuring 2001-2004. 2005

¹² Ibid.

¹³ CIHI. Medical Imaging Technologies in Canada: Supply, Utilization, and Sources of Operating Funds. 2006

¹⁴ CIHI. Supply, Distribution, Migration of Canadian Physicians. 2006

- The OECD predicts that by 2016, Canada will have the worst shortage of nurses of all OECD nations. Between 1994 and 2001, the number of RNs in BC per 10,000 residents declined from 74 to 68. This is the lowest nurse-to-population ratio in Canada.¹⁵
- In 2005, the average age of a nurse in BC was 46.4 years, 1.7 years older than the national average. In BC, RNs aged 50 and older represented almost 40% of the 2003 workforce.¹⁶
- In 2005, 47% of BC physicians were 50 years or older, with 17% of them over age 60. 52% of BC specialists were aged 50 years or older, while 43% of family physicians were aged 50 years or older.¹⁷
- The number of general practitioners in BC who are accepting new patients declined by almost 70% between 1999 and 2006¹⁸ while the BC population grew by 7.5%.¹⁹

¹⁵ Canadian Medical Association. Health Council sounds alarm over health human resources shortage (news release). Jan 27, 2005

¹⁶ CIHI. Workforce Trends of Registered Nurses in Canada. 2006

¹⁷ CIHI. Supply, Distribution, Migration of Canadian Physicians. 2006

¹⁸ Data supplied by The College of Physicians and Surgeons of BC.

¹⁹ BC Stats

THE RESPONSE: ADDRESSING THE PREMIER'S QUESTIONS

Question #1

What do the principles of the Canada Health Act really mean and how do we define them by law?

Under the *Constitution Act* (1867),²⁰ health care is defined as a provincial responsibility, and the provinces are responsible for the majority of health care delivery. The federal government has a very limited role in the delivery of care, but greatly influences provincial delivery and financing mechanisms. At its core, the *Canada Health Act* (1984) is a set of principles based on a funding agreement between the federal government and the provinces. In order to receive transfer payments from the federal government, provinces must meet the terms and conditions, i.e., satisfy the principles, of the *Canada Health Act* (CHA).

There are five principles contained in the *Canada Health Act*:

1. Accessibility
2. Comprehensiveness
3. Universality
4. Portability
5. Public administration

This section of the submission will discuss each of these principles in order.

These principles provide the foundation upon which Canada's provincial and territorial health care systems are built. Although BC has incorporated them into the *Medicare Protection Act* (1996), their prime legal importance relates to the financial penalties imposed by the federal government through withheld transfer payments should they be violated.

The provincial government does not have the ability to independently alter these principles. It is, therefore, understood that any recommended action most likely could not be accomplished by British Columbia in isolation, but would require dialogue and support from other provinces, in addition to the federal government.

The BCMA is adamant that the CHA principles must be restructured to remain meaningful in today's health care environment. In particular, the first two principles of accessibility and comprehensiveness must be strengthened, while a sixth principle of sustainability must be added.

1.0 Accessibility

The *Canada Health Act* stipulates that Canadians must have "reasonable access" to insured hospital and physician services. In the Act, reasonable access means (a) patients not having to

²⁰ The Constitution Act, 1867 Section 92.

co-pay for core services and (b) government and physicians entering into a negotiated contract for remuneration. However, the Act makes no reference to how long “reasonable” is.

This definition is inadequate and impractical; it is too often a crutch used for political purposes to mask the real deficiencies of the health care system. Reasonable access should be about a patient’s ability to obtain a core service, and to obtain it in a timely fashion. The current accessibility definition must be strengthened to meaningfully address the term.

Adequate and timely access to health care services continues to be the number one issue for British Columbians. Waiting lists for surgery and diagnostic tests, and wait times for emergency department care are key components of access. Many people wait far too long for services, yet are denied the right to do anything about it. The federal Minister of Health recently acknowledged that the courts will address this if government does not.

“It is time to declare it unacceptable in a nation as wealthy and as modern as Canada to have a health system which permits unconscionably long delays and offers patients no recourse to alternative treatment options within the publicly funded system. ... The Supreme Court of Canada itself has declared that our publicly funded system must offer patients timely care or it loses its monopoly.”

Honourable Tony Clement, Minister of Health, October 26, 2006

Access must be defined and determined within the context of a reasonable wait for service. This highlights the need to ensure adequate infrastructure, including information technology (IT). The new definition of access must address both of these components. The first is addressed immediately below, while the issue of infrastructure is addressed in the ‘Improving Health Care Delivery’ section of this paper.

1.1 Defining Accessibility – Maximum Wait Times

It is one thing to speak to the general need for adequate access, and yet another to put substance to the concept. The BC government is responsible for providing a supply of high quality core services that ensures adequate access. Access is the essence of a patient-oriented system and of the health care “contract” between Canadians and their governments. BC needs to demonstrate tangible progress in this area. A key tool for accomplishing this is for the BC government to implement evidence-based maximum wait time benchmarks.

Considerable work has already been done on the issue of wait lists, including:

- Western Canada Waitlist (WCWL) Project (2000-2005)
- Federal Wait Time Benchmarks
- Canadian Wait Time Alliance (WTA)
- BC Surgical Patient Registry
- BCMA Position on Emergency Room Overcrowding (2006)

Meaningful wait time benchmarks must be based on medical outcome evidence and professional opinion. Such work has already been done by the Wait Time Alliance (WTA), whose members include eleven medical specialty societies and the Canadian Medical Association. In 2005, the WTA established evidence-based benchmarks in the following five priority areas: radiology (including CT and MRI), nuclear medicine (diagnostic imaging), joint replacement, cancer care, sight restoration (cataracts) and cardiac care. These areas were outlined in the 2004 First Ministers 10-Year Plan to Strengthen Health Care. The WTA emphasized that the intent of these wait time benchmarks was to be considered “health system performance goals that reflect a broad consensus on medically reasonable wait times for health services delivered to patients.”

Based largely on the WTA effort, in December 2005 Health Ministers across Canada unveiled ten key benchmarks aimed at cutting wait times for the five medical services: nuclear medicine (diagnostic imaging), joint replacement, cancer care, sight restoration (cataracts) and cardiac care. These benchmarks reflect the time that clinical evidence shows is appropriate to wait for a particular procedure; however, they are not binding on any provincial or territorial government. That must change.

Over the past several years the federal government, in cooperation with the provinces, has made a commitment towards implementing wait time guarantees. The March 2007 federal budget announced “up to \$612 million to support jurisdictions that have made commitments to implement patient wait time guarantees.” British Columbia’s share of this funding, if allocated on a per capita basis, would be approximately \$60 million; this is in addition to the estimated \$715 million BC is scheduled to receive as part of the ten year Wait Time Reduction Fund announced in 2004. It remains unclear how the BC government plans to spend these funds, but the BCMA believes they should be directed towards the recommendations in this section.

Despite these commitments, the move towards implementing wait time guarantees by the provinces has been slow. Provincial governments appear nervous about the introduction of guarantees due to the potential financial obligation they represent, as well as public reaction in the event they are not met. If British Columbia truly wants to better define accessibility in law, then it must have the courage to implement meaningful guarantees. One small step in this direction was made when the federal government announced on April 4, 2007 that all provinces would commit to at least one wait time guarantee. BC is to implement an eight week guarantee for radiation therapy for cancer by 2010. However, the average wait time for radiation therapy in BC is typically less than three weeks so a wait time guarantee of eight weeks is not onerous. Furthermore, no recourse has been explicitly outlined if the BC government does not meet this mark.

The management and reduction of wait lists and times must not be limited to the five priority areas identified in 2004 by the First Ministers. Although these are important areas, it is critical that waits for other procedures or in other areas of the health care system not be ignored. Otherwise we will end up with the “balloon effect”, where focus on waits only in specific areas actually increases waits in non-targeted areas.

The Canadian Wait Time Alliance (WTA) has recently expanded their scope and is now preparing additional benchmarks in the areas of emergency and psychiatric care, reconstructive surgery,

and gastroenterology. These clinically driven benchmarks will extend the focus beyond the five priority clinical areas and begin to provide benchmarks across the continuum of health care services. This good work should continue and be expanded.

Reducing wait times will require a set of enhanced management tools such as central registries, clinical guidelines, best practices, information technology, financial incentives, overcapacity protocols and clinical prioritization tools. The BCMA supports the continued development and implementation of central registries in BC, like the Surgical Waitlist Registry. By providing a standardized tool for surgeons to prioritize patients on wait lists, BC will have a more consistent and accurate approach to managing wait lists for all surgeries. This registry will also improve the accuracy and reporting of wait list data which will ensure that patients with the highest urgency are served first.

1.2 Care Guarantee and “Safety Valve”

A common frustration among physicians and patients has been the lack of any recourse where the publicly funded health system fails to provide timely access. This gap in Canadian health policy must be addressed in a way that compels the system to provide timely care while preserving the right of Canadians to seek alternate care if the public system fails to deliver.

Establishing evidence based wait time benchmarks will require the BC government to set up a safety valve to address situations where the established time guarantees are not met. This safety valve provision would allow patients and their physicians to seek required care wherever it is available if the designated service is not provided to patients in the originally referred location and within the guaranteed time period. Treatment could be obtained at another public facility in or out of province, or in a private facility, in or out of country.

The private sector will play an increasingly important role as the public infrastructure adjusts to a new standard of care. Canadian health care delivery currently employs the use of many private facilities to deliver publicly funded services. Examples include physician offices, diagnostic centres, long-term care facilities, home care agencies and pharmacies. Private facilities are effective, efficient providers of publicly funded health services and our health care system would simply not function without them. The question is not whether private delivery should exist, but how society can make the most efficient and effective use of the private sector while retaining accountability to a public authority.

Both the CMA and the WTA have recommended the establishment of a “Health Access Fund” to enhance the portability of care for patients and their families by reimbursing the cost of care when services are not available provincially within the accepted wait time benchmark. The BCMA believes such a fund should be created to support patient care costs as part of the introduction of wait time benchmarks.

Including a safety valve provision in Canadian health care policy will hold governments accountable for meeting commitments to provide timely access to quality care and thus uphold the new definition of accessibility.

RECOMMENDATION #1

Canada's First Ministers should jointly seek an enhancement of the accessibility principle of the *Canada Health Act* in relation to core services by:

- a) implementing clear maximum allowable wait time benchmarks for all scheduled surgical and diagnostic procedures from time of referral through provision of service;
- b) providing the necessary infrastructure to ensure that "reasonable access" can become a reality; and
- c) ensuring that safety valve provisions are in place, so that if the public system cannot provide services within specified wait time benchmarks patients are able to access services elsewhere.

2.0 Comprehensiveness

The principle of comprehensiveness addresses the range of services that are insured under Medicare. These services are usually referred to as "core" services. With respect to the *Canada Health Act* (the Act), core services are understood to be those medically necessary hospital services, physician services and surgical dental services provided to insured persons. The province must ensure that core services are provided on a fully government funded basis to receive cash transfers under the Act.

As health care delivery has evolved, it has become evident that such a limited interpretation of core services is inadequate:

- More and more services have migrated out of the hospital setting. Many services previously provided in hospitals are now delivered through a combination of community-based services and drug therapy.
- Services that continue to be provided in hospitals increasingly involve "day surgery", or involve a much shorter stay, resulting in significant levels of community-based follow up care.

This array of services, many of which fall outside the existing definition of core, are funded in a variety of ways. Core services are fully government funded, however, beyond the core coverage involves a mix of government funding, patient cost-sharing and third party insurance. Some services are funded completely privately. There is no uniformity in the terms and conditions under which services may be partly covered under the public funding umbrella. This means an individual can receive certain types of necessary care for "free," while other types of care that may be more clinically appropriate, or otherwise needed due to the realities and/or deficiencies of today's health care system, require substantial patient co-payment. This double-standard approach is both outdated and illogical. Comprehensiveness in today's world requires a different set of guidelines.

If Medicare is to continue to meet the needs of British Columbians, the notion of core services must change to cover an array of services consistent with the realities of health care in the 21st century. Specifically, the definition of core services should be expanded beyond hospital and physician services.

RECOMMENDATION #2

Canada's First Ministers should jointly seek a redefinition of the comprehensiveness principle of the *Canada Health Act*. The provincial and federal governments must define core services to include medical, hospital, pharmaceutical, home care, long-term care and inpatient rehabilitative services and ensure that British Columbians have reasonable access to these core services under uniform terms and conditions.

This expanded definition suggests a different approach to the funding of core services – one that is more pragmatic and less ideologically driven, and that is defined by a set of uniform terms and conditions.

Canadians have consistently stated that they want a predominantly public, single payer health care system. They are prepared to, and do, pay for some health care services entirely out of pocket or partially through user-pay charges. Canada remains the only industrialized nation to permit user charges for some health care services yet preclude them for almost all medical and hospital care. The questions of why some services are subjected to co-payment while others are not, and why the proportions of co-payment vary significantly from service to service, need to be addressed.

British Columbians, as well as other Canadians, must be prepared to review the concept of full government funding. Patient cost-sharing is an acceptable part of the provision of many important health-related products and services. Furthermore, the *Canada Health Act* makes an explicit provision for chronic care co-payments. However, physician and hospital services are currently considered “off-limits”. Such restrictions should be removed. There is a need for a more rational discussion of the role of patient cost-sharing throughout the entire breadth of the health care system.

The application of cost-sharing arrangements must be done with appropriate care and sensitivity. They must be applied in a fair and equitable manner that takes into consideration those at a financial disadvantage so that access is not impeded.

RECOMMENDATION #3

All core services must be subjected to cost-sharing arrangements that are applied in a fair and equitable manner, ensuring that no one is denied essential care because of their financial situation.

3.0 Universality

The BCMA endorses the current definition of universality, recognizing that there are specific exclusions outlined in the *Canada Health Act*. Defining this principle further in law is not necessary given the provisions that already exist in the CHA.

What is not clear is if British Columbians understand these exclusions or believe they are fair. A common misperception is that the CHA applies to every Canadian equally. However, the *Canada Health Act* clearly outlines groups or services not covered by its principles.²¹ Some of these groups access services differently (and often faster) than other Canadians, which is legal under the CHA. For example, if a person covered under the Workers Compensation Act in BC is injured on the job and requires knee surgery, they will have access to expedited diagnostic services as well as the actual surgical procedure. If that same worker is injured at home, they are on the same waitlist as the general public and may wait significantly longer.

4.0 Portability

The principle of portability is intended to provide insurance coverage for Canadians traveling and/or moving between provinces as well as limited coverage for Canadians temporarily outside the country. Although not a requirement of the *Canada Health Act* (CHA 1984), the provinces have reciprocal billing agreements that resolve billings for residents receiving insured services out of province. This means that if a patient receives a service in another province, their home province will cover the cost of that service in most cases. In general, the BCMA does not believe the principle of portability requires further legal clarification. However, the BCMA believes that the administration of this principle should be made as seamless as possible for the patient. Quebec, in particular, frequently does not completely pay for services provided to its residents in other provinces.

5.0 Public Administration

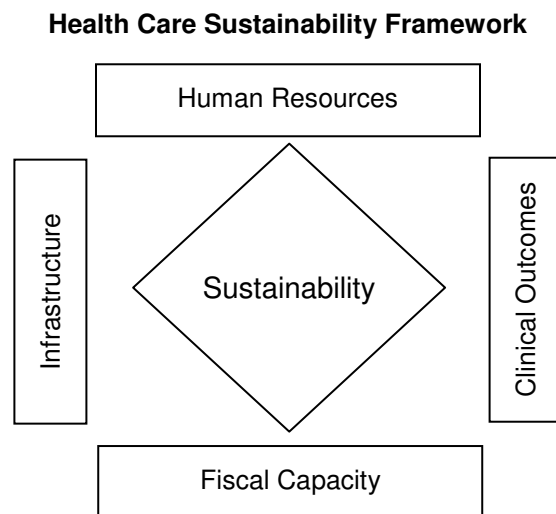
The principle of public administration is intended to ensure that the provincial health plan is overseen by, and directly accountable to, a public authority. In BC this authority is the provincial government which is ultimately responsible for its performance. The BCMA does not believe that any legal changes to this definition are required. However, better information needs to be provided to the public on what this principle means. Many individuals equate public administration with public delivery of services. The principle of public administration is not a requirement for public delivery of services, but rather a requirement of accountability of the performance of those services to a public authority. In order to meet this principle, the *Canada Health Act* states (s8(1)a): (a) the health care insurance plan of a province must be administered

²¹ "Insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation; "Insured person" means, in relation to a province, a resident of the province other than (a) a member of the Canadian Forces, (b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein, (c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or (d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services.

and operated on a non-profit basis by a public authority appointed or designated by the government of the province; (b) the public authority must be responsible to the provincial government for that administration and operation; and (c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Question #2**How do we ensure our system is sustainable for British Columbians in the long term?**

The BCMA agrees with the Premier that sustainability of our health system is of fundamental importance, and supports adding “sustainability” as the sixth principle of the *Canada Health Act*. But what does sustainability really mean? Fiscal sustainability is a critical component of the equation, but not the only component. Operational sustainability is equally important, in terms of human resources, as well as infrastructure and technology. The health system must also be sustainable in terms of the quality of care and outcomes provided within it. This relationship is represented by the diagram below. Achieving sustainability in BC will require a balance of these four components.



BC doctors believe that the health care system is presently unsustainable in all aspects. To address these inadequacies will require a concerted effort to stabilize the publicly funded health care system in terms of quality, infrastructure and human resources, while simultaneously ensuring its ongoing financial stability.

RECOMMENDATION #4

That the federal and provincial governments recognize a sixth principle of sustainability in the *Canada Health Act*, that meets reasonable and defined standards of:

- a) health human resources
- b) infrastructure
- c) clinical outcomes
- d) fiscal capacity

1.0 Financial Sustainability – What Does It Mean to British Columbians?

There is no debate that health care costs are increasing. Between 1990 and 2005 BC provincial health care expenditures increased by 138%. Over the same time, inflation only rose by 36%.

Establishing a “number” that represents a clear financial threshold for British Columbians for spending on core health care services is problematic. The proportion of public health expenditures reflects funding allocations based on public priorities and policy choices, including taxation policy. Health care is consistently ranked at or near the top issues for public concern. Yet, there is some notional level above which health care spending begins to crowd out other expenditures in which the public also has an interest.

The original intent of Medicare was to ensure that no Canadian suffered undue financial hardship in the event of an illness or injury. At the same time it strived to ensure Canadians were provided access to treatment regardless of ability to pay. Despite this commitment, the expectation of full government funding for all health care services today is as unrealistic as it is unachievable. The province’s changing demographics will have a significant impact on the tax base in the coming decades.

The most difficult future policy choice will be the determination of what proportion of expenditures the public is prepared to accept be supported by the general tax base versus an increase in co-payments. Clearly, that decision is also tied to the current principles of the *Canada Health Act*. As noted in the comprehensiveness section, our system has a double standard approach to funding necessary health care service. This needs to be addressed by incorporating a greater co-payment component for core services, while protecting those in financial need.

A related issue, the use of revenue generation from health care premiums should also be examined. While there are many points of view about the value of a premium system, the doctors of BC believe that premiums should be retained. Premiums impart a degree of cost consciousness. Currently, premiums cover less than 15% of all health care expenditures. Accountability could be enhanced if premium revenue more closely reflected actual costs. Given that most premiums are presently covered by employers as a benefit, the implications of such an initiative need to be closely examined.

The BCMA believes that access to care and the quality of care will be the key criteria applied by British Columbians in measuring the success of health system reform. Finding adequate revenue sources will be critical and should not be constrained by ideology.

RECOMMENDATION #5

Revenue for core services should remain a blend of premiums, general revenue, and co-payment.

2.0 Accountability and Prevention – Important Aides to Sustainability

2.1 Improving Accountability

Calls for expanded accountability in our health care system, whether at the political, delivery or patient level, are not new. In 1964, a federal Royal Commission on Health led by Justice Emmet Hall called for identifying the responsibilities of all those within the health care system. Moreover, the preamble of the *Canada Health Act* states that “future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians.” Better accountability leads to better use of the health care system which, in turn, can make the system more sustainable.

Few governments have sought to impose individual accountability measures for fear of political repercussions. However, in order to achieve a cooperative partnership, expanded accountability measures across the health care system are required. These measures must include those who use the system as well as those who manage it.

RECOMMENDATION #6

Increase Health Authority accountability by:

- a) Requiring Government and Health Authorities to annually publish status reports on their progress towards satisfying accessibility criteria, such as wait times.
- b) Linking Health Authority performance assessment to patient outcomes in addition to expenditure targets.
- c) Giving Health Authority Medical Advisory Committees (HAMACs) responsibility to submit, on an annual basis, a public and independent report to the Health Authority Board of Directors on clinical issues.

Increase accountability at the provincial level by:

- a) Providing each British Columbian with an annual statement of health system usage, including the associated costs of such use.
- b) Enacting whistleblower protection legislation for health professionals and administrative staff working in the Ministry of Health and Health Authorities.

2.2 Prevention – Sustainability Through Action

Prevention is a critical part of ensuring the sustainability of the health care system. Prevention activities can improve British Columbians’ quality of life and prevent or reduce the impact of many diseases. At no other time has the opportunity been so great or the impact so important around the subject of prevention in our society. Given what we know of the impact of our growing and aging population, effective prevention strategies adopted by British Columbians can blunt the impact of many trends in disease and use of the health care system. The Premier recognized the importance of this through the support of prevention campaigns such as Act Now!

While there are many worthwhile initiatives, the BCMA is focusing on four key areas that will have a significant impact on British Columbians: vaccinations, childhood health, tobacco, and

prevention incentives. Recommendations in each of these four areas should be immediately pursued.

RECOMMENDATION #7

a) *Vaccinations*

- Expand HPV vaccination coverage to include girls and women aged 9-26.²²
- Provide access to free influenza vaccinations for all British Columbians.

b) *Childhood Health*

- That the provincial government support the expansion of the Provincial Health Services Authority Health Assessment of School Aged Children Project for BC children that includes BMI measurement.
- Child health programs that emphasize nutrition and physical activity such as those included in ActNow BC should be expanded to include all BC schools.

c) *Tobacco*

- Increase funding for addictions services.
- Ban the sale of tobacco in BC pharmacies.
- Increase the BC tobacco tax to \$0.20 per cigarette or gram of tobacco and redirect all tobacco tax revenue to health care, not general revenue.

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Question #3**How can we improve health care delivery to live up to the CHA principles?**

If British Columbia is to effectively address the CHA principles as described above, important initiatives will be required. The current system must become more patient focused and deliver more available, timely, high quality and continuous care under uniform terms and conditions.

Many British Columbians have had good experiences with our health care system. This is a credit to the health care professionals that work in the system every day under increasingly difficult conditions. However, there are clearly areas where our province is not meeting acceptable standards. Waiting lists for surgery and overcrowded emergency departments are prime examples. It is unacceptable that Canadians are denied access to treatment by being forced to excessively wait for surgery or a long-term care bed, or to sit for hours in an emergency as a result of a deficient infrastructure. Our system must also ensure care for those who are marginalized due to mental illness or poverty.

Today, BC has neither enough health human resources nor acute and long-term care beds for the existing, let alone the future, population. Not only must we continue to build that infrastructure, we must also focus on supporting people in their own homes as long as is medically safe to do so. Over the next twenty years, the system will have an expanding need for enhancing care that is provided in the communities and patients' homes. How we manage the increase in chronic diseases amongst our growing population and aging seniors will be a critical factor in ensuring that the system functions effectively.

As a priority, the BC government needs to act quickly and decisively in the following critical areas:

1. Acute care
2. Primary care
3. Residential and home care
4. Health human resources

1.0 Acute Care

British Columbia is facing a considerable challenge with respect to its capacity to provide acute care. The application of the revised principles discussed above will further test that capacity.

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

System wide solutions are needed to help improve patient flow in hospitals. In the short term, the BCMA recommends adopting overcapacity protocols province-wide so that all hospitals have an organized and effective approach to manage situations where demand exceeds capacity. In addition to increasing the absolute number of acute care beds, inpatient bed capacity should be

improved by optimizing bed management such as expedited discharges and discharge processes.

RECOMMENDATION #8

That Health Authorities commit to renewable five year plans for expanding acute care bed capacity. Such plans should include:

- a) Target rates of utilization (per age/gender standardized population) for acute care services.
- b) Bed targets (e.g., funded beds per population) for each clinical service provided in HAs.
- c) Strict guidelines that all acute care hospitals in BC not exceed an average occupancy rate of 85% to allow for surge-capacity situations.

Wait times cannot be effectively reduced without substantive improvements to the province's operating room strategy. There are two approaches: bolster existing operating room capacity in the public sector, and consider more effective use of the private sector.

RECOMMENDATION #9

That government and Health Authorities expand operating room capacity in public hospitals by:

- a) Designating new "Scheduled Procedures Only" ORs in each Health Authority for chronic lengthy wait time procedures.
- b) Conducting efficiency reviews of current OR scheduling and logistics that include input from all staff (i.e. including booking clerks, porters, nurses and surgeons).
- c) Where feasible, eliminating hospital "corporate days" that involve closures of clinics, operating rooms and ward staffing.

A key component of any new strategy should include a rationalization of how the public and private sectors can be more effectively integrated. Private facilities are currently employed to deliver a variety of publicly funded health care services. The system simply would not function without this involvement.

Private facilities can frequently deliver services in a more efficient manner than publicly run hospitals and are capable of producing similar outcomes. If publicly funded insured services can be delivered more efficiently through the private sector, those efficiencies should be captured, provided it can be done within a properly regulated framework.

RECOMMENDATION #10

That government rationalize the integration of the public and private surgical and diagnostic delivery sectors. This integration must include:

- a) The regulatory framework within which both public and private care facilities function.
- b) The establishment of transparent performance and delivery standards for each facility.
- c) Contracting out scheduled procedures to reduce waitlists and achieve wait time benchmarks.
- d) Where necessary, utilization of private facilities as the safety valve if wait time benchmarks are not achieved.

The shortage of acute care beds is also a primary factor for emergency department (ED) overcrowding which has become a significant patient safety and quality of care concern in BC. The BCMA recommends setting a provincial benchmark for total ED length of stay that is measurable and linked to an accountability framework for performance assessment.

In particular, ED waits must be addressed as an immediate priority. In November 2006, the BCMA released a position statement with regard to ED overcrowding that recommended the BC government establish a maximum ED length of stay benchmark of less than six hours (from arrival to ED exit) and that all admitted patients must be transferred out of an ED to an inpatient area within two hours following a decision to admit.

RECOMMENDATION #11

Government must implement a five-part strategy to reduce emergency department (ED) waits and incorporate it into the performance agreements with Health Authorities by:

- a) Implementing maximum length of stay (6 hours from time patient enters the door) and wait time benchmark for admission to hospital (within 2 hours after the decision to admit) in every ED in BC.
- b) Adopting overcapacity protocols province wide.
- c) Expanding triage capacity immediately for EDs experiencing volume beyond their physical plant capacity, using portables if necessary;
- d) Creating regionally based “pools” of ED physicians and GPs with ED experience to provide float coverage in demand overload situations; and
- e) Introducing urgent care centres (with access to lab and x-ray services) that are in close proximity (or in hospital) to EDs that are routinely overcapacity.

Today’s acute care system lacks incentives promoting innovation and efficiency in care delivery. One method to increase operating efficiencies in hospitals and improve patient service is to increase the percentage of service-based funding (SBF) to Health Authorities, as an incentive to reduce wait lists. Under a service-based funding model, the government pays a fee for each individual cared for, based on the expected costs of treating the patient as diagnosed at the time of admission. Service-based funding creates incentives for hospitals to treat more patients, thus, reducing waiting lists.

However, service-based funding may not be suitable for all hospitals. For example, a rural hospital with a fluctuating volume of variable intensity could have difficulty sustaining a solely SBF model without a base budget. A blended funding model of block funding/SBF combination would be more flexible. Service-based funding can be targeted for scheduled procedures to increase throughput and block funding can be targeted to fixed capital costs like medical beds, ICUs, and ERs.

RECOMMENDATION #12

Government should implement a blend of block and service-based funding for Health Authorities to provide incentives to improve outcomes and performance.

2.0 Primary Care

Primary care is where opportunities to help meet some of the challenges in our system can occur. Projected increases in the prevalence of chronic conditions, ongoing concerns regarding patient access to primary care, and family physicians' increasing workloads all point to the need for further renewal in the primary care system.

Multidisciplinary care (MDC) is one possible solution to these challenges. MDC is an important component of a broader primary care approach designed to meet the need for delivering increasingly comprehensive services as the population ages and the incidence of chronic illness increases. If implemented properly, MDC can result in better coordination of care, help to alleviate physician shortages, better maximize health care resources, and improve patient outcomes (particularly for those with chronic conditions).

The use of clinical teams is becoming an increasingly important component of BC's GP Services Committee (GPSC) chronic disease management initiatives. BC has had success in using MDC teams, such as through the BCMA-sponsored Diabetes Collaborative where high levels of involvement by dietitians and medical office assistants (MOAs) were reported by participating GPs (BCMA survey 2006).

In May 2007, the BCMA and Ministry of Health launched the Practice Support Program (PSP) which will provide ongoing support to GPs interested in improving their clinical management of patients with chronic diseases, with greater assistance from their MOAs. This is a positive step towards developing MDC in BC, however, government should commit ongoing funding for MDC and undertake robust evaluations of MDC so that its impact on quality of care and cost is measured.

Despite these successes, concerns over increased costs, professional autonomy, liability, governance issues, scopes of practice, and payment methods remain.

The challenge is that today the only government support for MDC is in a community health centre/primary health care organization model. These models tend to cater to a small subset of

the GP and patient population. However, the vast majority of primary care in BC is delivered by community-based private group practice physicians.

BC cannot realize the gains of collaborative MDC if they are not implemented in physician offices, as the vast majority of British Columbians want a physician as their first point of contact with the health care system. Government must remove the administrative and financial barriers that prevent allied professionals from working within physician practices.

MDC teams should have a written delineation of responsibility and accountability that is in accordance with legislated scopes of practice. Legislated scopes of practice need to correspond to levels of training in order to ensure patient safety. Removing barriers to MDC implementation requires that regulatory bodies and professional associations be closely involved in any proposed changes to the scope of practice for allied health professionals who work with physicians.

MDC funding mechanisms should reflect these changes as physicians cannot incorporate these professionals (e.g., dietitians, nurses) without funding. Existing financial barriers to incorporating alternative care providers within physician offices must be removed in order to foster MDC.

RECOMMENDATION #13

Government must foster voluntary participation in multidisciplinary care by:

- a) Removing financial barriers to incorporating allied care providers within physician offices.
- b) Ensuring that expanded scopes of practice for allied health professionals are granted on the basis of sufficient training and demonstrated expertise.
- c) Ensuring that where health professions take on new levels of care they assume responsibility and liability for that level of care.
- d) Expanding successful General Practice Service Committee initiatives to other chronic disease management areas.

3.0 Residential and Home Care

The significant reduction of residential care beds in BC has placed considerable pressure on the acute care system as more people residing in acute care beds wait to be placed in residential care facilities. It is estimated that at least 10% of hospital beds are occupied by patients who would be better served in nursing homes, convalescent care or at home with appropriate community supports.

This, in turn, has backed up emergency departments in hospitals and resulted in serious emergency department overflows. Greater overall system costs are also incurred by the shortage of residential care beds, as acute care beds are much more costly than residential care beds.

Since 2001, government has focused on increasing the number of assisted living units. However, residential care beds and assisted living units are not interchangeable because the care needs between residential and assisted living patients are different. Although Health Authorities are

now building new residential care beds, they need to develop a longer term planning process for increasing home and community care capacity.

Adequate home care programs designed to assist patients to recuperate outside of hospitals and to live more comfortably in their own residences have not materialized. Since the late 1990s, home support services have shifted dramatically to clients with higher needs, and services have become more narrowly focused on medical tasks. The public system provides fewer and fewer daily living services such as meal preparation, shopping, housekeeping, and social contact. As a result, home support clients are more likely to rely on informal caregivers – often spouses or children – to provide preventive and maintenance care that used to be provided by home support services.

The burden of care giving can be heavy, especially for those who become serial caregivers – caring for children, then parents, then a spouse, over a period of many years. The need for respite is a key issue, as caregivers need a period of rest or relief on occasion if they are to continue in that role.

The economic burden is equally difficult. Remunerating informal care givers, either directly or indirectly through the tax system, would encourage and assist. The eligibility criteria for tax credits should be expanded to allow more informal caregivers who incur high out-of-pocket and employment-related costs to benefit regardless of their income. Another viable option is expansion of the Choice in Supports for Independent Living (CSIL) program that provides funding directly to home support clients and gives them the flexibility to purchase their own services. Under this program, family members who do not live with the client may be eligible to be paid for providing services to them.

RECOMMENDATION #14

In recognition of the existing crisis in long-term care, Health Authorities must:

- a) Develop renewable five year plans for increasing the number of funded and staffed residential care beds and assisted living units in their region.
- b) Expand home support services to meet growing demand by increasing access to, and the hours of care provided by, community health workers.

RECOMMENDATION #15

The BC government undertake pilot studies to support informal caregivers and long-term care patients, including those that:

- a) Explore tax credits and/or direct compensation to informal caregivers for their work.
- b) Expand province-wide respite relief program for informal caregivers that provides guaranteed access to respite services in emergency situations.
- c) Expand income and asset testing for residents requesting assisted living and long-term care.
- d) Promote information on advanced directives and representation agreements for patients.

4.0 Health Human Resources

Declining access to physicians is a growing concern amongst British Columbians. British Columbia requires approximately 400 new physicians each year to replace those who move, retire or die. Projections show a continued decline in the number of physicians per population as BC's population grows and ages. Even with expanded training levels, BC is not keeping pace. Sixty percent of family physicians in BC now either limit the number of new patients they see or do not take new patients at all.²³ BC has had to rely increasingly on recruiting international medical graduates (IMGs). IMGs make significant contributions toward the provision of medical services, however, to make our health system sustainable, BC should work towards self-sufficiency in producing its own medical workforce. The alternative is to tolerate a reduction in the availability of medical services at the very time that an aging population will require more services. Compounding this problem is the fact that BC's physicians are aging. The aging of BC's practising physicians represents a major concern as newer doctors are not working as many hours as their older colleagues. Younger physicians are appropriately placing more emphasis on a balanced lifestyle. Aggressive recruitment and retention strategies will be needed to bridge the gap between training programs and service vacancies.

Thankfully, BC has started to reverse this trend. In 2002, based on a commitment from the Premier, the expansion of medical training efforts in BC were aggressively pursued and BC medical student spots are increasing from 120 to 256 per year. Two hundred and twenty-four first year residency spaces will also be made available for Canadian medical graduates. Notwithstanding these increases, a number of factors indicate that BC will continue to experience significant physician shortages for at least the coming decade.

²³ College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada. Initial data release of the 2004 National Physician Survey: A collaborative project. 2004 [cited 2005 Feb 08]. Available from: http://www.cfpc.ca/nps/English/pdf/Research%20&%20Reports/Recent/Initial%20Data%20Release%202004%20NPS_Oct%2004_Updated%20Nov.pdf. As seen in the 2004 National Physician Survey, only 20% of FPs in BC said they have no restrictions and that their practice is open to all new patients. More importantly in BC, close to 60%, or 57%, of FPs said they are either partially or completely closed. From this we see significant increases since the 2001 National Family Physician Workforce Survey, in which only 4.6% of FPs said they were completely closed.

BC also has a province-wide shortage of many other health professionals, including nurses. The OECD predicts that by 2016, Canada will have the worst nurse shortage of all OECD nations, with a shortfall of up to 31% compared with demand.²⁴

It is vital that the BC government commit to a comprehensive health human resource strategy in cooperation with the health profession. Short and long-term strategies will be required to address the existing deficiencies in health human resource numbers and assure an adequate supply in the future.

RECOMMENDATION #16

The BC government must commit to a long-term health human resource strategy by:

- a) Continuing to expand BC's training capacity so that BC can meet its current and projected human resource needs with the goal of being self-sufficient.
- b) Increasing the number of residency training positions for Canadian medical graduates to a ratio of 1.2 positions per graduate.
- c) Increasing the number of residency training positions specifically for international medical graduates from the current level of 18 in 2007 (12 GP and 6 specialty) to 40 by 2010, focusing on areas of greatest need.
- d) Aggressively expanding recruitment and retention strategies to bridge the gap between training programs and service vacancies.
- e) Fast-tracking the development of training programs for physician assistants in British Columbia.

²⁴ Canadian Medical Association. Health Council sounds alarm over health human resources shortage. News Release. Jan 27, 2005.

CONCLUSION

At the outset of the Conversation on Health, the Premier asked for an open discussion about the future of our health care system. As the physicians of BC have outlined in this paper, there are significant challenges facing our health system. Inaction is no longer an option. Governments, both federally and provincially, need to take a hard look at these realities. Some of the changes required will be difficult and will need British Columbians to set aside the rhetoric that dominates health discussions today.

The BCMA remains committed to working with government towards ensuring that our health system is sustainable for patients today and tomorrow. The focus must remain on ensuring that our system can provide high quality care to patients when they need it. This submission provides some key solutions and BC's physicians urge their consideration.

LIST OF RECOMMENDATIONS

RECOMMENDATION #1

Canada's First Ministers should jointly seek an enhancement of the accessibility principle of the *Canada Health Act* in relation to core services by:

- a) implementing clear maximum allowable wait time benchmarks for all scheduled surgical and diagnostic procedures from time of referral through provision of service;
- b) providing the necessary infrastructure to ensure that "reasonable access" can become a reality; and
- c) ensuring that safety valve provisions are in place, so that if the public system cannot provide services within specified wait time benchmarks patients are able to access services elsewhere.

RECOMMENDATION #2

Canada's First Ministers should jointly seek a redefinition of the comprehensiveness principle of the *Canada Health Act*. The provincial and federal governments must define core services to include medical, hospital, pharmaceutical, home care, long-term care and inpatient rehabilitative services and ensure that British Columbians have reasonable access to these core services under uniform terms and conditions.

RECOMMENDATION #3

All core services must be subjected to cost-sharing arrangements that are applied in a fair and equitable manner, ensuring that no one is denied essential care because of their financial situation.

RECOMMENDATION #4

That the federal and provincial governments recognize a sixth principle of sustainability in the *Canada Health Act*, that meets reasonable and defined standards of:

- a) health human resources
- b) infrastructure
- c) clinical outcomes
- d) fiscal capacity

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 - Expand HPV vaccination coverage to include girls and women aged 9-26.²⁵
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- b) Increasing the number of residency training positions for Canadian medical graduates to a ratio of 1.2 positions per graduate.
- c) Increasing the number of residency training positions specifically for international medical graduates from the current level of 18 in 2007 (12 GP and 6 specialty) to 40 by 2010, focusing on areas of greatest need.
- d) Aggressively expanding recruitment and retention strategies to bridge the gap between training programs and service vacancies.
- e) Fast-tracking the development of training programs for physician assistants in British Columbia.



The BCMA's Council on Health Economics and Policy (CHEP) reviews and formulates policy through the use of project oriented groups of practising physicians and professional staff. Since 2000, the BCMA has produced the following policy reports:

- Turning the Tide I – Saving Medicare for Canadians (2000)
- Turning the Tide II – A New Course for Health Care (2001)
- Ensuring Excellence: Renewing BC's Primary Care System (2002)
- Getting IT Right: Patient Centred Information Technology (2004)
- Specialty Care in BC: A System in Distress (2004)
- Working Together: Enhancing Multidisciplinary Primary Care in BC (2005)
- Waiting Too Long: Reducing and Better Managing Wait Times in BC (2006)

The BCMA's submission to the BC's Conversation on Health was in part based on policy recommendations contained in the reports listed above. Full copies of the reports may be accessed at www.bcma.org.



