HEU Submission to B.C.’s Conversation on Health

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We are at a key turning point in Medicare’s history. Developing strategies for reforming rather than privatizing our public health services is critical to ensuring the long-term sustainability of our public system. This is the key message from the Hospital Employees’ Union to the B.C. government’s Conversation on Health.

The HEU is not alone in our conviction that health care solutions will be not be found through privatization. This is also the message of the Health Council of Canada’s 2007 report that synthesizes four years of public opinion polling (2002 to 2006) on the Canadian health system.¹

Overall findings from these polls tell an interesting story: while there has been increased attention on private provision, “Canadians remain firmly committed to universal health care,” but believe that substantive changes are urgently needed to reduce wait times and improve quality.² There is also broad support for additional home care services and a National Pharmacare Program.³ Backing up this demand for reform of public health services is the “overwhelming” agreement among the public that increased spending on health care, from both levels of government, is necessary.⁴

Strong support for our public system and the urgent need for reform were also clear messages from both the public and health provider Conversation on Health forums organized across B.C. This is quite a different message than what we heard from the provincial government at the outset of the Conversation on Health. It is clear that the government message regarding the lack of sustainability in the public system and need to privatize public health care did not resonate with British Columbians. What did emerge were lots of ideas and suggestions about how to improve public health service delivery and access.

Our submission focuses on a number of public solutions to ensure the long-term sustainability of our public health system. Before we discuss these solutions, we want to address the issue of sustainability raised by the provincial government – in particular the projection that health care costs will rise to 70 per cent of the provincial budget by 2017.

The Question of Sustainability

In the fall of 2006, both Premier Gordon Campbell and Finance Minister Carole Taylor claimed that health care spending could balloon to more than 70 per cent of the provincial budget by 2017. This claim is based on an unsubstantiated estimation of future health care expenditures of 8 per cent and an under-estimation of government revenues by 3 per cent.

It is not even supported by the finance minister’s own numbers (see Table I). If the government had developed its projection based on the average rate of increase in both
government revenues and health expenditures over the last ten years, health care spending would be at 40 per cent of the provincial budget in 2017 – less than it is currently and a far cry from the 70 per cent predicted by government.

Table I: Sustainability Assumptions and Conclusions

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<thead>
<tr>
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<th>Carole Taylor’s Numbers</th>
<th>BC Government Statistics</th>
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<tbody>
<tr>
<td>Health Care Cost Increases</td>
<td>8% increase a year</td>
<td>5.5% yearly increase from 1995-2005 (although only by 3.8% over last five years)</td>
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<tr>
<td>Government Revenue Increases</td>
<td>3% increase a year</td>
<td>6% yearly increase from 1995-2005</td>
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<tr>
<td>Percentage of Provincial Budget on Health Care</td>
<td>71% by 2017</td>
<td>40% by 2017 (in 2005 it was 43%)</td>
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We do acknowledge that the portion of provincial budget spending on health care has increased over the last ten years (from 1995 to 2005) from 34 to 43 per cent. But as a number of economists and commentators have pointed out, this increase is more a reflection of reduced revenues due to tax cuts and lower spending in every ministry other than Education, and not unsustainable increases in health spending per se. v

In fact, looking at health care as a portion of the provincial budget is ultimately measuring the wrong thing. The share of total income, i.e. gross domestic product...
(GDP), that we spend on health care is what matters, not the share of the provincial budget.

In B.C., provincial spending on health care as a percentage of our economy has remained relatively stable over the last 15 years at about seven cents on the dollar (6.8 per cent of GDP in 1991; 7.1 per cent in 2006).vi As Will McMartin, a political commentator affiliated with Conservative, Social Credit and B.C. Reform parties, notes,

There is no evidence of an explosion. Nor does the latest finance department forecast suggest that one is expected in the near future[…] Health spending, then, is increasing as a proportion of the government’s annual budget, only because the budget itself is growing smaller in relation to the B.C. economy.

Interestingly, the areas where health costs are growing fastest in health care – at more than twice the inflation rate – are those with the most private involvement, such as pharmaceuticals, medical technologies and private health care premiums.vii As Dr. Hugh Scott, President and CEO of Ontario’s Scarborough Hospital and former Executive Director of the McGill University Health Centre, notes,

Over the decade, expenditures in the public sector increased by 40 per cent, in the private sector by 145 per cent. This should provide a note of caution to those who would advocate for a greater role for the private sector in personal health care.viii

In this regard it is interesting to note that B.C. increased private sector spending by 48 per cent from 2001 to 2006. As a result, B.C. now ranks 4th in private spending in comparison to the other provinces and territories, up from 7th in 2001.ix In contrast, B.C. slipped from 6th to 9th position in per capita health expenditures between 2001 and 2006 compared to other provinces and territories. This is despite the fact that the economy in B.C. performed better than most other provinces. This suggests that there may be some potential to increase public spending on health. In his report, Is BC’s Health Care System Sustainable?, economist Marc Lee similarly notes,

By simply dedicating the same proportion of new economic output to health care – even after accounting for population growth, aging and health care inflation – we would have scope for some modest expansion of services[…] greater expansion or enrichment of public health care in the future is [also] possible but depends on societal willingness to pay more for better services and care.x

The polling results quoted in the introduction show very clearly that there is a willingness among Canadians to pay more for health care as long as the money is used to answer challenges like lengthy waits, crowded emergency rooms and staffing shortages.
Four steps to stronger public health care

Fortunately, evidence and experience show there are many concrete, practical solutions to deal with problems in public health care delivery. And while some of these solutions cost more, others will actually control the rate of cost increases over time because they shift care to the community and away from the most expensive part of the system, in-patient acute and emergency services.

These solutions aren’t rocket science. Leading health policy analysts, researchers and economists have been putting them forward for years. They’re at the core of the latest national commission on health care headed by Roy Romanow in 2002. Many of these proposed solutions have been successfully introduced in other parts of the world as well as here at home.

And these solutions work. They can strengthen public health care. But many are being ignored because every one of these solutions, if implemented on a broad scale, would raise serious doubts about the rationale for allowing more private, for-profit investment in health care.

We must heed the advice of the experts now. To do otherwise would be to risk robbing future generations of their fundamental right to access quality health care, when they need it, regardless of ability to pay.

1. Reducing waits – developing a team approach to surgical care

Lengthy waits for elective surgeries are at the core of many British Columbi ans’ frustrations with public health care – a problem described by some as ‘Medicare’s Achilles heel.’ Until public solutions are implemented province-wide, Medicare will not reach its true capacity to meet our health needs.

Effective solutions have been developed to reduce bottlenecks and improve patient flow for elective surgeries. These solutions include pooling doctors’ individual waitlists, coordinating multi-step procedures for those who need to see a series of specialists, and dedicating operating rooms in public hospitals for specialized elective surgeries.

A recent research report from the Canadian Centre for Policy Alternatives, Why Wait, Public Solutions to Cure Surgical Waitlists, highlights a number of projects in the Vancouver area that have dramatically reduced wait times for little or no additional costs:

The Richmond Hip and Knee Reconstruction Project where surgical innovations slashed median wait times by 75 per cent and increased efficiency by 25 per cent.

The Joint Replacement Access Clinic at North Vancouver’s Lion’s Gate Hospital, (a one-stop, centralized service for pre-operative and post-operative care), where the time for patients waiting for their first surgical consult was cut from
more than 11 months to just two to four weeks.

Vancouver’s Mt. St. Joseph’s Hospital, where operating room efficiencies and investments in technologies have allowed ophthalmologists to perform 50 per cent more cataract surgeries – taking 50 per cent more people off their waitlists – without any increase in operating room time.

The big story emerging from these projects is that better management of waitlists requires physicians to make the shift from working individually to working in teams – with their specialty group, primary care physicians, and other members of the health care team. These changes would require leadership from the provincial government that to date is not forthcoming.

Instead of promoting private solutions, the government should build on the success of these projects by making them the rule rather than the exception province-wide.

2. Better community care will keep people out of hospitals and emergency rooms

Hospitals are the most expensive place to provide medical care. But British Columbians are forced to turn to hospitals, particularly emergency rooms, when they lack better options for care. Overcrowded hospitals are a sign that we have not provided adequate alternatives.

Boosting preventative care and community-based services can keep health crises from developing and enable patients to be released from hospitals once their conditions stabilize.

Restore and improve home support

Home support provides cleaning and cooking, medication management, personal care, and social support for frail seniors and people with disabilities. This service acts as an early warning system by catching emerging health problems before they become crises. This can delay and even avoid more expensive long-term care and hospital services.

In 1998, Denmark introduced national legislation that required municipal governments to offer home-based services to all citizens 75 years and older, twice a year. They introduced this legislation after a local study found that seniors left on their own usually wait too long to seek help and a small amount of preventative care went a long way towards postponing and even avoiding the need for acute or long-term care services down the road.

A similar study in B.C. found that after three years overall health costs were 34 per cent higher in those health units that had eliminated basic services such as meal preparation...
and cleaning. The higher costs reflected a higher use of long-term, acute and home health services.

And yet despite this evidence, between 1997 and 2005 there was an 80 per cent reduction in access to home support for people who only require basic services such as meal preparation, cleaning and social support.

Restoring these services and integrating home support within the health care team would go a long way to postponing the need for more expensive institutional care.

Residential care that works

There are not enough residential care beds for the number of seniors who need them in B.C. today. Between 2001 and 2004, more than 2,500 long-term care beds were cut in the province. This shortage leaves seniors in hospital beds, waiting to be placed in long-term care.

An expensive consequence of these cuts is the potential for increased transfers from residential to acute care. Because there are fewer long-term beds, acuity levels are rising and there is a need for more staff and higher levels of training. But staffing levels have not kept pace with changes in resident needs.

Based on current research, we know that without enough staff to monitor changes in residents' health, ensure that they get proper nutrition and fluids, turn them in bed or assist them with walking, residents are more likely to end up with pressure sores, pneumonia, dehydration, malnutrition and broken bones from falls. These are conditions that often result in hospitalization.

A multi-disciplinary team of health professionals that includes doctors, nurse practitioners, pharmacists, rehabilitation personnel and nutritionists also reduces trips to acute care. In the Netherlands, where they have introduced these kinds of care teams into their nursing home sector, transfer rates to acute care are below 10 per cent a year.

24-7 multi-disciplinary community health clinics

Like a traditional doctors’ office, community health centres are often the first point of contact in the health care system. But they do more. They offer a team of health professionals – physicians, nurse practitioners, counsellors, outreach workers, pharmacists, dieticians and social workers – who provide a wide range of health services that can prevent and manage many conditions that lead to hospitalization.

Emergency room and hospital visits are often the last resort for people who are not able to access any other services. Those with chronic conditions, whose health is vulnerable and who require ongoing care, are particularly dependent on hospitals to meet basic
health needs. There is ample evidence to show that supporting people with chronic ailments in the community can dramatically reduce reliance on more expensive hospital and acute care services.

People living with heart disease, asthma, diabetes, depression and other chronic illnesses do much better when they have access to primary health services that include on-going support, education, nursing and outreach services along with health promotion strategies. Many of these services are funded outside doctors’ negotiated “fee-for-service” agreements. They can be provided by nurses, nutritionists, mental health outreach and community health workers.

Between 2000 and 2006, the federal government provided funding to support primary care reform in B.C. Most of this money was funneled through the health authorities to support increasing the number of nurse practitioners, expanding self-help groups for people with chronic conditions, encouraging doctors to join group practices, community clinics and more.

When the federal funding ended in March 2006, it was up to the health authorities to continue these innovations within existing budgets. The province did not provide additional funding, and as a result, many of these innovations were discontinued. Yet in 2007, the provincial government negotiated significant new funding – $422 million over four years – to support fee-for-service physicians to better manage patients with chronic conditions. The focus on physicians’ remuneration is very expensive – and problematic because it does not provide incentives that encourage multi-disciplinary care.

Provincial leadership is needed to ensure that primary care reform includes more than physicians. Providing funding directly to the health authorities to link primary care with continuing care (i.e. long-term care, home support, home nursing and rehabilitation services) is critical to make sure existing resources are used effectively to support people living with chronic conditions.

**Keep vulnerable citizens healthy**

In late November 2006, Vancouver Coastal Health reported a sharp increase in the number of Vancouver’s Downtown Eastside residents who were being hospitalized for two to four weeks with a severe strain of pneumonia. Officials believed that living conditions – homelessness, cramped single room occupancy (SRO) hotels, inadequate nutrition, untended chronic illnesses and more – led to the outbreak and the high rate of hospitalization.

Neglecting peoples’ basic needs, like decent housing and food, puts pressure on our health care system in the long run. This outbreak could have potentially been avoided if these British Columbians had the resources for improved health and decent living conditions.
People who live with mental health issues are another segment of the population who benefit greatly from preventative care. With early intervention and client-friendly community health programs, people with serious and persistent mental health issues are less likely to end up in crisis and in the hospital.

3. **Better use of our public health care investment**

Canada’s single-payer, tax-based public health care system is remarkably efficient. We spend about half as much on health care, per capita, as our American cousins. Americans pay almost three times as much in administration costs as we do in Canada. The so-called spending problem in B.C. and Canada has less to do with a lack of funds as it does with how those funds are used.

To meet our health care needs and keep health care spending within our means, we need to take full advantage of the efficiencies we can achieve within our single-payer, tax-based model.

**Control rising drug costs**

Drugs are now the second highest cost item in the whole health care system. That’s due to higher levels of prescription drug use, and the large price tag that comes with ‘new’ pharmaceuticals, which are often variations on less expensive, generic drugs.

There are solutions. B.C.’s reference-based drug program saves Pharmacare close to $50 million a year by covering the most cost-effective options in five drug categories. If this was expanded to cover a broader range of drug groups, more could be saved.

Another initiative known as academic detailing, based in North Vancouver, educates doctors directly about the costs and benefits of brand-name and generic pharmaceuticals, making them less reliant on drug company advertising. Started in 1993, this initiative now saves $1.50 for each dollar spent to run the program. There is no reason it could not be expanded to reach doctors across the province.xxii

Our provincial government also needs to work with the other provinces and federal counterparts to create a national drug strategy – one that uses our national bulk purchasing power to get better deals on pharmaceuticals, expand the reference-based program into a national drug formulary and better regulate the costs of brand-name and generic drugs.

**Invest public dollars in public infrastructure**

British Columbians are told that financing and building infrastructure projects like hospitals and roads through public-private partnerships (P3s) will save the public money. This claim is made despite the fact that there is a substantial body of evidence
from Britain, Australia and other parts of Canada to show that P3s actually drive up infrastructure costs, result in shoddy construction and reduce services.\textsuperscript{xxii}

However, in B.C., the provincial government has mandated that all public projects over $20 million be built as P3s even though the public sector can borrow capital at lower interest rates than the private sector. Case in point is the new P3 hospital in Abbotsford, where Partnerships BC admits that construction costs will run $35 million over what they would have been under a traditional public procurement.

So where are the benefits? When the accounting is done, all the projected savings from P3s turn out to be hypothetical assumptions based on ‘risk transfer.’ In the U.K., after a 15-year experiment with P3 schemes, tax-payers are outraged over cost overruns, poor design and construction, and inadequate service levels.\textsuperscript{xxiii} In 2005, the National Health Services Consultants’ Association wrote a letter to the Canadian Medical Association warning them off of P3s:

\begin{quote}
We believe that you have already experienced PFI (known in Canada as P3s or public-private partnerships) for hospital construction. This is another example of governments choosing quick, politically useful results without concern for the long-term consequences. Inevitably PFI hospitals are more expensive, as borrowing is at a higher rate and there has to be a profit for the shareholders. As a result, our first hospitals were too small. Now, although PFI hospitals must be at least as large as those they replace, many defects are appearing and the repayments – the first charge on the hospital’s budget – are causing financial problems. It is difficult to find anyone in the UK now prepared to support PFI except those in government and those set to profit from it.\textsuperscript{xxiv}
\end{quote}

Quite clearly, the continued use of P3 procurement strategies to build and maintain hospitals and other health care facilities will exacerbate rather than alleviate the sustainability crisis in our public health system. Yet the government persists. This is an area where a simple reversal in provincial policy is needed to ensure that health care infrastructure developments are cost effective and sustainable.

\textbf{4. Invest in health care workers}

There is no question that the significant and growing shortage of skilled health care workers, at every level within the health care system, is a threat to health care sustainability.

Training more health professionals requires putting additional funding into post-secondary health education programs. It also requires more innovative approaches for improving the utilization and education of the existing health care workforce.
Invest in internationally-educated health professionals

In B.C., there are thousands of health professionals, including nurses, doctors, pharmacists, dieticians and physiotherapists, who are not able to work in their chosen profession. If we invested in the technical upgrading and English language programs needed to train and certify these health care workers, the supply of appropriately trained staff could be significantly increased over the next five to ten years.

Right now, the Hospital Employees’ Union is working in partnership with the Vancouver Coastal Health Authority to support internationally-educated nurses, who are working in non-nursing roles, to become licensed practical nurses. This initiative could be expanded to include more health authorities and a broader range of health professionals.

Invest in our existing workforce

It is essential to ensure that staff working at all levels within our health care system are fully utilized and encouraged to contribute their knowledge and expertise to solving workplace problems. Transferring non-nursing duties to unit clerks and porters and increasing the role of care aides in acute care can help to address the nursing shortage. Similarly, laboratory assistants, rehabilitation assistants and pharmacy technicians can take on new responsibilities with appropriate training and support and help to alleviate shortages in these fields.

It is important for governments to value all those who work in health care if they want to attract and retain new and existing workers.

Conclusion

There is a sustainability crisis in health care but it is not due to increasing health care expenditures; rather the crisis was created by a failure of effective government leadership to enact necessary reforms to meet changing health care needs for British Columbians.

To this end we recommend that the provincial government:

1) Scale-up the very effective surgery waitlist projects so they are province-wide and cover all surgical procedures.
2) Restore and enhance preventative home support services.
3) Increase staffing and introduce multi-disciplinary primary care teams into residential care.
4) Develop 24-hour, multi-disciplinary, community-based primary care.
5) Increase housing and income support for vulnerable populations.
6) Support the development of a national drug formulary.
7) Publicly fund health care infrastructure developments.
8) Increase public investment in new post-secondary health care programs and in innovative projects to better utilize the existing health care workforce.

ii Ibid., page 3.

iii Ibid.

iv Ibid.

v BC Fiscal and Economic Review (2006), Tables A2.22 and 23 plus Budget tables 1.3
From 1999-96 to 2005-06 Social Services spending declined from 15 per cent to 10 per cent of provincial government expenditures and other Ministries (not including health, education and social services) declined from 23 to 20 per cent of provincial government expenditures.


vii Diana Gibson, Research Director, Parkland Institute and Colleen Fuller independent health researcher, Parkland Institute, president PHARMAWATCH.


