Executive Summary

BC does not have enough doctors in the right mix of specialties to meet the health care needs of British Columbians. What’s more, many of our specialists are approaching the age of retirement, and their places will not be filled quickly enough by the numbers of specialists being graduated in the province. This situation is contributing to long patient wait lists for surgery and other services.

Compensation for physicians and surgeons in BC is also affecting our ability to provide needed services, as is a lack of resources for the delivery of care. These are issues from the supply side of the health care services equation.

On the demand side, there is a need to examine the drivers of health care spending. We must recognize the significant expansion of treatments available to patients today compared to the past, and the growth in public expectations about access to those treatments. It is now beyond the ability of any provincial jurisdiction to meet all those demands and to cover all possible health care costs. Tough but informed, fair and open decisions about what should be universally available and what should be discretionary must be made. Clearly a process is needed for such decisions. Some proposals for solutions are made at the end of this paper.
The Submission

The Society of Specialist Physicians and Surgeons of BC (SSPS) is pleased to contribute to the provincial Conversation on Health. We believe our suggestions could help improve the provincial health care system – a system that directly affects every person in BC.

The SSPS represents the nearly 3,000 specialists in BC – doctors who have received specialized training in internal, diagnostic and surgical areas of medicine, i.e. all doctors who are not general practitioners (GPs). We are also consumers of health care and taxpayers. In drafting this submission, we have tried to consider the issues from the point of view of patients, who require safe, timely, and effective health services. Toward helping improve the system, we believe clear answers to some specific questions may be useful.

1. Does BC have enough doctors?

No. Federal and provincial governments made decisions about 20 years ago to reduce the number of medical school graduates to such a point that today Canada has considerably fewer physicians per capita than most similar developed OECD countries. Canada ranks 17th out of 20 OECD countries, with 1.8 doctors per 1,000 people. We are pleased that the provincial government has taken steps to reverse this trend, but given changing demographics and the very long training periods required, the benefits of these measures will not be apparent for some time.

2. How does BC compare to other Canadian provinces?

BC has fewer physicians per capita than the OECD average, but does have more doctors per capita than other provinces. However, in addition to the right number of physicians, we also need the right mix. Compared to elsewhere in Canada, BC has a surplus of 400 family doctors and a deficit of 125 specialists.

3. If BC has more GPs than the Canadian average, why do some people have trouble finding a family doctor?

BC does have more GPs than the Canadian average but still fewer than almost every other developed country. Nevertheless, in 2004, 89% of patients in BC had a family doctor – the same percentage as in 1994, and higher than the Canadian average of 86%. However, there are concerns about the future supply of these physicians because an increasing number of newly graduated GPs are choosing to work shorter hours in walk-in clinics providing brief, episodic care. Complex health problems are difficult to address in these clinics as compared to more traditional medical offices where physicians get to know their patients and their patient’s personal circumstances, sometimes over many years. The government has attempted to direct funding to more comprehensive care, but this measure may take some time to achieve results.
4. How are BC doctors paid?

The majority of doctors are paid by MSP on a fee-for-service basis. However, there are some on salary, contracts, sessional work or a combination of several different systems, depending on local or regional circumstances. As with many professions, there is a competitive national and international market for physician services. BC is most challenged by Alberta where higher payments, particularly for specialist services, attract specialists who might otherwise have chosen to work in BC. The resulting shortage of specialists affects service delivery in BC. Now that the federal and provincial first ministers have declared that the five national priorities for wait-time reduction are heart disease, cancer care, vision care, diagnostic imaging, and joint replacement, we expect that the provincial competition for specialist services will intensify.

5. What other factors besides physician income affect service delivery?

Capital spending on new equipment and hospitals is a major issue affecting service delivery. After years of restraint, recent new spending, for example on diagnostic imaging, has increased the number of CT and MRI scanners in BC. However, we still have far fewer than the OECD average, with Canada ranking 18th among 20 countries. Looking at another example, many more surgeries are done today in BC than a few years ago. However, hospitals must live within global budgets where they are paid a fixed annual amount unrelated to the volume of services delivered. With this system of funding, hospitals have no incentive to become more productive as increased work volumes simply bring greater costs with no corresponding increase in revenues. Every year hospitals in BC cut costs by reducing production such as by closing operating rooms. As a consequence, waiting lists continue to grow. On the other hand, recent experience in England has shown that a fee-for-service approach for hospitals effectively improves productivity as hospitals strive to do more work more efficiently, resulting in significant decreases in wait times. BC should consider a few pilot projects to see if similar improvements in productivity can be achieved here delivering more services without corresponding increases in costs.

We also note that the BC government’s 1991 “Closer to Home” report recommended reducing acute care hospital beds to 2.75 per thousand by 1995 (page B-100) from a level of 3.5 per thousand in 1990. This is well below the Canadian average of 3 beds per thousand population and even further below the 2004 OECD average of 4.1 beds. In fact, as the population has grown and aged, the actual number has fallen to 1.8 per thousand according to information provided by the BC Medical Association. The current acute care bed shortage has a significant impact on emergency room waiting times, critical care capacity and surgical cancellations. The result is a system that has failed to provide for even the most critical needs of the province’s citizens. The most recent example is the province’s continued undercapacity in neonatal intensive care beds.
6. Are health care costs “spiralling out of control”?

Everywhere in the developed western world, as individuals, provinces, and countries become more affluent and people live longer, more is spent on healthcare. The same is true in BC. Expressed as a percentage of GDP, healthcare spending in BC is not spiralling out of control as is frequently proclaimed in the media. In fact in 2005, at $12.8 billion, provincial government spending on health was under 8% of GDP, or in the same range as consumer spending on bars and restaurants, which no one characterizes as out of control. The difference of course, is that spending on bars and restaurants is a private expense and reflects a growing and vigorous economy, whereas health care costs are covered by the public purse.

As a percentage of total government spending, health care took up 40% of the 2005 BC budget, as compared to only 22% thirty years ago. Thus, while the economy of BC and spending on health care may be increasing at similar rates, total government spending on all services is not growing as rapidly. As a consequence, government spending on health care is taking up a larger slice of a relatively smaller pie and threatens to exceed 50% of all government spending. If we want to prevent public health care spending from squeezing out other important public programs, we must decide what are the essential health services that must be provided equally to all British Columbians and which services should be considered more discretionary.

7. Was Tommy Douglas wrong about Medicare?

Tommy Douglas’s original plan for Medicare was simply to pay the hospital and doctors’ bills. Canadians are justifiably proud of a medical system that ensures no family is denied treatment or is financially ruined by unexpected crises such as the need for emergency treatment for car accidents or cancer. However, the range of possible treatments and accompanying public expectations has dramatically changed in the decades since Medicare’s introduction. Given that no state or person can afford all possible treatments, we have to make hard choices to allocate public health care spending.

8. How should funding decisions be made?

The fact that making allocation decisions about spending on health care may be difficult does not excuse us from the exercise or justify a less-than-honest approach. We think that the debate should be as open and explicit as possible. The challenge is to stand firm in the face of painful realities. A good example of the conflict between long-term rational policy and short-term sentiment is the hypothetical case of the “missing pilot.” Based on a review of evidence, a panel of experts could decide that the cost of keeping aircraft and personnel in remote locations as part of a search and rescue program in the Eastern Canadian Arctic makes no sense. However, as soon as a pilot goes down in that region, we are inclined to spend enormous sums on the search, since we are no longer dealing with a theoretical problem but with a real person. Exactly the same issue confronts us when we decide that spending hundreds of thousands of dollars on drugs or
other treatments to extend someone’s life by a few months is not justified, but then are persuaded to relent when confronted with the face, name and family of one such individual. Unfortunately, such decisions, however understandable in the circumstances, may cost others access to much more rationally justifiable treatments, such as the ability to walk pain-free for many years.

9. Are there any fair and open ways to make funding decisions?

In theory there are good ideas, including the Oregon Plan and Medical Savings Accounts. In practice, neither of these concepts has been shown to improve service or reduce costs. The Oregon Plan is the most direct method. In this model, each year a decision is made about the total amount of public spending on health care. Based on available funding, services are offered down to a defined cutoff beyond which there will be inadequate funds. A panel of experts assisted by members of the public determines what constitutes the bundle of available services. Each year, the fund pays for a defined volume of work and services such as all emergency treatment to save life and limb, and a defined number of joint replacements, cataract operations, diagnostic tests and pharmaceuticals. Very expensive treatments with limited evidence of benefit are at the lower end of the list of priorities and might not be funded. The plan thus advocates explicit rationing by de-listing services.

Unfortunately, in Oregon the plan generated considerable controversy and has not achieved a reduction in public health spending. No other jurisdiction has been able to successfully implement a similar plan.

Medical Savings Accounts shift the locus of control for spending to patients instead of third parties like administrators to improve efficiency and reduce costs. Again, the plan sounds sensible, but an analysis of its implementation in Canada suggests it might actually raise costs by increasing spending on the relatively well (80% of patients consume less than $600 a year in health care) and might only produce modest savings by severely rationing care for the sickest patients (the 1% who account for more than 25% of annual health care costs).

A made-in-BC solution could include an explicit analysis of the areas of major spending and an open debate about the appropriateness of those areas of care and expense. For example, a move to better palliative care and death with dignity programs, with less emphasis on aggressive treatment where there is little benefit, could be an area for study, and could help contribute to a more sustainable system. We cannot afford to delay this type of discussion any longer.

We trust the comments and suggestions in this document will help move the conversation forward. The SSPS values our health care system and is deeply concerned about making the necessary improvements to ensure all British Columbians receive excellent health service whenever needed. We welcome any questions, concerns, and alternative points of view.
Proposals

1. Recognizing that current medical school expansion will have little impact on manpower needs for the next 10 years, BC should establish an aggressive recruitment strategy to ensure we attract the appropriate number and mix of physicians from out of province. Priorities should be based on objective data.

2. The BC government should work with the health authorities on a variety of pilot projects to determine if fee-for-service funding for certain services can improve hospital productivity.

3. A breakdown of the major areas of health care spending in BC should be published to help generate recommendations regarding priorities.

4. Funding must be based on a rational appraisal of results. By recognizing that spending on interventions with limited benefit affects our ability to fund more effective treatments we are obliged to make hard choices.

The SSPS would like to thank Dr Richard Eddy for his major contribution to this submission.